THESIS

Municipal Public Health Planning and Implementation in Local Government in Queensland: Achievements, Barriers and Success Factors

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Abstract

The furious pace of global urbanisation has serious impacts on the long-term sustainability and health of the local communities in which we live. The debate about relationships between population size, environmental management and human well-being must now encompass the fundamental concept of sustainability (Rees, 1992; WCED, 1990; McMichael, 2002; Hancock, 1996). Increasingly, the local municipal level is the most influential setting in which to change our relationship with the environment (Chu, 1994; Chu et al., 2000).

In the 1980s, the World Health Organisation (WHO) met this global challenge by advocating healthy public policy and laying foundations for its global Healthy Cities Movement. Significant support developed in the early nineties for participatory health planning action in local government: over 2000 cities worldwide developed municipal public health plans (MPH Plans). The Healthy Cities Movement through regional networks of cities and towns encouraged government partnerships with non-government agencies and industry, to anticipate and mitigate urbanisation’s negative impacts. In Queensland eighteen local governments have developed and implemented MPH Plans using a seven-step process (Chapman and Davey, 1997; WHO (1997b) to improve local planning for health and address the social determinants of health through agency collaboration.

There is however limited understanding and evidence of the success factors for the effective implementation of MPH Plans. Studies of the evaluation of Municipal Public Health Planning (MPHP) approaches have focused predominately on the evaluation of the process of planning, without conducting comprehensive evaluation of its implementation. The organisational barriers that contribute to ineffective health-planning implementation have not been well researched and documented. Here lies the gap in the research: MPHP requires thorough qualitative assessment, not only of the planning process, but also the implementation impacts.

This research explores the achievements, barriers and success factors associated with MPHP implementation in local government organisations by developing a process and impact evaluation framework and applying it to two MPHP projects in Queensland: one, local planning in an expanding tourist city of over 400,000 people; the second, a regional approach involving two provincial cities with a combined population of 100,000 residents. The research examines the degree of collaboration resulting from health planning and assesses if the aims of the MPH Plans have been met. MPHP is both a health promotion tool and a strategic business planning process applied in local communities: this research seeks to understand more about organisational strategic management issues that act as barriers to planning or impact on the success of planning outcomes.

This study design uses qualitative methods with a triangulation approach to analyse and understand the complexities of MPH Plan implementation. Grounded theory provides a methodology for interpreting
meanings and discovering themes from the comprehensive process and impact evaluation consisting of preliminary cases studies, key informant interviews, using specific process and impact indicator questions and an analysis of MPHP models compared to other CPHP models and legislative frameworks. The impacts of the intervention are discussed and relate to the implementation effects of MPHP on individuals and organisations including council, government and non-government agencies and on the community.

Achievements and barriers associated with MPHP are identified and discussed. Three main factors emerged. Firstly, MPHP had significantly increased the degree of intersectoral collaboration between the agency project partners, with particular success in clarifying the role of agencies in the management and delivery of public health services. The principles of successful partnerships need to be further articulated in local government settings to successfully implement MPHP. Secondly, positive political and organisational support was found to be a critical factor in the success of the planning implementation. Thirdly, and most importantly, the aims of the MPHP had not been substantially met due to a lack of financial and human resources. The study concluded that, although MPHP has strengths and weaknesses compared to other CPHP models, its features most suit local government.

Success factors recommended for effective MPHP include formalising collaboration and partnerships and improved agency organisational governance in planning; building individual and organisational capacity to strengthen strategic planning; integrating the many layers of regulatory planning in local government and other agencies; sustaining planning structures and processes through regulation and commitment to investment in implementation stages of MPHP. The study’s major recommendation is that, for MPHP local government should facilitate a three-dimensional platform approach: healthy governance – long-term vision, recognising the many layers of planning, supported by state legislation and local industry and with awareness of legislative planning frameworks; a platform mechanism – sustaining agency networking, hosting the stakeholder forum, supporting the advisory committee, enhancing communication; and strategy implementation – in the context of an improved understanding of organisational behaviour, local government and agencies must action priority strategies, formalising agency partners responsibility, articulating desired outcomes, monitoring progress and evaluation.

This recommended Platform Approach to MPHP provides an effective model for managing and implementing future MPH Plans, allocating resources three ways: to build people’s capacity to engage in planning mechanisms, to build organisational capacity to manage planning outcomes and to build more effective Healthy Cities planning approaches. The MPHP evaluation framework developed in this thesis could be used to evaluate other MPHP projects in local governments both in Australia and internationally.
Declaration of Originality

This thesis presents the original research of the author. This work has not been previously submitted for a degree or diploma in any university. To the best of my knowledge and belief the thesis contains no materials previously published or written by another person, except where due reference is made in the thesis.

Signed

Peter J Davey
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ASEAN</td>
<td>Association South East Asian Nations</td>
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<td>CDHAC</td>
<td>Commonwealth Department of Health and Aged Care</td>
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<td>CHP</td>
<td>Community Health Plan</td>
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<td>CPHP</td>
<td>Community Public Health Planning</td>
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<tr>
<td>CPHPR</td>
<td>Community Public Health Planning Review</td>
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<tr>
<td>CPHPRRP</td>
<td>Community Public Health Planning in Rural and Remote Areas Project</td>
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<tr>
<td>CPHUN</td>
<td>Central Public Health Unit Network</td>
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<tr>
<td>CR</td>
<td>Community Renewal Project</td>
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<tr>
<td>DEO</td>
<td>Desired Environmental Outcome</td>
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<td>DLGPSR</td>
<td>Department of Local Government, Planning, Sport and Recreation</td>
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<tr>
<td>EPA</td>
<td>Environment Protection Authority</td>
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<td>ERA</td>
<td>Environmental Relevant Activity</td>
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<td>ERAG</td>
<td>Eagleby Residents Action Group</td>
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<td>ESD</td>
<td>Ecologically Sustainable Development</td>
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<td>GCCC</td>
<td>Gold Coast City Council</td>
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<td>HBCC</td>
<td>Hervey Bay City Council</td>
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<td>HCM</td>
<td>Healthy Cities Movement</td>
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<td>IDAS</td>
<td>Integrated Assessment Development System</td>
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<td>IPA</td>
<td>Integrated Planning Act 1997</td>
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<td>IQ</td>
<td>Implementation Questionnaire</td>
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<td>KI</td>
<td>Key Informant</td>
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<td>LA21</td>
<td>Local Agenda 21</td>
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<td>LAP</td>
<td>Local Area Planning</td>
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<td>LG</td>
<td>Local Government</td>
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<tr>
<td>LG Act</td>
<td>Local Government Act 1993</td>
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<td>LPF</td>
<td>Legislative Planning Framework</td>
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<td>MCC</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MPH Plans</td>
<td>Municipal Public Health Plans</td>
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<td>MPHP</td>
<td>Municipal Public Health Planning</td>
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<td>MERIT</td>
<td>Monitoring, Evaluation, Review, Implementation Committee</td>
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<td>NEHS</td>
<td>National Environmental Health Strategy</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NPHP</td>
<td>National Public Health Partnership</td>
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<td>OB</td>
<td>Organisational Behaviour</td>
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<td>PAR</td>
<td>Participatory Action Research</td>
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<td>PHP</td>
<td>Public Health Plan</td>
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<td>QCPH</td>
<td>Queensland Centre for Public Health</td>
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<td>RFGM</td>
<td>Regional Framework for Growth Management</td>
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<td>ROC</td>
<td>Regional Organisations of Councils</td>
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<td>SEAL</td>
<td>Supportive Environments for Active Living</td>
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<td>SEQ</td>
<td>South East Queensland</td>
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<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>TWG</td>
<td>Intersectoral theme working groups</td>
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<td>WBRPHP</td>
<td>Wide Bay Regional Public Health Plan</td>
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<td>World Health Organisation</td>
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CHAPTER 1 INTRODUCTION

1.1 Introduction

The furious pace of urbanisation across the world is seriously impacting on the long-term sustainability and the health of local communities in which we live. There is growing awareness that the debate about the relationships between population size, environmental management and human well being that can no longer ignore the fundamentals of sustainability (WCED, 1990; Rees, 1992; Hancock, 1996; McMichael, 2002). In the eighties, as a response to this global challenge, the World Health Organisations (WHO, 1986) advocated for the building of local healthy public policy laying the foundations for a global Healthy Cities Movement (HCM). It has become increasingly apparent that the most influential setting to change our relationship with the environment is at the local level, particularly at the municipal setting (Chu, 1994; Chu et al., 2000). Over 2000 cities worldwide have developed municipal public health plans (MPH Plans) as a local response to managing rapid urbanisation.

Through its regional network of cities and towns the HCM encouraged government agencies when planning their cities to consider a partnership approach with non-government agencies and industry to mitigate the negative impacts of urbanisation. By adopting the core principles of the HCM, which included intersectoral collaboration, community participation and sound environmental management, local governments were empowered to think globally and act locally while developing multi-sector health planning (see WHO, 1986; Kickbusch, 1996). In particular, intersectoral collaboration enabled local agencies to collectively plan and improve declining social determinates of health (Chu and Simpson, 1994; Baum, 2002). Australia responded to this global challenge and developed a national public health partnership (NPHP) approach, with state and territory health agencies working in partnership. The NPHP introduced new public health management approaches to sustain environments and improve population health (NPHP, 2000). In several Australian states, including Queensland, state governments encouraged local councils to develop needs-based participatory municipal public health plans (Chapman and Davey, 1997; Baum, 2002).

In general the outcomes of municipal public health planning (MPHP) project research indicates that the initial phase of planning (the process of developing the plan) significantly increased the level of intersectoral action and placed health issues on the local agenda. The multi-sector MPHP committees that are established to coordinate the plan are a successful policy mechanism to increase joint agencies’ health outcomes. There is generally however limited understanding and a lack of evidence of the effectiveness of the implementation phase of health programs.
Takano et al., 1992; Rohrer et al., 1998; Cassidy et al., 2005). Cassidy et al. (2005) comment that even the most effective program faces two challenges: maintaining or expanding its capacity and sustaining its effectiveness over time. The process issues and impacts of MPHP implementation have not been examined comprehensively in Queensland to assess its sustainability over time. The success factors for effective on-going implementation of the MPH Plans, and in particular the organisational barriers for participating individuals, government organisations and community agencies that contribute to ineffective health-planning implementation, have not to-date been well documented.

The aim of this research is to evaluate both the process and the impacts of the MPHP projects under investigation. By investigating the achievements to date and barriers to the effective implementation of MPHP in local government settings in Queensland, success factors are discovered for the management of more sustainable MPHP implementation. There is a gap in the research base for MPHP models in local government organisations in Queensland. There is limited analysis of the impacts of MPHP, and only rarely is there an examination of the relationship between health promotion concepts, organisational behaviour, strategic management and the effective governance of MPHP. This knowledge is critical if we are to facilitate health planning as a way of improving the capacity of individuals, organisations and communities to sustain their environment and improve their health. In a competitive organisational environment, where resources are scarce and there are increased demands for evidence of planning project effectiveness, further evaluation of the implementation phase of MPHP is warranted. Because of the lack of evidence to support the success of MPHP implementation, the continued funding of these initiatives has been threatened and the desired direct and indirect health benefits to communities reduced.

This Chapter firstly introduces the contextual fields of the study. It discusses the concepts of urbanisation and health along with the global sustainable development challenges, the emergence of the ecological public health and the approaches of the HCM. It argues that strategic action through participative health planning is the most effective local level response to address health problems in communities. Secondly, the chapter will overview the partnership approach, linking health promotion action and the regulatory environment to more effective models of participatory health planning in organisations. Thirdly, it discusses the influence of organisational behaviour and strategic management on the governance of MPHP. Finally, it will explain the aims and purpose of the research, nature and scope of the research, research methodology and the structure of the thesis.

1.2 Background

Increasingly people are making connections between rapid urbanisation and the corresponding ecological crisis confronting the planet. According to the Chairperson of the World Commission
on the Environment (WCED, 1990, p.xvi) ‘there are environmental trends that threaten to radically alter the planet, that threaten the lives of many species upon it, including the human species’. It is clear that environmental, social and economic development go hand in hand, that there can be no health without socially and environmentally sustainable economic development (see Rees, 1992; Brown, 1994; Hancock, 2000; Goldie et al., 2005). The consequences of urbanisation make a major contribution to global environmental changes that threaten the very existence of life in the future; changes in the local environment increasingly affect health and social conditions in cities (WCED, 1990). Human development is intimately linked to improved human health and well-being. Throughout the world there is an increasing realisation of the need to respond to the negative impacts of urbanisation on local ecosystems. The fate of the world may well be decided at a local level in the cities and towns and villages (Ashton, 1992).

Over a decade ago, John Ashton (1992, p.23) commented that:

The rationale for focusing on public health in towns and cities is strong. The problems that were described in British Cities 150 years ago are all to be found in these cities today, albeit on a much bigger scale and with much greater consequences.

The WHO initiated the HCM in the late 1980s to implement the health promotion action areas of the Ottawa Charter in local community settings. The Healthy Cities approach encompasses variety of people, institutions, cultures and activities (Duhl, 1993). The WHO’s Healthy Cities program is based on a number of key principles (WHO, 1997b):

- Health should be an integral part of urban settlement management and development
- Health can be improved by modifying the physical, social and economic environment
- Conditions in settings such as home, school, village, workplace and city profoundly influence health status, and
- Intersectoral coordination for health is necessary at the local level.

Urbanisation has required city government to focus on improving land use and the built environment to cater for increasing densities and development activity; however, in this process they may have failed to adequately address the deteriorating social determinants of health caused by this development. A renewed emphasis on a more social view of health in communities was endorsed at the First International Conference on Health Promotion (WHO, 1986). The Charter clearly defined five important health promotion action areas to improve health in settings, including cities and towns: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (WHO, 1986; Kickbusch, 1996). The Bangkok Charter for Health Promotion of
2005 endorses these principles and purposes of health promotion as laid out in the charter and the subsequent global conferences held in Adelaide, Sundsvall, Jakarta and Mexico City.

The HCM has grown from strength to strength and continues to influence the health policy of participating governments and cities across the globe. The Alliance for Healthy Cities in the Asia Pacific Region (the Alliance) continues to promote the philosophies of the HCM. With support from the WHO the Alliance developed a collaborative organisational structure in 2002, which has grown to a network of over 39 member cities and agencies (Davey and Murray, 2003). Each member is working towards meeting the requirements of the Charter of the Alliance. This charter gives the responsibility of building healthy alliances to member local governments to work in partnership with local agencies and other member cities in the region. The Alliance requires members to develop demographic health profiles and a MPH, and to provide evidence of organisational policies that reflect the principles of the HCM. Comprehensive city health profiles represent key products of a Healthy Cities project and act as a basis for advocacy, for the setting of priorities and proved evidence of health issues (see WHO, 1994).

The HCM supports an ecological public health concept promoting equity, advocating for community participation and requiring collaborative multi-sectoral approaches when improving the health and environment in communities (Hancock and Duhl, 1988a; Duhl, 1992; Duhl, 1993; Chu and Simpson, 1994). The ecological public health concept advocates for a ‘settings’ approach that links and networks the local health and the environment actions of agencies. Tsouros (1995) noted for the first time that with the majority of the human species living in towns or cities we now have a desperate global need for the innovation and networking characteristic of the Healthy Cities network. A more holistic and integrated approach is then needed at the local level to provide physical, social and economic environments networking agencies that promote and maintain the health of populations (see Chu, 1994).

Creating settings for healthier and more sustainable cities requires new approaches to city planning at the local level. Each city has its own culture and diversity, its own political agenda and organisational capacity to respond to these global and local challenges. Traditional public health actions have focused on disease control and environmental protection, particularly in the areas of water quality, waste management, sanitation, and environmental protection (see Hamlin, 1998). These remain of paramount importance, but can no longer be viewed as adequate to address the complex range of factors that determine people’s health and well-being.

In Australia in the early nineties, to encourage the development of the HCM, the national government funded a national Healthy Cities program for three years (Baum and Brown, 1989; Ashton, 1992; Ashton, 2000; Ashton, 2002; Baum, 2002). The Queensland State Government adopted a partnership approach, supported the Healthy Cities thinking and funded the
Queensland Healthy Cities and Shires Project (Chapman and Davey, 1997; Dwyer, 1997). This network of agencies developed demonstration health projects using a partnership approach. The Health Promotion Branch of Queensland Health then facilitated small grants via a competitive grant to a local University to encourage local government to develop and implement MPHP. To initiate these plans Queensland Health (over a 5-year period to 2002) provided nine communities with seeding funding to commence the process (Chapman and Davey, 1997). Eighteen cities and shires in Queensland have since developed MPHP (Davey, 2004). MPHP was the first participatory health planning model to be developed in local government in Queensland. Queensland Health has more recently encouraged several other alternative health planning processes to be trialled in communities. These alternative processes are referred to in this research as community public health planning (CPHP). As late as 2005 several local governments and universities in Australia have become members of the Alliance and are continuing to implement the timeless philosophies of the HCM (see Davey and Murray, 2003).

Duhl (1992; 1993) discusses how our inability to develop systems of governance, which respond to the diversity and complexity evident in planning cities, helps explain why city authorities have proved so ineffective at addressing urban problems (WCED, 1990). There is a sense that politicians, city managers, agency decision-makers and health and environment professionals working in national and state local agencies may, for a range of reasons are contributing to the problems of an unhealthy city rather than working together across the sectors towards solving the problems. Local government and agency staff engaged in health planning require a variety of skills to be effective planners, including political awareness, health promotion skills, partnership building approaches, regulatory knowledge, experience in strategic management and planning and program evaluation expertise (see Duhl, 1993).

To create a healthier future for cities, communities must become engaged in and influence city development, and be part of the overall reform of city governance that places healthy environments and human development at the centre of concern (see Duhl, 1993; Hancock, 1996). The process suggests that developing solutions to problems on a community-wide basis requires partnerships between local government departments and agencies, both government and non-government. Hancock (1998) points out that partnerships between the public sector and local private industry will assist with improving the health of people, communities and the environment. There are also political elements that impact on the quality of life of cities, including promoting political commitment to health, advocating for a fundamental change in the local government relationship with its community and engaging participatory activities both within organisations and with outside agencies. In fact, the linkage between health promotion, organisational action and effective planning mechanisms has not been evaluated comprehensively. Improvements in these processes will directly and indirectly improve the health of populations.
It is important initially to understand the context of the HCM and MPHP approaches in Australia. While the approach helps local government and other stakeholders to develop partnerships and to collaborate, the end product is a dynamic strategic planning document that guides future local health actions (Chapman and Davey, 1997). Unfortunately the roles of state and local government and other agencies in the delivery of health programs and services are unclear and further research is required to understand the reasons why. The MPHP process in Queensland clarifies the participating agencies’ responsibilities for health strategies. Agencies have attempted to review their organisational structures to improve their effectiveness to deliver services (Davey and Logan, 2001a; 2001b). Local government has a legitimate leadership role in planning and building future healthy and sustainable cities for many reasons: it is a democratic organisation possessing political decision-making structures and having support from a political, bureaucratic, professional and technical administration, it has economic and resource capacity and opportunities for community participation and it is also required by legislation to develop integrated town plans and internal corporate plans.

MPHP is primarily a health promotion tool, a form of organisational strategic management for health at the interface of local government with the community it serves. This thesis argues that this interface has not been recognised by WHO or by participating agencies and for that reason its application may have been deficient. In fact, MPHP has been reported as a troubled testing ground for the application of strategic planning and strategic alliances (Eagar et al., 2001). If the MPHP is to be a successful tool in tackling the social determinants of health, it is important that the lessons of public health planning are understood (Garrard and Schofield, 1991; Smith, 1995; Harris and Wills, 1997). More rigorous evaluation of both the planning processes and the implementation impacts of MPHP is necessary if governments are required to continue to invest in this approach. This research will develop a process and impact evaluation of MPHP projects in Queensland and thus add to the body of knowledge on health planning and implementation processes.

The increasing international and national support for the HCM and its related health promotion and planning activities has increased the focus on their evaluation. One of the major challenges for Healthy Cities projects has been how to adequately evaluate them (Baum and Brown, 1989). The purpose of program evaluation of health and development work, including the evaluation of the planning models, is to measure the effectiveness of actions that can improve health. The HCM advocates for the formulation and adoption of local municipal public health plans (MPH Plans) and their evaluation. Broad models of participatory health and environment planning are being applied and tested in communities. These planning projects are demonstrating new ways to develop partnership approaches, improve strategic planning outcomes, build organisational and community capacity for engaging in needs-based planning, and facilitate community involvement in decision-making about local quality of life issues. MPHP is a political and
strategic management mechanism, within the organisational context of local government, which is designed to address the social determinates of health and improve the quality of life of residents in communities. Dwyer (1997) comments that the infrastructure for health-promoting-environments programs in terms of policy formulation, program design models and training was established [to support MPHP] and that the following stage was to promote sustainable and transferable health promotion programs in an increasing number of sites. Over 100 local governments are well placed to facilitate participatory health planning in Queensland, so far eighteen have adopted this policy approach: its evaluation will assist with decision making about its sustainability.

In summary, the MPHP process advocates for the formation of partnerships between local agencies with similar objectives to work together to improve health outcomes. Recent (since 2005) legislative requirements introduced into the Local Government Act by Queensland Health have provided a renewed interest, but still no mandate for Healthy Cities approaches and MPHP in local government. MPHP is not linked to town or corporate planning processes by regulation: there is however a new requirement for Councils to provide annual public health management reports. These recent changes require Councils to consider public and environmental health matters in the formulation of a corporate plan, strengthening the case for more effective planning tools, like MPHP.

1.3 Nature, Scope and Aim of Research

The thesis argues that the MPHP initiatives in Queensland will not be effective until local governments work with other government and non-government agencies and direct their resources to capacity building of individuals, organisations and communities and the planning models – not just to the initial MPH Plan development stage, but to the ongoing plan implementation. The scope of the research covers the following conceptual fields: urbanisation, sustainability and health; the HCM and the ecological public health; partnerships and health promotion; participatory health planning and the regulatory environment and organisations, strategic planning and MPHP governance perspectives. There are relatively few published articles to guide health professionals on the effective implementation of MPHP. The literature does provide examples of project achievements from process evaluation of the development phase of MPHP, but there is limited research on effective MPHP implementation: its achievements, barriers and success factors. MPHP is both a health promotion tool and a strategic business planning process applied in local communities: this research seeks to understand more about health promotion and organisational strategic management issues that act as barriers to planning or impact on the success of planning outcomes.

The research asks the question: What are the achievements of, barriers to and success factors for MPHP processes and implementation in local government?
The objective of the research is to develop and apply a process and impact evaluation framework to two MPHP projects:

- To investigate the extent to which the aims of the MPH Plans have been achieved
- To investigate the impact of the implementation phase of MPH Plans
- To compare and analyse the MPHP process to other state-wide participatory planning processes, documenting strengths and limitations
- To identify the success factors for effective MPHP, and
- To develop an effective MPHP implementation model.

Qualitative evaluation of the implementation phase of Healthy Cities’ participatory planning is neither well developed, nor documented: this research aims to fill this gap in knowledge. The aims of this research are to evaluative the process and impacts of the MPHP projects. There is a gap in the research base for the MPHP model. This thesis investigates the achievements and barriers to effective implementation of MPHP in local government organisational settings in Queensland so as to discover planning success factors and to construct an effective MPHP implementation management model. There is limited investigation into the impact of participatory health planning, and only rarely is there any analysis of organisational behaviour, strategic management, governance and monitoring issues. This knowledge is critical if we are to improve the capacity of individuals, organisations and communities to sustain their environment and improve their health.

The following wider questions were proposed during the research: Does intersectoral collaboration promote the implementation of MPHP? Do local governments build their organisational capacity and strategic management practices to engage adequately and legitimately in MPHP? Do partner organisations address governance measures to ensure their agencies’ strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the MPHP? Do local government and agency professionals have the legitimacy, resources and capacity to implement the strategies in the MPH Plan?

1.4 Methodology

The research was conducted over the period June 2000 to June 2006. The qualitative methodological framework designed for this study was the result of an extensive review of Healthy Cities evaluation methodology. Indeed, at the city level, qualitative studies of networking structures and processes are still rare in comparison with quantitative ones (Springett et al., 1995; Shiell and Hawe, 1996; Taylor-Powell and Rossing, 1996). Degeling (1995) argues that such network studies are urgently needed for understanding the real barriers to change in the development of healthy public policy.
Figure 1 illustrates the methodology framework of the research thesis, using a flowchart that describes the five stages of the qualitative research namely literature review, study design, methodology and data collection, findings and results and discussion and conclusion and recommendations. Each stage represented on the left side of the flowchart is supported by further detail (on the right side of the chart). The literature review has three contextual fields, which are described in detail in the thesis.

The study design involves the development of an evaluation framework with three stages of data collection and analysis methods. Firstly, an examination is made of the MPHP process through case studies, which include document analysis and preliminary process evaluation. Secondly, a MPHP Implementation questionnaire is constructed and tested on two MPHP projects. The research determines more specifically whether the aims of the two MPHP projects under investigation have been achieved; then from this knowledge it analyses the impacts of the implementation of the MPH Plans. Thirdly, the study examines the strength and limitations of the MPHP model and compares it to other community public health planning models (CPHP) in Queensland. This research uses a triangulation approach to investigate the success factors for effectively implementing MPHP (Baum and Cooke, 1992; Funnell et al., 1995; Shiell and Hawe, 1996; Taylor-Powell and Rossing, 1996).
The research examines the two stages of planning, namely, the initial plan development stage over a one-year period (process evaluation), followed by the plan implementation stage (impact evaluation), usually over the next three to five years. In this study, lessons learnt from the process evaluation in the preliminary case studies guide the impact evaluation. The Implementation Questionnaire (IQ) developed for Phase 2 commences with specific indicator questions about the process of implementing a MPHP (analysing the holistic aims of the MPHP projects), before focusing on the specific indicator questions regarding the implementation outputs of MPHP projects.

For the purposes of an accurate representation of the achievements and barriers relating to MPHP projects, it was decided to include both process and impact evaluation. In fact other researchers (Speller and Funnell, 1994; Funnell et al., 1995; Taylor-Powell and Rossing, 1996) indicated a similar approach when examining the implementation of healthy alliances in projects in England, arguing that it was difficult to separate planning process and planning impact evaluation.

1.5 Structure of Thesis

The thesis is in three main parts, after an introductory chapter: a total of 12 chapters. The three parts contain the literature review, the methodology, and the findings, discussion, conclusions and recommendations of the research. Chapter 1, the introductory chapter sets the scene of the research in the context of the thesis, develops the rationale, scope, nature and aim of the research, and the study methodology, then highlights the structure of each chapter.

Part 1, the literature review, includes Chapters 2 to 4. Chapter 2 reviews urbanisation, sustainability and health, discusses the emergence of the ecological public health, settings and health promotion and reviews the literature on the Healthy Cities approach. In this context, the chapter discusses the broader issues of the ‘global challenge’ of continuing improvements in health and environmental sustainability, particularly in a world of increasing urbanisation (Ashton, 2002). The WHO Healthy Cities approach is explained as a useful strategy in developing partnerships for health action in communities. This chapter argues the need for health planners to understand and apply the concepts of ecological public health in local government settings. In the light of the global challenge of managing unsustainable urban growth, participatory health planning is discussed as a ‘local response’ to these problems. The chapter concludes with an argument for an increased need for city health planning practices.

Chapter 3 reviews the literature on effective partnerships as an essential element of health promotion action when developing participatory health planning at the local level. The rationale of the chapter argues that partnerships are the key strategy for stimulating more effective health planning (and more specifically MPHP), and also that an understanding is required of the
history of partnership thinking both globally and locally. Chapter 3 argues that the principles of successful partnerships need to be further articulated in local government settings to successfully implement MPHP. Finally, the chapter analyses how best agencies can deal with participatory health planning in a complex legislative environment that regulates land use and town planning. Participatory planning in Queensland is not mandatory under legislation; even so it is guided by state and local government regulation and policy. A selection of health planning models and legislative planning frameworks trialled in Queensland will be reviewed and the salient features of each model examined from the basis of this understanding.

Chapter 4 examines organisations, strategic planning and MPHP governance. Having discussed in the previous chapter that health promotion philosophy is a foundation for MPHP, this chapter introduces other foundation philosophy, namely organisational behaviour (OB) and strategic management. The literature is reviewed to provide an understanding of the definition of management, namely planning, leading, coordinating and controlling. This chapter argues that there are linkages between organisational behaviour and strategic management and the governance of MPHP that are influenced by a changing external environment. Organisations working jointly on MPHP may need to modify their strategic management practices to build their capacity to deliver effective intersectoral approaches to health planning in communities. The chapter concludes that local government must be resilient to changing organisational culture and environmental factors when developing and implementing health-planning processes integrating strategic management and health promotion practice.

Part 2, Methodology, has two chapters. Chapter 5 investigates evaluation methodology that can assist with a greater understanding of how best to assess Healthy Cities and partnership approaches and health planning initiatives. This chapter discusses how to choose a methodological approach, by reviewing the theoretical traditions of qualitative research. In the context of understanding how to evaluate health promotion programs and providing techniques for evidence based health promotion, the chapter describes and examines process and impact evaluation as an appropriate framework to assess MPHP projects.

Chapter 6 develops the research design and conceptual framework of the study, and describes the research rationale, aims and specific objectives. The study design and methods adapted from discoveries in chapter 5 are applied in this chapter to develop the study’s qualitative evaluation framework. Three phases of data collection methods are detailed. Justification is provided for the links between the study design and the research interview questions, with specific discussion about how interview questions inform the evaluation frameworks. Methods of data analysis are discussed and grounded theory techniques are explained as the most suitable to allow exploration of meanings and interpretations from the case studies, key informant responses and comparative analysis in this research.
Part 3, the Findings and Discussion of the research, comprises Chapters 7, 8, 9, 10, 11 and 12. The triangulation approach to data collection methods included the use of document analysis, key informant interviews and document mapping. Three phases of data collection and analysis contribute to the evaluation framework in the research. Phase 1 of the data collection is described in Chapter 7 and 8. Chapter 7, a case study of the Gold Coast Community Health Plan, is developed from several perspectives. Chapter 8 describes the second case study, Preliminary Findings of a Process Evaluation of the Regional Wide Bay Public Health Plan. Phase 2 of the data collection, presented in Chapter 9, includes the results and findings of a comprehensive evaluation of the implementation stage of the same two MPHP projects. This dissertation evaluated the planning process and implementation impacts in each project using the Implementation Questionnaire (IQ) developed as part of the evaluation framework developed in Chapter 6. The key informants interviewed represented the opinions of politicians, managers, and health practitioners and agency partners. From the meanings and interpretations of the data findings, the achievements of and barriers to effective MPHP for these two phases of the research are examined.

Chapter 10 provides the results, findings and discussions of Phase 3 of the data collection, which represented the opinions of managers, health practitioners and agency partners involved in community public health planning projects (CPHP) across Queensland. The KI data findings are discussed and analysed. From the meanings and interpretations of the comparison of MPHP to other CPHP models, the strengths and limitations of MPHP are documented as the findings of Phase 3 of the data collection.

Chapter 11 discusses the joint findings of chapters 7, 8, 9 and 10 in the context of the ‘themes’ of the research, and recommendations including success factors for effective MPHP in light of the literature review. Chapter 12 provides the conclusions of the study and implications for further research.

1.6 Conclusion

This chapter has set the scene for the research, defined the research problem and highlighted the scope, nature, aims and methodology of the study. The following contextual fields were discussed: issues of urbanisation and sustainability, the ecological public health, the HCM, participatory health planning and MPHP, together with organisational behaviour, strategic planning and MPHP governance. In the light of the ‘Global Challenge’ of urbanisation in cities and towns, it is equally important to evaluate the processes and impacts of the MPHP, the ‘Local Response’ in Queensland to planning and implementing healthy and sustainable communities. Part 1, which now follows, contains the literature review of the three contextual fields of the research.
PART 1 LITERATURE REVIEW

CHAPTER 2 ECOLOGICAL PUBLIC HEALTH and the HEALTHY CITIES APPROACH

2.1 Introduction

This chapter firstly reviews urbanisation, sustainability and health, secondly discusses the emergence of the ecological public health, settings and health promotion, thirdly assists the reader to understand the design of cities for healthy and sustainable living and lastly reviews the literature on the Healthy Cities approach. In this context it discusses the broader issues of the ‘Global Challenge’ to continue improvements in health and environmental sustainability, particularly in a world of increasing urbanisation. The chapter summarises the global problems of increasing urbanisation and changing patterns of human consumption in a modern world. It links urbanisation and social change, reviews future urban health problems, and introduces the concept of ecological public health, while laying a foundation for understanding sustainable development and health. The WHO Healthy Cities approach is explained as a useful strategy in developing partnerships for health action in communities. This chapter argues the need for health planners to understand and apply the concepts of ecological public health in local government settings. In the light of the ‘global challenge’ to manage unsustainable urban growth, participatory health planning is discussed as a ‘local response’ to these problems. The chapter concludes with an argument for an increased need for sustainable health planning practices in cities.

2.2 Urbanisation, Sustainability and Health

2.2.1 Urbanization and Environmental Change

This section reviews the issue of urbanisation in the context of environmental change across the globe. Many writers have linked the growth of the human species with destruction of the environment and a catalyst for significant environmental change (Rees, 1992; McMichael, 1993; Hancock, 1993; Chu and Simpson, 1994; Perings and Ansuategi, 2000; Goldie et al., 2005). McMichael (1993, p.1) stated that Homo sapiens has existed for less than one ten-thousandth of Earth’s lifespan and, indeed, for less than one-thousandth of the time since animal life ventured from the oceans onto dry land. Indeed, it is just now becoming conceivable that within several generations the human species may face threats to its survival because of its disruption of Earth’s life-supporting ecosystems. He reports that compared with the hunter-gatherer era, which predominated until a short 10,000 years ago, human numbers have
multiplied one thousand-fold (including a massive ten-fold increase in the past 250 years) and our average daily per-person energy use is also about one thousand times greater. McMichael (1993) noted we are consequently overloading Earth’s capacity to absorb otherwise non-toxic waste gases, to replenish slowly renewable resources such as soil and groundwater, and to sustain genetic and ecological diversity. According to McMichael (1993) it is these disruptions that comprise an unprecedented threat to our life-support systems. What now confronts us, however, is quite different.

Increasing populations in and around cities, with their resulting unplanned urbanisation, have been the catalyst for the development of action-oriented Healthy Cities planning in parts of the globe. It is now important to understand the emerging impacts of urban development on the environment (see WCED, 1990; Rees, 1992; Hancock, 1996; McMichael, 2002). The WHO Expert Committee on Environmental Health in Urban Development defines an urban area as ‘a man-made environment, encroaching on and replacing a natural setting, and having a relatively high concentration of people whose economic activity is largely non-agricultural’ (WHO, 1991). Tsorous and Konvitz (1991) noted that investing in the health and the environment of cities means investing in the future, the survival and prosperity of our growing urban society. For thousands of years, famines, floods, plagues and war have confronted human populations. Crowded urban populations have provided a rich culture medium, an ecological bonanza of human-borne nutrients and energy, for infectious disease microbes.

WHO (1991) commented that the world is faced both by the massive degradation of the natural environmental and by the accelerating decline in the quality of life of many of those who live in the built environment of cities. Those two crises are related. The consequences of urbanisation make a major contribution to the global environmental changes that threaten the very existence of life in the future, while changes in the biosphere increasingly affect health and social conditions in the cities (see McMichael, 1993; Satterthwaite, 1993). Developing integrative policies and programs for health and ecological development requires firstly, strong political will; secondly a commitment to sustainability, equity, intersectoral collaboration, community involvement; and finally, close collaboration between national and local governments (Price, 1994; Price and Tsouros, 1996).

Hancock in 1994 comments that the overwhelming challenge we face in the 21st century, the dawn of the urban millennium, will be how to maintain and improve the health, well being and quality of life of the earth’s increasingly urban population. He shows concern, especially for the most disadvantaged members of society, recognising the world is faced with indefinite sustainability and deteriorating ecosystem health (Perings and Ansuategi, 2000). It is now acknowledged that a variety of social and ecological or environmental factors affect public health (Hancock, 1992; Hancock 1994; Chu, 1994; Baum, 2002; Goldie et al., 2005).
McMichael (1993) comments that the growth of cities, however, has great ecological significance for at least three reasons. First, in poor countries, the crowded makeshift fringes of cities testify to the population pressures on overloaded rural economies. Second, the artificial ecological setting of high-density city life alters the profile of health hazards, for example more ‘crowd infections’ and physical (industrial and traffic) injuries. Third, the existence of cities has adverse impacts on ecosystems, both directly, by pollution and by encroaching on farmland, wetland and coast, and indirectly, by distanced and disengaging humans from the rhythms of nature. This separation, this psychological detachment of humans from unpaved nature, helps confirm those social values and priorities that we in the First World have acquired and amplified since early in the industrial revolution. Urbanisation is thus both a consequence and a cause of global environmental change (McMichael, 1993, p.259).

As reported by WCED (1990), three quarters of the cities that contain more than ten million people are in developing countries. In these cities there are an estimated 100 million homeless adults and perhaps as many as 80 million homeless and in many cases abandoned children. Such rapid growth is not confined to the larger urban areas. The smaller cities and towns are also experiencing a growth that far outstrips the ability of urban services to cope, leading to a wide variety of health problems (Chu and Simpson, 1994: p.47). Although the average level of health has usually been better in cities than in rural areas, there are stark contrasts in health within those expanding urban populations, many of which are now seriously outstripping the urban infrastructure capacity. Overall, one in four people in these third world cities lacks safe water and over one-third of city-dwellers lack access to sanitation (see Satterthwaite, 1993; Price and Tsouros, 1996). The figures are much higher in the slums, where diarrhoeal disease is consequently rife – and continues to kill vast numbers of young children (Satterthwaite, 1993). In many of these cities, air pollution has now become a much graver public health problem that it is in rich countries.

Villages, towns and cities are a natural expression of human sociability, skills, hopes and fears. Over thousands of years, they have played the pivotal political and cultural role in agrarian and industrial populations. According to McMichael (1993), however, cities have become the locus of a new generation of ecological, demographic and political problems. An increasing proportion of the world’s expanding population, particularly in poor countries, is living in cities. Fertility rates in the third world urban poor are high. Much of the in-migration reflects the decline of rural life; ecological disruption and environmental disasters are likely to increase the move to the cities. By the year 2006, half of the world’s population will live in cities. By early next century, various large cities in India, Latin America and elsewhere will contain 20–30 million people (WCED, 1990).
A summary of the possible impacts on human population health, encompassing direct and indirect, immediate and delayed, and local and global effects, is shown in Table 1 (McMichael, 1993, pp.4–5).
<table>
<thead>
<tr>
<th>Environmental Change</th>
<th>Manifestation</th>
<th>Type (direct, indirect) and timing* (early, late) of adverse health effect</th>
<th>Indirect, early</th>
<th>Indirect, late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced greenhouse effect</td>
<td><strong>Global warming and other climate change</strong></td>
<td>Direct, early</td>
<td>Heatwave-related illness and death</td>
<td>Extension of vector-borne infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct, late</td>
<td>Natural disasters: cyclones, floods, landslides, fires</td>
<td>Food shortages due to impaired agriculture</td>
</tr>
<tr>
<td></td>
<td><strong>Sea-level rise</strong></td>
<td>Indirect, early</td>
<td>Increased risk of flash floods and surges</td>
<td>Consequences of damage to foreshore facilities, roads, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indirect, late</td>
<td>Inundation → social disorder, impaired sanitation, farmland loss</td>
<td>Destruction of wetlands → decline in fish stocks</td>
</tr>
<tr>
<td>Stratospheric ozone depletion</td>
<td><strong>Increased UV-B flux at Earth’s surface</strong></td>
<td>Direct, early</td>
<td>Sunburn, conjunctivitis Suppressions of immune system → increased risk of infection</td>
<td>Aquatic damage (reduced fish)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct, late</td>
<td>Skin cancer Suppression of immune system → increased risk of infection</td>
<td>Impaired growth of crops</td>
</tr>
<tr>
<td></td>
<td><strong>Acid rain</strong></td>
<td>Indirect, early</td>
<td>Effects on respiratory system</td>
<td>Impaired forest growth → reduced ecosystem productivity</td>
</tr>
<tr>
<td>Acid aerosols (from burning of</td>
<td></td>
<td>Indirect, late</td>
<td>Aquatic damage (reduced fish)</td>
<td>Impaired growth of crops</td>
</tr>
<tr>
<td>sulphurous fossil fuels)</td>
<td></td>
<td></td>
<td>Impaired growth of crops</td>
<td></td>
</tr>
<tr>
<td></td>
<td>**Erosion, sterility, nutrient loss, salinity,</td>
<td>Direct, early</td>
<td>Decline in agricultural productivity</td>
<td>Exposure to pesticides and fertilisers (may also cause algal bloom)</td>
</tr>
<tr>
<td></td>
<td>desertification**</td>
<td>Direct, late</td>
<td>Rural sector depression → migration to fringes of cities (see below row)</td>
<td>Consequences of silting up of dams and rivers</td>
</tr>
<tr>
<td>Land degradation: intensive</td>
<td><strong>Depletion of underground aquifers</strong></td>
<td>Direct, early</td>
<td>Lack of water for drinking and hygiene</td>
<td></td>
</tr>
<tr>
<td>agriculture, overgrazing</td>
<td></td>
<td>Direct, late</td>
<td>Decline in agricultural productivity</td>
<td></td>
</tr>
<tr>
<td>Land degradation: intensive</td>
<td><strong>Loss of biodiversity</strong></td>
<td>Direct, early</td>
<td>Deforestation → disruption of local culture</td>
<td>Deforestation → greenhouse enhancement</td>
</tr>
<tr>
<td>agriculture, overgrazing</td>
<td><strong>Destruction of habitat</strong></td>
<td>Indirect, early</td>
<td>Loss of potentially edible species</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Loss of genetic diversity; weakening of ecosystems</strong></td>
<td>Indirect, early</td>
<td>Loss of medicinal and other health-supporting materials</td>
<td>Greater vulnerability of crops and livestock Reduced viability of ecosystems</td>
</tr>
<tr>
<td>Other effects of overpopulation</td>
<td>**Proliferation of crowded urban slums (due to</td>
<td>Direct, early</td>
<td>Infection Malnutrition Homelessness Antisocial behaviours</td>
<td>Social disorder</td>
</tr>
<tr>
<td>(particularly in poor countries)</td>
<td>migration and high fertility)**</td>
<td>Direct, late</td>
<td>Infection Malnutrition Homelessness Antisocial behaviours</td>
<td>Chronic toxic effects of environmental pollutants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indirect, late</td>
<td>Social disorder</td>
<td>Consequences of overload of local ecosystems</td>
</tr>
</tbody>
</table>

*The designation ‘early’ and ‘late’ are notional, and indicate relative timing (McMichael; 1993, pp.4–5)
The problems arise because this potential is often not realised for many people living in urban areas, especially the poor or unemployed (Satterthwaite, 1993; Chu and Simpson, 1994). Lack of urban planning in areas where there are rapidly growing populations, expanding industrialisation and increasing traffic can lead to widespread problems in air quality, water quality and quantity, pollution, occupational hazards, traffic trauma, lack of health services, physiological stress, inability to take safe physical activity, waste disposal problems, and risks from chemical and industrial accidents (WCED, 1990). Poor planning in any community can also lead to some sections of the community having little access to services, inadequate and unsafe housing, poor diet and hygiene, and inadequate protection from exposure to environmental contaminants (adapted from Chu and Simpson, 1994).

More recently, in industrialised countries, the gains in health and longevity associated with increased wealth and education have been accompanied by a further population health hazard, namely the increase in communicable and non-communicable diseases (McMichael, 2005). Humans have never before tried living in cities with populations of several tens of millions of people. Such cities are rapidly becoming a spectacular, but formidable, social and ecological experiment (WCED, 1990). In developed nations like Australia the quality of life of residents in cities is perceived to be of a high standard (Chu and Simpson, 1994).

However in the experience of the author through extensive needs assessment in varied planning projects in communities, the outlook for quality of life for the socially disadvantaged and for specific cultural groups is quite the opposite. Urban areas do not necessarily imply severe health problems, as a WHO (1991) report points out. In theory, the city has great potentialities to protect and promote health (see Goldie et al., 2005; Hancock, 1992; Hancock 1994; Chu, 1994). Urban compactness, interdependencies, and economies of scale help to provide many services and resources for individual and social well being that are infeasible for dispersed populations, who must rely on urban centres for advanced medical care (WCED, 1990; Price and Tsouros, 1996). Relatively high levels of health enjoyed by upper and middle-class urbanities reflect the city’s potentialities (Chu and Simpson, 1994).

2.2.2 The Foundations of Sustainability and Health

The World Commission on Environment and Development (WCED) used the term ‘sustainable development’ in its 1990 final report, ‘Our Common Future’, and defined it to mean development that meets the needs of the present without compromising the ability of future generations to meet their own needs. It contains within it two key concepts:

- the concept of ‘needs’, in particular the essential needs of the world’s poor, to which overriding priority should be given, and
• the idea of limitations imposed by the state of technology and social organisation on the environment’s ability to meet present and future needs.

The Commission concluded that the goals of economic and social development must be defined in terms of sustainability in all countries – developed or developing, market-orientated or centrally planned. Interpretations will vary, but must share certain general features and must flow from a consensus on the basic concept of sustainable development and on a broad strategic framework for achieving it.

Sustainability and public health are closely aligned. Public health must be concerned with the large ecological problems facing humankind, a point made by Marc Lalonde (in Hancock, 1994) in addressing the American Public Health Association:

I want to close with some comments on what in the long term will be the fundamental determinant of our health. I am thinking of the ecological, energy and resource limitations of this planet... I know this matter goes well beyond the normal terms of reference of the health professional... but as people who are manifestly concerned with the well being of their fellow men and women, I would urge you to extend your mandate to future generations and to support the analyses and action necessary to ensure their survival (p.37).

Historically health has not had an ecological approach. In fact health is derived from the Old English, ‘haelth’, from which we have three entwined concepts: ‘hello’, whole and health (see Labonte, 1994; Labonte et al, 1999). Labonte (1994 p.19) notes that health is intrinsically holistic, and ‘we violate its richness when we focus only on biomedical conditions, morbidity and mortality’. Health is inherently a social phenomenon, embodying the quality of our relationships with one another. While health and disease are often considered to exist on a continuum, persons with chronic diseases or poor health behaviours often regard themselves as being in excellent health (*Healthy Toronto 2000*, 1987).

This traditional approach to health has transcended to the new public health, which incorporates concern for the links between health, environment and social structures. Labonte (1994) argues that with this new approach to public health, the health sector can engage in sustainable development decision-making. The ecological public health has received additional support with the incorporation of ecosystem stability and resource sustainability as prerequisites for health in the Ottawa Charter for Health Promotion (WHO, 1986; Kickbusch, 1994; Kickbusch, 1996). On the topic of creating supportive environments, the Charter further noted:

The inextricable links between people and their environments constitute the basis for a socio-ecological approach to health. The conservation of natural resources throughout the world should be emphasised as a global responsibility. The protection of the natural and the built environments and the conservation of natural resources must be addressed in any health promotion strategy (WHO, 1986, p.2).
Thus the Ottawa Charter anticipated the concerns of the World Commission on Environment and Development in the WCED (1990) report, ‘Our Common Future’, which provides the basis for our concern with sustainability. It is clear that, in the movement for Health for All through health promotion, the concepts and principles of sustainable development should play an important role.

The link between health and sustainable development has been further strengthened in several ways. First, there is the emphasis placed upon supportive environments for health at both the Second International Conference on Health Promotion in Adelaide in 1988 and the Third International Conference in Sundsvall in 1991. This is a fine ideal for each individual, but it is not an appropriate way to think about the health of populations. Populations are never free of disease, disability and premature death. Indeed, inter-individual differences in health and fitness are a continuing expression of the process of genetic variation and biological evolution. Sustainable development is defined as improving the quality of human life while living within the carrying capacity of the supporting ecosystems (McMichael, 1993).

Whether it is population growth, extreme inequity or over-consumption of certain commodities, policies and actions must be implemented to guide the development process towards sustainability (McMichael, 1993). In 1992 the world’s leaders adopted the principles of the Rio Declaration; some of the environmental problems that have evolved since are major threats to sustainable development – thus the importance of investing in improvements to people’s health and their environment (Corvalan et al., 1999). Population growth in itself is not bad if the country in question has the means to meet the basic needs of additional people; if economic growth was more equitable, this would more often be the case. Enormous inequities remain, however, regarding use of energy and raw materials, food consumption and water use. Thus while the developed countries are consolidating their share of global resource use and economic development, the least developed countries lag further and further behind in human development terms. Current economic driving forces are increasing rather than decreasing inequity (see WHO, 1997a).

According to the WCED (1999) development involves a progressive transformation of economy and society. The report suggests that a development path that is sustainable in a physical sense could theoretically be pursued even in a rigid social and political setting: but physical sustainability cannot be secured unless development policies pay attention to such considerations as changes in access to resources and in the distribution of costs and benefits. Even the narrow notion of physical sustainability implies a concern for social equity between generations, a concern that must logically be extended to equity within each generation (WCED, 1990). The overall result is increased pressure on land and water resources, increased household and hazardous waste, increased conflict between the economic imperatives of a ‘globalising’
industry and the health and environment protection needs of people (WHO, 1997a). The need for higher order and local level planning is paramount for sustainable land development in order to meet the needs of an expanding population. Health and environment issues can be considered along with sustainability in such planning.

Goldstein and Kickbusch (1996) comment that the world is being urbanised at a furious pace. They note that within 15 years, between 20 and 30 cities will have populations of over 20 million (see Kickbusch, 1996; Hancock, 1996; Goldie et al., 2005). As national government resources become more limited and the global trend towards political and administrative decentralisation gathers pace, city governments are emerging as stronger forces (Kickbusch, 1996). Many of the most pressing urban management problems are associated with rapid urban growth, including such environmental health issues as water supply, housing, pollution and solid-waste management, and the social health issues of marginalisation and violence.

The satisfaction of human needs and aspirations within their locations is the major objective of development across the world (WCED, 1990; Kickbusch and de Leeuw, 1999). The essential needs of vast numbers of people in developing countries for food, clothing, shelter and jobs are not being met; and yet beyond their basic needs these people have legitimate aspirations for an improved quality of life. A world in which poverty and inequity are endemic will always be prone to ecological and other crises. A communications gap has kept environmental, population, and development assistance groups apart for too long, preventing us from being aware of our common interest and realising our combined power: fortunately, the gap is closing, we now know that what unites us is vastly more important that what divides us (see WCED, 1990, p.89).

In its broadest sense, the strategy for sustainable development aims to promote harmony among human beings and between humanity and nature. In the specific context of the development and environment crises of the 1980s – which current national and international political and economic institutions have not and perhaps cannot overcome – the pursuit of sustainable development requires:

- a political system that secures effective citizen participation in decision-making
- an economic system that is able to generate surpluses and technical knowledge on a self-reliant and sustained basis
- a social system that provides for solutions for the tensions arising from disharmonious development
- a production system that respects the obligation to preserve the ecological base for development
- a technical system that can search continuously for new solutions, and
• an international system that is flexible and has the capacity for self-correction (WCED, 1990, p.109).

These requirements are more in the nature of goals that should underlie national and international action on development. These requirements can be considered a useful foundation for planning healthy and sustainable cities.

People in cities, particularly the poor and the newly arrived, experience stresses and exposures that result in a wide range of health problems, including communicable diseases, malnutrition, mental illnesses and chronic respiratory diseases (see Satterthwaite, 1993; McMichael, 1993; Goldie et al., 2005). Unhealthy conditions include poverty, inadequate food and shelter, insecure tenure, physical crowding, poor waste disposal, unsafe working conditions, inadequate local government services, overuse of harmful substances and environmental pollution. Around the world, cities attract young people from the countryside, lured by freedom from traditional bonds and ways of life, and by the promise of increased wealth and opportunity. Instead, many of them find only a new type of poverty (Goldstein and Kickbusch, 1996).

Poor people in cities often have to shoulder total responsibility for their basic needs in health, welfare and employment creation. Of particular concern to women are issues of social behaviour associated with the breakdown of the extended family and of the two-parent nuclear family; more women are working away from home, and more heads of household are single mothers. In the era of the AIDS epidemic, urban life often involves more transient relationships, especially for migrant workers, with early sexual activity among adolescents, high levels of prostitution, and a reduction in traditional methods of birth control (Goldstein and Kickbusch, 1996). With all these problems, environmental considerations in urban planning and management require far greater attention. The price of neglecting them, apart from the negative health and social impacts, may be to impair urban productivity and restrict future development options, because of unsustainable use or damage to natural resources (Goldstein and Kickbusch, 1996). In summary, the next few decades are crucial for the future of humanity. Pressures on the planet are now unprecedented and are accelerating at rates and scales new to human experience – a doubling of global population in a few decades, with most of the growth in cities; a five- to tenfold increase in economic activity in less than half a century – and the resulting pressures for growth and changes in agricultural, energy, growth and development are also growing (WCED, 1990). New technologies and potentially unlimited access to information offer great promise (WCED, 1990).

From an organisational perspective, many writers suggest that the integrated and interdependent nature of the new global challenge and its issues contrasts sharply with the nature of the institutions that exist today (see Satterthwaite, 1993; McMichael, 1993; Goldie et al., 2005).
These institutions tend to be independent, fragmented and working to relatively narrow mandates with closed decision processes. Those responsible for managing natural resources and protecting the environment are institutionally separated from those managing the economy (WCED, 1990). The real world of interlocked economic and ecological systems will not change; the policies and institutions concerned must. This new awareness requires major shifts in the way government, non-government and individuals approach issues of environment, development, and international cooperation (WCED, 1990). The linkage between all stakeholders needs strengthening at a community level; local government is well placed to facilitate this process.

In a local context, the Australian National Strategy for Ecologically Sustainable Development uses the term ‘ecologically sustainable development’, or ESD, which it defines as ‘development that improves the total quality of life, both now and in the future, in a way that maintains the ecological processes on which life depends’. This and the many other definitions of sustainable development recognise that we need to link development with protection of the environment in order to protect and manage ecosystems and natural resources which are essential for fulfilling basic human needs and improving living standards for all (Cotter and Hannan, 1999).

2.2.3 Agenda 21 – Key Principles of Sustainability

In 1992, the United Nations Conference on Environment and Development – the Earth Summit – developed Agenda 21, a blueprint for action to achieve sustainable development. This global policy approach laid a foundation for MPHP in Queensland. Agenda 21 called upon governments around the world to take a course of action to implement that blueprint. Local Agenda 21 (LA21) is a program aimed at implementing sustainable development at the local level (Cotter and Hannan, 1999). Because so many of the problems and solutions being addressed by Agenda 21 have their roots in local activities, the participation and cooperation of local authorities are determining factors in fulfilling its objectives. Local authorities construct, operate and maintain an economic, social and environmental infrastructure, oversee planning processes, establish local environmental policies and regulations, and assist in implementing national and sub-national environmental policies (see Low Choy, 1996). As the level of governance closest to the people, they play a vital role in educating, mobilising and responding to the public to promote sustainable development (see Cotter and Hannan, 1999: Agenda 21, paragraph 28.1)

Local governments (Councils) are one of the nine ‘major groups’ named in Agenda 21 as being fundamental to working towards sustainable development. The others include women, youth and children, Indigenous people and their communities, non-government organisations, trade unions, business and industry, scientists and technologists, and farmers (Cotter and Hannan,
Locally, the 1997 Newcastle Declaration from the ‘Pathways to Sustainability’ Conference (an international conference focusing on the challenge of sustainability for local government) clarified and re-stated the commitment of local government to Agenda 21 and sustainable development:

Sustainability is a global necessity and LA21 is a fundamental framework for enhancing local and global sustainability (Newcastle Declaration cited in Cotter and Hannan, 1999, p.11).

A number of principles form the foundation of sustainability, and hence a LA21, in Australia:

- **Integration** – the effective integration of environmental, social and economic considerations in decision-making
- **Community involvement** – recognition that sustainability cannot be achieved, nor significant progress make toward it, without the support and involvement of the whole community
- **Precautionary behaviour** – where there are threats of serious or irreversible environmental damage, lack of full scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation
- **Equity within and between generations** – fairness and equal access to opportunities both within our lifetimes, and as for future generations
- **Continual improvement** – the declining environmental situation means there is an imperative to take immediate action to become more sustainable and to make continual improvement, and
- **Ecological integrity** – to protect biological diversity and maintain essential ecological processes and life-support systems (Cotter and Hannan, 1999, p.12; Low Choy, 1996).

LA21 comprises systems and processes to integrate environmental, economic and social development. Founded on a strong partnership between local government and the community, the progress towards local sustainable development is guided by the preparation of a long term strategic action plan that integrates existing policies and programs and an agreed future direction (Cotter and Hannan, 1999). LA21 provides the basis for debate on and awareness of sustainable development at the community level (Low Choy, 1996). Low Choy (1996) suggests that the main focus of LA21 is to involve all groups in sustainable development planning in the major areas of economic, social and environmental development. This focus on participation clearly sets LA21 apart from other initiatives that focus more on the achievement of outcomes for sustainable development (Cotter and Hannan, 1999) – significant positive outcomes should result from an effective LA21 process:

- Stronger community and local government partnership
- Ongoing community involvement in the resolution of sustainable development issues
• Integrated decision-making which takes all foreseeable economic, social and environmental considerations into account

• Development, implementation and periodic review of a long term, integrated action plan which incorporates sustainable development principles, and

• Changes that promote a continual improvement toward sustainable development.

These principles have been embraced by the state and territory governments in Australia and have flowed down to the third level of government, local government. Currently in Queensland legislation in areas of town planning, environment and health, and local government legislation, as well as in the strategic directions of state health agencies, concepts like integration, community involvement, agency partnerships, equity, and continued environmental improvement are well known.

In Queensland a Healthy Cities and Shires Office was established in 1993 with state government [Queensland Health] funding (Chapman and Davey, 1997). The office primarily developed health partnerships with key stakeholders, including local government, to broaden the definition of health and, in doing so, to promote future health and sustainable local government planning by involving communities in articulating their wider health needs (Chapman and Davey, 1995a; 1995b). LA21 formed the foundation of the Healthy Cities approach, and subsequently this global policy gave direction to the MPHP initiatives.

2.2.4 Designing Cities for Healthy and Sustainable Living

The goal of designing Healthy Cities has figured repeatedly in the history of societies. Plato, wrestling with the ideals of the Greek city-state, gave it serious attention. The nineteenth-century enthusiasm for Hygiea, the City of Health, was a reaction against the poor urban conditions caused by the industrialisation era. The European Office of WHO implemented the Healthy Cities project in the 1990s and other countries from around the world have joined in to reinvent actions to improve the conditions of cities (WHO, 1994; 1998; 1997b). Proponents of this project argue that people build cities: cities should therefore be for people, not for commerce, cars, or industry. Decision-making should therefore involve the communities and groups concerned. The urban environment should be conceived and planned on a ‘human’ scale, to promote community identity and autonomy and to foster social contact and good health (WCED, 1990).

In developed nations, communities and their policy-makers have usually planned for the foreseeable future only; city growth has been incremental and haphazard (McMichael, 1993). Under the growing pressures of urbanisation and immigration many of these cities are faltering under demographic and social strain. In third world counties, poverty and a lack of planning persist as the dominant influence on the shape of tomorrow’s mega cities, undermining future
prospects for better health in those cities. WHO argued that sustainable, health-promoting urban development requires policies, plans and programs based on an understanding of the urban system as an organic whole:

Urban development should not exceed the capacity of local ecosystems, and should support rural and regional health and prosperity. The attainment of those ideals is, of course, impeded by population growth and poverty. Therefore, at least as a holding operation, until widespread urban poverty and its worst effects are alleviated, we need broad physical guidelines and social strategies to guide urban growth and land use (cited in WCED, 1990, p.140).

Urban development cannot be based on standardised models. Development possibilities are particular to each city, and must be assessed within the context of its own region. What works in one local government may be totally inappropriate in another city (Davey et al. 2003). The WCED report commented in 1990 that, although technical help from central agencies may be needed, only a strong local government can ensure that the needs, customs, urban forms, social priorities, and environmental conditions of the local area are reflected in local plans for urban development. But authorities have not been given the political power, decision-making capacity, and access to revenues needed to carry out their functions. This leads to frustration and to continuing criticism of local government for insufficient and inefficient services (WCED, 1990). Participatory health planning identifies the health priorities of a community, detailing in the health profile the hazards faced by the community, and lists priority actions to overcome these issues.

2.3 The Emergence of the Ecological Public Health Concept and Healthy Cities

The emergence of the ecological public health concept provided a foundation for the HCM to work across the settings (Hancock, 1994; Labonte, 1994; Chu et al., 2000; Ashton, 2002). McMichael (1993) argues that ecology is concerned with the healthy interaction of living creatures in a closed system. Humans interact with each other as well as with other living creatures, and these interactions can have important effects on the health of all partners in the complex closed ecosystem of our planet (McMichael, 1993). We ignore this reality at our peril.

In the long term, the health and survival of a population cannot be sustained if the carrying capacity of its ecosystem is exceeded. For the human species (whether considered as component populations or as a whole), this criterion of living within the carrying capacity of ecosystems is less straightforward than for other species. For the human species as a whole, however, we cannot sever the connection. It is this ecological underpinning of population health that is now threatened by the burgeoning size and economic activity of Homo sapiens (McMichael, 1993). The ecological principle has been applied to public health (Chu and Simpson, 1994).
Health care systems worldwide are increasingly faced with the dilemma of balancing the expansion of health care services, demands and costs with the constriction of economic resources (Siler-Wells, 1988); and the new health risk patterns of global ecological risk and health impacts associated with the socio-economic, political and cultural conditions of industrialised societies (Kickbusch, 1989, p.29). These challenges have led to recognition of the interdependence of sustainable development and health and the emergence of the new public health. The new public health does not contradict the ‘old public health’; it merely goes beyond it to move to a broader, ecological approach (Chu and Simpson, 1994).

Public Health in the nineteenth century was introduced in response to the health risk patterns present at the time (air, water and food-borne infectious diseases, diseases of poverty and generally poor living conditions). Winslow (1920) proposed an early definition for public health:

Public health is the science and the art of preventing disease, prolonging life, and promoting physical (and mental) health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, and education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health (cited in Chu and Simpson, 1994, p.2).

In the 1980s in Australia, as in other industrialised countries, inequality in health outcomes became more evident (Rootman, 1988; Bauman, 1989; McMichael, 1993; Rootman et al., 1997). There is a clear inverse relationship between socio-economic status and risk factors on the one hand, and the common causes of mortality on the other. Moreover, there is a direct relationship between socio-economic status and preventative health behaviour and screening. More alarmingly, there is increasing evidence that the ‘inequality gap’ – the disparity in health status between the most and the least affluent – is widening, which will result in even more inequality in the future (Bauman, 1989). Good health is the foundation of human welfare and productivity.

What is required is a broad-based health policy: this is essential for sustainable development. In the developing world, the critical problems of ill health are closely related to environmental conditions and development problems (McMichael, 2003). These include air pollution and the respiratory illnesses it brings, the impact of housing conditions on the spread of tuberculosis, the effects of carcinogens and toxic substances, and the exposure to hazards in the workplace and elsewhere (WCED, 1990). In developed nations, although clean water, sewage systems and safe food reduce infectious diseases, a broad range of lifestyle diseases, land use and city development issues dominate the health agenda.
In response to the challenge of promoting sustainable and equitable health development, as early as 1977 the WHO ‘Health for All Strategy’ proposed five health promotion strategies: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services. These five strategies formed the bases of the new public health and the Ottawa Charter (1986). The new public health has since gained worldwide acceptance and has renewed a tradition of public health ‘which argues that health is intimately tied to overall conditions of living’. This means that the key to improving population levels of health lies outside of the traditional health domain (Pederson et al., 1994, p.1). The Ottawa Charter is a timeless policy and is still acknowledged in the 2000s in the WHO Bangkok Charter for Health Promotion, which supports a settings approach and participatory approaches advocated by the Ottawa Charter some 15 years earlier (see WHO, 1986; 2001b).

Under this framework an ‘ecological approach to public health’ has emerged in recent years. As the world is increasingly faced with new global environmental problems such as the ozone layer destruction and the widespread contamination of soil, air and water, the new approach would not only ‘move from the “behaviour epidemiology” and “surveillance” mode to a more environmental and social approach, but would aim to tackle the “risk patterns” with an ecological approach’ (Kickbusch, 1989). Kickbusch suggested that for public health to contribute to a more sustainable future, it must:

- Develop proposals for legal and institutional reform that strengthen the promotion and protection of health
- Ensure that the potential health effects of the new environmental risks are seriously considered in policy decisions at all levels
- Ensure that health and environmental impact statements become part of governmental planning and accountability
- Ensure that the public is fully informed on risks to their health
- Give priority to closing the health gap, and
- Open the debate on the sustainability of health development itself.

In order for public health to contribute to a more sustainable future, we must give serious concern to developing methodologies and mechanisms that stress accountability to the public and that support integrative strategies: on the basis of this premise, the concept of Healthy Cities was introduced by WHO to communities, governments and non-government agencies (Kickbusch, 1989, p.27). The next section details this approach.
McMichael in 1993 defined public health as the organised attempt by society to understand the determinants of poor health and to improve the level, and the equality, of health within a population. A society’s particular public health goals reflect the prevailing values and perceptions about the preventability of health problems. The First Public Health Revolution unfolded in nineteenth-century Europe as that society sought to ameliorate the adverse health effects of squalid living conditions: poor sanitation, poor housing, dangerous work environments and air pollution (Ashton, 1992; 2002). These health-directed interventions were embedded in a broader matrix of social progress and economical development that contributed other improvements in population health (McMichael, 1993). Health hazards and poor health are distributed evenly both between and within populations. Inequalities in power and wealth between rich and poor countries, amplified by the inequality of the world trading system, continue to create disparities in the material standard of living, the quality of the local physical environment and the productiveness of local ecosystems (see Ashton, 1992; Hancock, 1993). Major disparities in population health have resulted according to McMichael (1993).

For some years there have been attempts by those championing health promotion to influence the public policy agenda and develop what has come to be called ‘healthy public policy’ (see Hancock and Duhl, 1988a; Hancock and Duhl, 1988b; Baum and Brown, 1989; Ashton, 1992; Duhl, 1993; Hancock, 1996; Chu and Simpson, 1994; Baum, 1995). People’s social and economic circumstances strongly affect their health throughout life, so health policy must be linked to the social and economic determinants of health (WHO, 1998). The World Health Organisation Healthy Cities project is one such attempt to do both: develop healthy public policy and address the social determinants of health at the local level (Tsourus, 1995; Pederson et al., 1998). Building healthy public policy is a time consuming process, because it involves developing a new infrastructure supportive of health promotion and it requires a critical mass of people to hold in their consciousness the vision involved. Healthy Cities ask for a radical change in public policy and this will take time and commitment (Goumans and Springett, 1997).

Comprehensive health development approaches in a Healthy Cities project include ‘healthy villages’, ‘health-promoting schools’, ‘health-promoting workplaces’ and ‘health-promoting hospitals’. Healthy Cities may be a ‘standalone’ project in a given city, or may be the health component of a larger development effort that involves such areas as urban infrastructure, land management, municipal finance and industrial development. WHO actively promotes the Healthy Cities approach worldwide, not least by organising inter-country meetings in all regions, on a regular basis, to review the progress of the participating cities and to facilitate the exchange of health and environmental technologies as well as of experiences with successful projects (Goldstein and Kickbusch, 1996). Other writers differ in opinion: Ziglio et al. (2000)
comment that there is some evidence that the overall impacts of the WHO Healthy Cities and other settings innovations have been relatively limited [in Europe], but that the practice of health promotion within a number of countries has developed considerably because of it (Ashton, 2000; 2002).

In Australia in 1989, the National Health and Medical Research Council took some important steps forward in assessing the public health impact of both ozone layer depletion and climate change (NHMRC, 1992). Substantial, well-referenced reports have resulted from both assessments. However, the committee established in 1990 to advise the Commonwealth Government on climatic warning, comprising scientists from climatology, atmospheric physics, agricultural agencies, and environmental science, did not invite a public or environmental health expert on to the panel. There is an urgent need for the Commonwealth Department of Health to develop a stronger capacity in environmental health, and for government to ensure that health is a ‘major player’ in the environment arena.

A wide-ranging restructuring of the environment sectors by state and national governments occurred in the early 1990s in Australia. Rearrangement of the bureaucratic structure has resulted in Environmental Protection Authorities (EPAs) being developed in all states. A basic rationale is to consolidate fragmented legislation and dispersed functions within a single authority. However, these agencies are giving relatively little explicit attention to public and environmental health agendas or to acquiring competent public health input. Conserving the environment is a conceptually and administratively simpler objective than is the protection of the public’s health. The public health network must therefore campaign for the inclusion of public health in environmental protection and management. Health planning at a city level can address the building of partnerships between agencies, breaking down the barriers through partnerships in the implementation of integrated community planning.

The Commonwealth Department of Health, through the NHMRC, in 1997 evaluated the role and function of environmental health impact assessment (EHIA). This project examined the purposes and procedures for incorporating consideration of the population health impact into the environmental impact assessment process already widely used for new land developments in Australia. Formal health risk assessment and evaluation procedures were proposed. As stated earlier, while traditional public health responses can readily be made to local environmental problems, dealing with the macro-aspects of environmental degradation needs a different approach aimed principally at national and global levels. Participatory health planning at a local level traditionally does not deal with these macro-aspects of environmental degradation but attempts to add value to the global cause by guiding local action for local problems.
2.4 Healthy Cities Approach

Goldstein and Kickbusch (1996, p.4) define the concept of a healthy city:

A Healthy City is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to support each other in performing all the functions of life and in developing to their maximum potential.

The Healthy Cities program builds on the WHO definition of health ‘as a state of complete physical, mental and social well being’, and has its roots in the public health culture of many parts of the world; indeed, many of the public health innovations in the past and present have sprung from the local level (see Hancock, 1993; Hancock, 1994; Hancock and Duhl, 1988a; Hancock and Duhl, 1988b). WHO in 1985, as previously outlined, proposed a health promotion scheme to be known as the Healthy Cities project (Baum and Brown, 1989). The intention was to devise ways of applying the principles and strategies of health for all through local action in cities, putting them firmly on the agenda of local government.

The value of this program to cities has been demonstrated by its unexpectedly rapid expansion to hundreds of cities and towns, not only in the industrialised world but also increasingly in the developing world (Goldstein and Kickbusch, 1996; Hancock, 1994). The reason for cities to participate is not because their cities are especially unhealthy, but rather that the city wants all its citizens to live in a healthier city (Copenhagen Health Services, 1994). Based on this principle all cities could become part of the WHO targets for health for all. What has emerged since the inception of Healthy Cities is a sense that it has helped to change the way governments, particularly local government, think about, understand and make decisions about health (Tsouros, 1995). The 1948 WHO Constitution requires member national governments to take responsibility for the health of their people [by providing adequate health and social measures]. Implementation of WHO Healthy Cities policy supports the rights of all people to realise their full potential (WHO, 1995a).

In the work of Healthy Cities projects, attention is given to the principle that health can be improved by modifying the physical environment and the social and economic determinants of health. Although various urban development activities (housing, industry, infrastructure, etc.) can cause health hazards if they lack health and environmental safeguards, more importantly they offer health opportunities (Chu and Simpson, 1994). They can enhance the health status of the population, provided that they are accompanied by health promotion and protection measures (Goldstein and Kickbusch, 1996; Chu and Simpson, 1994). Originally WHO proposed 53 Healthy Cities broad based multi-sectoral urban indicators to describe and compare the determinants of health in participating cities, this approach presented formidable challenges (WHO, 2001a; Doyle et al., 1997). However this study is not focusing on the debate about use
of indicators to evaluate projects, but is more concerned with improving municipal health by stronger partnerships between agencies and by organisational effectiveness.

The concept of Healthy Cities is an important expression of the new public health, applying Rene Dubos’ well-known phrase of thinking globally and acting locally. Some of the key strategies in the Healthy Toronto 2000 report and in many similar projects in the worldwide healthy cities / communities movement express the importance of community involvement in decision-making; community empowerment and control; ecological strategies for sustainable cities; the addressing of social injustice and inequalities in health at the local level; the encouragement of community self-reliance and local economic development; and the addressing of issues of peace, safety, non-violence and tolerance. Life in cities, then, can reduce or enhance the well being of residents. In many ways cities and towns represent the reality of political, economic and social decisions made locally, at a state level, nationally and globally (WHO, 1997b). On the other hand, past and present progress by local communities has created the identity of each city. WHO (1997a) Healthy Cities documentation notes that the impact of urbanisation and the state of our cities and communities result from patterns of development that have yielded differing forms and location of infrastructure: organisation of public buildings and public space; residential areas and services including health; and recreational and cultural facilities. Aggregations of people bring together a range of skills and new ideas and ensure that the accumulated wealth, services, education, and cultural opportunities can potentially be provided efficiently and effectively (WHO, 1997a).

A social model of health describing the links between environmental factors and health outcomes has been recognised and acted on since the early days of the public health movement (Chu and Simpson, 1994). This public health action planning method considers health as an outcome of the effects of all the factors affecting the lives of individuals, families, and communities in different ways and through different pathways (Hancock, 1993). This view is a contrasting approach to the medical model, which underpins disease-focused interventions (Chu and Simpson, 1994). This view makes health care services responsible for improving and maintaining health. A linking of these models is fundamental to the good health and quality of life of residents in communities.

WHO (1997b, p.40) Healthy Cities documentation attempted to conceptualise a new model of the interrelationships between all the activities taking place in communities and all the challenges in cities. This approach is highlighted in Figure 2. The model describes the relationships between cities, sustainable development, global environmental crises and the outcome of a healthy society in a healthy environment.
The social, economic and environmental contexts, which contribute to the creation of health, do not operate separately from or independently of each other (Ashton, 1992; Chu and Simpson, 1994). Rather, they are interacting and interdependent, and it is the complex interrelationships between them, which determine the conditions that promote health (Hancock, 1993; WHO, 1997b).

Trevor Hancock (1993) describes the new conceptual model of human development. Figure 3 describes the model’s three main areas: community, environment and economy. The outcome of the interrelationship of these areas can be conceptualised as health or, more broadly, as human development. The model suggests that good health and sustainable human development will be achieved only if the relationships between the areas are equitable, sustainable and liveable. Community conviviality, environmental viability and economic adequacy need to balance. Community conviviality is related to the web of social relations, civic community and social solidarity (see Labonte, 1994). Environmental viability refers to the quality of the local ecosystem, including air, water, soil and the food chain (Hancock, 1993). Economic adequacy means having a level of economic activity that can meet basic needs. In this model a healthy community has an integrated approach to developing all its components and tries to be equitable, liveable, sustainable and cohesive, to achieve high environmental standards and to be adequately prosperous (Chu and Simpson, 1994). MPHP in Queensland is underpinned by Hancock’s model of health and human development (Chapman and Davey, 1995a; Chapman and Davey, 1997).
The Healthy Cities Movement (HCM) is, or should be, a fundamental challenge to the established order, the established way of doing things: it is a new way of ‘doing’ politics and policy, a new way of sharing power more equitably, an approach wholly consistent with the health movements that lie at the heart of the ecological public health philosophy (WHO, 1995a). The WHO (2000) Regional Guidelines for Developing a Healthy Cities project were developed to support the development of cities in the region. Even though the guidelines serve as a useful reference document for more innovative local and national initiatives, there are still many unresolved aspects, including the little experience in thorough evaluation of projects up to 1999. The guidelines highlight factors that contribute to sustainability of Healthy Cities initiatives; these include strong political support, community ownership and demonstration of positive outcomes: ‘Sustainability depends on keeping the values, vision and concept of Healthy Cities alive’ while developing sustainable planning process mechanisms secures intersectoral collaboration, finance, human resources, skills training and community participation (WHO, 2000, p.11).

O’Neill and Simard (2006) reflect that the international HCM since its beginning in 1986 has been one of the flagship enterprises of the new vision of health promotion. The program is seen as a privileged way to establish healthy public policy at the local level (Hancock and Duhl, 1988b; Kickbusch, 1989). By 2006 the HCM has several thousand participating communities on all continents (Kenzer, 2000; Harpham et al., 2001; Takano and Nakamura, 2001). Effective and sustainable healthy cities planning is complex and demanding (WHO, 1997b). It involves developing a climate with the political will for planning for health: strategies must also accommodate the unique political, economic, social, cultural and organisational context of cities.
and their organisation (see Hancock, 1994). This thesis will concentrate on better understanding the capacity of individuals and the organisational context of MPHP in local government at the interface with communities (see Ashton, 1992; Duhl, 1993; Hancock, 1996).

de Leeuw (1999) focuses on urban social entrepreneurship for health and provides another dimension to better understand a way of tackling the social determinants of health through community-based action. This approach recognises the important individual characteristics of health practitioners or project managers who have refined their skills to analyse, communicate, advocate, mediate and direct scarce resources towards activities with the highest potential gain, thereby achieving health gains in communities in difficult circumstances. The contribution of individuals and their skill base could have a significant impact on the effectiveness and sustainability of planning; more research is required to understand the contributing factors to sustainable planning.

Drawing up a MPHP serves to generate awareness of health and environmental problems among municipal authorities, non-governmental agencies and communities, and to mobilise resources to deal with the problems. The plan should not be considered a one-off exercise that will generate all the necessary actions to solve the city’s health problems once and for all; rather it should be seen as a process of consultation, data-gathering and analysis that continually opens new channels of communication. The plan may include programs or projects for specific settings; such as schools, workplaces, marketplaces and health care locations (Goldstein and Kickbusch, 1996). A key issue is that the way national policy supports the local programs may influence the project. In some countries, it has been helpful to establish a National Healthy Cities Network. A clear commitment by such a body to local government policies that reduce marginalisation or the exclusion of poor communities from social and economic life and services can greatly assist local efforts (Goldstein and Kickbusch, 1996).

2.5 City Health Plan: A Tool to Implement the Healthy Cities Approach

WHO initially encouraged the development of participatory health planning at a community level through the implementation of MPH Plans or public and environmental health plans. City Health Plans (CHP) or similar community needs-based planning processes have been developed more recently, particularly in Europe (see WHO, 1997b). A CHP is a broad and extensive plans for improving health: cities committed themselves to producing these during the second phase of the WHO Healthy Cities Project in Europe. Both style of plans, set out the city’s vision of health and the steps it intends to take to achieve that vision: as WHO reported in 1997 a CHP is an important landmark for any city. The process of MPHP, which is an early version of the new concept of the CHP, is similar to the WHO City Health Plans developed in Europe, with similar elements of intersectoral and interdepartmental collaboration, community participation and
sound ecological management (see WHO, 1997b). City Health Plans acknowledge that opportunities to improve the health of citizens involves action by many different sectors of the city, and that all of these agencies should be involved in health planning, not just the health sector alone.

Accordingly, intersectoral collaboration is an important strategy in the implementation of health promotion activities to achieve a healthy city. Intersectoral collaboration has been expressed and defined in many ways and using different terms: for example, intersectoral cooperation, coordination, coalitions, healthy alliances, social movements or formal inter-organisational arrangements (Chapman and Davey, 1997; WHO, 1997b). Strobl and Bruce (2000) comment that the large scale Liverpool City Health Plan had a significant challenge to gain broad collaboration and participation in its policy development, but there was wide agreement that this process was vital. They reported that participants needed more time to consider the implications of the CHP, the need to keep stakeholders together to implement and revise the plan and questioned the feasibility to develop urban health policy on a more routine basis.

Most initiatives taken principally for environmental reasons improve human health, although this may not be explicit. In exploring new responses to the health problems found in cities and towns, the WHO Healthy Cities project represents the relationships between municipal departments, other bodies and the community and represents the policy framework as ‘pillars of health’ (Hancock and Duhl, 1998a; 1998b and WHO, 1997b). Figure 4 highlights the need for cities to extend or develop existing collaboration, both horizontally within the city and vertically with other levels of government and the wider community. This model of integrated action underpins the ‘Healthy Cities Approach’ to planning work in Queensland in developing MPHP in local government.

WHO (1997b) documentation comments that formulating a city health plan is an important process for a city because the plan:

- places the challenges related to health and the quality of life on the agenda of policy-makers within local government, health authorities and other organisations
- links health gains to environmental issues
- rationalises scarce resources, including people’s time and energy
- establishes a basis for monitoring the progress of initiatives and evaluating success
- develops a basis for budgeting for the development of appropriate services and programs for health
• demonstrates the commitment of city organisations to greater participation in local decision-making, and

• can improve the experience of living in cities, neighbouring areas and communities over time.

Effective planning is complex and demanding (WHO, 1997b). It involves developing a climate with the political will for planning for health, which means that the strategies must accommodate the unique political context of cities and their organisation. Drawing up a Municipal Public Health Plan serves to generate awareness of health and environmental problems among municipal authorities, non-governmental agencies and communities, and to mobilise resources to deal with the problems. The plan should not be considered a ‘one-off’ exercise that will generate all the necessary actions to solve the city’s health problems once and for all; rather it should be seen as a process of consultation, data-gathering and analysis that continually opens new channels of communication (WHO, 1995a; Goldstein and Kickbusch, 1996).

The plan may include programs or projects for specific settings, such as schools, workplaces, the marketplace, and health care locations (WHO, 1995a; WHO, 1995b; Goldstein and Kickbusch, 1996). A key issue is whether or how national policy supports the local programs and may influence the project. In some countries, it has been helpful to establish a National
Healthy Cities Commission or Network. A clear commitment by such a body to local government policies that reduce marginalisation or the exclusion of poor communities from social and economic life and services can greatly assist local efforts (Goldstein and Kickbusch, 1996).

Partnership approaches are required to collectively plan for improving the health of communities; MPHP is a WHO Planning Model that has its foundation in sustainable development and that links health, environment and other agencies in local area planning (see Chapman and Davey, 1997; WHO, 1995c). MPHP is an approach to improving the health of communities characterised by the influences of the new public health (see Chu and Simpson, 1994; Davey, 1997). The following section discusses the new public health and the ecological public health, as well as exploring further the history of the Healthy Cities approach in Australia.

In Australia a National Healthy Cities Office was established for three years in 1994 to support the concept of Healthy Cities across the states and non-governmental agencies. Both a formal and an informal network supported Healthy Cities projects across Australia (Kaplan, 1992; Lowe, 1994; Baum, 2002, Chu and Simpson, 1994) MPHP in Queensland (Chapman and Davey, 1997) can be best described as both a process and a product. The product is a dynamic strategic planning document that guides future local public health planning and actions, while the process facilitates the development of partnerships between local government and other stakeholders to identify and seek solutions to identified priority health issues. The MPHP developed in Queensland – the centre of this research dissertation – is demonstrated through the Healthy Cities and Shires Framework in Figure 4 (see Chapman and Davey, 1997). This framework places local government as the key stakeholder facilitating MPHP, with other agencies in a settings approach to health.

The National Public Health Partnership (2000) developed a case study noting that MPHP provides an opportunity for local government to engage the community, government and non-government agencies in addressing the public health issues in their municipality. It commented that there was a need for a policy and legal framework and gave an example of Victoria Health Act (1958) specifying that one of the functions of councils is the preparation of a MPHP every three years. This background paper reported that the public health plans in Queensland were not required under any legal framework, but local and state government agencies worked together with the Healthy Cities and Shires Queensland to coordinate the health promotion initiative. Other important issues reported from MPHP by NPHP (2000) included the building of trust between partners, the conflict councils had in accountability to other levels of government and communities, the resources needed to implement the plan, and the need for improved information systems and evaluation; as well, MPHP needed broader skills, which were not
always available in local government. However, a range of successful projects emerged from MPHP. More research is required particularly on the organisational and management issues that impact on the success of MPHP.

The guiding principles for MPHP in Queensland include inter-sectoral collaboration, interdepartmental collaboration and community participation. The process advocates for the formulation and adoption of local public and environmental health plans. The process in Queensland is called MPHP; however, each community has named its planning process based on local agendas such as community health plans or public health plans. Each plan involves the collaboration of many different sectors, departments and the community in decision-making about public and environmental health matters that impact on the quality of life of residents in local government areas. Figure 5 describes the Healthy Cities approach in Queensland (Chapman and Davey, 1997).

A seven-step model for MPHP was published by Chapman and Davey (1997). At the end of the first phase of the pilot projects in Queensland, the process for developing a ‘Municipal Public Health Plan’, as presented in Figure 6, was published in a resource book (Chapman and Davey, 1995a; 1995b).

Figure 5: Healthy Cities and Shires Framework
(Source: adapted from Chapman and Davey, 1997, p.85)
In developing MPHP, decisions have to be made at a community level as to what level of participation will be built into the project. Achieving meaningful participation means changing organisations and supporting the community’s involvement. Health planning initiatives need to consider the balance between token involvement and full public consultation and participation.

The development of wide-ranging health and environment agency participation is a key factor for the success of collaborative approaches to health planning in cities (Chapman and Davey, 1997; Davey and Logan, 2001a). Representatives of agencies and communities should be involved in the process of developing, carrying out and evaluating a city health plan. Community and agency participation in the planning process has to be clearly structured and agreed upon in the scope of the pending health initiative. MPHP has its foundation in LA21 initiatives; however its focus is on improving human health and environment outcomes at a local level (Chapman and Davey, 1995a). MPHP is concerned with the physical and social environment and disease control, adding quality to life within a local government structure, the third level of government in Australia (Hamlin, 1998; Chapman and Davey, 1997; Davey, 1997). MPHP has to a greater extent prioritised human health over health of the natural environment, but obviously these two issues are firmly linked. In comparison, LA21 planning has an emphasis on the preservation of a sustainable natural environment as a priority in planning.

Figure 6: A Seven-Step Model for MPHP
(Source: Chapman and Davey, 1995a, p.37)
2.6 Conclusion

Chapter 2 reviewed urbanisation, sustainability and health, discussed the emergence of the ecological public health, settings and health promotion and reviews the literature on the Healthy Cities approach. In this context, the chapter discussed the broader issues of the ‘global challenge’ of continuing improvements in health and environmental sustainability, particularly in a world of increasing urbanisation. The WHO Healthy Cities approach was explained as a useful strategy in developing partnerships for health action in communities. This chapter argued for health planners to understand and apply the concepts of ecological public health in local government settings. In the light of the global challenge of managing unsustainable urban growth, participatory health planning was discussed as a ‘local response’ to these problems. The chapter concluded with an argument for an increased need for city health planning practices.
CHAPTER 3  PARTNERSHIPS IN HEALTH PROMOTION: THE REGULATORY ENVIRONMENT AND PARTICIPATORY HEALTH PLANNING

3.1 Introduction

The Healthy Cities approach advocates for effective partnerships as an essential element of health promotion action when developing participatory health planning at the local level. If partnerships are the key to effective health planning (and more specifically MPHP), then an understanding is required of the history of partnership thinking both globally and locally. The chapter then argues that the principles of successful partnerships need to be further articulated in local government settings to successfully implement MPHP. The chapter also analyses how best agencies can deal with the complexities of participatory health planning in a regulatory environment. The existing health, environment and development regulation and planning frameworks in place lay the foundations for healthy and sustainable communities. Participatory planning in Queensland is not mandatory under legislation; even so it is guided by state and local government regulation and policy. Using this understanding, combined with a conceptual mapping process of a selection of community public health planning models trialled in Queensland, the research examines and compares the salient features of selected CPHP models that are used in local government.

3.2 Partnership Approaches and Health Promotion Concepts

This section argues that partnership approaches and health promotion concepts are the building blocks for successful MPHP. It describes health promotion action in Australia based on partnerships thinking. The term partnership has been extensively adopted throughout the world to describe a wide variety of public interest ventures, from loosely structured relationships committed to sharing or disseminating information to the other extreme of parties carrying on business activities (Little, 1997). The health promotion profession increasingly use the concept of partnerships to deliver more effective programs. Gillies (1998) defines partnerships as a voluntary agreement between two partners to work cooperatively toward a set of shared health outcomes. Little (1997) suggests that in law a partnership has well defined legal meanings for its extensive rights, obligations and liabilities. Partnerships in public health suggest that a number citizens and agencies enter a relationship, which implies certain levels of trust and commitment to common goals. Partnerships allow for sharing of resources and expertise; formalising these arrangements will significantly improve the sustainability of partnership processes and the ongoing development of programs (Scott, 1997). Partnerships are an important strategy to implement health promotion activities to achieve a healthy city (Costongs and Springett, 1997).
The advocacy for a multi-sector collaboration emerged with the primary health care movement in the late 1970s. Public health partnerships became important in the 1990s as a strategy to improve the coordination, cooperative, collaboration, and community participation of public health planning and implementation in responses to global, national, and local challenges. Public health partnership development was central to the themes of the following conferences and reports spanning over a twenty-year period, and included several significant milestones:

1. The 1978 Primary Health Care Conference
2. The 1986 1st International Health Promotion Conference
3. The 1987 Bruntland’s Report on Environment and Health
4. The 1992 UN Conference on Environment and Development in Rio
5. The 1994 WHO Global Strategy for Health and Environment
7. The 2000 WHO Mexico City ‘Bridging the Equity Gap’ in the 5th Global Conference on Health Promotion, and

At the First International Conference on Health Promotion (WHO, 1986), health promotion was defined as a ‘process of enabling people to increase control over and to improve their health’. The five elements critical for health promotion were listed as:

- Healthy public policy
- Supportive environments
- Community action
- Development of personal skills, and
- Reorientation of health services.

At the Second International Conference on Health Promotion in Adelaide in 1988 the need for healthy public policies took centre stage. It became clear that policies that make social and physical environments health enhancing are not the responsibility of the health sector only. Sectors such as environment, transport, agriculture, trade, industry, education, and communications have also to be accountable for the health consequences of their policy decisions. The four aspects of supportive environments highlighted at the Third International Conference on Health Promotion at Sundsvall, in 1991 were:

- The social dimension, which includes the ways norms, customs and social processes affect health
- The political dimension, which requires governments to guarantee democratic participation in decision-making and decentralization of responsibilities and resources
- The economic dimension, which requires a re-channelling of resources for the achievement of Health for All and sustainable development, and
- The need to recognize and use women’s skill and knowledge in all sectors, including policy making and the economy, in order to develop a more positive infrastructure for supportive environments.
A supportive environment is of great importance to health. It is the inclusion of the physical, social, spiritual, economic, and political environments that makes it possible for people to lead healthy lives. This supportive environment recognises the interdependence of all living beings, the need for collaborative action and the need to achieve health equity and social justice. Deliberations at the Earth Summit in Rio de Janeiro in 1992 as discussed in Chapter 2, stressed that ‘development’ means meeting the needs of people, including their health and well being, and improving the environments on which people depend. Health, environment and sustainable development are inextricably linked.

A report of the World Health Organisation in 1997 to the special session of the United Nation General Assembly made the following statement:

A new perspective on health has emerged, whereby health is seen as an essential component of sustainable development, which requires concerted action, by all sectors of society. The 21st century calls for a new health system, which is partnership-oriented, population-health based, and proactive rather than reactive. The health sector must serve as a guide to and be a partner in these actions so that health concerns are represented appropriately at all stages of implementation (WHO, 1997a).

These are the foundations on which Health Promotion principles and actions are built. At the Fourth International Health Promotion Conference held in Jakarta in 1997, the conference set priorities for global health promotion in the 21st century and called for a global health promotion alliance (MacDonald, 1998). This support for alliances was reiterated at the Fifth Global Conference on Health Promotion held in Mexico City in 2000, and at the Bangkok Charter for Health Promotion in 2005, which called for bridging the health equity gap both within and between countries, and which stated that, since health promotion addresses the fundamental determinants of inequity in health, it represents a viable and strategic response to bridging the health equity gap.

Good health is a social goal. Its determinants are found in the physical, political, economic, socio-cultural and ethical environments that influence our lives (Chu and Simpson, 1994). Its responsibility therefore must lie in the hands of all those who shape and control these diverse environments. Partnerships for health have become an increasingly important mechanism for achieving health for all (WHO, 1997c). The process of health promotion, particularly the settings approach, relies heavily on the fostering of partnerships to give people and organisations opportunities to increase control over and improve health (Ashton, 2000; 2002; Chu et al. 2000). There is a clear need to break through the traditional rigid sector boundaries to create new partnerships for health. Partnerships to create healthy settings serve multiple interests. For the health sector, it means increasing the momentum for improving health by putting health on both its and other sectors’ agendas. For other sectors and community groups,
getting involved in health – combining health with their own sector – facilitates reaching their own sector goals and outcomes (NPHP, 2002).

The success then of healthy settings projects depends largely upon how successfully partnerships have been built between individuals, communities, governments, non-governmental organisations, the private sector and other relevant groups (Ashton, 2002). Of the various driving forces that make settings healthy, intersectoral action and community participation stand out as the most important. MPHP requires both intersectoral collaboration between agencies and interdepartmental action within local government, as well as community participation in decision-making about health needs and services. A participatory relationship with the community leads to more effective program implementation and better sustainability. Essentially intersectoral collaboration and community participation are the major driving forces for the success of healthy settings projects (WHO, 1997c).

In healthy settings approaches, in this case MPHP models, decisions have to be made, not only about partnerships with other agencies, but also regarding what level of community participation (resident involvement) will be built into the project. Brager and Sprecht’s (1973) ‘ladder of participation’ (cited in WHO, 1997b) describes different degrees of participation, with respect to levels of control as well as participant action, and illustrative examples for achieving it. A range of participation with communities can be achieved, from communities having high levels of control and participation in decision-making to having low levels of input and no participation (see Laverack and Labonte, 2000). Achieving meaningful participation means changing some organisational processes and supporting the communities’ involvement. Health planning initiatives need to consider the balance between ‘token’ involvement and ‘full’ public consultation and participation (WHO, 1997c). The development of wide-ranging health and environment agency participation is a key factor for the success of collaborative approaches to health planning in the city. Representatives of agencies and communities should be involved in the process of developing, carrying out and evaluating health plans. Community and agency participation in the planning process has to be clearly structured and agreed upon in the scope of the pending health initiative (WHO, 1997b; NPHP, 2000).

Partners become not only stakeholders but also shareholders in health. Creating new partnerships for health and social development, between different sectors and at all levels of governance in society, offers an essential mechanism for the practice of health promotion (WHO, 1997b). Collaboration and co-operation provide a sustained joint effort to achieve a common mutually beneficial outcome. Hancock (1999, p.275) notes that ‘a healthy community is one that has high levels of social, ecological, human and economic capital; the combination of which may be thought of as ‘community capital’. He concludes that the challenge for communities in the 21st century is to increase all four forms of capital by working with partners,
making human development the central purpose of governance and more closely integrating social, environmental and economic policy at a local level (Hancock, 1999). Hancock summarises by challenging us to learn how to create community capital as a fundamental strategy for creating a healthy city.

According to the WHO (1997c; 1997d) Healthy Cities documentation, coordination focuses on bringing different parts of a system or operation into effective working relationships. A collaborative approach is underpinned by the commitment of different stakeholders to work together for mutual benefit. Collaboration is a means of achieving coordination. The WHO (1998) key principles for successful public health partnership are summarised as follows:

1. Develop a shared clear goal, vision and values
2. All partners need to be able to trust and have respect for each other
3. The process needs to be transparent and informed
4. All partners are equal and all decisions/actions are negotiated
5. The roles and responsibilities of each partner need to be negotiated and clearly defined, and
6. Commitment by all partners to see the process through to completion.

The steps in developing a partnership include identifying the areas that people and organisations can work together determining priority issues; identifying potential partners; reaching a partnership agreement (an MOU); developing strategies together; developing the partnership Health Action Plan; listing achievement; and reviewing and evaluating the partnership (NPHP, 2000; 2002). Health policy development is not only about vertical and horizontal interaction and negotiation: it is also about learning (Goumans and Springett, 1997). IPAA (2002) notes that there is emerging research supporting the placement of these concepts on a continuum based on the degree of change and commitment required (the terms are not interchangeable). The IPAA’s hierarchy develops through the sequence of networking, cooperation, coordination and collaboration to partnerships at the highest level. These clear guidelines for developing partnerships have influenced the design of participatory health planning models in community settings and are a positive way forward for health action.

In the process of consultation with the community and with many different agencies and groups, an effort is made to develop a ‘vision’ of the future direction of the city, and to understand its current (and past) strengths and qualities (Goldstein and Kickbusch, 1996). Health Promotion in the last decade has had to consider the impact of global economic forces engendered by the deregulation of markets; initiatives in relation to human rights; democracy; environmental degradation; military expansion; and information technologies (Held, 1996). Gillies (1998)
comments that health promotion set against a background of growing gaps in health status and health care around the world – by socio economic status; between geographical groups; by gender, race and ethnicity and age groups (WHO, 1996a) – has had to maintain the benefits accrued from best efforts to promote the health of individuals and groups at local and national levels.

The philosophy of health promotion aims for a change in thinking about concepts of health and to shift from a narrow view of health care policy towards a broader perspective of healthy public policy or health related policies (Pederson et al., 1998). Health is not just avoiding disease; rather, health is conceived as ‘the extent to which an individual or group is able to change or cope with their environment’ (WHO, 1986 cited in Costongs and Springett, 1997). These broader concepts of health acknowledge the contribution by various sectors, with intersectoral collaboration the strategy for enhancing health promotion. Addressing the need for action by sectors other than the health sector is vital in responding to public health problems (Nutbeam, 1994; 1996). Programs should focus on the health of individuals and populations through approaches based on alliances and partnerships to improve health outcomes (Gillies, 1998).

Participatory health planning at a local government level is a strategic approach to creating health alliances between agencies, with positive benefits for health action. Gillies (1998) states that ‘an alliance for health promotion can be defined as a collaboration between two or more parties that pursue a set of agreed goals for health promotion’. This definition applies similarly to pursuing a set of agreed goals for health planning. Partnerships for health promotion focus on health outcomes rather than on specific health promotion goals; therefore a partnership for health promotion is defined as ‘a voluntary agreement between two or more parties to work cooperatively towards a set of shared health outcomes’ (Gillies, 1998). Through intersectoral collaboration, organisations notice different value systems which develop different solutions to health-related problems; this in turn raises awareness of their own values and may contribute to their willingness to learn and change (Costongs and Springett, 1995).

Davey and Logan (2001a; 2001b) reported the need for public health planning project partnerships to be formalised by ‘signed-off’ agreements between agencies wanting to work together. Informal partnerships can have sustainability issues, based around the different priorities of the collaborating agencies and community groups. The results of a study in Liverpool indicated that joint working had been reasonably effective in developing the City Health Plan in Liverpool, but that more attention should be paid to the process of people working together, rather than an emphasis on formal joint structures (Costongs and Springett, 1995; 1997). The Liverpool City Health Plan was designed not only to coordinate the health activities of partner agencies, but also to integrate purchasing, service and business plans of the key organisations in the city. To achieve this work, the approach developed a communication
process that included an intersectoral management team and four multi-sectoral working parties. Engel et al. (1994) points out that it is the independent and co-ordinated joint working of the full range of possible participants that stimulates processes of innovation and change. Joint working and networking are the main components of intersectoral collaboration, and are really creating a platform for agency and community group discussion. As Hazen (1994) argues, dialogue occurs when people speak and listen to one another in mutuality, reciprocity and co-inquiry. In doing so they change their shared reality, encouraging reflection on those experiences.

The skilled health promotion facilitator sets up conditions where this sharing of ideas and experiences can occur regularly in a community setting, with the aim of promoting changes in the way organisations think about health concerns. Costongs and Springett (1995) conclude from their research that producing a city health plan revolves around the way people work, the effectiveness of which is related to the participants’ background (from the community, government or non-government or industry), the commitment of their agency and their personalities. These three characteristics determine the degree of power the participants have, how the group perceives them, and their functioning in the group, with all characteristics contributing to the success of intersectoral collaboration. Joint working is an effective process in the development of a health plan. Costongs and Springett (1997) noted that in Liverpool, because organisations took joint ownership of the city health plan, organisations, groups, and individuals began to change their views about public health issues in the city.

3.3 Health Promotion and the National Public Health Partnership in Australia

Participatory health planning in local government develops a vision for a healthy community; this usually includes quality of life issues. Disease prevention is a primary objective. Disease prevention in the Australian population can be categorised by three broad approaches, namely health protection, health promotion and preventive health services (AIHW, 1998; CDHAC, 1999; Cromar et al., 2004). Health protection is activity related to communicable diseases (immunisation; control and management of HIV/AIDS) and to food safety and environmental health hazards, largely through regulation, notification and environmental modification (AIHW, 1998). Health promotion is a combination of health education and the promotion of policies and environments conducive to healthy lifestyles, such as activities assisting people to increase control over the determinants of their health (nutrition, smoking, and alcohol consumption), thereby improving their health, and programs aimed at whole populations or population subgroups, as well as counselling and advice delivered by health professionals in a clinical context (Chu and Simpson, 1994; Wise and Signal, 2000). Preventive health services include activities usually delivered on an individual basis by health professionals, but which may be organised at a population level, such as cancer screening and family planning services. A MPHP has
elements of all three broad approaches to disease prevention (Chapman and Davey, 1995a; Lowe, 1994; Dwyer, 1997).

In Australia’s federal system of government, responsibilities are divided between the States and Territories and the Commonwealth. State and Territory health departments have primary responsibility for a wide range of public health functions, including the delivery of hospital and community health services, while the Commonwealth Department of Health and Ageing funds primary care through general practitioners. The Commonwealth is responsible for the development of national strategies, information materials and national campaigns, but health promotion activities are developed and implemented mainly by State and Territory health departments (personal comm. see CDHAC, 1999). The Commonwealth Department of Health and Ageing initiates, funds and participates in a number of national programs, such as the National Drug Strategy and the National Immunisation Program, in partnership with the States and Territories. The Commonwealth also works with the WHO and other international organisations in major international health projects, and with individual countries in capacity building and health promotion (NPHP, 2000).

The National Public Health Partnership (NPHP, 2002) brings together the Commonwealth, State and Territory health departments to promote national population health effort and to provide a focal point for collaboration between government agencies responsible for public health policy and action. This approach is consistent with most industrialised countries (see Robertson, 1998). NPHP has an advisory group of non-government organisations and an Aboriginal and Torres Strait Islander Working Group. Key partnerships have been formed between governments, non-government organisations, stakeholders and experts to work in areas such as Aboriginal and Torres Strait Islander health, mental health and healthy ageing (NHMRC, 1992; NPHP, 2000; NPHP, 2002).

In addition to partnerships involving governments, networks of non-government organisations have been formed (see Queensland Council of Social Service, 1998). An example is the Chronic Disease Prevention Alliance; members include the Heart Foundation, the Stroke Foundation, Diabetes Australia, the Cancer Council and the Kidney Foundation. The Alliance will focus initially on strategies for improving nutrition and increasing physical activity in the Australian population.

Australian and international research shows that targeted investment in prevention can produce better health gains than equivalent spending on treating illness once it has occurred. Over the past hundred or so years, there has been a shift in disease patterns in Australia from a predominance of communicable diseases to an increase in preventable chronic diseases with behavioural risk factors (AIHW, 1998). While the traditional emphasis on health protection and
public health infrastructure must be maintained, there is more emphasis on health promotion, informing individuals and facilitating healthy lifestyles (NHMRC, 1992; NPHP, 2000; NPHP, 2002). There is increasing recognition of prevention as a fundamental component of a sustainable health system.

There is support for participatory health planning at a national level in Australia. The National Public Health Partnership (NPHP, 2000) asks why public health practice needs a planning framework. The framework aims to contribute to public health planning in three broad ways, namely a common language, a systematic approach and the integration of action by the recognition of commonalities. More specifically, the framework identifies ten public health intervention types including collaboration, partnership building and community and organisational development in broad domains such as environmental health, communicable disease, lifestyles and health.

Scott (1997, p.2) at a public health partnership symposium in Queensland commented ‘working together in partnership has the potential for more efficient, effective and sustainable action than could be achieved by each of us working alone’. A multi-sectoral Queensland Public Health Forum (QPHF) was established as an outcome of the symposium. The Forum has over 29 public, environmental and social health agencies that meet every three months to collaborate on health initiatives through partnership approaches. The approach is based on the NPHP philosophy and funded jointly by the Australian Government and Queensland Health. At a local level, the Eat Well Queensland Strategy developed by the QPHF is a good example of improving health outcomes through partnership capacity building. Partnerships are the key to successful integration and to significant improvements in joint agency outcomes and population health (Robertson, 1998).

The foundation of good planning is also discussed in the NEHS (CDHAC, 1999). From a national perspective the National Environmental Health Strategy supports health planning that shapes Australian towns and cities (CDHAC, 1999, p.51). The Strategy notes that the key to creating healthy environments is good planning that recognises potential health impacts from the outset. A range of tools is recommended to achieve planning, including legislation that supports healthy planning at the local level. The strategy highlights that environmental health is highly intersectoral in nature, and that a commitment to partnerships is essential for improving environmental health. This requires all stakeholders and affected groups to recognise their common aspirations, to develop common goals, to work to strengthen their communication and links and to forge partnerships on common action (CDHAC, 1999). It encourages engagement with partners to design and implement the ‘whole of government’ regional framework for growth management for sustainable futures. Queensland has endorsed NPHP and EnHealth recommendations, together with a range of other state and local planning policy, in a complex
array of planning frameworks. The process of developing structured planning mechanisms in levels of government is aimed at creating a sustainable foundation for health gains. In Queensland, several structured frameworks have been developed at both state and local level, as a response to the growth of populations from urbanisation.

3.4 Participatory Health Planning and the Regulatory Environment in Australia

This section examines both the impact of the local government, health and environment acts and regulations and the interface with participatory health planning. Brown et al. (2001) comment that integrated frameworks linking environment and health were reviewed, that special reports were prepared by all states, and that interviews were held with key informants to identify and collect materials on such frameworks. Brown et al. base the following discussion on information from the review, which itself used information provided in 1999 by the researcher on the status of Queensland integrated planning frameworks.

The Local Government Act 1993 and the Local Government Finance Standards 1994 (LGFS) each have a statutory requirement for all local governments to plan for local and regional issues. The act requires all local governments in Queensland to develop corporate plans and operational plans (see Local Government Act s507, s510 and LGFS Part 3 Corporate and Operational Plans). The Local Government Act and the LGFS require local government to prepare and adopt a corporate plan in an integrated response to the present and future needs of the community (see Brown et al., 2001; Dodds, 2000; Cromar et al., 2004). The plan must include an assessment of local and regional issues, a statement of strategic direction, a statement of objectives about the issues affecting its area, and strategies for achieving the objectives. There is a mandatory three-year corporate planning cycle, with a requirement for Councils to develop an annual operational plan. The assessment of local and regional issues, and the local government’s response, must include its role in a range of issues (Chapman and Davey, 1997). These included community development and human services, environmental management (since 1994) and (more recently in 2005) environmental and public health management (Local Government Act 1993; Cromar et al, 2004).

Queensland Health supported a process to amend section 16(1)(d) of the LGFS to require Councils to include environmental and public health management matters in their corporate plan. In 2005 Queensland Health wrote a discussion paper encouraging local government to adopt a Healthy Cities approach and supported planning models like MPHP. They advocated for participatory needs-based health planning to provide health data (from health profiles, needs assessment and health service gap analysis) to the Council corporate plan. This process relies on local agency, community groups and resident health concerns, linking health, disease prevention and management issues into the strategic directions of local government corporate planning.
There is an opportunity then for Council to link the health strategies to higher levels of state regional and other agency planning.

A consultation process is required in the development of the corporate plan (see LGFS s17). The consultation process is based on submissions and comments from residents rather than from focus groups or public meetings. This style of consultation could limit the community’s involvement in the planning process. Corporate plans are reviewed every three years. An annual Operational Plan is required and should include methods by which objectives of the corporate plan can be achieved. Operational plans are reviewed every year. The planning requires processes and outcomes, which are mostly internal to Council: the plan must contain objectives and performance measures. Performance management in local government assists in monitoring the objectives of the corporate plans; however, most reviews of the corporate outcomes of Councils are internal organisational documents, and remain unpublished.

The Health Act 1937 was reviewed in Queensland (over a ten-year period), leading to the new Public Health Act being gazetted by the Queensland Government in 2005. From August 1995, several discussion papers were circulated to stakeholders. A summary of the new The Public Health Act 2005 (PH Act) shows that its impact on health planning is minimal:

- the PH Act and regulations mainly support the traditional public health and clinical services approach
- the PH Act does not contain any requirements for mandatory community public health planning, and
- in Queensland MPHP will not be included as a planning mechanism in state legislation unless local government advocate for its inclusion and its subsequent funding.

Brown et al. (2001) state that planning frameworks supporting whole-of-government action for environmental health are by definition working towards integration, linking community and government action, and social and environmental futures. While legislation is more likely to be about keeping things uniform and stable in our compartmentalised administrative and information systems, integrative frameworks are inherently about supporting diversity and change. There are two types of planning frameworks: those frameworks driven by legislation and government, which are mandatory, and those initiated by a drive for integration, which are mostly voluntary (Brown et al., 2001, p.54).

Brown et al. (2001) deduce a paradox in community action for environmental health planning, in that mandated integrated planning frameworks are increasing, but are striking difficulties in implementation, while voluntary frameworks can be judged viable or non-viable in relation to their current legislative and administrative context. The paradox suggests that a change-oriented planning framework (like MPHP in Queensland) lacks long-term effectiveness without
legislative underpinning. This study will research this issue with key stakeholders in Queensland. In the opinion of the writer, what Brown et al. suggest is only one dimension of the problem.

Reynolds (2004) notes that environmental laws in Australia comprise laws protecting biodiversity and conservation and environmental protection laws that control pollution; both areas have significance for public health. Environmental protection laws punish those who cause environmental harm (Reynolds, 2004). The Environmental Protection Act, regulations and codes of practice have been reviewed and rewritten in the last 10 years in Queensland. The legislation developed is best practice, innovative and modern in its approach to reducing ‘environmental harm’. Environmental sustainable development (ESD) is a foundation of the Act and the regulation governing air, water, waste and noise quality. With respect to linking health and environment, there is strong acknowledgment of ‘environmental stewardship’ in the Act and policies of the EPA: this approach has had an impact on health outcomes for communities. The EPA is concerned with licensing medium to large sized industry activities, referred to as ‘environmental relevant activities’ (ERA). EPA delegates the task of managing smaller ERAs such as engineering and car repair workshops to local government. This partnership between the levels of government links health and environment matters at a regional and local level, reducing the impacts of industry on communities. Because the laws relating to improving the environment are separate to public health laws, and managed by separate departments, then MPHP can act to bring agencies strategically together over common issues for both the betterment of health and the environment.

The Department of Local Government, Planning, Sport and Recreation (LGPSR) facilitates the regional framework for growth management in south-east Queensland, with input from the Regional Organisations of Councils (ROCs), EPA, Queensland Health, Queensland Transport, Indigenous groups and non-government agencies. The linkage between health and environment is developing well in this regional planning process. At a regional level the EPA and Queensland Health work in collaboration with local government MPHP projects. This planning framework will be discussed in detail in the following section.

Many local governments have corporate environmental management systems to meet the demands of the above state legislation. These internal project management approaches assist in developing best practice within Council. ‘Best Practice’ implies, for example, state-of-the-art recycling programs, sewage treatment and waste management. In this process, there are partnerships established between health and environment departments within Council. As a result, community conditions improve over time.
3.5 The Influence of Land Use and Development Planning on Participatory Health Planning

This section discusses the major land use and development planning issues in Queensland that relate to increasing urbanisation and quality of life issues for communities, including planning models currently used in Queensland (described in Table 2). Katsof as early as 1994 (cited in Chu and Simpson, 1997), suggested a need to develop integrated planning in the land use and human services sectors in Canadian cities. Hancock (2000) argues that healthy communities and suburbs must be both environmentally and socially sustainable, given that health depends on the quality of the built and natural environments (see Baum and Palmer, 2002). Integrated land use and development planning in Queensland then should influence the aims of participatory health planning projects.

### Table 2: Planning Models in Queensland

<table>
<thead>
<tr>
<th>CPHP Models supported by Local Government and Queensland Health</th>
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<tr>
<td>• Environments Australia and Local Government – LA21</td>
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<tr>
<td>• State and Local Government MPH</td>
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<tr>
<td>• Queensland Health – Community Public Health Planning in Rural and Remote Areas Project (CPHPRRAP)</td>
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<td>• Queensland Health – Place Management (Place)</td>
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<td>• Queensland Health Public Health Units – Supportive Environments for Active Living (SEAL)</td>
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<td>• Queensland Health Public Health Units – The Bowen Project (Bowen)</td>
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<th>Indigenous Planning</th>
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<tr>
<td>• Commonwealth Departments – Indigenous 10 Year Partnership Planning Palm Island Vision Planning</td>
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<td>• Commonwealth Departments and Queensland Health – Yarrabah Partnership Planning</td>
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<tr>
<td>• Queensland Health – Cape York Planning</td>
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<td>• Queensland Health – Cherbourg 10 point Health Planning Other Planning Projects</td>
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<th>Other Agency Planning with Outcomes for Health</th>
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<tr>
<td>• Queensland Housing – Community Renewal</td>
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<td>• Queensland Housing – Urban Renewal</td>
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<td>• Department of Transport – Safe Communities</td>
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<td>• Department of Community Engagement – Regional Communities Program</td>
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#### 3.5.1 The Integrated Planning Act 1997 and Associated Planning Schemes

In December 1997 the Queensland Government enacted the Integrated Planning Act. England (2004) comments that a more multi-disciplinary approach to planning is now more assured in Queensland with this Act in place. The purpose of the Integrated Planning Act 1997 and Guidelines (IPA) is to seek to achieve ecological sustainability by coordinating and integrating planning at the local, regional and state levels (Florian and Morton, 2000; England, 2004). The policy objectives of this legislation and guideline are to manage the process by which development occurs and manage the effects of development on the environment. The concepts of ecological sustainability as defined in this legislation have had growing importance both globally and nationally in the past decade (Florian and Morton, 2000). The Queensland Government is a signatory to the Commonwealth Governments National Strategy for Ecological
Sustainability. In advancing Queensland’s commitments towards ecological sustainability, the state government has applied these principles in the context of the planning and development assessment framework created in IPA (England, 2004).

While IPA defines sustainability in outcome terms, it also describes a series of actions to demonstrate how the achievement of these outcomes may be advanced. For example, decision-makers are required to:

- take account of both short-term and long-term environmental effects of development across the State and locally
- apply the precautionary principle
- seek to provide equity between present and future generations
- encourage sustainable use of resources
- lessen or avoid adverse environmental effects of development
- supply infrastructure in a coordinated, efficient way and encouraging urban development in areas with adequate infrastructure, and
- apply standards of amenity, conservation, energy, health and safety in the built environment that are cost effective and for the public benefit (Florian and Morton, 2000; England, 2004).

The IPA establishes a framework for integrating all development related assessment systems in local and state government into one system. Known as the Integrated Assessment Development System (IDAS), it is integral to the operation of IPA. This guideline recognises that an integrated decision-making system on its own does not guarantee good decision-making (England, 2004). Integrated policy also must exist to guide the decision-making process. Integrated policy is the outcome of integrated planning. The IPA establishes principles about regional planning, to include the formation, composition and conduct of regional planning advisory committees. For example the South East Queensland Regional Planning Committee has stakeholders from the EPA, Queensland Health and Department of Transport and many others sectors. Linkages between health and environment are articulated in the Regional Plans (Queensland Government, 2005b).

The IPA also establishes planning schemes; these instruments firstly involve the local government preparing a statement of proposals for its planning scheme (the Town Plan) and consulting with the community and the State about the proposals (see Florian and Morton, 2000; Dodds, 2000; Cromar et al. 2004). The first phase requires local government to identify and seek feedback on the scope of matters to be addressed in the planning scheme. Proposed options for dealing with those matters are considered. In the second phase the scheme is reviewed,
approved by the Minister, taken back to the community for feedback and then publicly notified, before final approval. Planning Schemes are reviewed every three years (England, 2004).

One of the features of planning schemes is the concept of desired environmental outcomes (DEOs) which link back to the broad outcomes for ecological sustainability identified in the Act (see England, 2004). DEOs interpret these broad outcomes in a more localised context of the local government area and in turn provide the context for the scheme measures (strategies, policy positions, codes, etc.). For example Redcliffe City, with a population of 150,000, has only about five DEOs, with each DEO being a broad visionary statement. The author notes that the DEOs are very broad higher level mission statements, not specific needs based strategies, for these reasons MPHP strategies compliment the DEOS in the town plan. State planning policies are also developed by state agencies and are processed in similar fashion to planning schemes.

In general, the state agencies (like health, transport, EPA) can contribute to the IPA process by providing specific policies. For example, if a development is proposed in a local government area, the State can require the land use developer to provide assurances that there will be minimum impacts from air pollution, noise pollution, etc. from such development.

Queensland Health, through the Environmental Health Strategic Branch, established links with the Department of Local Government, Planning, Sport and Recreation (DLGPSR) in the development of DEOs (Florian and Morton, 2000). It was proposed that a State planning policy be created for all land use development, to take into consideration the impacts on Public and Environmental Health Planning. Florian and Morton (2000) proposed that a series of DEOs be developed for health matters. It was suggested that this state planning policy would link environment and health matters at a local level. The project had no success initially in 2000 to place public and environmental health on the land use agenda, but in more recent times, health and social issues have been included as a priority in the SEQ Regional Plan (see Queensland Government (2005a).

Town planning has a legal foundation but the mechanisms to improve health issues in communities are not well articulated in the IPA process. This appears common across cities, with the health agenda only partially being addressed in town plans. At a municipal level though, local area planning (LAP) has been the planning instrument used in selected Queensland councils to provide community infrastructure needs assessment information to the Corporate Plans in the LGA and the land use issues in the planning schemes in the IPA. All Councils are encouraged to develop a LAP process to assist with current community needs information in the town planning process. The larger councils like Brisbane City Council (BCC) and Gold Coast City Council (GCCC) have developed local area plans (LAP) suburb by suburb. LAPs assess not only infrastructure needs, but also health and safety issues, using a participatory framework for consultation with community groups, industry, government and
non-government sectors. The process is time consuming and there is a lot of duplication with the same stakeholders being represented on each suburb LAP Committee. BCC is reviewing this planning framework in favour of a more efficient regional approach to health planning.

MPHP is an appropriate alternative planning process to collect quality of life and health focused data and provides community and agency supported strategies for the town plan. The professional barriers between town planners, social planners and environmental health officers in Councils have reduced the opportunity to have a more integrated approach to needs-based partnership planning. Municipal public health planning has not been made mandatory in Queensland; councils that participate in this process do so voluntarily to enable a greater focus on health needs, policy issues and service provision. However in 2006 the Local Government Act was amended to require councils to include public and environmental health matters in their corporate planning process. This approach encourages councils to develop a health plan to feed information to the corporate plan but is only a voluntary policy. The policy goes further and suggests that council use the Healthy Cities approach. These changes serve only as a partial attempt to legitimise MPHP. This thesis examines the processes of MPHP, in an attempt to develop more integrated and effective health planning approaches that adequately inform the IPA and corporate plan in local government, so as better decisions can be made about the provision of health services by collaborating agencies.

3.5.2 Activities in Regional Planning

IPA provides for a whole-of-government approach to planning and this has developed well in South-East Queensland since 1997 (see Queensland Government, 2005a; 2005b; England, 2004). To respond to the challenge of the fastest growing metropolitan region in Australia, governments and key community groups in the region have developed an integrated set of regional policies and actions, called the Regional Framework for Growth Management (RFGM). This approach does address health promotion: the social determinants of health and issues of social capital in an urban landscape (Baum and Palmer, 2002). The current RFGM was endorsed in 1998 and the process developed the first SEQ Regional Plan (see Queensland Government, 2005b). The Department of LGPSR facilitate this planning process with input from the Regional Organisations of Councils (ROCs), EPA, Queensland Health, Queensland Transport, Indigenous groups and non-government agencies (Brown et al., 2001). The linkages between health and environment have developed since this regional planning process was enacted, but there is no consistency between councils across the state in relation to priority health needs and services. Information from each local government area feeds into this regional planning process, and similarly planning information will feed the other way to local government about regional issues such as air pollution. Even so the emphasis is on land use planning not on integrated health services delivery: this represents a significant weakness in the
planning. A MPHP can fill the gap with information about the agreed to health needs of the city and region (see Chapman and Davey, 1997; Davey, 1999).

The first Regional Plans covered 16 chapters and focused on a holistic approach to planning. There are many stakeholders identified and a participatory committee system drives the process. The RFGM included chapters on conservation of the natural environment, natural economic resources, water and air quality, regional landscape, urban growth, residential development, major centres, economic development and employment location, social/human services, liveability, cultural development, transport, water supply, waste management, and indigenous involvement. A framework for health and environment linkages is well established and is clearly identified in the plan in each of the above chapters. For example, Chapter 10 of the regional outline plan includes an objective to develop communities where people have fair and equal access to services, with a particular focus on affordable housing, employment and the full range of social and community functions. The comprehensive priority action area is defined with objectives, principles, priority actions and lead and supporting agencies. Public Health Planning is one of the many priority actions and Queensland Health is the lead agency with ROCs, Local Government and NGOs as the supporting partners. Further links will be developed for health and environment in the implementation of this planning process. This approach if developed in other parts of Queensland would link health and environment agencies in improving quality of life issues in communities.

The South-East Queensland Regional Plan (Queensland Government, 2005b) sets out the responsibilities of all state and local government agencies to work in collaboration on agreed priority planning actions across the region. Each local government in the region sits on the South-East Queensland Regional Organisation of Councils (SEQROC), which links with the SEQ Regional Plan 2005–2026. Within the SEQ Regional Plan 2005–2026 the regional outline plan describes the various priority action areas and accountable agencies. Similar planning frameworks exist in eight other regions in Queensland.

To date the SEQ Regional Plan 2005–20026 has successfully initiated and developed a range of strategies that are helping to create a positive future for the region. The following strategies have been delivered in South-East Queensland:

- Integrated Regional Transport Plan
- Regional Air Quality Strategy
- Economic Development Strategy
- Metropolitan and Key Regional Service Centres
- Regional Landscape Strategy, and
- Cultural Strategy.
Queensland Health has representation on the above strategy committees and has established a communities and local government team to implement priority actions. Functions include community public health planning, development of partnerships, community capacity building, addressing the social determinants of health and health impact assessment. A key function of this Committee is to engage with communities through local government, universities and other agencies to develop structured mechanisms for the development of MPH Plans, which are considered to be the tool to achieve healthy planning at a local community level. This function builds the local capacity to identify and respond to priority public health issues and to mobilise appropriate resources. Queensland Health is the lead agency in coordinating and actioning priority health actions in the regional plans. These include implementing actions, including developing collaborative area-based public health projects; reducing drug and injury related harm; enhancing child and youth health and well being and improving health outcomes for Indigenous people.

Local governments are represented on SEQ Regional Plan Committees, and also participate in the SEQROC, which brings the mayors of Councils together on a regular basis to action the SEQ Regional Plan activities (Brown et al., 2001). SEQROC also discusses improving regional approaches to community service delivery. These structured policy initiatives are important in legitimising the processes of planning that enable better health infrastructure and services to be developed in communities. Avenues for securing funding for the priority action areas are sought in the process.

Legally requiring councils to develop and implement a MPHP, as part of the IPA process and the Public Health Act, would not only legitimise the health planning agenda, but give it the same status as land use planning, thus enabling governments to budget for and fund its development. In the meantime, perhaps a stronger voice from Qld Health and local government in the whole of government committee process would also be of benefit. In most cases in the researchers opinion this voice needs backing with evidence of priority health needs of communities, another step in the MPHP process that would benefit local and regional planning (see Davey and Logan, 2001b).

3.6 Local Government – ‘A Public Health Partnership Protocol’

Local governments in Queensland, through the peak body of the Local Government Association of Queensland (LGAQ), have signed a protocol agreement with Queensland Health that sets out agreed-to action plans for issues of common interest, and provides a framework to undertake joint activities. In the public health planning action area of the protocol, the parties have agreed to enhance mechanisms for collaborative community public health planning (see LGAQ, 2000). This protocol advocates for formalised planning processes including, for example, Local
Government Corporate Plans, IPA Planning Schemes and MPHP. This is another example of structured mechanisms and formalising partnerships to legitimise the actions of health planning initiatives.

Davey and Logan (2001a; 2001b) concluded that the development of legitimate planning frameworks has allowed Queensland Health to provide funding to local government to develop MPHP. Appendix A highlights all MPHP projects developed and implemented in Queensland. Davey and Logan noted that the MPHP model has many positive outcomes, in developing both participatory processes between agencies and a strategic planning document for health. Davey and Logan (2001a; 2001b) also comment that the structures are right for integrated health planning within local government communities. The key structural mechanisms of health planning that have provided a sustainable foundation for MPHP projects in Queensland include:

- Policy support from National Partnerships and Strategies such as NPHP and EnHealth
- Whole-of-government approach at State level
- Inclusion in Regional Planning Frameworks
- Partnership approach to planning such as Queensland Health/Local Government Protocol, and
- Political support from Local Government (see LGAQ, 2000).

3.7 Community Public Health Planning In Queensland

The literature review identified several core community public health planning (CPHP) models being implemented in Queensland local government communities with health promotion foundations. Table 2 provides a list of first, the variety of community public health planning models facilitated by the health sector, designed specifically to deliver health outcomes in communities; and second, the Indigenous planning and other agency planning outside of the health sector. This second group includes planning models designed to deliver social, economic development, transport, housing, and safety outcomes as a priority, but not to directly deliver health outcomes. However, these other models do over time have indirect health benefits. All of the planning projects in Table 2 were active at the time of writing this thesis.

This thesis reviews the CPHP literature and discusses the features of the following CPHP models:

- Local Agenda 21 (LA21)
- Healthy Cities Approach: Municipal Public Health Planning (MPHP)


- Community Public Health Rural and Remote Planning/Participatory Action Research (CPHPRRAP), and
- Supportive Environments for Active Living (SEAL).

These models are in fact health promotion approaches, using planning mechanisms that lead to health promoting action in settings and have impacts on the health status of populations. The CPHP models reviewed in this chapter are discussed in chronological order from the earliest model implemented in Queensland to the most recently developed. The health promotion theory and planning practice characteristics of each model will be examined in the following categories: CPHP historical context of models and health promotion; CPHP health promotion principles and best practice elements; CPHP governance through partnerships, CPHP organisational context and funding; and CPHP planning, implementation and evaluation process. An understanding of the features of these models will assist in the development of the data collection processes in Part 3 of the Thesis.

3.7.1 CPHP Historical Context of Models and Health Promotion

From the Earth Summit in Rio de Janeiro in 1992, hosted by the United Nations Conference on Environment and Development, came Agenda 21, a plan to achieve sustainable development actions. Agenda 21 has four areas: social and economic development, resource management, strengthening participation of major groups and means of implementation. Local government authorities (Councils) are identified in Agenda 21 as important to actions for sustainable development. LA21 resulted as a means to build strategies at the local level that are based on the principles of Agenda 21 (see Cotter and Hannan, 1999).

LA21 proposed a comprehensive set of objectives globally and in the program in Australia, including that:

- by 1996, most local authorities in each country should have undertaken a consultative process with their populations and achieved a consensus on ‘a LA21’ for the community
- by 1993, the international community should have initiated a consultative process aimed at increasing cooperation between local authorities
- by 1994, representatives of associations of cities and other local authorities should have increased levels of cooperation and coordination with the goal of enhancing the exchange of information and experience among local authorities
- all local authorities in each country should be encouraged to implement, and
- a monitor programs which aim at ensuring that women and youth are represented in decision-making, planning and implementation processes.

MPHP has its foundation in the WHO HCM. The international HCM was initiated in Europe in 1986 as a means of supporting the WHO’s Health for All strategy and implementing the action
areas of the Ottawa Charter (WHO, 1986). MPHP has been the ‘tool’ used in many local communities in Queensland to plan and implement more efficient public and environmental health services and conditions.

The WHO’s Healthy Cities program is based on a number of key principles. Firstly, health should be an integral part of settlements (urban) management and development and can be improved by modifying the physical, social and economic environment. Secondly, conditions in settings such as home, school, village, workplace and city, profoundly influence health status. Finally, intersectoral coordination for health is necessary at the local level (WHO, 1997a; 1997b; 1997c).

The Healthy Cities project is noted to have important political and process elements:

- It promotes political commitment
- It advocates for a fundamental change in the local government relationship with its community
- The process advocates participatory activities, and
- It suggests that developing solutions to problems on a community-wide basis requires partnerships between both local government departments and outside government and non-government agencies.

The ecological public health concept according to Brown (1989) is an holistic approach that focuses on creating environments (physical, social, cultural and economic) to ensure that individual and community choices can be healthy choices. The approach is intended to support the concept of the new public health as ecological in perspective, multi-sectoral in scope and collaborative in strategy. MPHP has adopted these values (Brown, 1989).

The process advocates for the formulation and adoption of local public and environmental health plans called Municipal Public Health Plans (MPH Plans). This involves the collaboration of many different sectors, departments and the community in decision-making about public health matters that impact on the quality of life of residents in local government areas.

In Queensland, since 1994 many Local Government communities have developed MPH Plans. The process has been driven by the Healthy Cities and Shires Network based at Griffith University in the School of Public Health since 1996. A network of interested health and environment professionals has supported the process. The process applies the ‘new’ public health approach, namely the settings approach, in communities for managing and facilitating public and environmental health gains.
Links are established with a range of charters, reports and frameworks regarding public health policy and the health of rural and remote populations. These charters, reports and frameworks include:

- New Horizons in Health (WHO, 1995a), and

Rather than basing itself on a particular global planning model, the CPHPRRAP identifies that it is about establishing and trialling a new model of health service delivery.

Six key external developments have been identified as major contextual factors influencing the development of this project. These are listed in the Annual Evaluation Report (Dower et al., 2000, pp. vii–viii) as:

- International and national acceptance that the social determinants of health must be addressed if health gains are to be achieved
- National policy directions for rural and remote Australia stressing the need to work in a collaborative way with rural communities, fostering self-reliance at the same time as providing a fair share of available public resources for health
- A recognition that public health services have not in the past been accessible to smaller communities and that new and innovative models are needed
- An acknowledgement that the health status of many people in small rural communities (both Indigenous and non-Indigenous) is unacceptably below that of those in major cities
- The importance of an organisational milieu in which the introduction of new forms of public health practice, such as capacity building, do not easily fit with current practices and the need to build a wider constituency for change, and
- A well founded recognition that in many rural and remote towns past experiences with government initiatives have been negative and disempowering and that this initiative would have to constantly demonstrate a locally empowering approach. This is especially so in the towns chosen for this Project where greater than 70% of the town’s population are in the 4th and 5th quintile of the Socio-Economic Indexes for Areas (SEIFA).

This model recognised value in facilitating change and developing structures and processes at both the local community level and within government (Dower and Bush, 2001, pp.39–40). At the local community level, this model operated to enhance the capacity of a number of local communities to address their own public health determinants. Fourteen local communities took part in this project: Thargomindah, Cunnamulla, Morven, Augathella, Yowah, Tambo, Aramac, Muttaburra, Winton, Bouria, Dajarra, Camooweal, Croydon and Julia Creek (Dower and Bush,
At the wider government level, this project operated to disseminate project innovations, ensure wide support for the project and create a climate of change within which community capacity building could take place.

The Queensland document ‘SEAL: A Strategic Framework for Action’ (2001) states that historically SEAL followed planning examples from Europe, United States and Western Australia, for example:

- Barcelona public space policy – new parks, squares and promenades
- Lyon social public space policy – renovation of numerous public spaces
- Strasbourg renovation of public space and public transport
- Freiberg people orientated city and green traffic policy
- Copenhagen: better city step by step program – pedestrian-friendly main street, transforming many inner city areas into wholly or partially car-free space, and a targeted policy to create better conditions for bicycles traffic, and
- Portland pedestrian orientated policy – detailed design guidelines.

The SEAL framework can be linked to policies (*Active Australia – A National Participation Framework*), legislation (*Integrated Planning Act 1997*) and strategies (*Queensland Physical Activity Strategy 2001–2006*). The Queensland document *SEAL: A Strategic Response for Action* (SEAL, 2001) cites the following as the current context and challenges:

- Supportive Legal Environments: indicating there is the potential for SEAL initiative under the IPA
- Supportive Physical Environments: indicating the opportunity to make physical activity an incidental aspect of getting around in everyday live. Also highlighted is ‘responsive environment’ and that the layout and design of an area makes a difference to the ability of people to access and use what that place has to offer, and
- Transit Orientated Development (a mixed-use community within an average of 600 m walking distance of a transit stop and core commercial area): also highlighted, including characteristics of pedestrian-friendly and cycle-friendly neighbourhoods and principles of the walkable neighbourhood.

It is believed that a high proportion of the Queensland population are not physically active enough to achieve health benefits. The SEAL strategic framework for action aims to provide a basis for coordinated Whole of Government and community action for the creation, enhancement and sustainability of environments that support active living. The approach is based on the concept that by achieving greater participation in active living pursuits such as recreation, sports, fitness, arts, and culture they will be providing personal, social, economic and environmental benefits to Queenslanders. To achieve this greater participation in active living, convenient and safe local environments need to be provided.
The SEAL framework is intended to assist the Queensland Physical Activity Strategy, which is based on partnerships between government and non-government organisations to encourage better coordination of policy, programs and services and better use of available resources. The SEAL framework aims to assist the ‘Environmental Focus Area’ of the strategy, which specifically aims to create safe, accessible, sustainable and well managed environments that support participation in regular physical activity.

3.7.2 **CPHP Health Promotion Principles and Best Practice Elements**

The general principles of LA21 (Cotter and Hannan, 1999) include:

- Key principles of sustainability
- Integration
- Community involvement
- Precautionary behaviour
- Equity within and between generations, and
- Continual improvement.

In 2001 the GCCC released the document ‘Gold Coast City Council 2001, S.E.E the Future Society-Economy-Ecology’, which forms the ‘beginning of Council’s action plan, or Local Agenda, for sustainability in the 21st century, our LA 21’. This action plan covers the spectrum of our city, its society, its ecosystem and its economy. Case studies in the manual ‘Our Community Our Future: A Guide to Local Agenda 21’ (Cotter and Hannan, 1999) provide funding comments, with limited monies of $60,000 for a project officer actually committed to the projects. The case study reports that:

As the LA21 develops through an evolving partnership between community, industry, government and Council, it will allow us to see the future we wish for the City (p.65).

Low Choy (1996) reported that sustainable development must first be achieved at the local level in order for global and national initiatives to be successful. He found that for the LA21 sustainable partnership plan in Johnson Shire in Queensland to be sustainable, it needed full council support and there was a need to maintain the community partnership initiatives through the three-year implementation phase of the project.

Chapman and Davey (1997) describe the Healthy Cities project as a major initiative proposed by WHO to put ‘Health for All’ and Ottawa Charter philosophy into practice at the local level. MPH Plans were a tool to strategically manage local planning for health. MPH goals include gaining political commitment to health and encouraging structural change to support the
political commitment. This approach aims to include development of a strategic planning
document for public health at the local level and a process which develops partnerships around
public health at the local level. Its strategic objectives include:

- A planning document that demonstrates the local community’s and agencies’ vision for a
  health and sustainable future
- A written document that clarifies ways in which key agencies can work towards creating
  and maintaining health environments for its community
- A dynamic document that sets out clear goals, objectives, strategies and targets to meet
  prioritised health needs
- A plan that focuses on goal-directed rather than regulation-driven administration and
  building new partnerships to promote public and environmental health, and
- The ensured involvement of intersectoral collaboration, interdepartmental collaboration,
  and community participation.

The guiding principles focus project managers on developing healthy alliances that include
increased intersectoral collaboration, interdepartmental collaboration and community
participation outcomes (Chapman and Davey, 1997).

CPHRPRRAP had good general documentation based on current health promotion philosophy
and several best practice elements that will be discussed in this section. The project stated seven
guiding principles:

- Project activities and strategies (implemented within communities) will be community
driven to address areas of need identified by participant communities. The power and
energy of the project must primarily reside in the community, not with the project
personnel
- Project activities and strategies will value and utilise the diversity of communities
- Project activities and strategies are aimed at developing participant community capacity.
Participant communities’ baseline capacity may be at any point along a continuum
- Project activities and strategies will preferably utilise existing participant community
networks, understanding that nominally ‘weak’ links are of particular significance in
extending project reach to a wide representation of community members. Strategies will
be developed to facilitate the inclusion of marginalised groups or communities where no
existing networks or advocates exist
- The philosophy and practice of action learning will be incorporated into project activities
and strategies at all levels: community, organisational and intersectoral
- Training activities developed by the project will be culturally, contextually and
  participant appropriate, and
- The project will be implemented within a context of sustainability where sustainability is
  understood to relate to community capacity, not individual programs (Dower et al., 2000).
The SEAL project is focused on the development of three health promotion action frameworks:

- Better practice integrated planning for physical activity in a local area
- Better practice community participation in planning for a local area, and
- Better practice program development and service delivery for increasing participation in physical activity in a local area.

The project establishes and maintains effective and collaborative partnerships among state and local government, non-government organisations and the private sector and communities. Partnerships are important to the project and are designed through a reference group of planning agencies, consultants, Sports and Recreation Queensland, the Heart Foundation and Queensland Health (SEAL, 2001).

The LA21 approach was set in the national context and funding but required a local organisational context for implementation, namely local government. The Australian Commonwealth government and some state governments have provided resources and funding to promote ecological sustainable development (ESD) (Cotter and Hannan, 1999). The LA21 program is a local government initiative developed by Environ Australia, through support from the Commonwealth Government. Environ Australia is a non-profit group supporting local government ESD initiatives in Australia (Cotter and Hannan, 1999). Because many of the problems and solutions being addressed by Agenda 21 have their roots in local activities, the participation and cooperation of local authorities will be a determining factor in fulfilling its objectives. Local authorities construct, operate and maintain economic, social and environmental infrastructure, oversee planning processes, establish local environmental policies and regulations, and assist in implementing national and sub-national environmental policies. As the level of governance closest to the people, they play a vital role in educating, mobilising and responding to the public to promote sustainable development. In Queensland, neither the LGAQ nor the EPA has introduced the Agenda 21 process as a policy direction. However, the LGA has Agenda 21 principles already incorporated in their organisation. The Department of LGPSR used Agenda 21 to guide the early directions of the IPA.

The MPHP was set in the National Public Health Partnership (NPHP) organisational context of partnerships outcomes. Limited funding was provided to local and state government to develop this health promotion process. The National Public Health Partnership (NPHP) asks why public health practice needs a planning framework (NPHP, 2000). The framework aims to contribute to public health planning in three broad ways, namely a common language, a systematic approach and the integration of action by the recognition of commonalities. More specifically the framework identifies ten public health intervention types including collaboration, partnership
building and community and organisational development in broad domains such as environmental health, communicable disease, lifestyles and health.

From a national perspective the National Environmental Health Strategy supports health planning that shapes Australian towns and cities (CDHAC, 1999, p.51). The Strategy notes that the key to creating healthy environments is good planning that recognises potential health impacts from the outset. A range of tools is recommended to achieve planning including legislation that supports healthy planning at the local level.

The foundation of good planning is also discussed in the NEHS. The strategy highlights that environmental health is highly intersectoral in nature, and that a commitment to partnerships is essential for improving environmental health. This requires all stakeholders and affected groups to recognise their common aspirations, develop common goals, work to strengthen their communication and links and to forge partnerships on common action (CDHAC, 1999). From 1994 to date, 18 Local Governments have developed and implemented MPHP. Queensland Health has partly funded the planning with seeding grants of up to $20,000. The initial pilot project included the funding of a project coordinator, assisted by a Steering Committee in the development of a framework for guiding the development of Municipal Public Health Plans in nine Councils. Local Government is seen as the facilitator of collaborative partnerships between relevant stakeholders to address factors affecting health in the community (Chapman and Davey, 1997).

Queensland Health through health promotion policy and the activities of the Public Health Units has supported and:

- initially funded a Healthy Cities Office and project 1992–1995
- provided seeding funding to 11 Councils to develop MPHP 1995–2000, and
- funded MPHP local government initiatives statewide.

Local Governments have invested monies into MPHP since 1995 by way of salaries and provision of administrative support for the development and ongoing implementation of the plan.

CPHPRRAP was a Commonwealth Department of Health funded project initiative, administered by the Queensland Health. This project was funded by Queensland Health (via the Commonwealth Department of Health and Family Services, 1998) through the Health Systems Strategy Branch and Public Health Services, and as a component of the Public Health Outcomes Funding Agreement (Dower et al., 2000, p.vi). Project funding in the range of $2,170,000,000 (Dower and Bush, 2001, p.17) was provided to 14 local communities for a three-year project span. The intention of the funding was to enable the development and implementation of local
public health initiatives. Resourcing agreements were made between the participating communities and Queensland Health. As part of this process, and in various forms, each community identified an auspicing body through which they would apply for funding. In this way, local funding models were developed, including the establishment of local management structures in each community through which the funding provided by Queensland Health could be allocated to specific locally identified community projects (Dower and Bush, 2001, p.47). The development of resourcing agreements between Queensland Health and local communities has been recognised as a way of providing funds directly into communities for flexible locally driven needs-based activities and for communities to have control over local public health activities (Dower and Bush, 2001, p.42).

Investments of the project were identified and mapped according to the following four components (Dower and Bush, 2001, pp.72–76):

- Policy, e.g. resource agreements, community review processes, operative relationships
- Finances [resources], e.g. to determine network strengths and weaknesses, to allocate finances, for evaluation
- The human and intellectual [training and education], e.g. in PAR, in capacity building, in CAPRI, developing skills of project teams, developing skills of community members, and
- The social [social relations], e.g. placement of local coordinators, development of relations between network partners – local project coordinators, local action groups, auspicing bodies, government and non-government agencies.

The Supportive Environments for Active Living (SEAL) Strategic Framework for Action is a Queensland Health, Public Health Services initiative, intended to assist implementing the Environments Focus Area of the Queensland Physical Activity Strategy. The framework is based on Heart Foundation South Australia’s ‘Supportive Environments for Physical Activity’ project work. The project was conducted and funded as a pilot project in Eagleby, a lower income suburb where private consultants were engaged for the community consultation phase at minimal costs. The goal of the project was to increase the opportunities for, and participation in physical activity in the local area. Full-time staff from the Health Promotion Unit of the South Coast Public Health Unit implemented SEAL as part of their daily roles and responsibilities.

3.7.3 **CPHP Governance through Partnerships**

LA21 can have links to existing policies, programs and activities according to the 1999 Environns Australia Manual:

- Corporate Planning
- Integrated Local Area Planning
• Ecologically Sustainable Development Plans
• State of Environment Reporting
• Local Conservation Strategies, Socia and Cultural Plans, Recreational Plans and Local Economic Plans
• Environmental Managements Systems, and
• Strategic Land Use Planning (Cotter and Hannan, 1999).

Legitimacy and authority for MPHP have been established through internal government policy, organisational directives and legislation, particularly the LGA. MPH Plans have legitimacy where the plan has been endorsed by local government through the requirements of the LG Act to have a corporate plan that assesses the needs of communities.

Local Governments of Queensland through the peak body of the LGAQ have signed a protocol agreement with Queensland Health. This protocol (LGAQ, 2000) sets out agreed-to action plans for issues of common interest and provides a framework to undertake joint activities. In the Public Health Planning Action area, the parties have agreed to enhance mechanisms for collaborative community public health planning. This protocol refers to the primary existing planning process and advocates for formalised planning processes, including for example:
• Local Government Corporate Plans
• IPA Planning Schemes
• Regional Communities Program, and
• MPHP.

This is another example of structured mechanisms to formalise the partnerships and legitimise the actions of Public and Environmental Health planning initiatives.

The CPHPRRAP in its approach to governance acknowledges that collaborative, community based and capacity building health service approaches require changes in conventional notions of governance. Instead of operating in a top-down fashion, new arrangements of governance require such dimensions as:
• Alliances and partnerships
• Self-government
• Independent and autonomous networks, and
• New management paradigms (Dower et al., 2000, pp.88–95).

The CPHPRRAP has attempted to incorporate many of these new arrangements of governance so that new relationships can be developed between communities and government. The project
has developed locally based structures to facilitate dialogue and exchange between communities and Public Health Services. For example, project co-ordinators are placed locally, there is extensive community consultation and local funding models have been developed so that financial accountability is devolved to the local level. In the second year’s future directions and recommendations, the CPHPRRAP has documented that it needs to pay particular attention to the issues of governance so that local public health leaders can become involved in decision-making about public health services in an active and meaningful way (Dower and Bush, 2001, p.79).

SEAL has developed an appropriate governance structure to implement CPHP. If the project is a stand-alone project within the community, a reference group is developed as part of the project. Other SEAL Partnerships are important after the project has identified and clarified the issue and the need for a partner. To promote community ownership over the process, the project works with the Eagleby Residents Action Group (ERAG), previously set up as part of the Community Renewal Program process. The role of ERAG is to provide accountability between government managed initiatives and the local community.

These partnerships should be formed with organisations with common interests from similar sectors (Dower and Bush, 2001). Formal agreements such as MOU agreements may be needed to establish administration; decision-making processes; accountability for deadlines, costs, results; and resource commitment and expectation of each party.

### 3.7.4 CPHP Planning and Implementation: Evaluation Process

LA21 has five steps identified in the planning process described in Table 3.

**Table 3: Five Steps in the Local Agenda 21 Model**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Preparing the ground</td>
</tr>
<tr>
<td>2</td>
<td>Building partnerships</td>
</tr>
<tr>
<td>3</td>
<td>Setting the vision</td>
</tr>
<tr>
<td>4</td>
<td>The action plan</td>
</tr>
<tr>
<td>5</td>
<td>Implementing, reporting, monitoring and reviewing</td>
</tr>
</tbody>
</table>

Source: Cotter and Hannan, 1999, p.8

The Gold Coast Case Study implemented a LA21 project (see case study in Cotter and Hannan, 1999), suggesting that the Corporate Plan in Council indicated that responsibility lies within each of the Directorates and that the Planning Environment and Transport Directorates has
primary responsibilities for reporting the Council’s progress towards ESD. The strategy sets forth a model for progressing ecological sustainable development in the City by:

1. Identifying the governance structures currently in place to steer the City toward its future
2. Identifying the current long-term action plan of the Council to effect the Council’s vision for the City
3. Identifying key reporting roles for monitoring the City’s progress, and
4. Identifying the need for a Technical Advisory Group to assist the Executive Officers to steer the Council’s implementation of the Action Plan and to advise on the need for further and continuing improvement.

The *Environs Australia Manual* (Cotter and Hannan, 1999) recommends developing a shared vision involving community and Council. The manual highlights two success stories: Manly Council and the City of Nedlands. Manly Council conducted separate workshops for Councillors, Council staff and community groups. It also hosted a one-day community forum, sent a random survey to residents and used discussion papers. The City of Nedlands conducted a seminar and the results assisted Council staff to prepare a draft sustainability plan.

The LA21 monitoring and evaluation process is more than just determining that an activity has been completed: the process should include asking the following questions:

- Does the process continue to involve the community?
- Does it still involve all sections of the Council?
- Is there still commitment to the process by Council?
- Are visions and goals still relevant or have circumstances changed?
- Are the knowledge and priorities left still appropriate?
- Are the indicators the most appropriate? (Cotter and Hannan, 1999).

MPHP has varied implementation and evaluation arrangements. On the completion of the plan a monitoring, review and implementation committee is formed, consisting of the agencies that have signed off on the planning document and under the guidance of the local government Councillors/health professionals and Queensland Health professionals, this committee steers the implementation process. Both process and impact evaluation have occurred in Queensland and papers have been presented at local and international conferences (Davey, 1997; 1999; Davey et al., 2003; Davey 2006a; Davey, 2006b). MPHP allows for community engagement at three stages of the seven-step model: the community is engaged in focus group discussions regarding health needs and services and surveyed to collect quantitative data on health and quality of life issues; individuals from communities participate in Working Groups to identify priorities for actions and strategies to address health needs; and the draft document/plan is forwarded to the
community for comment. Appendix A represents a comprehensive list of MPHP projects that have been funded by state and local governments respectively in Queensland since 1986.

The CPHPRRAP developed a multi-level and dynamic project structure incorporating:

- The Project Coordinator – Manager of Public Health Services, who oversees the project
- The Project Manager – to manage operations, based in Brisbane
- Local Project Coordinators – three coordinators based according to Public Health Services zones, to facilitate community driven action and to develop partnerships, and
- Local Community Action Groups.

Participatory Action Research (PAR) was chosen as the method for guiding the development and implementation of the CPHPRRAP. The process of PAR was intended to enable communities to develop their own research agendas (rather than have them imposed upon them from the outside) and to respond to the specific needs of their community.

The CPHPRRAP has a four-stage implementation model. These stages have not occurred in a linear fashion: they occurred concurrently depending on the needs of the communities and coordinators. Within each stage there were specific and interconnected activities or mechanisms carried out at both community and organisational levels:

- Establishing Foundations – at an organisation level, such as developing plans, recruiting staff, and setting up support structures
- Community Engagement – at community and organisational levels, in which communities were selected and invited to take part
- Community Mobilisation – in which various mechanisms were employed to build capacity and introduce a local funding model, and
- Community Support – in which the focus was on the enhancement of community capacity (Dower and Bush, 2001:vii-viii, 21-25).

The CPHPRRAP built an evaluation process into its project framework and project implementation stages. The project adopted ‘Realistic Evaluation’, an evaluation model developed by Pawson and Tilley (1997, cited in Dower et al., 2000). Within this evaluation framework, the project used a wide range of data collection processes including event logbooks, semi-structured interviews and documentation reviews. The application of the ‘Community Capacity Health Development Index’ assesses the extent of capacity developed across four domains:

- Network partnerships (the formation of partnerships between health development structures)
• Knowledge transfer (the transfer of knowledge between partnerships)

• Problem solving (the problem solving abilities between and within health development structures), and

• Infrastructure supports (the development of infrastructure to ensure a network can deliver and sustain a program).

The goal of the SEAL planning process is to implement the SEAL initiatives at statewide, regional and local levels through the use of recognised statewide, regional and local planning policies, legislations, strategies and guidelines. Policy objectives include:

• To contribute to the achievement of ecological sustainability by integrating supportive environments for Active learning matters into the prescribed functions and powers of the IPA

• To integrate SEAL matters into the Planning Scheme of local government authorities across Queensland

• To integrate SEAL matters into the LA21 of local government authorities across Queensland, and

• To integrate the strategic objectives and strategies of the Environments Focus Area of the Queensland Physical activity strategy into all SEAL work across Queensland.

SEAL has nine process steps documented in a comprehensive user manual (see Table 4).

| Stage 1: | Making people part of the bigger project |
| Stage 2: | Beginning community engagement |
| Stage 3: | Establishing the partnership with the community |
| Stage 4: | Communicating with the wider community |
| Stage 5: | Implementing the participatory action research data collection and analysis process |
| Stage 6: | Developing the SEAL Plans for action based on findings from data collection and analysis |
| Stage 7: | Obtaining community feedback on SEAL Action Plans |
| Stage 8: | Evaluating the strength of community capacity building |
| Stage 9: | Continuing ongoing implementation, monitoring and evaluation of SEAL Action Plans |

The framework document provides a checklist to assess the strength of a coalition and recommends some tools for evaluating the community capacity building initiatives. Community participation is sort in the form of participatory action research. Local people are recruited and
employed as co-researchers in the PAR process with government representatives. Finally, all residents deliver SEAL in the context of multi-sectoral agencies working with local government town planners and agreeing to the provision of safe, convenient and attractive physical environments that enable active living. With this in place, quality of life and the determinants of health become part of the planning process.

In summary, Queensland Health, through their strategic plan, continue to support and fund CPHP projects in local government as part of their ‘healthy partnerships’ outcomes area (Queensland Government 2004). Many local governments have developed MPHP in partnership with Queensland Health funding, other councils have not required such support. An understanding of the features of CPHP and LPF is relevant as a background discussion prior to the case studies and process and impact evaluation conducted in Chapter 7, 8 and 9 of Part 3 of the thesis. In Chapter 10 an analysis is conducted of selected CPHP models and LPF and their strengths and limitations are examined, discovering achievements and barriers and key learnings for effective MPHP.

3.8 Conclusion

The following chapter reviews organisations and strategic planning in the context of a need for governance arrangements for strategic health planning. Lessons are learnt from two perspectives of MPHP, namely participatory planning as a health promotion approach and a strategic management approach; in each case it could be argued that there is a need for capacity building of individual and organisations for MPHP to be effective and sustainable.
CHAPTER 4  ORGANISATIONS and STRATEGIC PLANNING:
MPHP GOVERNANCE

4.1 Introduction

Chapter 4 examines organisations, strategic planning and MPHP governance. Having discussed in the previous chapter that health promotion philosophy is a foundation for MPHP, this chapter introduces other foundation philosophy, namely organisational behaviour (OB) and strategic management. The literature is reviewed to provide an understanding of the definition of management, namely planning, leading, coordinating and controlling. This chapter argues that there are linkages between organisational behaviour and strategic management and the governance of MPHP that are influenced by a changing external environment. Organisations working jointly on MPHP may need to modify their strategic management practices to build their capacity to deliver effective intersectoral approaches to health planning in communities. The chapter argues that local government must be resilient to changing organisational culture and environmental factors when developing and implementing health-planning processes integrating strategic management and health promotion practice.

4.2 Organisations and Governance

Organisations working on MPHP need to modify their organisational behaviour and internal strategic management practices to deliver effective internal processes and intersectoral approaches to participatory planning. There are linkages between organisational behaviour, governance and strategic management and improvements in the effectiveness of MPHP. MPHP and other planning models are a form of strategic management for health at the interface of local government and the community served. Wheelen and Hunger (2004) define strategic management as that set of managerial decisions and actions that determines the long-run performance of an organisation. It includes environmental scanning (both internal and external), strategy formulation (strategic and long-range planning), strategy implementation, evaluation and control. MPHP develops a set of agreed-upon decisions and actions that may determine the performance of the health of the community where it is applied; CPHP models that attempt to improve the quality of life of residents of a community are, by definition, a form of strategic management.

This section will explain the concept of ‘organisations and governance’. Hancock (1996, p.20) comments that ‘the implications of the concept of healthy communities for government and governance are profound’. There is a move away from command and control mode of governance in Australia to governance through multiple organisations and stakeholders working
together (IPAA, 2002). MPHP is driven by the key aim of organisations working together. If we have a greater knowledge of the theory of organisations it may assist in understanding the governance requirements needed to make them more effective and sustainable.

All organisations have several basic aspects in common. Perhaps the most obvious common element organisations will have is a goal or purpose. Stoner et al. (1985, p.9) states that organisations perform an essential function: by overcoming our limitations as individuals, organisations enable us to reach goals that would otherwise be much more difficult or even impossible to reach. Organisations are a means of preserving knowledge and are essential because they store and protect most of the important knowledge that our civilisation has gathered and recorded. In this way, they may help to make that knowledge a continuous bridge between past, present, and future generations (Stoner et al., 1985). Organisations are important for still another reason: they provide their employees with a source of livelihood, personal satisfaction and self-fulfilment. Organisations are essential to our society whether they are government or non-government, public or private sector in nature. The question we should be concerned with is how we can make both large and small organisations more effective in meeting our needs and in particular the needs of our communities.

Stoner et al. (1985) comment that the management of organisations involves planning, organising, leading and controlling organisational members, in order to achieve stated goals. In moving organisations towards their goals, managers adopt a range of interpersonal, informational and decision roles. Managers at different levels of the organisation require and use different types of skills. Managers’ work with and through other people: they are responsible and accountable; they must balance competing goals and set priorities; they must be able to think analytically and conceptually; they are politicians, diplomats and decision-makers. Above all, Stoner et al. (1985) note that managers in organisations must be alert to the need to interchange their many roles as the occasion arises. In the researchers experience environmental health officers needed to develop a diverse set of skills to develop and implement CHPs. In many cases, these health professionals do not have the organisational skills and knowledge to achieve this. This is because, in most cases, their skill base is not in organisational behaviour but in the science and promotion of public and environmental health. These officers also lack theoretical and practical experience in strategic management and planning. In summary, the process of organisational management, in many of the texts reviewed, contains the activities or functions of planning, organising, leading and controlling. Management then, is the process of planning, organising, leading and controlling the efforts of organisational members using all organisational resources to achieve the stated organisational goals (see Tyson, 1998).

Planning implies that managers think through their goals and actions in advance. Organising means that managers co-ordinate the human and material resources of the organisation. Stoner
et al. (1985) comment that the effectiveness of an organisation depends on its ability to obtain resources to reach its goals. Leading describes how managers direct and influence subordinates, getting others to perform essential tasks. The term ‘controlling’ is defined as managers attempting to ensure that the organisation is moving towards its goals. Before managers can organise, lead or control, they must make the plans that give purpose and direction to the organisation. Before quality of life can be improved in the community setting, managers, health practitioners and agency and community representatives need to make plans that give purpose and direction to their organisation or setting. Upper level managers generally devote most of their planning time to the long-term organisational vision and strategies of the entire organisation. Managers at lower levels plan mainly for their own departments, becoming involved in short-term strategising. Variations in planning responsibilities also depend on the organisation’s size and purpose, and on each manager’s specific function or activity. In public sector organisations, planning could be a statutory obligation and linked to budgetary allocations.

In Queensland, there are many examples where managers implement the statutory planning requirements of local and state government, such as town planning and corporate planning required by the IPA. It is important for managers, health professionals and agency and community representatives to understand the roles of organisations and management in short-term and long-range planning in the overall planning scheme.

4.3 Organisational Behaviour and Impacts on Planning

This section introduces organisational behavioural thinking and suggests that we need to understand this concept to enable improvements in participatory planning. Organisational behaviour (OB) is a field of study that investigates the impact that individuals, groups and structure have on behaviour within organisations (Robbins et al., 1998, p.10). OB studies three determinants of behaviour in organisations to enable organisations to work more effectively. It emphasises firstly behaviour as related to jobs, work, absenteeism, employment turnover, productivity, human performance and management. Secondly, organisational behaviour offers a number of challenges and opportunities for managers. Lastly it can help improve quality and employee productivity by showing managers how to empower their people and empower organisations that are linked to them, as well as design and implement structural change programs. Effective planning for health at a local government organisational level requires managers with OB knowledge and skills: managers are required to empower staff as well as the communities they work in.

There are links between the OB issues of productivity, absenteeism, turnover and job satisfaction and effective and efficient participatory planning. Firstly, an organisation is
productive if it achieves its goals, and does so by transferring inputs to outputs as effectively as is possible, and usually at the lowest economical cost. As such, productivity implies a concern for both effectiveness and efficiency. One of OB’s major concerns is productivity. We want to know what factors influence the effectiveness and efficiency of individuals, of groups and of the overall organisation (Robbins et al., 1998). Similarly, MPHP needs positive tangible outcomes for communities, especially improvements in short, medium, and long-term outcomes. For the planning to be effective, the strategies implemented must have an impact on the state of health of communities. In summarising, to be sustained, participatory health planning must be productive, satisfying the needs of individual, agency and community organisations. The impact of OB issues on MPHP is not documented in the literature, and this represents a gap in knowledge that needs investigation.

Absenteeism is the second OB issue of interest to this research. It is interesting to note that the cost of absenteeism to Australian employers has been estimated at just over $7 billion a year. Mark Wooden (cited in Robbins et al., 1998) comments that absenteeism ‘is not insignificant and represents almost two per cent gross domestic product’. These figures indicate the importance to an organisation of keeping absenteeism low (Robbins et al., 1998). Participatory health planning attempts to invite all stakeholders to the networking table, in order to participate in sharing the efforts and responding to community needs. More importantly, when key players are absent from the organisational activities required by the participatory health planning process, health-planning outputs of the project could be reduced.

Thirdly, staff turnover is an important OB issue. Local and state government and community organisation staff turnover could be a significant factor influencing the effectiveness of health planning in communities. For example, if there is a large turnover of participants representing agencies at health advisory and stakeholder meetings during the development and implementation of the MPHP, planning outcomes could be affected. Participant turnover on project management teams (PMTs) impacts on the goals and objectives of health planning. Resident representative turnover on participatory planning activities could be a limiting factor to effective MPHP. A high rate of turnover in an organisation increases recruiting, selection and training costs. It can also mean a disruption in the efficient running of an organisation, when knowledgeable and experienced personnel leave, and replacements must be found and prepared to assume positions of responsibility. All organisations and project committees of course, have some turnover. If the right people are leaving the organisation or the project committee – for example, the marginal and sub-marginal employees – turnover can be positive. It may create the opportunity to replace an employee or committee member with another with higher skills or motivation, open up increased opportunities for promotions, and add new and fresh ideas to the organisation (Robbins et al., 1998, p.25). Similarly, there are positive and negative factors in the
impact of turnover of agency representatives on effective strategic health planning; this issue needs more clarification and research.

The final variable that Robbins et al. (1998) discuss is job satisfaction, which is seen as the difference between the amount of rewards employees receive and the amount they believe they should receive. Unlike the previous three variables, job satisfaction is unique because it represents an attitude rather than behaviour. Why is it then that it has become one of the more significant organisational issues? This is probably because of its demonstrated relationship to performance factors, and the value preferences held by many OB researchers (Robbins et al., 1998, p.25). In other words, the success of MPHP could be dependant of many factors, including how the employee sees the plan providing job satisfaction and rewards, compared to other tasks in their organisation.

OB focuses on values. Values are important to the study of OB, because they lay the foundation for the understanding of attitudes and motivation, as well as influencing our perceptions (Robbins et al., 1998). Individuals enter an organisation with preconceived notions of what ‘ought’ and what ‘ought not’ to be. Of course, these notions are not value-free. On the contrary, they contain interpretations of what is perceived as ‘right’ and ‘wrong’. Further, they imply that certain behaviours or outcomes are preferred over others. As a result, values cloud objectivity and rationality. Do health practitioners’ values support MPHP as an approach to improving quality of life in communities? Do the attitudes and values of individual politicians, health managers and agency partners impact on the success of the health planning? Robbins et al. (1998) comment that values generally influence attitudes and behaviour.

Education and training of staff in organisational behaviour and strategic health planning can assist in aligning the values of the organisation and people. In most cases with MPHP, the task of health planning is not seen as part of core business of local government, but ‘as another task to do on top of many other tasks’. There is little published data that demonstrates people being rewarded for this type of extra activity. Many project officers have been promoted or moved ‘upwards’ or ‘across’ in and to other organisations, due to their increase in skills and knowledge gained while participating in CPHP (Chapman and Davey, 1997). Only as recently as 2005, the identification of public and environmental health management issues became a legitimate requirement of Councils under the LGA. With this prerequisite, more Council staff may become engaged with health planning activities, independent of their own values. Health planning outcomes may be improved if knowledge of OB by all stakeholders took equal priority with health promotion skills as perquisite to MPHP when developing and implementing MPHP.
4.4 Managing Capacity Building

This section will introduce the definition of management, highlight the theory and function of management and discuss the skills required by managers in the workforce. Health planning outcomes may be improved if there was a requirement for all stakeholders involved with MPHP to have a higher level of management skills and knowledge.

4.4.1 Defining Management

Management has been called ‘the art of getting things done through people’. This definition, by Mark Parker Follett, calls attention to the fact that managers achieve organisational goals by arranging for others to perform whatever tasks may be necessary, not by performing the tasks themselves (Stoner et al., 1985, p.7). MPHP project managers may well need a foundation in management studies to effectively develop and sustain the implementation of MPHP. In the early 1900s, French industrialist Henri Fayol wrote that ‘all managers perform five management functions, they plan, organise, command, coordinate and control’. Today we have condensed these down to four; namely planning, organising, leading and controlling (Stoner et al., 1985).

As stated earlier, Robins et al. (1998) define management as the process of planning, organising, leading and controlling the efforts of organisation members and of using all other organisation resources to achieve stated organisational goals. A process is a systematic way of doing things. We define management as a process because all managers, regardless of their particular aptitudes or skills, engage in certain interrelated activities in order to achieve their desired goals.

These four aspects of management and their relationship to effective MPHP will be discussed in this section. Firstly, Robbins et al. (1998) comment that planning implies that managers think through their goals and actions in advance. Their actions are usually based on some method, plan, or logic, rather than on a hunch. MPHP is the health planning methodology under review in this dissertation, and is simply a logical management methodology to plan for health. For public health in Australia for the last two decades, participatory health planning has been gaining momentum; however, many health initiatives are still bordering on the knowledge and experience of health professionals, rather than on a combination of this experience and comprehensive needs assessments. For MPHP to be effective the comprehensive needs assessment process requires sound planning foundations. The second part is organising, which means that managers coordinate the human and material resources of the organisation. The effectiveness of an organisation depends on its ability to coordinate its resources to attain its goals. The more integrated and coordinated the work of an organisation, the more effective it will be. Achieving this coordination is part of the manager’s job (Robbins et al., 1998; Wheelen and Hunger, 2004). Thirdly, leading describes how managers direct and influence subordinates, getting others to perform essential tasks. By establishing the proper atmosphere, they help their
subordinates to do their best. Every organisation contains people, and it is management’s job to
direct and coordinate these people. This is the leading function of a project manager with the
responsibility for a MPHP project. When managers motivate employees, direct the activities of
others, select the most effective communication channel or resolve conflicts among employees,
they are engaging in leading.

Finally, controlling means that managers attempt to ensure that the organisation is moving
towards its goals. If some part of their organisation is on the wrong track, managers try to find
out why and set things right. It is clear, then, that organisations perform this essential function
by overcoming our limitations as individuals, and by enabling us to reach goals that would
otherwise be much more difficult or even impossible to reach. After the goals are set, the plans
formulated, the structural arrangements delineated, and the people hired, trained and motivated,
there is still the possibility that something may go amiss. To ensure that things are going as they
should, management must monitor the organisation’s performance. Actual performance must
be compared with the previously set goals. If there are any significant deviations, it is
management’s job to get the organisation back on track. This monitoring, comparing and
potential correcting is what is meant by the controlling function (Robbins et al., 1998; Wheelen
and Hunger, 2004). It follows that health professionals involved in MPHP need a range of
management skills to deliver satisfactory health planning outcomes. The research will examine
the level of management skills of the politicians, managers, health practitioners and agency
partners engaged in several MPHP projects in Queensland.

MPHP stakeholders engage with managers and project managers while involved in Healthy
Cities approaches. These managers achieve things through other people (Wheelen and Hunger,
2004). They make decisions, allocate resources and direct the activities of others to attain goals.
Managers do their work in an organisational setting. An organisation is then a consciously
coordinated social unit, composed of two or more people who function on a relatively
continuous basis, to achieve a common goal or set of goals Stoner et al. 1985). Based on this
definition, manufacturing and service firms are organisations and so are schools, churches,
military units, retail stores, police departments, and local, state and federal government
authorities: ‘The people who oversee the activities of others and who are responsible for
attaining goals in these organisations are managers’ (Robbins et al., 1998, p.5).

Managers are also responsible for designing an organisation’s structure. MPHP projects are
designed by the project team members to fit somewhere into the management structure of local
government. The reason the term ‘somewhere’ has been used, is that no two organisations have
the same culture or structure, so the MPHP needs to be tailored to fit the organisational and
management situation under analysis prior to the development of the MPHP. Managers
determine what tasks are to be done, who is to do them, how the tasks are to be grouped, who
reports to whom and where decisions are to be made, usually within a department or section of an organisation. Project Managers have similar responsibilities, but are focused on a single project, within a department or section of the organisation.

### 4.4.2 Management Skills

Still another way of considering what managers do is to look at the skills or competencies they need to successfully achieve their goals. There are three essential management skills according to Robbins et al. (1998): technical, human and conceptual. These skills encompass the ability to apply specialised knowledge or expertise. When considering skills held by the professionals such as civil engineers, tax accountants or surgeons, one will typically focus on their technical skills. Through extensive formal education, they have learnt the special knowledge and practices of their field. Of course, professionals do not have a monopoly on technical skills and these skills do not have to be learnt in schools or formal training programs (see Robbins et al. 1998). All jobs require some specialised expertise and many people develop their technical skills on the job. Robbins concludes that the ability to work with, understand and motivate other people, both individually and in groups is a core element of human skills (Wheelen and Hunger, 2004).

Many people are technically proficient but interpersonally incompetent, which impacts on communication in an organisation or project (Wheelen and Hunger, 2004). They might, for example, be poor listeners, be unable to understand the needs of others or have difficulty managing conflicts. Since managers achieve results through other people, they must have good human skills to communicate, motivate and delegate. Managers must have the problem-solving ability to analyse and diagnose complex situations. These are conceptual skills. Decision-making, for instance, requires managers to spot problems, identify options that can correct them, evaluate these options and select the best one. Managers can be technically and interpersonally competent yet still fail because of their inability to rationally process and interpret information and problem solve (Robbins et al., 1998; Wheelen and Hunger, 2004). All of these skills are required to successfully implement MPHP in local government: in a changing organisational environment the capacity building of government and non-government agency project managers and health practitioners involved with MPHP needs to be further investigated.

The capacity of local government managers and health practitioners to develop and implement effective MPHP is a key issue in Queensland. MPHP has been conducted by only 18 of some 100 local governments, even though this represents planning coverage of over 50% of the population of Queensland: the remaining local governments have been limited by lack of staff capacity to understand OB and strategic management and support MPHP objectives. It is very important that the sustainability of participatory health planning is considered as an
organisational issue and the governance of the planning addressed in the design phase of planning.

4.5 Basic Model of Strategic Management

Wheelen and Hunger (2004, p.2) describe strategic management as:

That set of managerial decisions and actions that determines the long-run performance of a corporation. It includes environmental scanning (both external and internal), strategy formulation (strategic and long-range planning), strategy implementation, and evaluation and control.

The study of strategic management, therefore, emphasises the monitoring and evaluating of external opportunities and threats in light of an organisation’s strengths and weaknesses. Strategic management, as a field of study, incorporates the integrated concerns of business policy with a heavier environmental and strategic emphasis and can be applied to the health sector (Wheelen and Hunger, 2004; Ashton, 1992; Chapman and Davey, 1997; Takano et al., 1992; Rohrer et al., 1998. Figure 7 describes the basic elements of the strategic management process developed by Wheelen and Hunger (2004).

The four building blocks in the strategic management process in Figure 7 are similar to the stages of development of a Healthy Cities project, particularly MPHP (Chapman and Davey, 1997; WHO, 1997b). In most WHO Healthy Cities approaches worldwide, MPHP use, knowingly or unknowingly, the basic elements of strategic management processes, generally referring to these as health promotion processes or techniques.

In the Strategic Management Process in Figure 7 environmental scanning is the monitoring, evaluating, and disseminating of information from the external and internal environments to key people within the corporation. Its purpose is to identify strategic factors – those external and internal elements that will determine the future of the organisation. The simplest way to conduct environmental scanning is through SWOT Analysis. SWOT is an acronym used to describe those particular strengths, weaknesses, opportunities and threats that are strategic factors for a specific organisational setting. The researcher has used this technique when developing MPHP in several community settings. Internal to organisations are their own strengths and weaknesses,
which impact on their effectiveness. The external environment consists of variables, opportunities and threats from outside the organisation, which are not typically within the control of management. These variables form the context within which the organisation exists. They may be general forces and trends within the overall societal environment or specific factors that operate within an organisation’s specific task environment (Wheelen and Hunger, 2004).

The second building block is strategy formulation, the development of long-range plans for the effective management of environmental opportunities and threats in the light of corporate strengths and weaknesses. It includes defining the corporate mission, specifying achievable objectives, developing strategies, and setting policy guidelines (Wheelen and Hunger, 2004). Although all employees might be involved in the strategic process, specifically in relation to implementation, most strategic decisions originate with senior management (Viljoen and Dann, 2000). Viljoen and Dann (2000) comment that fundamental to effective strategic planning and management is the development of the organisation’s goals: the goals of an organisation provide the basic sense of direction for its activities. They use the word ‘goals’ to include the organisation’s purpose, mission and objectives, terms defined and discussed below.

A strategy of an organisation forms a comprehensive master plan stating how the corporation will achieve its mission and objectives; a MPH Plan forms a comprehensive community health master plan. Master plans attempt to maximise competitive advantage and minimise competitive disadvantages (Wheelen and Hunger, 2004). In the case of MPHP, there could be competition between departments within local government, from other sectors who are also planning in the same community, or perhaps from adjacent communities, all trying to obtain funding for similar health initiatives. In some communities in Queensland, there is competitiveness between politicians, managers, agencies and health practitioners supporting different participatory health planning models (see Davey et al., 2003).

Strategy implementation, the third issue in Wheelen and Hunger’s (2004) model, is the process by which strategies and policies are put into action through the development of programs, budgets and procedures. This process might involve changes within the overall culture, structure, and management system of the entire organisation. Except when such drastic corporate-wide changes are needed, however, the implementation of strategies is conducted by middle and lower level managers with review by top management. Sometimes referred to as operational planning, strategy implementation often involves day-to-day decisions in resource allocation (Wheelen and Hunger, 2004). A policy is a broad guideline for decision-making that links the formulation of strategy with its implementation. Organisations use policies to make sure that employees throughout the organisation make decisions and take actions that support their mission, objectives, and strategies (Wheelen and Hunger, 2004). In local government in
Queensland, many policies have been developed to operationalise the MPHP and other planning frameworks. These policies build governance and accountability into the organisation so that plans can be implemented within budgetary guidelines.

Program implementation is an important aspect of strategy implementation. A program is a statement of the activities or steps needed to accomplish a single-use plan. Because MPHP consists of many strategies, which are broken down to specific actions or programs, it is important to distinguish this point. It makes the strategy action-oriented. Programs also have budget allocation. A budget is a statement of the organisation’s programs in dollars terms. Used in planning and control, a budget lists the detailed cost of each program. Procedures, sometimes termed standard operating procedures (SOP) are a system of sequential steps or techniques that describe in detail how a particular task or job is to be done. They typically detail the various activities that must be carried out in order to complete the corporation’s program (Wheelen and Hunger, 2004). In Queensland where planning is mandated by acts and regulation – for example town planning schemes – corporate planning, good governance and accountability processes follow. Policies, budgets and programs are well documented.

A legislative requirement in the local government acts and regulation for mandatory MPHP would encourage managers to embrace strategic management approaches, which in turn would improve management capacity to plan and fund healthy communities. Voluntary MPHP, which is in fact health promotion action-oriented, has not shown the same level of governance or accountability when developed and implemented in communities (Smith, 1995). This could be a barrier to effective and sustainable MPHP: more discussion is centred on these governance and accountability issues in Chapter 11.

In their guidelines for MPHP development, the Department of Health in Victoria (1996) documented MPHP in local government as a strategic planning process closely related to community aspirations and needs. This report also states that an advantage of MPHP in Victoria is that the process is capable of achieving both corporate goals relating to public health and related goals in community and economic development. Smith (1995) cited in McBride and Hulme, 2000) argues that general planning processes are not well understood within the health area, and MPH Plans in Victoria have not been seen as strategic plans. He also suggested that both local and state governments had underestimated the barriers and challenges to such a planning development. In particular, there was a lack of planning skills and leadership; a lack of development of meaningful indicators of health and health outcomes; and a lack of knowledge of the impact of State Government policies (Smith, 1995). More research is needed to understand the link between strategic management and MPHP, and how local government can better manage and respond locally to the global challenge of meeting the health needs of communities.
Figure 8: Strategic Management Model
(Source: Wheelan and Hunger, 2004, p.10)
The fourth issue in the Wheelen and Hunger (2004) model encompasses evaluation and control, the processes by which corporate activities and performance results are monitored so that actual performance can be compared with the desired performance. Managers at all levels use the resulting information to take corrective action and resolve problems. Although evaluation and control make up the final major element of strategic management, these aspects can also pinpoint weaknesses in previously implemented strategic plans, and can stimulate the entire process to begin again (Wheelen and Hunger, 2004). In every organisation there are essentially two prerequisites for success, namely, efficiency and effectiveness (Viljoen and Dann, 2000). Efficiency relates to how well an activity or operation is performed: this is determined predominantly by the internal structure and operations of an organisation (methods, procedures, systems, rules). Efficiency also ensures that an organisation ‘does things right’ (Viljoen and Dann, 2000). Strategic management improves organisational effectiveness and is predominantly focused on creating effectiveness, because it is concerned with the long-term compatibility between an organisation and its relevant cultural and external environment.

Wheelen and Hunger (2004, p.10) further describe the elements of this process (in Figure 7) with an expanded strategic management model seen in Figure 8. This expanded model demonstrates the elements and relationship between strategy formulation, strategy implementation and evaluation and control, including the important mission, objectives, strategies and policies in the development of long-range strategic plans. It also defines the strategy implementation component of the model as having programs, budgets and procures. Performance of the strategic plan is measured in the final evaluation and control component of strategic planning and is the area of strategic management where actual results are measured. MPHP developed in Queensland by Chapman and Davey (1997) was adapted from the WHO approach to health planning (see WHO, 1995b; 1997b; 2000). The MPHP approach is in fact a strategic management model with similar components to the model by Wheelen and Hunger (2004). It includes a mission, themes or issues, objective, strategy, responsible partner agency, timeframe and performance indicators. The MPHP adds a partnership dimension to the strategic management process not included in Wheelen and Hunger’s model.

An organisation’s mission is the purpose or reason for the organisation’s existence. In this thesis the mission shows what the local government is providing to society: public and environmental health services (Wheelen and Hunger, 2004). The mission of an organisation constitutes its reason for existence, its fundamental purpose, including its character and values, and provides the context for developing specific objectives and strategies; this mission is often formalised and documented in a mission statement (Viljoen and Dann, 2000). Stoner et al. (1985) point out that the mission of an organisation is the unique aim that sets the organisation
apart from others of its type; narrower than its purpose, the mission is the broadest aim that a particular organisation chooses for itself.

MPHP projects develop a mission statement (or a vision) for the community, usually a mission to improve the quality of life of residents of a community, as exemplified below in those of the City of Gold Coast community health plan and the Hervey Bay public health plan:

The Vision Statement for the City of Gold Coast CHP:

> The citizens of the City of Gold Coast are its greatest resource and will be supported in achieving and sustaining a healthy environment and lifestyle by harnessing collective knowledge, experience, creativity and diversity (Forward of GCCHP, 1997).

The Mayor of Hervey Bay, Cr Bill Brennan, stated their mission:

> The Hervey Bay Public Health Plan (HBPHP) will be a catalyst for closer working relationships in the future, to maintain and enhance the quality of life and lifestyles we came to Hervey Bay to enjoy (Forward of HBPHP, 1999).

Objectives are the end results of planned activity. They state what is to be accomplished by when and should be quantified if possible. The achievement of objectives should result in fulfilment of an organisation’s mission. The term ‘goal’ is often used interchangeably with the term ‘objective’ (Wheelen and Hunger, 2004). The purpose of an organisation is its primary role as defined by the society in which it operates. Viljoen and Dann (2000) note that ‘purpose’ is therefore a broad aim, applying not only to a given organisation, but to all organisations of its type in that society. Stoner et al. (1985) comment that an objective is a target that must be reached if the organisation is to achieve its goal. Objectives are by nature more specific than the mission statement, and are in fact the translation of the mission into specific, concrete terms against which results can be measured.

### 4.6 Strategic Planning in Organisations

This section will define and describe strategic planning and will include an examination of the characteristics of this process, the foundation planning tool in MPHP.

#### 4.6.1 Strategic Planning

Strategic planning is the process of selecting an organisation’s goals: determining the policies and strategic programs necessary to achieve specific objectives en route to the goals; and establishing the methods necessary to assure that the policies and strategic programs are implemented, thereby enhancing organisational performance (see Schraeder, 2002; Stoner et al., 1985) This comprehensive definition might be distilled into a shorter one: ‘Strategic planning is
the formalised, long-range planning process used to define and achieve organisational goals’ (Stoner et al., 1985).

The literature and research on goal-setting theory show how effective specific goals are on performance. In the late 1960s, Edwin Locke (Stoner et al., 1985, p.184) proposed that intentions to work towards a goal are a major source of work motivation. That is, goals tell an employee what needs to be done and how much effort needs to be expended. The evidence strongly supports the value of goals. More to the point, we can say that specific goals increase performance; that difficult goals, when accepted, result in higher performance than do easy goals; and that feedback leads to higher performance than does non-feedback (Robbins et al., 2004; Nankervis et al., 2005; Dwyer et al., 2004). Legislative planning frameworks and CPHP models, which were discussed in Chapter 3, set broad-based health, environment and social goals for communities within a strategic planning process.

Strategic planning and strategic management are not isolated events or procedures, but rather are ongoing and interrelated activities within the organisation. Strategic management was discussed previously, but in terms of strategic planning in an organisation it must meet the challenges of a constantly changing environment. The success of strategy should be measured using the concept of strategic ‘fit’; that is, how well the activities of the organisation meet the requirements of the environmental context (Viljoen and Dann, 2000). One of the key misconceptions regarding strategic planning is that strategy is something with which the organisation concerns itself once a year or once every three years. Viljoen and Dann (2000) comment that successful organisations understand strategic management to be a living, evolving process within the organisation, not something that finishes once the strategic plan is written. The management process of implementation of MPHP in an organisational and strategic management setting, once the health plan is written, warrants further research.

4.6.2 Characteristics of Strategic Planning

There is no universally accepted definition of strategic planning. There would probably be more agreement on five important characteristics of strategic planning (Stoner et al., 1985) that deal with fundamental or basic questions. Firstly it provides answers to such questions as ‘What business are we in and what services should we provide?’ ‘Who are our clients or customers, and who should they be?’ It provides a framework for more detailed planning and for day-to-day managerial decisions. Secondly, faced with such decisions, a manager can ask, ‘Which of the available courses of action will be most consistent with our strategy?’ It involves a longer time frame than other types of planning. Thirdly, it provides a sense of coherence and momentum to an organisation’s actions and decisions over time. Fourthly, it is a top-level activity in the sense that top management must be actively involved. This is because only top
management has access to the information necessary to consider all aspects of the organisation; and commitment from top management is necessary in order to generate commitment at lower levels (Stoner et al., 1985).

Good strategic planning systems avoid tokenism. There is a real commitment towards planning, particularly in planning priority health services with communities: people at all levels in government, non-government, community groups and residents are empowered to contribute fully (see Milewa, 1997; Bennett, 1994; Barker et al., 1998; Chapman and Davey, 1997). Plans should be based on the contributions of many minds, not a few (Viljoen and Dann, 2000). Plans should not ‘sit on the shelf’. Strategic planning implies a process of planning, and the subsequent process of implementation of the strategies.

4.7 Organisational Objectives and the Changing External Environment

To achieve organisational objectives, strategic managers (including project managers) employ internal skills and resources appropriately within the context of a changing external environment. Organisations exist only because they perform some function that society or communities demand –supplying either goods or services to satisfy a socio-political need (Tosi, 1984). In either case the external environment impacts on the organisation. Strategic managers must carefully monitor the relevant external environment to ensure that the organisation continues to perform its primary functions effectively (Weinshall and Raveh, 1983; Viljoen and Dann, 2000). Strategic Management then is essentially the management of the interface between the organisation and its external environment. It is differentiated from all other areas of management, by virtue of the fact that it concerns the interface between all elements of the external environment and all internal areas and characteristics of an organisation (Viljoen and Dann, 2000). MPHP is a form of strategic management at the interface of local and state government organisations and other intersectoral agencies that deliver programs that impact on health outcomes. This interface is where progress can be made in MPHP strategic goals.

The external environment then consists of those elements outside of an organisation that are relevant to its operations. Organisations are neither self-sufficient nor self-contained. They exchange resources with the outside environment and depend on it for their survival. Raw materials, money, labour, and energy are external environment inputs that organisations acquire, transform into products or services, and then provide as outputs to the external environment (Stoner et al., 1985). Figure 9 below describes the external environment, with both direct-action and indirect-action elements. Examples of direct-action elements are consumers, government departments, competitors, unions, suppliers and financial institutions (Stoner et al., 1985). Indirect-action elements include the technology, economy, and politics of society: they affect the climate in which the organisation operates and have the potential for becoming direct-action.
elements. When changes in public expectations concerning business behaviour lead to new government regulations, indirect-action elements become direct-action elements (Stoner et al., 1985).

The Healthy Cities project was initiated in Europe in 1986 as a means of supporting the WHO Health for All strategy and implementing the actions areas of the Ottawa Charter. The strategy concentrated on intersectoral collaboration and community participation; in fact, by doing this, local government defined their external environment and sought partnerships with other agencies to implement joint work, based on improving direct services and indirect benefits to communities (WHO, 1986). This research investigates the degree of collaboration with the external environment, whether the MPH effectiveness has improved because of the collaboration, and how local and state government and non-government agencies have participated in MPH projects in settings in Queensland. MPH Plans are strategic business plans which to be sustainable must adapt to the changing external environment.

![External Environment of Organisations](Source: Stoner et al., 1985, p.78)

The most important way managers adjust to the external environment is through the development and implementation of plans for their organisations. As discussed in the previous chapter, MPH is a dynamic living document flexible enough to change with the external factors in communities. Organisational plans may be simple, short-range, and restricted in scope; or they may be sophisticated and encompassing. The potentially most sophisticated and encompassing plans embody both the basic concept of the organisation and the strategies it will follow to achieve its objectives (Stoner et al. 1985).

4.8 Nature and Significance of Corporate Culture

One final element that is frequently crucial to the successful implementation of an organisation’s strategy is the development of a supportive organisational culture. Culture is a
complex component of strategic management. It is hard to isolate the dimensions of culture and to manage those elements in the appropriate way (Viljoen and Dann, 2000). Every organisation has a unique culture that reflects the combined wisdom acquired in the organisation in its attempts to adapt to its internal operations and to a changing external environment (see Trompenaars, 1998 cited in Viljoen and Dann, 2000). There appears to be considerable evidence that suggests organisations with a strong culture are better at implementing strategic plans (Cassidy et al., 2005). They understand what needs to be done to achieve the objective, and seem to be strongly motivated to take appropriate action. Strong culture organisations display unified goal-oriented behaviour, which appears to provide employees with an intrinsic guidance system and to prevent bureaucratic malaise (Viljoen and Dann, 2000). Perhaps the barriers to the development and implementation of successful MPHP are routed in organisational culture issues in local government and allied agencies providing health services. Certainly trying to build partnerships between organisations with different cultures can be a difficult task. Corporate culture may be a barrier to MPHP. There could also be a link between organisational culture in local government and MPHP effectiveness, and this link needs further investigation.

4.9 Strategy Utilises the Core Competencies of an Organisation

The term ‘core competencies’ is a term or concept that is used extensively, but that is rarely fully understood or clearly defined. In essence, core competencies are those activities of the organisation that create unique value (Quinn and Hilmer, 1994). These activities are not necessarily those on which the organisation spends the most time, but are those that have the potential to create sustained competitive advantage. Quinn and Hilmer (1994) have identified seven key characteristics that activities should display in order to be considered an area of key competency.

These core competencies are:

- Based on skills and knowledge sets rather than products and functions
- Flexible, long-term platforms capable of adaptation and evolution
- Unique sources of leverage within each step, which adds value to the activities of the organisation (value chain)
- Areas where the organisation can dominate
- Aspects of the organisation’s activities that are important to their customers (or residents), and
- Activities that are embedded in organisational systems.
Strategic management, through its emphasis on analysis and planning, helps to identify what aspects of the organisation’s activities are in fact its core competencies. Similarly, the process of MPHP helps to clarify the role of agencies in a community and allows the planning committee to list the core functions of each agency in health promotion and environmental health (see Leger, 1997; CDHAC, 1999; NPHP, 2000). Clear identification of core competencies through the strategic management process can allow organisations to move on from their current industry focus into diversified fields with an increased probability of success (Viljoen and Dann, 2000). Improved skills and knowledge in strategic health planning could assist with more sustainable planning processes and outcomes in local government in Australia. An unpublished report by Commonwealth Health and Ageing in 2000 identified core skills and competencies in environmental health, including competencies in public health planning. In the researcher’s opinion and experience, transfer of these skills to managers and health practitioners in local government has occurred slowly.

Strategic management practice requires politicians, managers and health practitioners to have a broad knowledge of the organisation and their community, and in particular of the role of local government and partner agencies in improving health services. The very nature of strategic decisions usually means that, in implementing decisions, changed practices or behaviour are required across a broad spectrum of organisational activities. As a result, strategic managers must have a good grasp of what goes on throughout the organisation to understand the impact their decisions will have, and whether or not the organisation will be able to cope (Viljoen and Dann, 2000). Similarly, managers and health practitioners engaged with participatory health planning would be expected to have a broad understanding of strategic planning and of public and environmental health and health promotion.

4.10 A Need for Strategic Management of Participatory Health Planning

Strategic management and participatory planning are intrinsically connected. A strategic plan follows a logical and cohesive process which allows staff members to feel a sense of ownership and which can be implemented by effective leaders. The plan will add value to any organisation, large or small, government or non-government. It is important that a clear differentiation is made, however, between the strategic plan itself, and strategic planning and management (Viljoen and Dann, 2000). The plan is the physical document or outcome of the planning process. For example, a MPH Plan is both a process and a product (Chapman and Davey, 1997). The implementation of a well-structured strategic plan enables members of the organisation to set and maintain realistic goals and standards that are clearly agreed to by the organisation as a whole. In the case of MPHP the community, the key stakeholders, make an agreement to work together to put into place the strategies. This occurs usually by way of letters of intent to work together or memorandums of understanding (Chapman and Davey, 1995a). It could be argued
that the plan is not the end of the strategic planning process: it is simply a tangible representation of a particular stage in the process that clarifies the direction and objectives of the organisation.

The major advantage of strategic planning is that it provides consistent guidelines for the organisation’s activities. By using strategic planning, managers give their organisations clearly defined objectives and methods for achieving these objectives. Their organisations have a clear purpose and direction. In addition, the planning process helps managers anticipate problems before they arise and deal with problems before they become severe (Stoner et al., 1985). Another important advantage of strategic planning is that it helps managers make decisions. Strategic health planning has the clear purpose of helping agencies on intersectoral committees to make health decisions. The careful analysis provided by strategic planning gives managers more of the information they need to make good decisions. Strategic health planning also minimises the risk and the chance of inappropriate decisions, because goals, objectives, and strategies are based on evidence and developed by teams of interested politicians, agencies, health professionals and residents.

At this point it should also be noted that different organisations have terminology preferences, when referring to a strategic plan or to different levels of the planning process. A corporate plan is the term often used to refer to the highest level of planning in the organisation (Viljoen and Dann, 2000). Business plans refers to the strategic plans development by small business units within the overall corporate structure. The terminology for participatory health planning in the public sector differs only marginally from that used in the private sector. In general, government and non-government agencies are driven similarly by strategic planning. Public sector agencies have internal corporate plans with annual operational plans. Some agencies have community consultation built into their strategic planning mechanisms to allow for community input. Since 2005, as was discussed in Chapter 3, local governments are required not only to comply with, on one dimension, a 20-year visionary regional land use and infrastructure planning process, but also on another dimension to have internal to Council a three-year strategic corporate planning process. This process supports the yearly operational and small business unit plans that have budget allocation to enable strategies to be initiated. In all cases input is sought from residents via a community consultation process. This process is a statutory requirement. As previously mentioned, the LG Act requires all Local Governments in Queensland to develop corporate plans and operational plans.

In town or regional planning organisations, ‘strategic plan’ refers to technical aspects of the profession, hence the term ‘corporate plan’ is preferred. Corporate planning is also defined in the LG Act in Queensland. The LG Act and the LGFS require this statutory approach as a way of consistent planning across local and regional issues. Unfortunately the corporate planning
process has not placed health on the agenda of all local government in Queensland to the satisfaction of Queensland Health. Brown et al. (2001) argue that this process generally does not identify activities that link environment and health as an immediate priority of local governments, rather economic development and infrastructure become the major priority in corporate plans, with mixed outcomes for the environment and quality of life of residents. MPHP can provide health needs to the corporate plan, therefore placing health on the planning agenda. The MPHP process commenced as a stand-alone broad based participatory health plan supporting the Healthy Cities approach, but not well connected to other planning processes in that community (SEAL). But over the last decade, from the mid-1990s, MPHP has evolved as a comprehensive strategic health planning ‘tool’. It develops intersectoral action, collects community health needs, refines these needs into city strategies and presents a health plan for the city linked to other planning mechanisms. Some argue that a MPH Plan would not be required if the corporate planning process was more holistically applied to communities. However the intersectoral action created by MPHP is positive for health outcomes. More research is required on the degree of collaboration developed by MPHP and whether the strategic aims and objectives of MPHP have been met.

MPHP has developed as formal strategic planning in that it requires a considerable investment of time, money and people. In some organisations it may take years for the strategic planning process to function smoothly. Sometimes organisations defer important decisions until newly established and evaluation procedures are completed. This can result in lost opportunities. A further disadvantage is that strategic planning sometimes tends to restrict the organisation to the most rational and risk-free option. Managers learn to develop only those strategies and objectives that can survive the detailed analysis of the planning process. Attractive opportunities that involve high degrees of uncertainty or are difficult to analyse and communicate may be avoided or overlooked (Stoner et al., 1985). MPHP was reported as a time consuming process, complex but important to place health on the strategic agenda of organisations and communities. Tsouros (1995) stated that research was needed in strategic planning with this kind of strategic thinking being relatively new in the field of health and social policy. This will require new strategic planning theory and methodology to be developed in the health sectors.

The background paper on integrated public health practice published by the National Public Health Partnership (NPHP, 2000) makes comment that MPHP is a strategic and collaborative public health planning process lead by local authorities. NPHP warn that there is a risk of duplication and confusion as many local authority planning processes address similar and related issues. The report introduces the concept of integrated public health practice, but does not link this approach with the integration of the strategic business plans of all agencies. Health
outcomes do not come from the health sector only: allied agencies’ planning needs also to link with health planning. It would seem from this literature that the health system talks of integration of delivery systems and settings based programs, but does not address the complex nature of linking the business plans of the agencies in those settings.

What is missing is a coherent use of strategic business planning, the integration of these instruments in a ‘whole of government and community’ response to MPHP, and an outcome of maintaining and improving quality of life for citizens. This definition of strategy indicates that the task of strategic managers is to identify, choose and implement what they believe will be winning strategies for their organisation, and for MPHP, for their community.

4.11 Integration of Strategic Health Planning and Health Promotion

The philosophy of the WHO Healthy Cities Movement (HCM) discussed in the previous chapter focuses around encouraging cities and towns to participate in a process of goal setting for health, and working collectively to implement strategies (Chapman and Davey, 1997). MPHP is a strategic planning process ensuring that expenditure is targeted to the areas of greatest need, and in which it is likely to be most effective (Department of Health, Victoria, 1996). MPHP is a management tool for helping local government determine the direction of public health priorities by identifying key programs and strategies required to accomplish their objectives and progress. Chapman and Davey (1995a) reported that MPHP in Queensland was a dynamic strategic planning exercise that guided future public health planning and actions.

There have been many approaches used by the health sector in the development of healthy communities. However, the programs vary on the basis of the level of community involvement, leadership of the program and the extent to which national and state priorities set the agenda. In general, most planning programs do not recognise the planning within the organisational context, but concentrate on a health promotion perspective. In all cases no reference has been made either to the link between organisational behaviour and effective planning, or to building the management capacity of people and the structure organisations, or to improving strategic planning processes in the health sector. Goumans and Spingett (1997) comment not only that it is important to have supportive national or state policies, but also there is a need to develop formal structures that see health as part of the mainstream activity of all organisations. They reinforce the need to place health cities planning on the political agenda. The development of MPHP provides an opportunity to make such linkages: this thesis will test whether this has occurred.

It is important in this study to define the elements of strategic planning, in order to understand the basis of community public health planning frameworks developed by Agenda 21 and the WHO approach. The literature does not present strategic business planning as the foundation of
the Healthy Cities Planning Approaches. This is a fundamental omission in the WHO Approach: it appears as if MPHP is a creation of WHO to be applied to communities as a health promotion concept only, whereas in the researcher’s opinion MPHP is an extension of the basic elements of the strategic management process, but applied to communities not corporations. If this is the case then the application and effectiveness of the MPHP process and implementation may be hindered.

The community can be seen as a public corporation, and the principles of organisational behaviour and management that apply to private sector business can also be applied to participatory health planning in community settings. People need capacity building and to develop core skills in strategic management, in order to be educated and empowered to develop and implement MPHP or similar participatory health planning approaches. Most health promotion practitioners have a sound understanding of the social determinates of health, but lack capabilities in basic strategic planning. The foundations of the two concepts are linked by theory, but this link is not understood in practice in Queensland. Perhaps more research and capacity building is required to build an organisational culture to sustain MPHP.

4.12 Conclusion

This chapter has discussed organisations and strategic planning and has linked this theory to the governance of MPHP as a conclusion to Part 2, the literature review section of the thesis, where the contextual fields of the study were reviewed. This included a review of the global challenge and local response including chapters about ecological public health, participatory health planning and organisations, governance and strategic planning. Part 3 of the thesis discusses qualitative evaluation theory as it applies to evaluation of Healthy Cities approaches and health planning evaluation (Chapter 5). From this comprehensive analysis Chapter 6 outlines the study design of the thesis, including the conceptual framework.
CHAPTER 5  EVALUATION OF HEALTHY CITIES APPROACHES AND MPHP

5.1 Introduction

Ever since their beginning in 1986, Healthy Cities’ approaches all over the world have been confronted with the issue of poorly developed evaluation processes. This chapter firstly discusses how to choose a methodological approach, and examines quantitative and qualitative evaluation to provide an understanding of appropriate evaluation methods for Healthy Cities projects. The initial aim of this chapter, and an important starting point for all research, is to develop a theoretical orientation for the thesis by examining the theoretical traditions of qualitative research. Chapter 5 then discusses aspects of social research, including discussion about aspects of action research and the implications for future research. The health promotion program evaluation technique, described as process and impact evaluation, will be examined and the chapter will discuss how best to evaluate health promotion programs, including Healthy Cities and MPHP projects. This chapter thus provides insight into the reasons for the chosen qualitative study design that is explained in Chapter 6.

5.2 Choosing a Methodological Approach

This research has involved neither quantitative methods nor epidemiological approaches, but has experimented with qualitative approaches to evaluate participatory health planning. Often a distinction is made between quantitative and qualitative research in health promotion evaluation (Hawe et al., 2004). Quantitative research attempts to measure and score changes occurring as a result of the program (Hawe et al., 2004). Hawe et al. (2004) observed that quantitative approaches usually produce less detailed information from a larger number of participants than qualitative methods, but are considered better for developing evaluation mechanisms for testing changes to health status, health behaviour and knowledge resulting from a health program. Patton argues (1990) that qualitative methods permit the evaluator to study selected issues, cases, or events in depth and detail; the fact that data collection is not constrained by predetermined categories of analysis contributes to the depth and detail of qualitative data. Qualitative methods in public health have considerably improved over the last fifteen years, particularly in relation to evaluating settings approaches in communities. This approach is relevant to the evaluation of MPH Plans.

Dean et al. (1993) commented that the importance of doing away with the inappropriate and unnecessary conflict between quantitative and qualitative approaches needs greater recognition. It is extremely dysfunctional when these approaches are viewed as competing and mutually
exclusive (Dean et al., 1993). Nutbeam (1999) notes that the most compelling evidence of
effectiveness of health promotion programs comes from studies that combine different
methodologies: quantitative and qualitative. Qualitative research can have elements of
quantitative and qualitative research.

Baum (2002) notes that public health is becoming increasingly methodologically eclectic and
uses a range of methods from a variety of social science disciplines and epidemiology. Dean et
al. (1993) found that Healthy Cities evaluations have used a combination of quantitative and
quantitative surveys, which together assess the success of the intervention. However in the
researchers experience, the question ‘why weren’t quantitative methods used?’ is always asked.
The answer often given is that qualitative evaluation is about discovering key learnings in the
context of the project under observation, not statistical comparisons and probability. Also, the
unstructured and descriptive nature of the data collection process in qualitative research often
sits uneasily with those favouring quantitative research strategies. However, qualitative
research can also provide evidence for decision-making similar to that of quantitative research.
Neuman (2003) concludes that qualitative theory is inductive; the analysis proceeds as does
quantitative methods, organising data and extracting evidence to present a coherent consistent
picture of the findings. Baum (2002) argues that public health practitioners should not be
wedded into any particular methodology but should use those tools best suited to the particular
public health problem on hand. This debate distracts researchers from developing robust
qualitative evaluation frameworks and may be the reason for a lack of published evaluation
materials on Healthy Cities project implementation. In relation to this observation, there is no
standard template for evaluating public health programs. This thesis does not intend to pursue
the complex differences between qualitative and quantitative research any further than this
immediate discussion, but will justify the use of qualitative methods in the remaining sections.
Each project, including Healthy Cities projects, requires the development of a unique evaluation
framework.

In general, research on Healthy Cities projects historically has been qualitative (see Springett et
al., 1995; de Leeuw, 1999; McBride and Hulme, 2000; Strobl and Bruce, 2000). Methods of
qualitative research in Healthy Cities project evaluation are constantly being debated at
conferences across the globe, in an attempt to refine the use of qualitative methods. The Healthy
Cities research community has been more active with the number of articles on qualitative
research increasing in recent years using observation, document analysis and key informant
interviews as the foundation of qualitative methods (Bruce et al., 1994; de Leeuw, 1999;
McBrinde and Hulme, 2000; Strobl and Bruce, 2000). This gives the researcher some confidence
that qualitative research has a broad set of common tools or techniques for improving our
capacity to evaluate public health programs. Qualitative research has been labelled as a softer
evaluation method compared with quantitative research, but the researcher, from his experience, agrees with Yin’s statement that, ‘paradoxically the “softer” a research technique, the harder it is to do’ (Yin, 1989, p.26).

A qualitative approach is the most appropriate method to evaluate MPHP. As Patton (1990, p.13) suggests, ‘interviewing and observation are mutually reinforcing qualitative techniques and a bridge to understanding the major themes involved in qualitative evaluation methods’. Qualitative research then captures and discovers meaning from the evaluation. Lofland and Lofland (1984) outlined four features of qualitative research, which are relevant to this thinking. They commented that it is beneficial to the qualitative study if the researcher has had long-term involvement in the evaluation process and understands the topic. This can lead to another problem often cited about qualitative research, in that in using unstructured data collection techniques by the observer where their bias may distort the data (Hawe et al. 2004). Whether researchers use quantitative or qualitative methods, it is important that they realise that both methods can produce bias and invalid or unreliable data. They also comment that in these circumstances and to reduce levels of bias, the data should contain a large amount of pure description of action, people, activities and that the data should contain direct quotations from the participants, note-taking, and audio recordings (Lofland and Lofland, 1984).

For example, according to Lofland and Lofland (1984) as the researcher is attempting to establish how a person thinks about, acts and feels, the researcher’s level of participation in the qualitative analysis involves a tension between the requirements of objective and independent analysis, and the proximity from which the social issue (in this case, effective MPHP planning) can be studied. The question is whether these changes are so large that they negate the benefits obtained by closer observation afforded by actual participation. The debate about participatory action or action research is a continuation of this approach, and is of interest to this study (these issues will be highlighted latter in this chapter). In summary, the evaluation framework must be designed to remove the bias that qualitative methods can bring to the study; this may involve the use of several types and sources of data, refereed to as a triangulation approach (Hawe et al. 2004).

This research seeks the attitudes and opinions of a broad group of politicians, managers, health practitioners and agency partners, across three local government areas, in a qualitative inductive assessment of achievements, barriers and success factors associated with the MPHP projects. In summary, quantitative studies on health and environment indicators or epidemiological statistics or a combination of quantitative and qualitative evaluation would not have been relevant to this study; however, as this research is set in an organisational and community setting, and being more concerned with the processes and impacts of participatory health planning projects than with quantitative indicators or epidemiological issues: a qualitative approach is most suitable.
5.3 Theoretical Orientation for the Qualitative Research

The aim of this section, and an important starting point for all research, is to develop a theoretical orientation for the thesis by examining the theoretical traditions of qualitative research. This section explores the theoretical traditions and practice of qualitative research to assist with understanding and progressing the thinking required to develop more effective evaluation tools for Healthy Cities projects.

Research should always proceed with some level of theory and provide linkage of the knowledge from different studies into more abstract theory. Theory emerges slowly, concept-by-concept and finding-by-finding, in and across specific areas of study. Over time the concepts and empirical generalisations emerge and mature (Neuman, 2003, p.66). Researchers approach the building and testing of theory from two directions. Some begin with abstract thinking, logically connect the ideas in theory to concrete evidence, and then test the ideas against evidence. Others begin with observations of empirical evidence and, on the basis of this evidence, generalise and build towards increasingly abstract ideas. Liamputtong and Ezzy (2005) place theory as integral to the practice of qualitative research. Several theoretical traditions have influenced and informed qualitative research (Denzin, 1997; Vidich and Lyman, 1994). According to Liamputtong and Ezzy (2005) these include positivism, post-positivism, interpretive ethnography, phenomenology, symbolic interactionism, feminism, poststructuralism and postmodernism, and finally hermeneutics. Positivism and post-positivism are oriented towards quantitative and qualitative research and will be described. The traditional measures of the positivist paradigm encompassed logical-deductive and quantitative measurement: randomised control studies and a valid and value free objective science (Costongs and Springett, 1995). Positivist science has given way to the methods of the post-positive paradigm, which argue that reality is subjective and can be approximated only. Both theories have however generated considerable debate among qualitative researchers (Liamputtong and Ezzy, 2005).

In the last decade, a quiet ‘methodological revolution’ has been taking place in the approach to evaluation (Denzin and Lincoln, 1994). A growing literature recognises the move away from reliance on methodologies derived from a positivist paradigm to more post-positivism. Unfortunately, the association of quantitative techniques with positive methods and qualitative with post-positive approaches has led to the belief that debates about how to evaluate health promotion are again about qualitative versus quantitative methods (Springett et al., 1995). Springett et al. (1995) conclude that the positive approach is not suitable for health promotion: this led researchers to the post-positive paradigm. Liamputtong and Ezzy (2005) emphasise that there is no singular agreed-upon set of methods for conducting qualitative research. Baum (2002) concludes that the most logical and scientific research approach is to choose a study design that will provide the most comprehensive and valid answers in the face of inevitable
constraint. Some post-positive evaluation studies draw on techniques commonly used in political science and organisational research (Goumans and Springett, 1997).

The evaluation framework chosen by researchers may not be well understood by other researchers, so it is important to state the theoretical framework and move on to developing the methods of collecting qualitative data. The evaluation of Healthy Cities projects fits well into the dimensions of post-positivism oriented towards qualitative social research. Neuman (2003) defines social theory as a system of interconnected abstractions or ideas that condense and organise knowledge about the social world. Social research is a series of methods people use systematically to produce knowledge; social theory compliments grounded theory. It is an exciting process of discovery, combining theories or ideas with facts in a systematic way using imagination and creativity (Neuman, 2003, p.2). Denzin and Lincoln (1994) conclude that there are many ways to analyse data. Liamputtong and Ezzy (2005) discuss content analysis together with different methods of coding data and computer-assisted data analysis. Health promotion activities, being components of the complex social world, cannot be precisely measured; but by using the range of qualitative techniques now available, measurement of the effectiveness of health promotion programs is made possible.

Grounded theory is a post-positive paradigm, part of the symbolic integrationist tradition and one of the more influential research methodologies utilised in qualitative research (Liamputtong and Ezzy, 2005). Straus and Corbin (1990, cited in Neuman, 2003, p.52) argue that grounded theory uses a systematic set of procedures to develop an inductively derived theory about a phenomenon. Neuman (2003) stated that a grounded theory approach pursues generalisations by making comparisons across social situations. Grounded theory suggests that theory can be built through careful observation of the social world, being deductively derived from the study of the phenomenon it represents (Glaser and Strauss, 1968). Lincoln (1992, p.375) argues that ‘qualitative methods and grounded theory exhibit greater utility, power, and synergies with emerging concepts in health research and provide more stakeholder-based policy analysis and opportunity for evaluation studies’. Patton (1990) comments that qualitative methods are particularly oriented towards exploration, discovery and inductive logic:

An evaluation approach is inductive to the extent that the evaluator attempts to make sense of the situation without imposing pre-existing expectations on the program setting. Inductive designs build with specific observations and build toward general patterns, with categories or dimensions of analysis emerging from open-ended observations, as the evaluator comes to understand the existing program patterns (Patton, 2002, p.15).

These definitions are similar in one aspect: all are seeking an understanding of meanings and interpretations. In inductive theory, researchers develop a theoretical understanding only after data has been collected. Many researchers adopting an inductive approach use grounded theory;
‘grounded theory is part of an inductive approach, in which a researcher builds ideas and generalisations based on closely examining and creatively thinking about the data’ (Neuman, 2003, p.51).

At the centre of grounded theory is thematic analysis, and the process of organising, coding and sorting data, coding pieces of texts and collating all those coded the same way. As the research progresses evaluation concepts are refined, generalisations formed and preliminary relationships developed. Polgar and Thomas (1990) comment that qualitative research involves the investigation of specific individuals, with the investigator seeking to understand the thoughts, feelings and experiences of individuals, focusing on direct, face-to-face knowledge of people coping with their issues in a natural social setting. In this sense the research is holistic, in contrast to the more reductionist approach of quantitative research. Theories that result from the findings are grounded in real world patterns (Glaser and Strauss, 1968). Patton argues that qualitative analysis is guided not by hypothesis but by questions, issues, and a search for patterns. This approach is different from the hypothetical–deductive approach of experimental designs that require the specifications of main variables and the statement of specific research hypotheses before data collection begins (Patton, 1990).

The theory for this MPHP evaluation was constructed from the qualitative field research; the findings of this thesis have been created from grounded theory – a process of trying to explain, interpret, and render meaning from the qualitative data arising from previous efforts to make sense of case studies, focus group findings and key informant interviewee attitudes and opinions. Micro-level events thus form the foundation for a more macro-level explanation of the qualitative data.

Qualitative research was once described as a strategy of ‘calculated chaos’ (Lofland and Lofland, 1984); however with these modern evaluation approaches, qualitative evaluation is now more reliable. Researchers by immersion in interviews and participant observations can discover process and impact evaluation issues, mainly by reading and rereading the data. Accordingly, they discover multiple explanations and themes, new perspectives, linkages, understandings and theories (Liamputtong and Ezzy, 2005).

Patton (2002, p.12) argues that a ‘naturalistic approach’ to qualitative research does not attempt to manipulate the program or its participants for the purposes of evaluation. This approach is useful for studying program implementation and studying the differences between programs at different locations. A naturalist enquiry is open and sensitive to unanticipated variations and deviations from plans. Baum (2002, p.162) notes that most professional disciplines have increasingly adopted a qualitative research methodology in recent decades, as this is better suited for coping with complexity and naturalistic settings. However, others argue for
methodological pluralism when advocating the value of qualitative methods (Davies and Kelly, 1993; Baum, 1995; Baum, 2002; Daly et al., 1992; Scott-Samuel, 1995). Qualitative evaluation data begins as raw, descriptive information about programs and people in programs (Patton, 1990).

A detailed qualitative evaluation study provides a detailed description of program processes and program implementation, descriptions of the types of participants and kinds of participation, the program’s effect on participants, observed changes, outcomes, and impacts and an analysis of program strengths and weaknesses as reported by people interviewed, including key informants in the community (Patton, 1990). This form of naturalistic inquiry has been selected to enable a description of unfolding program processes and impacts that have resulted from an existing seven-step health planning process demonstrated in three diverse communities in this research (Chapman and Davey, 1997). Whatever the case, the selection of a naturalistic process over an experimental design approach is a design issue, not a data collection issue. From a data viewpoint, qualitative data is however the primary focus in naturalistic inquiry (Patton, 1990). Patton (1990) comments that aspects of the classic deductive evaluation approach measure the relative attainment of predetermined clear, specific and measurable goals. This study combines deductive and inductive approaches to provide goal-free evaluation in which the evaluator gathers qualitative data on program impacts through direct observation of program activities (Patton, 1990).

Coalition theory is one theory that could assist the conceptual thinking in the development of the study’s evaluation framework, which examines a range of benefits of partnership planning, including improved agency collaboration in MPHP. Discussion of coalition, alliance or partnership theory centres around various theorists’ contributions (see Gamson, 1961; Rickey, 1962). Gamson defined coalition theory as the study of ‘temporary alliances among individuals, that is, who will join with whom in any specific instance’ (Gamson, 1961). Coalition theory was previously used to study political alliances (O’Neill et al., 1997). The five parameters of coalition theory have been detailed in Table 5. These parameters are important predictors of the processes in which intersectoral action will occur. Coalitions vary according to the level and number of agencies that want to participate seriously in joint action. O’Neill et al. (1997) note that the organisational context is a significant context in determining the existence and effectiveness of intersectoral health action. Their study reviews the aims of the MPHP project which included levels of intersectoral collaboration across the various government and non-government agencies to understand the degree of collaboration and its impact on planning outcomes.
Table 5: The Parameters and Impact of Coalition Theory

<table>
<thead>
<tr>
<th>Parameters of Coalition Theory</th>
<th>Impact on Coalition</th>
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<tbody>
<tr>
<td>Initial distribution of resources</td>
<td>Sense of purpose, information, prestige, authority derived from size, etc.</td>
</tr>
<tr>
<td>Rewards from participation</td>
<td>Pay-off for joining the coalition that could not be obtained alone, expected value of future decisions according to the probability of the coalition functioning well</td>
</tr>
<tr>
<td>Inclination to join with any other player whatever that player’s control of resources may be</td>
<td>Development of positive, negative and neutral positions/ties by players to participate</td>
</tr>
<tr>
<td>Effective decision point – rules of the coalition, e.g. decision-making, conflict</td>
<td>Level of resources influences voting power or informal agreement in the group to aim towards consensus</td>
</tr>
<tr>
<td>Organisational context</td>
<td>Levels and amount of government and non-government involvement increases organisational importance</td>
</tr>
</tbody>
</table>

(Source: O’Neill et al., 1997)

O’Neill et al. (1997) tested the notion that intersectoral health-related action should be made a central concept in health promotion and reported that, up to that date, this approach had failed more often than it had succeeded. Healthy Cities evaluation had been founded on the principle that increased partnerships would increase health promotion action, which, in the long-term, would improve health outcomes.

Gillies found that the greater the level of local community involvement, both in setting agendas for action and in the practice of health promotion, the larger the impact. In a local government case study on a Healthy Cities project, Gillies (1998) reported that the most effective partnerships started with those already acquainted. In summary, the more practical the project, the more likely people were to become involved. Furthermore, this case study found that keeping strong links with the political authorities provided health gains and that coalitions were more effective in an economic environment with a minimal resource infrastructure. ‘Believing in the cause’ was found to be an important determinant to the coalition’s sustainability. Consensual decision-making was found to be an appropriate method in a successful coalition, along with documented conflict resolution processes; however, O’Neill et al. (1997) commented that sub-groups that naturally emerged in some cases served as competition for the coalition, which was unhelpful to decision-making processes. Their study noted that having experts well-placed in the community’s power structure in the group assisted with actions, and concluded that coalition theory proved useful in unravelling agency coalition mechanisms, and could be a promising tool for studying and implementing intersectoral health-related interventions: one must go past the global enthusiasm for intersectoral action, especially when empirical evidence points to the failure of intersectoral coalitions.
Therefore Healthy Cities researchers need a better understanding of which partnerships work, under what conditions. For example, Gillies (1998) researched the effectiveness of partnerships in health promotion. He reported that partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, are effective in ‘tackling the broader determinants of health and well being in populations in a sustainable manner as well as promoting individual health related behavioural change’ (Gillies, 1988). This approach needs testing to examine if the theory supporting intersectoral action does in fact impact on the outcomes of participatory health planning.

5.4 Action Research Methods

This thesis has not attempted these methods in its design, but it is important to understand the approaches for future MPHP evaluation. Also this style of research methods need explanation in this study, primarily because selected participatory planning models studied in Chapter 3 used participatory action research (PAR) and elements of this approach should be considered as a possibility for health planning research design. Postmodern qualitative researchers try to present analysis that acknowledges the situational and political nature of their analysis; they tend to favour action research (AR) or unobtrusive methods or participatory action research (PAR). Ritchie (1996) argues that the theoretical bases of AR and PAR are in social science and are similar. Shared interest between the researcher and community is essential in conducting good quality AR or PAR.

AR was developed by Kurt Lewin’s work as early as 1946, and has been applied in education and management research in developed countries such as the USA, UK and Australia (Hart and Bond, 1995; Kemmis and McTaggart, 1988; Kemmis and McTaggart, 2000). However, while PAR has been used with people in developing communities, AR methods are associated with empowered people in developed countries. PAR prevents oppressed people from becoming passive objects by allowing participants to give input to the research, rather than have research ‘done to them’ as in conventional research methods. Participatory action research (PAR) is rooted in neo-Marxist approaches to community development, aiming to examine the political structures that impact on marginalised groups. PAR aims to broaden the research participants’ knowledge so that the research becomes a learning activity. Participatory action research has its theoretical framework in linking the process of knowing to learning, aiming to transform social realities (de Koning and Martin, 1996; Liamputtong and Ezzy, 2005, p.182).

Based on the researcher’s experience, participatory health planning evaluation in Queensland has its origins in aspects of AR theories. Some writers describe PAR as the intersection of two approaches, namely participatory research and action research (see McTaggart, 1993; Kemmis and McTaggart, 2000). De Koning and Martin (1996, p.3) argue that ‘for some, PAR means...
involving field-level health workers in the research in order to sensitise them to the needs of a community; for others it means research which is an integrated part of a process towards empowerment and emancipation.’ Reason (1994, p.328) points out that there are several different communities of PAR practitioners who represent their work in different ways. PAR means different things to different people. Liampittong and Ezzy (2005) argue that in practice PAR’s key concepts are interrelated and include participation, education, and collective action. PAR produces knowledge and action directly useful to the group or community; through research, education or capacity-building and socio-political action; and by empowering people to become involved in research and use their new knowledge. Ritchie (1996) noted that the major differences between these two approaches are in the relationship between the researcher and the community. He comments:

In action research the [evaluator] instigator is most likely to be involved with the project with shared values and similar use of language, while in participatory research, the [evaluator] instigator may be from a different sub-culture, being better resourced and educated than the other participants (p.207).

In Building Communities from the Inside Out, Kretzmann and McKnight (1993) proposed an action research approach working with communities and organisations to evaluate planning projects. One other key feature of AR is that this style of research attempts to integrate organisational and political action, and is therefore quite suited to evaluating Healthy Cities approaches and participatory health planning in communities. Whichever is used, qualitative methods allow the evaluator to be led by participants’ comments on the program and to take an unstructured approach in attempting to understand participants’ experiences and the meanings they generate from the program (Hawe et al., 2004).

5.5 Evaluation of Public Health and Health Promotion Programs

Baum (2002, p.14) comments that the distinguishing feature of public health is its focus on populations rather than individuals. This focus requires a consideration of population planning in order to better understand the needs of the population. Thus, from a public health planning perspective, health and disease impact on the population’s health, not just on individual health (Baum, 2002, p.15). For these reasons health promotion program evaluation must focus on populations, including community level. Hawe et al. (2004) comment that qualitative evaluation approaches in public health are particularly good for discovering unintended effects and understanding why these effects occurred.

Better quality evaluations in health promotion will lead to better interventions and improvements in public health. Nutbeam (1999) comments that the evaluation of health promotion programs is a complex enterprise. He notes that the use of a diverse range of data and information sources provides more relevant and sensitive evidence of multi-dimensional health
promotion intervention’s effects than a single ‘definitive study’. Given this complexity Nutbeam argues there can be no single ‘right’ method or measure to evaluate program effectiveness, and no absolute form of evidence. He suggests that evidence of effectiveness is then inextricably linked to the entry point (issue, population, setting), the method of health promotion intervention, and the measure of outcome used to judge ‘success’. Hawe et al. (2004) comment that all too frequently health promotion programs have been established on the basis of limited research and implemented with little or no evaluation. As a consequence many programs have been established with poorly conceived and unrealistic objectives, and with no effective mechanism for management, quality control or monitoring. These authors conclude these programs are often doomed to failure and, even when ‘successful’, have not been capable of yielding supportive evidence to ensure their continued existence. A commitment to good health promotion practice means a commitment to the planning and evaluation of programs (Green and Tones, 1999; Hawe et al., 2004).

Kreuter et al. (1996) proposed that there is a need for a common set of indicators to measure community-level interventions in health promotion programs. The challenge is to devise indicators from the perspective of local government, organisations and systems as well as from individual viewpoints (Gillies, 1998). This thesis shares this objective, and identifies with Gillies’ conclusions by recording the achievements, barriers and success factors associated with MPHP initiatives in Queensland, thus seeking to gain, through process and impact evaluation, a better understanding of effective planning and the implementation of participatory health planning action in local government. The concept of social capital development in the theoretical and practical evaluation of projects of health promotion is the way forward (Gillies, 1998).

Gillies states:

> It could be argued that despite publication of the Ottawa Charter in 1986 and the development of the successful WHO Healthy Cities Program in the eighties, individualism still continues to dominate many of the practical health education and disease prevention agenda at least in industrialised nations. The construct of social capital may assist to develop theoretical frameworks that promote collaborative alliances, partnerships for health promotion; the existing evidence is optimistic (1998, p.99-100).

Nutbeam (1999) comments that in evaluating the effectiveness of health promotion programs it is important to be clear about what is actually meant in health promotion by ‘effectiveness’. In contemporary health promotion a range of measures is used to define ‘effectiveness’. These measures have been developed into outcome hierarchies that emphasise the difference between short-term impact and long-term outcomes (Nutbeam, 1998; 2000). Evaluation of short-term impacts should measure the effectiveness of changes in individual knowledge and skills that follow educational interventions to social action, changes in social norms that follow social
mobilisation or community development interventions, and changes in policy or organisational practices that follow health advocacy. Nutbeam (1999) judges longer-term outcomes by monitoring changes in the health determinants that flow from the short-term impacts of health promotion interventions, such as the participatory health planning being studied in this thesis.

Rada et al. (1999) have made a promising four-dimensional conceptual framework for evidence-based health promotion, combining specific evidence with cultural and political considerations to assist decision makers in government and health provider organisations to undertake ‘evidence-based’ purchasing of health promotion. This framework is relevant to evaluating the broad theory of MPHP and is very relevant in this thesis. The framework represents a multi-dimensional approach that:

- Provides scientific evidence of need and effectiveness (scientific dimension)
- Fits policy frameworks and government obligations (organisational dimension)
- Is sensitive to social and cultural needs (socio-cultural dimension), and
- Adopts recognised health promotion principles (health promotion dimension).

This model can be applied to specific health promotion strategies that are contained within MPHP to measure levels of effectiveness, but it does not directly consider the measurement of the effects of structural change, partnership approaches, and capacity building on the determinants of health.

Baum (2002) comments that community-based health promotion programs, typical of the new public health, pose particular challenges to evaluators. Springett et al. (1995) have developed a different health promotion evaluation framework that includes the development of evaluation aims reflecting the personnel beliefs, values, and perceptions of the people involved. Any evaluation framework must include appropriate evaluation methodologies that ensure these particular issues are also incorporated. Few published materials have been completed on the evaluation of the implementation of any type of participatory health planning process – MPHP, city health plans, community public health plans, public and environmental health plans, or sustainable cities planning (WHO, 1996a; Chapman and Davey, 1997; WHO, 1997b; Cotter and Hannan, 1999).

5.6 Process, Impact and Outcome Evaluation

The purpose of the evaluation is to understand how things worked or did not work, why and what improvements can be made (Ellis et al., 1990). Springett et al. (1995) suggest that there is a need for a framework for evaluating health promotion because the planning and implementation of an evaluation has an important impact on its outcome. Designing evaluation frameworks, particularly for qualitative studies, is challenging. Before deciding on an evaluation methodology it is important to consider the process of assessing the goals and purpose of the evaluation. With this in mind, it is useful to consider the three types of evaluation Hawe et al.
(2004) present in Evaluating Health Promotion: first, process evaluation, which measures the program’s activities, program and recipients; second, impact evaluation, which measures the program’s immediate effects and whether the program meets its objectives; and third, outcome evaluation, which measures the program’s long-term effects and whether the program meets its goals. Commentators on Healthy Cities evaluations are in near consensus in placing heavy emphasis on process issues that focus on the institutional and participatory aspects of the project (Werna and Harpham, 1995; Harpham et al., 2001). It is important to do these three forms of evaluation in sequence to avoid premature evaluation – evaluating a program before it is likely to work (Hawe et al. 2004). Both impact and outcome evaluations measure the effect of policy process and its long-term goals (Springett et al., 1995). Outcome evaluation is concerned with the longer-term effects, usually corresponding with the program goal, but is rarely developed for most health promotion programs. Werna and Harpham (1995) used process and impact indicators to evaluate Healthy Cities projects and agreed that the following indicators should be evaluated: the degree of involvement, municipal change, linkages, capacity building and sustainability.

The distinction between process and impact evaluation is not absolute; impact evaluation can come under the umbrella of process evaluation when it measures small impacts or outputs within a program. Process evaluation is designed to assess whether the program planned has been set up and run as intended. Process evaluation then covers all aspects of the process of program delivery and includes examining, for example, session content, attendance and what participants think of the program. Hawe et al. (2004) agree that process evaluation is simplistic and that in practice there are grey lines between process and impact evaluation, with both types of evaluation being done at the same time. Funnell et al. (1995) comment that process and impact evaluation link together in an evaluation, with evaluators needing to do both forms of evaluation in parallel. Evaluation is about measuring change and documenting learnings. It should therefore be more than just a management tool; giving equal weighting to process and impact evaluation ensures this happens. Impact evaluation involves an assessment of a program’s effects, but at different levels. Impact evaluation is concerned with the assessment of the immediate effects of the program and usually corresponds with the measurement of the program aim and objectives (Hawe et al., 2004).

Hawe et al. (2004) raise concerns about health planning evaluations having been conducted as process evaluations rather than impact evaluations. This means programs are often evaluated prematurely, before they are functioning optimally, when they are less likely to be having an effect. Instead, programs should be evaluated for their impact over a longer time frame. Hawe et al. (2004) also mention that ‘it is not unusual’ to suggest that the people who design and conduct the programs cannot carry out all the evaluation tasks necessary in health promotion,
mostly due to time and resources constraints. Evaluation costs should be built into the initial program budget so that resources can be allocated accordingly. Hawe et al. (2004) note that this does not always occur: program managers end up both implementing a program and evaluating its effectiveness, with limited resources.

Lowe et al. (cited in Springett et al., 1995) point out that health promotion programs may fail due to their ineffective implementation, rather than to their design. The researcher has observed that the literature places little emphasis on impact evaluation, instead concentrating on initial process and limited impact evaluation. Impact evaluation needs more attention, and is more important than process evaluation in terms of evidence based health promotion. Because of the complexity of evaluation of the implementation of health promotion programs, these evaluations are seldom undertaken – but researchers should ask the questions, ‘how did things work?’, ‘what were the successful program outputs or results?’, or ‘what improvements were made?’ Thus, part of a good evaluation process is measuring the impacts or outputs of decision-making and providing decision-makers and other interest groups with information about short-term changes (Hancock, 1993). However impact evaluation without process evaluation is insufficient because it gives no information about the process that has achieved a particular effect (Ziglio, 1991).

5.7 Evaluating the Healthy Cities Approach

Healthy Cities approaches, including MPHP evaluation, often use grounded theory techniques as they generally have intersectoral and participatory approaches, with evaluation derived from participants’ opinions. The issue of assessing whether or not the Healthy Cities projects are making a difference has always been a key issue; the search for the proper way to evaluate the set of interventions generated by the HCM has not advanced much (O’Neill and Simard, 2006). There are even fewer examples of evaluation of MPHP, which WHO advocates as a Healthy Cities policy intervention in local government environments. Evaluation specialists list several reasons for evaluation, increasingly focused on the capacity of stakeholders to find something useful and relevant in their projects (see Patton, 1990; Lincoln, 1992). O’Neill and Simard (2006) note that the main reasons are to assess whether the Healthy Cities project has changed anything in municipal political processes, in the health of the community and in any other characteristic; to maintain political legitimacy, comparing projects between cities (demonstrating the success of local projects mobilises the community and sustains future projects); and to contribute scientific knowledge. MPHP evaluation frameworks should address these key points.

The increasing international and national support for Healthy Cities projects and related ‘settings’ activities has led to increased attention on their evaluation. At the Fourth International
Conference on Health Promotion, ‘New Players for a New Era: Leading Health Promotion into the 21st Century’ (Jakarta, 21–25 July 1997), the working groups concluded that Healthy Cities projects may be evaluated in four domains:

- their progress in formulating and implementing a health plan
- their commitment, the city’s involvement and local leadership on the project
- their establishment and operation of a ‘Healthy Cities committee’ and of task groups that involve the various stakeholders, and
- their progress in networking with other healthy cities or projects.

WHO (1997b) refers to assessing the goals of evaluation, and commented that the important goals of evaluation were to monitor progress in relation to the key project aims (mobilising the community to implement the city health plan, raise awareness, carry out capacity-building, networking); to provide analyses of the experiences in order to build a stronger and more effective project; and to increase the knowledge and research base for health cities implementation and monitoring. These domains and goals of evaluation provide some initial direction for MPHP evaluation. Although Cronbach et al. (1980) criticise the excessive amount of attention given to aims and objectives, because this gives the evaluator too much power to determine what activities become primary in a project. In other disciplines like strategic management performance measurement of actions in business plans always measures progress against objectives. The health sector can learn from more traditional business sector approaches to monitoring program outcomes. This evaluation of progress against the original aims is common practice in most private and public sector organisations and should also apply to the HCM. (for one such example see Harpham et al., 2001).

Ouellet et al. (1994) has developed a holistic process evaluation model that centres on evaluating Healthy Cities programs. This preliminary evaluation framework consisted of external and internal environments, with levels of interaction (coherence of objectives, intersectoral action between partners and citizen participation. This model led to a better understanding of the concepts of ‘conflict’, ‘structure’ and ‘activities’ when implanting Health Cities projects. The preliminary evaluation framework developed by Ouellet et al. (1994), which tested eight variables and contained specific questions asked of participants, gave better understanding and meaning to the Healthy Cities program. These questions included the extent to which laws and overall political and economic issues influenced the implementation and results of the Healthy Cities initiative; whether partners shared common objectives; the level of citizen participation; the extent to which groups were involved in project implementation; what was in place in the project to manage the role and function of participating agencies and people; the goals of each agency and its expectations; and the participants’ level of satisfaction in the planning. The framework contained a mix of process and impact evaluation styles.
At the same time, Goldstein and Kickbusch (1996) suggested indicators for healthy cities as a way forward for program evaluation. The evaluation model was based on Goldstein’s experience working (at the WHO Unit for Urban Environment) in cities such as Accra, Lahore, Chittagong, Ibadan, Rio de Janeiro and Teheran. The framework had three dimensions: assessing health indicators (life expectancy, vaccination coverage, etc.), socio-economic indicators (mean years of schooling, adult literacy, employment, etc.) and environmental indicators (the number of people in poor housing areas, drinking water coverage, level of parasitic disease, etc.). This early model for Healthy Cities evaluation did not include issues such as participation and community decision-making, the levels of agency participation or the organisational support for the community as factors in improving health – factors that other models have explored in the last fifteen years (see Baum and Cooke, 1992; Ouellet et al., 1994; Costongs and Springett, 1997; O’Neill and Simard, 2006). Hancock and Duhl (1988b) proposed a set of categories to evaluate whether a city was healthy – geography, demographics, political structures, to mention a few – but suggested no specific way to measure them. The type of evaluation to be used in such projects is not well defined; however, there are a variety of examples where indicators have been used to assess progress of cities towards the 38 goals for Health for All (WHO, 1984). This thesis has avoided using quality-of-life indicators to assess the effectiveness of participatory planning, mainly because of the complexities of demonstrating direct causes and effects between the planning intervention and the indicator outcome. Inevitably, associations are difficult to make in the short to medium term, and extensive indicator measurement is expensive.

Goumans and Springett (1997) examined evidence from ten cities in the Netherlands and the United Kingdom that were part of the WHO Healthy Cities projects. They wrote that the overarching goal of the WHO Healthy Cities project was to raise awareness on where and how health is created, and to influence agencies other than those traditionally responsible for health when developing strategies to create supportive environments for health. Local authorities had a role to create such environments. The ten cities were evaluated on five key elements of policy change: supportive national strategies, development of formal structures that mainstream health in all departments and agencies, shared ownership and commitment by all organisations, development of health as a core activity of organisations, capacity building to meet the new health roles; and building political agenda. They found that no substantive policy change had taken place. In almost all cases the Healthy Cities initiatives were still projects rather than policies and, where plans had been developed, they were insufficient to move health care up the policy agenda, let alone actually raise health levels.

There are many published studies that assess the benefits of joint working or intersectoral collaboration. In a study of joint working in thirteen Healthy Cities projects, Boonekamp et al. (1999) found that in the healthy public policy decision-making process the structural and
strategic opportunities for interdepartmental work, as well as for active community participation, were perceived to be insufficient, thus needing strengthening. A review by Roe et al. (1997) of nineteen international databases revealed a total of 185 published references to the evaluation of alliances or partnerships for health promotion since 1986. Springett et al. (1995) examined participants’ perceptions of the effectiveness of joint workings during the production of Liverpool’s city health plan. The results suggested that joint working had been reasonably effective in developing city health plans in Liverpool, but more attention needed to be paid to the process of individuals working together than on formal inter-organisational structures. The study identified that personal relationships and political differences between different stakeholders play an important role in the opportunities for the implementation of intersectoral policies.

Gilles (1998) has analysed forty-three of these published references to find which types of alliances or partnerships appeared to work effectively and why, and to determine the nature and extent of the alliances’ impacts. She concludes that – however one defines the outcomes and whoever the partners in the process are – the stronger the representation of the community and the greater the community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gains (Gillies, 1998). Gillies reasons that this is related to shared agenda setting, shared power and participatory decision-making. Mechanisms for involving people in planning and in providing an opportunity for dissent are important because the process engages real attitudes and opinions. This is evidenced by community representation in community action. Formal organisational structures facilitate agency partnerships through shared decision-making – such as co-ordinating Councils and community committees: key factors for the promotion of health and particularly effective at a local level (Heath et al., 1995; Wojtowicz et al., 1992; Kumpusalo et al., 1996). Healthy alliances tend to include more formal or structured partnership mechanisms than informal networks.

Speller and Funnell (1994, p.5) defined a healthy alliance as ‘a partnership of organisations and individuals that enables people to increase control over and to improve health and well being, emotionally, physically, mentally, socially and environmentally’. A healthy alliance has its goals in the improved health of a community. A growing body of evidence indicates that healthy alliances or collaborations develop in phases. Each phase needs to be nurtured and allowed to develop fully for the alliance to be successful (Taylor-Powell and Rossing, c.1996). Gillies’ 1998 study on alliances concluded that best practice alliances cross health, education, social welfare, environment, transport, tourism and employment sectors and span public, private and non-government agencies. In Gilles’ study the majority of these initiatives were organised at national, district or local levels and aimed to be sustainable and long-term. Several studies have reported the need for tangible and practical means of maintaining initiatives and for building
flexibility in project plans to allow for changes in direction made necessary by structural changes in the wider national or global environment (Gillies, 1998). This model could assist with the design of the evaluation framework for the process and impact evaluation used in this thesis.

One method used in city health plans is intersectoral collaboration, which brings agencies together to plan jointly. Springett et al. (1995) noted that several cities within the WHO Healthy Cities Project have developed city health plans, that is, broad strategies to improve the city’s health. They concluded from their research that intersectoral collaboration, based on ‘networking’ and ‘joint working’; brings about change at the city level. City health plans acknowledge that opportunities to improve citizen health are found in many sectors of the city, so implementation of projects is best achieved through effective intersectoral collaboration (Springett et al., 1995). The Springett et al. paper indicated that joint working had been reasonably effective in developing Liverpool’s city health plan, but that more attention should be paid to the process of individuals working together, rather than on formal joint structures.

It is important to have appropriate structures in government particularly Councils, to allow the alliances with citizens to improve levels of engagement in local health planning. One reported shortcoming of the healthy cities initiative in both Australia (Baum and Cooke, 1992) and Canada (Ouellet et al., 1994) was the inability to engage local citizens in productive decision-making about health and social welfare and in policy development. Part of having appropriate structures for planning included holding community focus groups around health issues, to improve participation in public health planning (Merciere, 1997; Davey and Logan, 2001a). Gillies (1998) has found that local policy development around a single issue is more likely to attract participation from local citizens than city-wide healthy public policy, because the latter lacks a sense of relevance and emotional connection. Davey (2004) has found that agency’ representatives from local government value participation in city wide health planning. In such planning meetings, local residents have attended as representatives of community groups, rather than as individuals. It may not always be necessary to engage residents directly, but provision needs to be made for community groups to be represented and feedback to be given to residents.

There are many examples of partnerships to plan for a healthy city. Gillies (1998, p.104) stated that a good partnership requires ‘relevant needs assessment combined with the setting up of committees crossing professional and lay boundaries to steer, guide and account for the activities and programs implemented’. A WHO Kuching (City) Healthy Cities Project in Malaysia had increased support from politicians and agencies for city planning, and had alliances between government, city officials, local businesses and energetic individuals (Gillies, 1998). The ‘Clean and Healthy Environment Program’ in Java, Indonesia, which emerged from a National Health Development Plan, contained needs assessment and community committees,
as well as increased village and local environmental groups participation, so that they met every three months (Gillies, 1998). A multi-sectoral health promotion network project was reported to be successfully operationalising a network of agencies and community groups to mobilise the community members in Wide Bay (Davey et al., 1999) Finally, it was noted that encouragement awards given by the government to local authorities for engaging in a participatory planning process improved collaboration among agencies and residents and increased political support for health (Chapman and Davey, 1997).

MPHP projects encourage partnerships between intersectoral agencies across all levels of government and non-government sectors. Studies conducted by Gilles (1998) have analysed macro-level partnerships, involving many partners that are trying to influence the structural determinants of health. There are many health projects based on improving the physical, working, economic and social environments that are working with partnership or healthy alliance principles (Davey and Murray, 2003). Developing social capital as part of the theoretical and practical project of health promotion is also important (Gillies, 1998). The WHO Healthy Cities projects have demonstrated a significant impact on health promotion practice globally. However, community capacity strengthening, participation, agenda-setting, empowerment, political management and networking approaches that define the HCM have yet to be underpinned by a coherent explanatory model and therefore, not surprisingly, by a consistent means of measuring success (Hancock, 1993).

The HCM presupposes the existence of community members participating in local agenda settings that rely on mutual trust, similar expectations and a willingness to be engaged. The capacity for communities to engage in health promotion and planning action needs to be nurtured and developed. In the researcher’s experience of developing eighteen MPH Plans in Queensland, each community has its own level of willingness to be involved in participatory planning, and most of this involvement is at an agency or community group level, not as individual residents. Community consolation could be improved to include the valuable experience and perceptions of residents (see Davey, 2004).

To monitor the progress of intersectoral collaboration initiatives, the WHO Healthy Cities project identified the need for project indicators so that comparisons could be made within a city. These project indicators would also stimulate change (WHO, 2001a). Speller and Funnell (1994) developed process and impact indicators within a quality evaluation framework in the HEA Multi-Sectoral Collaboration for Health Evaluation Project. Their model generated a series of specific evaluation questions that indicated if the aims of the project were met, if the effectiveness of healthy alliances and their impact on structural change within participating organisations that are implementing health promotion programs. Speller and Funnell (1994) aimed to develop measurement tools for practitioners trying to research participatory models of
health promotion. They noted that the phrase ‘healthy alliances’ was coined to describe the establishment of arrangements for joint working, collaboration, or co-operation between agencies in order to achieve the ‘Health of the Nation’ targets relating to working across agency and professional boundaries.

Indicators can combine both quantitative and qualitative measures and be subjective and objective. Indicators of health promotion policy need then to focus on the intersectoral decision-making process, interactions between partners, policy processes and policy implementation. Indicators should be relatively simple to collect and use; sensitive to short-term change; capable of analysis at the small-area level; and related to health, HFA, health promotion and Healthy Cities projects; they should also carry social and political punch (Speller and Funnell, c.1994). They need to be able to capture dynamic processes, and to cover both the process of policy making and the outcomes of specific decisions made.

Evaluations of Healthy Cities approaches involve then two particular evaluation challenges, first the broad array of health and environment issues that are addressed, and second the wide array of partnership and community participation in the project. WHO proposed that HCM evaluations should include the sole use of process issues (de Leeuw et al., 1992; Davies and Kelly, 1993;), supplemented by a few impact indicators (Baum and Cooke, 1992), and parallel use of both types of indicators (Draper et al., 1993; WHO, 2000). Process and impact evaluation are most suited to examining the performance of Healthy Cities projects and particularly MPH Plans.

5.8 MPHP Evaluation in Australia

The first attempts by researchers to assess the Australia HCM were documented by Baum and Cooke (1992), who evaluated a participatory healthy cities project involving three categories of research activity. These included a needs assessment; a process evaluation of the project and collation of information on policy changes, collaboration and partnerships developed, level of community involvement and tools used (such as key informant interviews, surveys of intersectoral group members and analysis of local media); and an analysis of extra funding the project obtained. Many of the more recent evaluations are based on Baum’s work. Hawe et al. (2004) defines planning and evaluation:

Planning, to take in the needs of the target group and the best of current knowledge as to how to meet these needs. Evaluation, to find out the effects of the program, who has benefited and who has not (p.5).

Eagar et al. (2001) categorise city health planning as program planning for health promotion and give details of a case study on MPHP in Victoria. Planning for health improvements requires somewhat different skills from those required in planning for health services; program planning in health promotion requires the technical capacity to analyse health problems and their
determinants, the communication skills to engage the affected community, and a clear understanding of the factors – both within the health system and outside of health – that are amenable to change (Eagar et al., 2001). One of the advantages of strategic health planning processes is that they traditionally include in their plans performance indicators that are measurable over short-, medium- and long-term time frames. In any case, monitoring the outcomes of all these strategic planning processes is complex, involving multiple activities with evolving and changing objectives (Baum, 2002, p.185). Consequently the evaluation has to be similarly complex (Baum, 2002).

The process and impact evaluation framework reported by Garrard and Scholfield (1991) in their study of Victorian MPHP used qualitative approaches to ask participants specific questions about MPHP process and implementation. Question areas included impressions of involvement in the planning, internal organisation of the planning, administrative arrangements, steps in planning, positive and negative aspects of community consultation, quality of training resources, planning support mechanisms, constraints, benefits, legal, financial, resourcing impacts and the early outcomes of planning. This, one of the few published evaluation framework in the literature reviewed, focuses mainly on internal organisational issues and legal and financial constraints of planning. However, an assessment of the degree of collaboration between agencies and improved planning outcomes is not a factor and therefore is a weakness of the study. This was difficult to understand considering the MPHP model in Victoria was developed in a similar way to the framework for environmental sustainability under LA 21. This framework encouraged intergovernmental and intersectoral collaboration, giving a lead role to local government on creating visions and setting goals, and on local strategic planning underpinned by community participation.

The 1988 Health (General Amendment) Act introduced the requirement that the Victorian government undertake MPHP (McBride and Hulme, 2000). Significantly this legislative change signalled a new strategic direction in public health based on locally identified needs and priorities. There was initially a cautious response by local government for several reasons: it was additional work that needed extra funding and staff training, there was no consultation with local government about the intent of the legislation, and the planning scope was uncertain and resource hungry.

An evaluation of MPH Plans in a pilot program summarised the outcomes of the first eleven pilot plans in Victoria (Garrard and Schofield, 1991). MPHP was the combined effort of state and local government to respond to the new public health. The Councils involved agreed that developing MPHP over a twelve-month period was a starting point in an ongoing process of improvement and refinement. MPH Plans gave greater recognition to local municipal areas as a primary unit for planning and coordinating public health services, but needed greater resourcing
to be implanted effectively. Barriers to planning recorded by Garrard and Schofield (1991) included restricted resources in developing plans; strained state and local government relationships; the changing views of public health; the changing roles of local government staff; and the changing responsibilities of environmental health officers, the professional group who were implementing the plans. Early evaluation of MPHP in Victoria was restricted to process evaluation, but Garrard and Schofield reported similar barriers to effective planning implementation. Health professionals came to understand the implications of implementing the ‘new’ public health and MPHP, realising the urgent need for resources for implementation. Some short-term impacts of MPHP included increased collaboration between departments in Council, increased awareness of the broad scope of public health, and the use of the plan as a document to lobby funding (Garrard and Schofield, 1991).

MPH Plans in Victoria were developed in the mid-1990s during a changing policy environment: laws were reshaped to mandate for MPHP and local governments underwent massive structural changes. The 210 Victorian Councils were radically amalgamated into seventy-eight, all Councillors were sacked, rates were severely capped over several years, competitive tendering (CCT) was introduced, and other accountability measures were imposed. Planning’s importance increased in this restructuring process; however, all writers agree that Council staffs’ capacity to implement MPHP was limited.

Through the implementation of MPHP processes, Councils have endeavoured to deliver on integrated and strategic approaches to their communities’ health needs, with varying degrees of success (Eagar et al., 2001). MPHP in Victoria has been a troubled ground for the application of strategic planning and strategic alliances. McBride and Hulme (2000) argue that perhaps local governments were not ready to develop and implement MPHP in such a new environment, while environmental health officers were lacking the capacity to understand the new public health and how to work in partnership in communities. Eagar et al. report that this has largely been due to several factors – in particular, organisations’ varying expectations about their role in MPHP and health practitioners feeling disconnected from political and management leadership during the process of planning. The levels of government and other agencies that supported MPHP had differing roles in planning and implementation, ranging from being legitimate systems of government, to being service delivery agents for state governments. This lack of standardisation in planning processes weakened the planning outcomes. In all, Eagar et al. report limited improvements in social health outcomes as a result of MPHP in Victoria. If the MPHP is to be a successful tool in tackling the social determinants of health in Victorian communities, the lessons of local health planning and promotion, together with reflections on both the state government’s boundaries and the organisational and efficiency reforms to local government, must be heeded (Smith, 1995; Harris and Wills, 1997).
Victoria is the only state in Australia that, through legislation, requires local government to develop participatory health plans. MPHP has offered Councils an opportunity to progress from circumscribed health hazard surveillance to being developers of supportive healthy communities (Eagar et al., 2001). The potential of this new role depends on local government thinking and operating in a strategic, integrated and participatory way with its community. McBride and Hulme (2000) describe continuing uncertainties for Victorian municipal public health plans, questioning whether a legislative vehicle is still appropriate for realising local governments’ potential to affect their populations’ health. This article is one of the few that include an in-depth qualitative analysis of MPHP (see also Harris and Wills, 1997; Smith, 1995).

Discussing the current state of Victorian MPHP and practice, the article found an increased legitimacy for planning; an ambivalent policy environment (inconsistent support from Councils); unclear benefits of external collaboration; limited community participation; and confusion about models for health planning. While there was a more solid acceptance of the MPHP role by Victorian local governments, there were also a significant number of barriers to effective implementation (McBride and Hulme, 2000). The policy environment was confusing, with Councils unclear about which MPHP model to adopt. This led to further debate about Council versus community ownership models and whether MPHP constitutes a ‘Council plan’ under the law; whether it is shared with community residents and is partly owned by the community; whether it is a product and process approach in which an action plan is developed with a supporting dynamic partnership approach (Chapman and Davey, 1997) or a strategic or comprehensive approach in which all Council actions are incorporated either in one planning document or directly into the Council Corporate Plan. Smith (1995) had similar responses in his study and found that MPHP leads to a stronger, more consultative role with agencies and communities that include identifying local health issues and developing plans. However, planning processes were generally not well understood within the health areas and MPH Plans have not been regarded as strategic plans. Also McBride and Hulme (2000) reported that Councils considered that they had a relatively minor responsibility for MPH Plans, and this caused managers to lack any ownership of the process. This is a major barrier to effective participatory planning and this ownership constraint requires testing in Queensland projects.

Another example of evaluation of participatory planning included the twelve ‘social ecology’ questions for evaluating Healthy Cities initiatives (Hill, 1999). This approach acknowledges the complex interrelated nature of processes involved in fostering health, sustainability and change and provides some insight for this research into gathering information on MPHP evaluation in Queensland. The questionnaire included personal, social, environmental and general sections. Intersectoral collaboration was part of the social section: the questionnaire asked whether the project intended to have collaborative community structures and functions to build and maintain
social capital. In general, small meaningful collaborations were reported as being a positive dimension for health planning. Hill (1999) concludes that planning to be effective requires support for building personnel capital and sustainability. This evaluation will address capacity building needs of individuals and organisations and the relationship to effective MPHP.

In Queensland an argument about the need for mandatory health planning in local government has existed for a decade without being resolved. There is in fact no legislation in Queensland requiring that Councils have a MPH Plan. However, MPHP is used as a participatory planning tool to provide a framework for gathering community needs, which are then collated into a strategic planning document supported by multi-sectoral community advisory committees. Strategies agreed to by communities are fed to other layers of planning and planning cycles in local government. In Queensland the IPA demands healthy and sustainable town planning practices. The LG Act also requires that Councils have corporate and operational plans; also, under the environmental protection acts and regulations, Councils must consider ecological sustainable development and are indirectly required to involve communities in planning.

Queensland’s Public Health Act has been in constant review for ten years, and any attempts to legally require Councils to have a MPHP have fallen on deaf bureaucratic ears. Somewhat paradoxically, Queensland Health’s legislative frameworks still reflect the old public health, yet their health promotion frameworks are cutting edge. It appears that the devolution of health planning to local government would require further state government funding and, for these reasons, MPHP will continue to be voluntary in selected Councils. At this stage, in 2005, twenty Councils have developed comprehensive MPHP, with the majority of the larger population-based Councils accepting this approach.

There are several layers of impacts, in particular those related to the direct effects on the program’s participants or organisations and those indirect impacts that flow on to the community in some way. Impact evaluation is not about what is measured, but is instead about measuring the sequence of events during the program (Hawe et al., 2004). Both process and impact evaluation are important, allowing health promotion and environmental health professionals to use MPHP achievements, barriers and success factors as evidence of health promotion or health planning’s effectiveness in order to justify increasing resources for proactive planning. This evidence-based decision-making approach should be used at state and local levels in Queensland. However, in the researcher’s experience many planning projects do not allow for evaluation funding for process, impact or outcome evaluation.

Chapman and Davey (1997) in the paper ‘Working ‘with’ communities, not ‘on’ them: A changing focus for local government health planning in Queensland’ describe a participatory approach to health planning in local government that aims to make communities more liveable,
reduce social inequalities and address the determinants of health. The participating projects developed process evaluation, however comprehensive impact evaluation was not conducted due to budget constraints. This could also be due to the complexity of evaluation and the inherent difficulty this presents, with some projects being evaluated too early, or perhaps to a lack of capacity or of project funding to have robust evaluation; alternatively, evaluation may be a low priority for project participants. In summary, there are limited implementation evaluations of MPHP, but the literature does provide sound guidance for designing a process and impact evaluations framework for projects associated with the HCM. The study design based on the analysis in this chapter, is described in Chapter 6.

5.9 Conclusion

Chapter 5 investigates evaluation methodology that can assist with a greater understanding of how best to assess Healthy Cities and partnership approaches and health planning initiatives. This chapter discussed how to choose a methodological approach, by reviewing the theoretical traditions of qualitative research. In the context of understanding how to evaluate health promotion programs and providing techniques for evidence based health promotion, the chapter describes and examines process and impact evaluation as an appropriate framework to assess MPHP projects.
CHAPTER 6 CONCEPTUAL FRAMEWORK, STUDY DESIGN and DATA COLLECTION

6.1 Introduction

Chapter 5 addressed the theory and practice of qualitative research methodology and the foundation linkages relevant to the design of this research. The chapter examined health promotion evaluation techniques; assessed process and impact evaluation methods; and provided conceptual knowledge from several existing evaluation frameworks for Healthy Cities approaches.

Chapter 6 brings the focus more closely onto the actual research design by working through three sections:

- Developing the conceptual framework
- Presenting the study design, and
- Outlining the data collection phases.

The conceptual framework for this study is developed through the research rationale, the research question and the specific research objectives that emerge from it. This then leads to a need to understand data collection methods and analysis techniques. The chapter introduces the research design through discussion of the techniques that complement this design, examining the methods used for data collection, which include case studies, focus groups and key informant interviews. The study’s three important phases of data collection and analysis are described in depth, within the context of the study’s evaluation framework developed for this research to assess MPHP. The evaluation framework was adapted from the review of Healthy Cities program evaluation methodology described in the previous chapter. The evaluation framework describes the comprehensive process and impact evaluation which included a triangulation approach consisting of preliminary cases studies, key informant interviews, using specific process and impact indicator questions, and an analysis of MPHP models compared to other CPHP models and legislative frameworks. The evaluation framework developed in this research could be used to evaluative future MPHP projects.
6.2 Developing the Conceptual Framework

6.2.1 Research Rationale

The research rationale provides the justification for the proposed research, including its overall goal. It includes its guiding philosophy, its underlying assumptions and its relevance to problems identified in the literature. The most important task is to describe how the proposed research will help fill a gap in existing knowledge or solve a particular problem.

MPHP is a strategic business planning process applied in local communities. MPHP utilises two stages of planning: an initial one-year plan development stage followed by plan implementation typically spanning three years. This research, which focuses on evaluation of the implementation phase of MPHP, targets three diverse cities with a combined population of over 750,000 people.

The purpose of this research project is to discover an effective approach to implementation of MPHP. The MPHP initiatives in local government may not be sustainable unless local government, state governments and agencies form partnerships and direct their resources to building their organisations’ capacities to support the ongoing strategy implementation stage of MPH Plans. The MPHP model may also need further conceptual and practical development.

6.2.2 Research Question

A research question emerges from the needs and rationale of the research. The answer to the research question helps to fulfil the purpose and objectives of the research. As suggested in Liamputtong and Ezzy (2005, p.291), the research question helps to move the focus from the general literature down to the specific problem. The research question of this thesis was constructed out of information derived from two main sources. The first influence was the researcher’s enquiry, initially from knowledge gathered through the focus on organisational behaviour found in undergraduate business studies, and later through further understanding and experience gained from participation in an innovative postgraduate program that focused on the ‘new’ public health. The second factor was the opportunity, provided by funding from local and state government in Queensland, not only to coordinate the development and implementation of 18 MPH Plans in Queensland but also to develop resource manuals, write earlier case studies on MPHP, publish papers and present conference papers (see Chapman and Davey, 1997; Barker et al., 1998; Barker and Davey, 1999; Barker and Yakimoff, 2001).

The three contextual fields of this study – namely, ecological public health and Healthy Cities approaches; partnerships, health promotion and organisations; strategic planning and MPHP governance issues – have theoretical and practical linkages and will guide and inform the
research. This connection allows for further exploration of the WHO’s ‘Healthy Cities’ concept of MPHP, designed earlier to address a range of political, social, economic and environmental issues at the local community level. In engaging in needs-based participatory health planning in local government areas, WHO advocate that local government and partner agencies should address the social determinants of health.

The research asks the question: What are the achievements, barriers and success factors associated with the MPHP process and implementation in local government?

### 6.2.3 Research Objectives

The study seeks to evaluate the process and implementation impacts of MPHP. This analysis of the aims and implementation impacts of the MPHP projects helps to identify the achievements, and barriers and success factors associated with MPHP.

The objective of the research is to develop and apply a process and impact evaluation framework to two MPHP projects to:

- To investigate the extent to which the aims of the MPH Plans have been achieved
- To investigate the impact of the implementation phase of MPH Plans
- To compare and analyse the MPHP process to other state-wide participatory planning processes, documenting strengths and limitations
- To identify the success factors for effective MPHP, and
- To develop an effective MPHP implementation model.

Other research on MPHP has conducted process evaluation, but there are limited implementation evaluations published. This research will construct an Implementation Questionnaire (IQ) and test the framework on two MPHP projects. The features of the MPHP model are compared to other CPHP models in Queensland. The research builds an effective implementation model for future MPHP. However, the research conducts both process and impact evaluation, because it has proved difficult to separate these two evaluation processes (Funnell et al., 1995). By answering the above specific questions the research then considers the achievements, barriers and success factors associated with effective MPHP processes and implementation.

The research has focused on three domains: first, individual responses; second, organisational governance issues; and last, the most valuable features of the planning models. The features of an effective and sustainable MPHP implementation model were discussed with managers, health practitioners and agency partner organisations. Their answers constitute the outcomes of the research.
6.2.4 Conceptual Framework

The conceptual framework performed several basic functions in the definition of the study’s central contextual fields. It clarified the main variables to consider, the relationships among them, and the way their information combined to be able to answer the research question (Liamputtong and Ezzy, 2005, p.292). The framework then revealed the relationships implicit in the model between important stages of the study.

There are many traditional theories that guide qualitative research. This research drew on social research traditions for its theoretical foundation. The study is a process and impact evaluation which uses a triangulation approach: collecting data from preliminary case studies, which included focus groups and document mapping; focused in-depth key informant interviews using specific process and implementation output indicator questions to assess the achievements and barriers to effective MPHP. Grounded theory techniques were used to examine the meanings of the results and interpret the findings. Themes emerged from the findings of the three phases of data collection, which inform the discussion in the thesis.

The research develops a process and impact evaluation framework (EF) in the study design. This EF is a tool for evaluating the MPHP process and the MPH Plan implementation stages of MPHP, in order to understand more effective ways to implement MPHP and improve the health of local communities. An Implementation Questionnaire (IQ) was also developed and assessed the activity and progress towards a set of planning aims and developed a set of implementation impact questions that can be used to assess the MPHP project effectiveness. The conceptual framework diagram is contained in Figure 10.

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**Figure 10: Conceptual Framework**

- **Healthy Cities Movement: Healthy Cities & Shires, Queensland**
- **Municipal Public Health Planning**
- **Process & Impact Evaluation of Two MPH Plans**
- **Learnings**
- **Achievements and Barriers**
- **Success Factors**
  - Individual
  - Organisation
  - Community
- **Other Factors**
- **Model for Managing MPH Plan Implementation**
- **Effective MPH Plans**
The following wider questions were proposed during the research: Does intersectoral collaboration promote the implementation of MPHP? Do local governments build their organisational capacity and strategic management practices to engage adequately and legitimately in MPHP? Do partner organisations address governance measures to ensure their agencies’ strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the MPHP? Do local government and agency professionals have the legitimacy, resources and capacity to implement the strategies in the MPH Plan?

6.3 Research Design and Methods

This section describes the research design – the logical and systematic planning and directing of a piece of research (Attig and Winichagoon, 1993). Research designs emerge from translating a general scientific model into varied research procedures. However, while qualitative research can follow a series of guidelines, this style of research is more flexible to allow for unforeseen problems. It details the phases of the study design, including qualitative techniques, data collection, research location, and methods and data analysis techniques. The research is social research, which conducts a process and impact evaluation. The study design has benefited from and been informed by continued discussion over several years with project participants and other researchers about what evaluation techniques are required for MPHP. This parallels the experience of other researchers in other parts of the world (see Baum and Cooke, 1992; Ouellet et al., 1994; Costongs and Springett, 1997; O’Neill et al., 1997; O’Neill and Simard, 2006). This discussion has continued informally and formally at local MPHP projects advisory and implementation meetings and workshops attended by the researcher during the development and implementation phases of MPHP projects in Queensland. Table 6 describes the study design and details the evaluation methods used in the three phases of data collection.

A triangulation approach comprising four methods was undertaken in this research. Each technique will be explained in the following sections. The practice of qualitative evaluation in this study then requires an understanding of cases studies, focus groups and key informant interview and questionnaire techniques. The three phases of data collection that make up the study will then be discussed.

6.3.1 Triangulation

This section will discuss the triangulation approach that has been used to collect qualitative data in this study. A triangulation approach comprising four methods was undertaken in this study. Denzin (1978) described five types of triangulation, namely, data source triangulation, researcher triangulation, theory triangulation, methodological triangulation, and interdisciplinary triangulation. Patton (1990, p.161) outlined four types of triangulation methods, and commented that ‘triangulation is seldom a straightforward process in analysis’.
These methods strengthen the data analysis and include collecting different kinds of data on the same question, using different fieldworkers and interviewers to avoid biases, using multiple methods to study a program, and using different perspectives (or theories) to interpret a set of data (Patton, 1990, p.161). This may require comparing program documents and other written evidence that could corroborate interviewees’ responses and checking the data’s consistency and validity.

Neuman (2003) comments on the history of triangulation, with its roots in surveyors and sailors who measured distances between objects by making observations from multiple positions. Neuman describes several types of triangulation including triangulation of measures, observers, theory and method. The most important to this study is the triangulation of measures whereby researchers take multiple measures of the same phenomena. By measuring something in more than one way, researchers are more likely to see different aspects of a problem. In this study, the researcher used this technique by asking similar questions of two KI groups, including politicians, managers, health practitioners and agency partner organisations, as well as residents and agency staff who attended community focus groups. Several key stakeholders were interviewed more than once over a three-year period and across the three phases of data collection. Furthermore, documents like the minutes of steering group meetings were reviewed to provide another angle for the issues.

Patton (1990) states that data descriptions and data analysis must be balanced. In considering what to omit, a decision has to be made about how much description to include. Detailed description and in-depth quotations are the essential qualities of qualitative reports. However, a certain amount of raw data can be omitted to provide a focused and yet still comprehensive description of the findings (Patton, 1987). Part 3 of this thesis includes detailed descriptions and direct quotations to allow readers to fully understand the depth of the study design as well as to record the opinions and thoughts of the study participants.

The evaluator bears responsibility for helping stakeholders and other readers of the research determine strengths and weaknesses of various parts of the description and analysis. From the researcher’s experience qualitative analysis does not have the statistical significance tests of quantitative analysis. However, in qualitative research the researcher may be required to make substantive judgements about variations in the credibility of different stakeholder opinions. For example, questions arise such as: When are patterns ‘clear’? When are they supported by the data? When are patterns ‘weak’? Substantive significance is a matter of judgement. Readers of this study will make their own decisions and judgements about these matters, but the evaluator’s opinion and perspective has been reported. This researcher argues that no one knows the data better than the analyst who has struggled to make sense of the findings and then tried to communicate that sense in the thesis (see Patton, 1990, p.164). Patton supports this argument:
‘[A]s in all other aspects of qualitative methods, the person conducting the inquiry is the critical element in determining validity, meaningfulness of the findings and credibility’ (Patton, 1990, p.164).

This has been true in this research into MPHP and its comparisons to other health planning models and legislative frameworks operating in Queensland. This study developed a research framework that included a basic set of process and impact indicator questions to test MPHP’s effectiveness. These questions were presented to groups, key informants and other stakeholders across several identified community and organisational settings. The answers to such questions have been interpreted to determine future directions for sustainable MPHP.

6.3.2 Use of Case Studies

This section will describe case studies as a meaningful method in this research. Paton (1987) notes that case studies are likely to produce the best theory. It is important to document case studies in research so that health professionals, Council staff and community representatives can learn from the successes of and barriers to previous projects. Case studies of MPHP projects in Queensland document a historical and accurate foundation for research in this thesis. Phase 1 of the data collection included gathering information to develop case studies on MPHP.

Baum (2002, p.164) defines case studies as empirical enquiries using multiple sources of evidence that are useful when researchers want to present an accurate and detailed view of a particular phenomenon. Baum feels that their main advantage is that they allow study in a natural setting (2002, p.164). They permit the study of people’s interactions, allowing the researcher to develop his methodology as more is discovered about a setting and the complexity of the subject. Baum (2002) reported that significant insights have been produced in sociology through the use of case studies. Patton (1990) noted that case studies have become accepted as evaluation tools, their value being recognised by such organisations as the World Bank and US Aid. Patton commented that case studies are particularly important when the evaluation aims to capture individual differences or unique variations from one program setting to another, or from one program experience to another.

Ashton (1992) noted that the Healthy Cities Project was an international initiative that builds on the evaluation and description of case studies of city projects. The Noaralunga Healthy Cities evaluation (Baum and Cooke, 1992) draws on a number of case studies and presents a series of factors that help or hinder the implementation of a community-focused project. The case study approach can inform public health practice. Chapman and Davey (1995a; 1995b) edited and published a resource manual of MPHP case studies, which documents the planning processes of three local governments. Patton (1990, p.19) suggests that case studies become particularly relevant when one needs to understand some planning situations in great depth, as they are rich
in lessons learnt and provide direction for improving future planning processes. Documented case studies on the process of developing MPHP in Queensland have proved to be a useful method of disseminating information about best practice to health professionals in local government (Chapman and Davey, 1995a; 1995b).

Baum (2002, p.164) found that case studies usually collect information from a variety of sources including in-depth individual or group interviews, interview or self-completion surveys and the collection and analysis of relevant documents. Case studies help researchers connect the micro level actions of individual people to the large-scale social structures and processes at the macro level (Neuman, 2003, p.33; Vaughan, 1992). Neuman (2003) argues that case study research raises questions about the boundaries and defining characteristics of a case: with each question comes a new generation of thinking and theory.

As indicated earlier in this chapter, this researcher was an advisor to these specific planning projects while employed in the university sector. Being both an advisor to the CHP project and an observer and participant in the planning processes created an opportunity to engage in this action research and to evaluate the planning projects from 1998 to 2002. The roles of advisor, observer and participant in the health planning process created an opportunity to collect information that would contribute to the case studies in this thesis. These case studies, developed in Phase 1 of this research as a critical component of the research design, offer possible benchmarks of key learnings for managers, health practitioners and staff in community agencies. The case studies will be documented in Chapters 7 and 8 of this thesis.

6.3.3 Use of Focus Groups

This section discusses the theory behind focus groups and their practical techniques in qualitative study. Stewart and Shamdasani (1990, p.7) reported the origins, in the Office of Radio Research at Columbia University as early as 1941, of focus group studies in which audiences evaluated responses to radio programs. The technique was later developed by Merton (1946) to be used in group settings. Thus, what is known as a focus group today takes many different forms. Baum (2002, p.173; Owen, 1993) found that this methodology originated as a means of gaining accurate information about consumer product preference. From a practical perspective, Baum (2002, p.172) defines focus groups as involving open-ended interviews with between five and ten people on a particular focused issue for up to two hours. Focus groups are now used commonly in health promotion needs assessment and in both exploratory and theory building research within public health (Baum, 2002, p. 173; de Koning and Martin, 1996).

Focus groups, according to Baum (2002, p.173), can be used either to either supplement or validate quantitative and qualitative data, or as a self-contained method of data collection. Focus group data can be triangulated with results from other data-collection methods. Focus groups
bring together groups of people to provide information to the researcher. However, in most cases they act as an education session on the debated topic. Hawe et al. (2004) define a focus group as another name for a group interview or a group discussion where the focus is on a particular topic of interest – usually a health problem or a response to a situation or issue. Focus groups provide a relatively simple and accessible way to collect information from the target group using a discussion outline. The facilitator keeps the session on track while allowing people to talk freely. Hawe et al. (2004) argue that a focus group is an effective method for qualitative research when the research is principally interested in both a range of opinions and a broad understanding of why participants think and act the way they do.

Focus groups have their problems. They can be restrictive to people who have difficulty expressing their opinions, as other members of the group can hinder their opinions. In the researcher’s experience conducting community focus groups, it has been found that even though they are potentially an economical method of data collection, some participants’ attitudes can bias the findings. In some cases one or two attendees can take over proceedings and make their viewpoints dominate the agenda at the expense of quieter participants. The facilitator should have the skills to moderate participant input and to subjectively record all views in the room.

Most writers in this area discuss aspects of focus groups like group composition, number of people in a group, how to recruit participants, representativeness, time of discussion, non-threatening setting, understanding things to measure, range of views on an issue, use of expert moderator, or whether consensus is a desirable outcome (Baum, 2002; Hawe et al., 2004; Owen, 1993). In this dissertation the focus groups were conducted in the initial phase of the data collection and were assisted by the case studies: this will be explained in a later section. Focus groups provide opportunities for networking of key agencies. In most cases the makeup of this study’s focus groups represented a broad cross section of the community and the region.

6.3.4 Use of Key Informant Interviews

This section briefly describes the methods of data collection and the key informant interview techniques. Grounded theory is a useful theory for analysis of qualitative data and is used in this thesis as discussed in Chapter 5. There are several types of analyses in qualitative evaluation, including content analysis, discourse analysis, semiotic analysis, grounded theory, and thematic analysis (also referred to as grounded theory). All require a careful identification of the units of analysis. Therefore, steps in qualitative analysis are the identification of the units of analysis. The units may be discoveries, meanings, interpretations, practices, encounters, narrative structures, organisations or lifestyles. The units of analysis will usually be decided upon through examination of previous research on the topic, the theory to be used and the uses for which the research is designed. While some researchers may have a clear idea of their units
of analysis, in exploratory studies the research may explore a number of different units concurrently. This study utilised content analysis in components of Phase 1 and 3 of the methods data collection, but in general used thematic analysis to interpret meanings and discuss the results and findings.

In every phase of this study’s data collection, KI interviews provided the primary data collection methodology. There are several types of interviews that need explanation in this section. Semi-structured interviews have been used in Healthy Cities evaluations to gain in-depth knowledge of the issues under discussion (Baum and Cooke, 1992; Ouellet et al., 1994). This style of interview is a suitable method for gathering knowledge about the functioning of processes (Patton, 1990). Semi-structured interviews sit somewhere between the fixed questions and forced responses of surveys and the open-ended and exploratory unstructured interviews with no fixed interview schedule (Liamputtong and Ezzy, 2005).

Patton (1990), however, describes three kinds of qualitative data collection techniques:

- in-depth, open-ended interviews: this data consists of direct quotations from people about their experiences, opinions, feelings, and knowledge
- direct observation: this data from observations consists of detailed descriptions of program activities, participant behaviours, staff actions, and the full range of human interactions that can be part of program experiences, and
- written documents, including such sources as open-ended written items on questionnaires, personal diaries and program records, document analysis yields excerpts, quotations, and entire passages from records, correspondence, official reports, and open-ended surveys.

Under the influence of positivism, both structured and semi-structured interviews have been conceptualised as a behavioural event rather than as linguistic and interpretative (Holstein and Gubrium, 1995). In-depth interviews are also described as focused interviews, unstructured interviews, non-directive interviews, open-ended interviews, active interviews, and semi-structured interviews. For these reason Liamputtong and Ezzy (2005) suggest that one should use the term ‘focused interview’ or ‘in-depth interview’ rather than ‘structured’ or ‘semi-structured’.

This research used a focused in-depth style of key informant interview, with a combination of structured and open-ended questions. The questions were developed in the process and impact evaluation framework used in the data collection phases (described in the following section). The interviews were recorded and transcribed into electronic format. Prior to the interview each participant was forwarded a consent form asking for a signature agreeing to the use of the data in this thesis.
The importance of identifying evaluation questions for Healthy Cities project evaluation are discussed by Baum and Brown (1989), Goldstein and Kickbusch (1996), de Leeuw (1999), and Werna and Harpham (1995). Figure 11 lists the sample evaluation questions (devised by Harpham et al. in 2001) used to evaluate Healthy Cities projects. The purpose of evaluation in health and development work is both to measure the effectiveness of health-improving actions and to plan future actions. Baum and Cooke developed a monitoring and evaluation model for the Noarlunga Healthy Cities Project as early as 1992. The model comprised an evaluation plan with eight steps: focus, formulate questions, design strategy, co-ordinate plan, collect data, analyse data, report, reassess. This is a helpful example of the comprehensiveness of the steps in evaluation. In the researcher’s experience, most of the emphasis on evaluation has been on formulating the questions, not on the research design itself. Question formulation is a very important step, but it is only one step in Baum and Cooke’s model. More attention could be given to the other steps in future evaluations. Since the Ottawa Charter was launched in 1986, there has been growing interest in developing approaches to health promotion that tackle broader social, economic and environmental determinants of health. MPHP combines the partnership approach in tackling the broader social, economic and environmental determinants of health.

<table>
<thead>
<tr>
<th>Sample Study Questions</th>
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<tbody>
<tr>
<td>Degree of Involvement</td>
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<tr>
<td>List key stakeholders, stakeholder perceptions, level of involvement.</td>
</tr>
<tr>
<td>Has the project involved many groups eg women, the poor, city leadership?</td>
</tr>
<tr>
<td>Municipal Change</td>
</tr>
<tr>
<td>Any policy changes due to the healthy cities project?</td>
</tr>
<tr>
<td>Any changes in approaches to the planning work?</td>
</tr>
<tr>
<td>What financial and human resources have been mobilised?</td>
</tr>
<tr>
<td>Linkages</td>
</tr>
<tr>
<td>What intersectoral collaboration has occurred?</td>
</tr>
<tr>
<td>Levels of networking with other projects and cities?</td>
</tr>
<tr>
<td>Capacity-Building</td>
</tr>
<tr>
<td>Extent of individual technical and organisational institutional strengthening?</td>
</tr>
<tr>
<td>Project sustainability?</td>
</tr>
<tr>
<td>Project costs?</td>
</tr>
</tbody>
</table>

Figure 11: Sample Evaluation Questions
Source: Harpham et al., 2001, p. 114

Harpham et al. (2001) concluded in their study that political mobilisation was weak, levels of community participation varied, and the MPHP lacked needs assessment and other base-line data. At the municipal level political support was required but non-existent; it was replaced by management support, which of course is equally important (Harpham et al., 2001). Planning coordinators, however, had a limited capacity to facilitate the design of such plans, so plans did not generally exist.
6.4 Development of Evaluation Framework for the Research

The evaluation framework developed for the study included a process and impact evaluation with three phases of data collection described in Table 6. Phase 1 contains two MPHP case studies, those of the GCCHP and the Wide Bay Regional Public Health Plan (PHP). The research evaluated the Gold Coast City planning project and the joint Wide Bay regional planning project (both Maryborough and Hervey Bay Cities). This first phase involved describing each project using case studies and process evaluation, utilising a triangulation approach to understand key learnings from the MPHP projects. This included internal document analysis, review of minutes of meetings and published reports, analysis of the results of vision workshops and the interpretation of the opinions of staff, agency representatives and residents.

A comprehensive MPHP IQ was developed in Phase 2 of the research. This qualitative evaluation consisted of focused in-depth key informant interviews with local project participants (politicians, managers, health practitioners and agency partners) and examined the process of planning (specific process indicator questions) and the impacts of the implementation. The IQ was developed and tested in the participating cities. The questionnaire examines the achievements of and barriers to effective MPHP examining whether the aims of the two MPHP projects under investigation were met and analysing the degree of collaboration between agencies engaged in the planning. It also provided a more specific examination of the implementation impacts of the two MPHP projects.

Phase 3 compared and examined the strengths and limitations of the MPHP to other CPHP from a Review of Community Public Health Planning (see Davey et al., 2003). This included key informant interviews and document mapping and analysis of the strengths and limitations of selected community public health plans (CPHP) implemented across Queensland; and focused in-depth key informant interviews with statewide managers, health practitioners and agency partners.

Each phase of the research informs the next phase: meanings and interpretations from the data allow for the development of research themes, which are then discussed in light of the literature review in Part 3 of the study. The researcher investigates the achievements of, barriers to and success factors for effective MPHP in local government in Queensland. The following three sections will detail the study methods and describe Phase 1, Phase 2 and Phase 3 data collection, describing the research methods, data collection processes and techniques used in each phase.

The themes from the results and findings of the three phases of data collection are discussed in Chapter 11.
<table>
<thead>
<tr>
<th>Period</th>
<th>Research Method</th>
<th>Research Location</th>
<th>Study Design</th>
<th>Data Collection Methods</th>
<th>Analysis and Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000–2006</td>
<td>Social and Qualitative research:</td>
<td>Queensland MPHP Projects</td>
<td>Development of Evaluation Framework (EF) – Process and Impact Evaluation with 3 phases of collection</td>
<td>Triangulation approach Case studies (document analysis, focus groups, questionnaires), key informant interviews and document mapping</td>
<td>Grounded theory</td>
</tr>
<tr>
<td>2001/2002</td>
<td>Phase 1</td>
<td>Gold Coast City Community Health Plan     Wide Bay Regional Public Health Plan Maryborough City Hervey Bay City</td>
<td>Two Preliminary Case Studies. One case study includes a process evaluation</td>
<td>• Observation • Document analysis • Focus group process evaluation • Project participant process evaluation questionnaires</td>
<td>Learnings</td>
</tr>
<tr>
<td>2002/2003</td>
<td>Phase 2</td>
<td>Gold Coast City Community Health Plan Wide Bay Regional Public Health Plan Maryborough City Hervey Bay City</td>
<td>Develop Implementation Questionnaire (IQ) and Test IQ on two MPHP Projects Evaluate the aims of the MPH Plan: • have the aims and main elements of the MPHP Plans been achieved? • Are there improved levels of intersectoral collaboration (Specific indicator questions) What are the MPHP Implementation Impacts on: • Individuals • Organisations • Communities (Specific indicator questions)</td>
<td>19 focused in-depth local project key informant interviews with politicians, managers, health practitioners and agency partners</td>
<td>Achievements and barriers</td>
</tr>
<tr>
<td>2003/2004</td>
<td>Phase 3</td>
<td>Statewide CPHP Review (2003)</td>
<td>Analyse the CPHP Review data and compare and emphasis MPHP features</td>
<td>Analyse data from 17 in-depth key informant interviews with state-wide managers, health practitioners and agency partners</td>
<td>Comparisons of MPHP to other CPHP Strength and limitations of MPHP</td>
</tr>
</tbody>
</table>
6.4.1 Data Collection Methods: Phase 1

Phase 1 data collection contributes to the writing of two case studies using a triangulation approach. A range of data sources provides information for the study. Qualitative data was collected through literature review, examination of published and internal report document analysis, analysis of minutes of meetings, monitoring activities and observation at meetings by the researcher at the Gold Coast Project. Hancock and Duhl (1988a) and Labonte et al. (1999) note that unless data is turned into stories that can be understood by all, it is not effective in either political or administrative processes of change. In evaluating healthy cities or settings-related projects one needs to understand, as well as describe, the needs of a community. Each community studied in Phase 1 of the data collection had developed comprehensive quantitative demographic health profiles that provided the primary data for the needs assessment. The health profile data did shape the strategies in the planning documents, but was not subject to further analysis in this research.

The first case study in this research describes the GCCHP project. It reports on the planning process and short-term implementation outcomes. The second case study, titled ‘Wide Bay Preliminary Evaluation: Regional Approach to Public Health Planning with Local Implementation’, describes the planning process and preliminary process evaluation of the joint Maryborough City and Hervey Bay City MPHP Project. Appendix B contains the process evaluation questionnaires including ‘vision workshop’ evaluation containing focus group questions, the Project Management team (PMT) survey and the working group survey forms used in the research.

Evaluating Phase 1 provided insight into designing Phase 2 of the study. Preliminary case studies in Phase 1 assisted the researcher to develop an evaluation framework in Phase 2 of the study design: to measure the effectiveness of the partnerships and the aims and impacts of the MPHP.

6.4.2 Data Collection Methods: Phase 2

Phase 2 of the research was conducted in 2002. It consisted of designing an implementation questionnaire (IQ) from the literature, from projects studied in Phase 1 and the experiences of the researcher, to enable a comprehensive process and impact evaluation of two MPHP projects. This required the in-depth, focused interviews with KI involved locally with the two projects. Within the study design the KI are categorised as politicians, managers, health practitioners and agency partners. These categories help to give the data clarity.
The methodological framework designed for Phase 2 of this study was the result of an extensive review of the Healthy Cities evaluation methodology in Chapter 5. At the city level, qualitative studies of networking structures are still rare in comparison with quantitative ones (Springett et al., 1995). Degeling (1995) argues that such network studies are urgently needed for understanding the real barriers to change in developing healthy public policy.

Shiell and Hawe (1996) argue that programs that have community or community processes for health promotion as their focus need some indicators distinct from individual outcomes. This study has developed a framework for reviewing MPHP that promotes the use of process and implementation impacts to measure both the effectiveness of collaborative planning and whether the aims of the projects have been met. In this phase of the data collection, the researcher has developed an evaluation framework by adapting a review of two papers:

- Taylor-Powell and Rossing’s c.1996 study, ‘Evaluating Collaborations: Challenges and Methods from the Department of Continuing and Vocational Education’, Madison, and

These papers had set out to evaluate collaborations and outcomes for participatory health action.

The evaluation methods used in these studies formed the foundation of this study design. There are also important contributions from the literature review, from the findings of Chapter 6 on qualitative evaluation methods and from other previous studies identified in Healthy Cities projects. The researcher has also contributed several main elements and specific indicator questions from personal observations and findings from the case studies (see Chapters 7 and 8).

Speller and Funnell (c.1994) designed and tested a practical qualitative evaluation tool to measures the effectiveness of the work of healthy alliances (Funnell, et al., 1995). This tool was designed in response to the WHO Health for All strategy and the increasing interest in multi-sectoral working and community participation for improved health in the United Kingdom (UK). A series of stakeholder workshops and consensus forums in 1993 led to this evaluation of improvements in the quality of healthy alliances in the UK. Speller and Funnell (c.1994) designed their evaluation at a time when many local governments and health authorities in the UK were initiating ways of working together for health along the line of the Healthy Cities project. Taylor-Powell and Rossing (c.1996) noted that there was sometimes confusion about the meanings of terms like collaboration, coalition, and partnerships. They suggest a hierarchy as one progresses from networking to collaboration, with collaboration as the highest form of shared resource relationship. This research study places agreed-to agency partnerships as the highest level of healthy alliance, followed by intersectoral collaboration, a middle-level process,
and places shared vision and networking, described as important informal collaborative processes, at the lower end of the scale.

Healthy alliances were a central theme to ‘the Health of the Nation’, as seen in ‘Working Together Towards Better Health: a UK Government Approach’. This approach emphasised the importance of healthy alliances in the delivery of community health services during a period when the WHO Health For All strategy was implemented across the entire Kingdom. Similarly, in Australia, the Commonwealth Government’s National Public Health Partnership Approach (1999) promoted intersectoral collaboration and linked this policy towards local government health planning. Powell cited in Speller and Funnell (1994, p.5) defined healthy alliances as a partnership of organisations and individuals aiming to increase control over and to improve health and well being, emotionally, physically, mentally, socially and environmentally.

In this present research into MPHP, the guiding principles all relate to improving health in communities by improving the effectiveness of intersectoral collaboration, organisational and community decision-making and environmental conditions. Speller and Funnell’s work is relevant to this research: they evaluated healthy alliances in geographical regions where community health needs were identified by purchasers and providers of health services, and then developed joint strategic plans. These plans consisted of agencies and communities agreeing to objectives and actions plans to meet their needs.

Alliances are seen as occupying the space between agencies and community groups, forming links between them and, through synergy, creating solutions to health concerns. More and more local communities are taking on the ultimate responsibility for determining resident quality of life; in a time of inadequate resources new inter-sectoral relationships are emerging (Taylor-Powell and Rossing, c.1996). In a period of increased accountability in government, the degree of collaboration and its contribution to improved community health needs further investigation. As described in the literature review in Part 2 of the thesis, MPH Plans are strategic health plans with aims, strategies, actions and timeframes and desired outcomes. The WHO Healthy Cities Project identified the need for project indicators to monitor progress, to make comparisons within cities, and to stimulate change. It was recommended that indicators be selected using the following criteria: relatively simple to collect and use; sensitive to short-term change; capable of analysis at the local level; related to health, Health for All, health promotion and the Healthy Cities Project; and carry social and political clout (WHO, 2001a).

The Questionnaire developed in Phase 2 of the Data Collection section of this study measures progress towards the aims of the MPHP and the degree of collaboration that is generated by MPHP, and investigates the planning implementation activity in order to measure performance.
Figure 12 contains the guiding principle of the Healthy Cities approach in Queensland (see Chapman and Davey, 1997).

<table>
<thead>
<tr>
<th>Inter-sectoral collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community participation in health decision-making</td>
</tr>
<tr>
<td>A focus on equity</td>
</tr>
<tr>
<td>Sound ecological management</td>
</tr>
</tbody>
</table>

Figure 12: Healthy Cities - MPHP Guiding Principles
(Source: Chapman and Davey, 1997, p.84)

Speller and Funnell (c.1994) developed a set of indicators for multi-sectoral groups to use in assessing their effectiveness. This set of indicators has been adapted for this study by the researcher, with the modifications based on his understanding of the individual and organisational and community agency context in local government participatory planning in Queensland. Figure 13 describes the study design of the process and impact evaluation in Phase 2 of the Data Collection.

The framework does not directly address measurement of health gains. Over time the MPHP’s priority strategies – those implemented in communities – will, along with other factors, lead to better health outcomes. The framework is organised into two interrelated sets of indicators, process issues and implementation impacts. The indicators allow for the examination of the MPHP process issues and the implementation impacts, and the evaluation provides information regarding the effectiveness of the MPHP, by improving the capacity of people to engage with MPHP, improving the capacity of organisations to develop healthy alliances and implement MPHP and improving the features of the planning models.
The Implementation Questionnaire addresses evaluation of the planning aims and the implementation impacts of MPHP. The aims of the two projects to be evaluated in this study reflect those characteristics considered necessary for a successful MPHP. Specific questions are asked of participants about meeting the aims of each MPHP project. Each aim has two or three main elements to break the aims into manageable parts. At this next level, answers to specific indicator questions demonstrate the implementation impacts in that area. A MPHP project that successfully achieves the key aims of the project and impacts on individuals, organisations and communities will be more likely to deliver positive health outcomes in communities.

Figure 14: Phase 2 - MPHP Evaluation of Project Aims

Figure 14 demonstrates an example of how the aims of a MPHP project (intersectoral collaboration, community participation, interdepartmental involvement, partnerships and shared vision), lead to a better understanding of the implementation impacts of the planning and towards understanding effective methods of MPHP.

Tables 7 and 8 describe the aims and main elements of the GCCHP and the WBRPHP. The table contains the aims and the main elements considered in each project. The aims of the two projects evaluated in this thesis varied; the projects had three common aims, but had similar main elements and specific questions. The evaluation surveys used for the key informant interviews of each MPHP project in Phase 2 of the research are contained in Appendix G and H.
### Table 7: Gold Coast Community Health Plan – Implementation Process Issues: Aims and Main Elements

<table>
<thead>
<tr>
<th>AIMS</th>
<th>Inter-sectoral Collaboration</th>
<th>Community Participation</th>
<th>Equity in Health</th>
<th>Broad Socio-ecological View of Health</th>
<th>Evaluation and Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Levels of collaboration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared objectives and group purpose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Composition of working parties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resources adequate to achieve its objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interdepartmental involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partnerships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Levels of community participation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Empowerment and decision-making</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issues for equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special need groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approach to determinants of health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traditional core and non-core business</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared ecological vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 8: Wide Bay Regional Public Health Plan – Implementation Process Issues: Aims and Main Elements

<table>
<thead>
<tr>
<th>AIMS</th>
<th>Inter-sectoral Collaboration</th>
<th>Community Participation in local decision-making</th>
<th>Interdepartmental Involvement</th>
<th>Partnerships</th>
<th>Shared Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level of collaboration</td>
<td>Level of community involvement</td>
<td>Collaboration between Council departments</td>
<td>Joint working</td>
<td>Development of a shared vision in community</td>
</tr>
<tr>
<td></td>
<td>Shared objectives and group purpose</td>
<td>Empowerment and decision-making</td>
<td>Changing roles of departments</td>
<td>Resource sharing</td>
<td>Accountability</td>
</tr>
<tr>
<td></td>
<td>Composition of working parties</td>
<td></td>
<td>Organisation of work practices</td>
<td>Communication</td>
<td>Accountibility</td>
</tr>
<tr>
<td></td>
<td>Resources</td>
<td></td>
<td>Management support</td>
<td>Teamwork</td>
<td>Monitoring of activities and evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Support</td>
<td></td>
</tr>
</tbody>
</table>
The participants’ answers to specific questions about the implementation impacts are an indication of whether the MPHP has been successful. The responses to the specific questions demonstrate a respondent’s view of the MPHPs impacts. The impacts relate to the implementation effects of a MPHP intervention on individuals and organisations including Council, government and non-government agencies and on the community.

An understanding of implementation impacts can lead to improvements in MPHP outcomes and in time residents’ quality of life may be improved. The main elements of the implementation impacts and categories are listed in Table 9.

<table>
<thead>
<tr>
<th>Impacts on Individuals and Organisations</th>
<th>Impacts on the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits and Support for MPHP</td>
<td>Plan Exposure</td>
</tr>
<tr>
<td>Health Policy on the Agenda</td>
<td>Quality of life of the residents</td>
</tr>
<tr>
<td>Health and Environment Activities</td>
<td>Community agency strategic plan</td>
</tr>
<tr>
<td>Best Practice Planning for Health</td>
<td>Agency cooperation</td>
</tr>
<tr>
<td>Infrastructure Change</td>
<td>Implementation Impacts</td>
</tr>
<tr>
<td>Skills Development</td>
<td>Future challenges</td>
</tr>
<tr>
<td>Visibility and Media</td>
<td></td>
</tr>
</tbody>
</table>

The implementation impacts are broken down, first to lower-level categories then further, to specific questions asked of participants of the MPHP implementation (refer Table 10 and Appendix G and H). In this study, implementation impacts can be defined as the impacts of planning implementation: they measure what the plan is actually achieving. Implementation impacts are organised into categories and specific questions are developed depending on the types of impact on individuals and organisations and the local community. Table 10 lists the implementation impact categories and the specific study questions. The same set of questions was used to evaluate in both the MPHP projects.
Table 10: Implementation Impacts: Specific Impact Indicator Questions

<table>
<thead>
<tr>
<th>Impacts on Individuals and Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits and Support for MPHP (Political, Management, Health Practitioner, Agency Partner)</strong></td>
</tr>
<tr>
<td>What do you think are the benefits of having a MPHP?</td>
</tr>
<tr>
<td>What political support is provided for the MPHP during implementation?</td>
</tr>
<tr>
<td>Has the MPHP increased political support within your organisation?</td>
</tr>
<tr>
<td>Is there management support for MPHP in your Council/your organisation?</td>
</tr>
<tr>
<td><strong>Health Policy on the Agenda</strong></td>
</tr>
<tr>
<td>What policy changes have resulted in your organisation as a result of the MPHP initiative?</td>
</tr>
<tr>
<td>List Barriers to success</td>
</tr>
<tr>
<td><strong>Health and Environment Activities</strong></td>
</tr>
<tr>
<td>What are the most inspiring examples of public and environmental health planning outcomes by Councils that you are aware of?</td>
</tr>
<tr>
<td><strong>Best Practice Planning for Health</strong></td>
</tr>
<tr>
<td>Have you any examples of the MPHP process integrating with other planning processes?</td>
</tr>
<tr>
<td>What are characteristics of best practice community public health planning?</td>
</tr>
<tr>
<td>How significant is MPHP compared with other planning initiatives in Council/in your organisation?</td>
</tr>
<tr>
<td>What is your overall assessment of the state of MPHP and practice within Local Government?</td>
</tr>
<tr>
<td><strong>Strengths and Weaknesses</strong></td>
</tr>
<tr>
<td><strong>Infrastructure Change</strong></td>
</tr>
<tr>
<td>What structural, organisational or environmental changes which have a potential impact on the health of the target population have resulted from the MPHP activities?</td>
</tr>
<tr>
<td>Have there been changes in attitude of interdepartmental agencies in Council in relation to the objectives of the project?</td>
</tr>
<tr>
<td><strong>Skills Development</strong></td>
</tr>
<tr>
<td>What training has been provided to improve the knowledge and skills of the participants involved with MPHP?</td>
</tr>
<tr>
<td><strong>Visibility and Media</strong></td>
</tr>
<tr>
<td>To what extent have the community agencies and residents been informed about this MPHP process throughout the planning stages?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impacts on the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Exposure</strong></td>
</tr>
<tr>
<td>How much direct contact has there been between the project and the community during implementation?</td>
</tr>
<tr>
<td>What level of community participation has occurred during implementation?</td>
</tr>
<tr>
<td>List what strategies have been funded or achieved since implementation commenced?</td>
</tr>
<tr>
<td><strong>Quality of life of the residents</strong></td>
</tr>
<tr>
<td>Has the MPHP impacted directly on the quality of life of residents since implementation?</td>
</tr>
<tr>
<td><strong>Community agency strategic plan</strong></td>
</tr>
<tr>
<td>Is the MPHP process or strategies in the plan part of the community agency strategic plan?</td>
</tr>
<tr>
<td><strong>Agency cooperation</strong></td>
</tr>
<tr>
<td>What changes have you noted in your agency as a result of the MPHP project?</td>
</tr>
<tr>
<td>Has cooperation between the agency and the University been beneficial?</td>
</tr>
</tbody>
</table>

In summary, Phase 2 of the research was conducted in 2002. It consisted of a comprehensive process and impact evaluation of the same MPHP projects studied in Phase 1. This required in-depth interviews with seventeen key informants (KI) involved locally with the projects. The KI were categorised as politicians, managers, health practitioners and agency partners and included the following breakdown in Table 11.
Table 11: Key Informant Categories Phase 2

<table>
<thead>
<tr>
<th>Categories</th>
<th>P Politician</th>
<th>M Manager</th>
<th>HP Health Practitioner</th>
<th>AP Agency Partner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Participants</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>19</td>
</tr>
</tbody>
</table>

The results from the MPHP evaluation survey in Phase 2 of the data collection conducted at the Gold Coast CHP and the Wide Bay PHP will provide new meanings and interpretations and these discoveries will form the themes of the study discussed with regard to the literature review, leading to the conclusions and recommendations.

6.4.3 Data Collection Methods: Phase 3

In Phase 3 of the data collection, building on the findings of the first two phases, MPHP was compared to other Queensland community public health planning models and legislative frameworks. This required an analysis of historical data from the CPHP Review. This Review conducted in-depth interviews with KI involved with broad-based health planning initiatives statewide. KI were selected from the following categories: manager, practitioner and agency partner. A theme analysis was conducted on the Phase 3 data set and the results and findings of the research are discussed in Part 3 of the thesis in light of the literature review.

The researcher conducted a research-consulting project funded by Queensland Health in 2003 (see Davey et al. 2003). Part of the data set collected in this project, titled ‘Community Public Health Planning Review’, is used in this thesis. In fact, the researcher developed the KI questions used in this review in Phase 2 of the data collection. The researcher obtained consent from Queensland Health to use the findings in this thesis. The Queensland Government in their Strategic Plan in 2002 was committed to improving the services provided to the community, including improving relationships with the community and other government sectors in order to enable community needs to be adequately addressed.

There is increasing recognition that community public health planning processes at the local level provide opportunities for communities to articulate their needs, including those related to public health, and, with relevant local agencies, to work through the range of competing priorities to set their agenda for action. There are many models of community public health planning within and outside Queensland, each with a different auspicing body, differing methods of community engagement and a changed role for state and national priorities in setting the local health agenda. Despite this, health managers and practitioners have limited information, particularly regarding the selection of the most appropriate health planning model.
for a particular community situation. The review was to address this reported lack of a cohesive, coherent and coordinated approach to CPHP across Queensland. The project was designed to assist in developing a shared vision for the future of Queensland Health’s investment in community public health planning processes.

A subset of the results and findings of this review of CPHP is presented in this thesis. There is an emphasis on further understanding the achievement, success factors and barriers associated with MPHP, but from a broader group of key informants. It is timely to evaluate the attitudes and experiences of this group of key stakeholders, considering it has been three years since the launch of both GCCHP and Wide Bay PHP. Managers, practitioners and agency partners from statewide agencies have been able to reflect on and report their experiences on CPHP, and this provides for a comparison with MPHP. In the researcher’s experience, healthy cities planning approaches have been compared to similar approaches only; there is little comparative research with planning from other disciplines. This represents a ‘silo’ effect for participatory health planning within the health sector, and relinquishes opportunities for the integration of planning thinking. This phase of the research attempts to recognise the contributions of other social planning models and the impact of legislation on planning outcomes.

The research identified eight core CPHP models and processes that were being implemented in Queensland communities involving Queensland Health and local government (listed in Table 12). Other land use, development planning and legislative planning frameworks that were linked to health but driven by other state agencies in Queensland were examined using the conceptual mapping framework.

Table 12: Community Public Health Planning Models and Legislative Planning Frameworks

<table>
<thead>
<tr>
<th>Community Public Health Planning Models</th>
<th>Legislative Planning Frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Public Health Planning in Rural and Remote Areas Project (CPHPRRAP)</td>
<td>Integrated Planning Act 1997 (IPA)</td>
</tr>
<tr>
<td>The Bowen Project (Bowen)</td>
<td>Regional Framework for Growth Management (RFG)</td>
</tr>
<tr>
<td>Place Management (Place)</td>
<td></td>
</tr>
<tr>
<td>Supportive Environments for Active Living (SEAL)</td>
<td></td>
</tr>
<tr>
<td>Local Agenda 21 (LA21)</td>
<td></td>
</tr>
<tr>
<td>Municipal Public Health Planning (MPHP)</td>
<td></td>
</tr>
<tr>
<td>Local Area Planning (LAP)</td>
<td></td>
</tr>
<tr>
<td>Towards Ten Year Indigenous Partnerships</td>
<td></td>
</tr>
<tr>
<td>Community Renewal</td>
<td></td>
</tr>
</tbody>
</table>

Phase 3 of the data collection had two sources, namely document mapping and analysis and key informant focused interviews. In Part 2 of this thesis, selected models and frameworks from the literature are reviewed. In Phase 3 a survey was designed to review eight planning models and three legislative frameworks in Queensland, informed by an extensive conceptual mapping exercise. The ‘conceptual mapping framework’ used for the analysis is contained in Appendix I.
Only a subset of this data was used in this phase. This research compared the following features: history and context; and the purpose, strengths and limitations of each model; emphasising the features of MPHP. Seventeen key informant focused interviews were held. This study analysed these data on the strengths and limitations of selected models and frameworks and focused on the KIs’ responses relating to the success factors and barriers associated with MPHP. There were three categories of KI in Phase 3 of the data collection, as listed in Table 13.

Table 13: Key Informant Categories Phase 3

<table>
<thead>
<tr>
<th>Categories</th>
<th>No. of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>M Manager</td>
<td>5</td>
</tr>
<tr>
<td>HP Health Practitioner</td>
<td>4</td>
</tr>
<tr>
<td>AP Agency Partner</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

The research collected opinions, attitudes and perceptions of managers, practitioners and partners involved with CPHP in Queensland. The researcher, in collaboration with the reference group at Queensland Health (Davey et al. 2003), identified 17 KIs in Queensland who could assist with providing information for this stage of the project. The researcher designed a questionnaire containing ten evaluation survey questions to gather focused information on community public health planning in Queensland (see Figure 15). The issues identified at the time of the literature review formed the foundation of the qualitative questions. Appendix J contains the Phase 3 evaluation survey. These questions formed the general interview topics, but more specific issues were also probed through other questions. Interview data was recorded through note taking. Seventeen interviews were conducted by phone during June 2002. Interviews ran for some one to two hours each.

- Awareness of community public health planning (CPHP) models
- Involvement in health planning
- Knowledge of best practice elements of CPHP
- Key learnings
- Overall assessment of CPHP
- Future challenges and barriers
- Preferred models
- Health impacts from CPHP
- Other agencies that should be involved in CPHP
- Other miscellaneous comments

Figure 15: Phase 3 - Evaluation Survey Questions

There are many models of public health planning at a community level within and outside of Queensland, each with a different approach, auspicing body, method of community engagement, and role of state and national priorities in setting the local agenda. Despite this, there is limited information available for health practitioners, in particular, in relation to selecting the most appropriate model for a particular situation. This study collected existing
reviews of the many social planning models. It also assessed attitudes and opinions from current processes in Queensland through in-depth focused interviews with seventeen key informants including managers, practitioners and partners across sectors involved with health planning. The research recognised the importance of taking an inter-sectoral approach, and not restricting the analysis solely to the health sector.

6.5 Conclusion

This chapter presented the research’s study design and methodology based on the examination of relevant qualitative theory in Chapter 5, through explanations of the research’s rationale, question, and objectives, and of the scope and nature of the research, which led to the conceptual framework for the study. The rationale for using this framework was described in the context of the other evaluation studies of Healthy Cities approaches and healthy alliances. The chapter then outlined the qualitative evaluation techniques used in each of the three phases of data collection. Of particular importance in Chapter 6 was the development of the study design and evaluation framework, and the IQ – the principle instrument of the research. The results and findings of the study are presented in the first four chapters of Part 3 of the thesis.
PART 3 FINDINGS, DISCUSSION and RECOMMENDATIONS, CONCLUSIONS

Preamble

This section will explain the structure of Part 3 and introduce Chapters 7, 8, 9, 10, 11 and 12. Earlier, Chapters 2, 3 and 4 provided the theory that underpins MPHP, including issues of urbanisation, ecological public health, participatory planning theory and organisations and strategic planning. The previous chapters (5 and 6) examined qualitative theory and practice and defined and described the conceptual framework and study design for the research. In Part 3, there are four chapters of findings from the research, Chapters 7, 8, 9 and 10. Figure 16 describes the evaluation framework developed for this process and impact evaluation and depicts the linkages between the three phases of data collection.

Chapters 7 and 8, Phase 1 of the data collection document process findings for two preliminary case studies of MPHP developed and implemented from 1997 to 2001. These case studies demonstrate the history, the steps of planning and individual, organisational and community health planning issues to further understand the process stage of planning. The Community Health Plan (CHP) in the City of the Gold Coast City (1997 to 2000) in a local approach to planning within one city and is discussed in Chapter 7; and the Wide Bay Regional Approach to Public Health Planning (PHP) with Local Implementation Project (including the cities of Maryborough and Hervey Bay) is discussed in Chapter 8. A preliminary process evaluation is also conducted at the Wide Bay Project. The materials in these case studies were derived from the researcher’s attendance at a sample of MPHP Advisory Committee meetings and from an analysis of relevant internal Council minutes, policy documents and publications.

Chapter 9, presenting Phase 2 of the data collection, discusses and examines the results and findings of the MPHP IQ tested in 2002 and 2003 on the two MPHP project sites, using the IQ described in the previous chapter. Responses to the comprehensive questionnaire from key informants involved directly with the development and implementation of the two MPHP projects are recorded and interpreted. Key informants interviewed were also associated directly with the projects.

Chapter 10 describes the results and findings of a second series of KI interviews, this time with a broader group of stakeholders than those in the KI interviews of Chapter 9: these stakeholders were directly involved with the development and implementation of participatory planning projects state-wide. The chapter compares and examines the strength and limitations of MPHP to selected CPHP models and Legislative planning frameworks (LPF) in Queensland. This
Phase also emphasises the key learnings and salient features of selected models tested in local government.

From the comprehensive process and impact evaluation of MPHP projects and models across Chapters 7, 8, 9 and 10, the research identifies key learnings, achievements, barriers and strengths and limitations of MPHP in local government in Queensland. The collective study findings and recommendations including the success factors for MPHP are discussed in Chapter 11 and the conclusions of the study are documented in Chapter 12.

Figure 16: Evaluation Framework: Flowchart of Three Phases of Data Collection
7.1 Introduction

This case study will first describe a preliminary evaluation of the MPHP project (referred to as CPHP at GCCC) from 1997 to 2005 by way of document analysis, then evaluate the process phase of planning and map the outcomes of the implementation phase of the work. The case study will use the seven steps in the MPHP model as a framework for evaluation. Data have been collated from a review of published and unpublished papers and conference proceedings, internal Council reports and from content analysis of the minutes of the CHP Project Executive Committee, the Project Advisory Committee, the Implementation Committee and Focus Group meetings held by the GCCC. The documents examined were:

- CHP Joint Project Executive and Project Advisory Committee Meeting Minutes: 6 August 16 and September 1997
- CHP Working Party (WP) Meeting Minutes: 15 August 1996 (this committee met regularly during the CHP process: example of initial meeting minutes)
- CHP Implementation Committee (IC) Meeting Minutes in 1998: 21 January, 13 May, 18 November; in 1999: 21 April, 21 July, 10 November; in 2000: 16 February, 17 May, 16 August, and

An external consultant reviewed the GCCHP in 2002. Findings of this report will also be introduced into the case study (ERM, 2002). For the purposes of this case study, each step of the planning will be documented and discussed not only using the above internal Council reports and minutes of meetings but also referring to other related material (see Barker et al., 1998; GCCHP, 1997; Chapman and Davey, 1997; Barker and Yakimoff, 2001).

7.2 Background to the Gold Coast CHP Project

The Gold Coast City has developed as a major domestic and international tourist destination. The Gold Coast City stretches from Beenleigh to Coolangatta in south-east Queensland and includes 70 kilometres of coastline (Barker and Yakimoff, 2001). The city offers a wide range
of lifestyle opportunities and urban facilities. These features portray a favourable picture, yet an alternative side to the area exists, partly due to the city’s prosperity. High living costs, a lack of affordable housing, increasing crime, minimal public transport services, and increasing pressure on the natural environment from development and urban growth, were issues presented to the focus groups during the development of the CHP. These issues were reported as being of growing concern in the community (Barker et al., 1998).

7.3 Overview of the Plan

In its introduction the Healthy, Sustainable Gold Coast Community Health Plan 1997–2000 comments that CPHP is assisting Council to plan for the future health of the city. Its main aim is to provide strategic direction, with the plan essentially guiding a whole-of-government and community approach to health development since 1997. This involves consultation with the government, the community, special needs groups and residents.

The GCCHP adopted a socio-ecological approach to planning for healthy and sustainable communities, embracing the principles of the Healthy Cities approach (Barker and Davey, 1999). Barker had suggested earlier, in 1996, that Council was recognised as being closest to the local community; with local government being pivotal to other sectors and levels of government, the role of Council was to direct the CHP project. Council facilitates the activities of the numerous service providers and residents in the community who influence health decisions: working ‘with’ communities, not ‘on’ communities (Chapman and Davey, 1997). The plans introduction commented that local government should be at the forefront of planning for the enhancement of health and well being of the people at the Gold Coast (GCCHP, 1997).

In 1995, the Council received an Encouragement Award from Healthy Cities and Shires Queensland (funded by Queensland Health) of $5000 to develop MPHP. The Council resolved on 3 November 1995 to ‘embrace the concept of a Municipal Public (Community) Health Plan for the City’. This Council document noted that it was very important for the project to be endorsed by the Council, that a Chair was appointed to the Project (an elected representative or Councillor), and that provision was made for monies to flow to the project. The Council made a decision to develop the health plan during a period of unprecedented organisational restructuring and political repositioning (Barker and Yakimoff, 2001). During this period the then state government amalgamated two adjacent local government areas, Gold Coast City and Albert Shire, into one large GCCC. Councillor Jane Grew commented in the CHP Council Minutes 17 April 1996: ‘The major focus of the plan will centre around achieving a healthy lifestyle and maintaining a sustainable environment’.

The project gave the Council a unique opportunity to provide more health promotion focus for its expanding operations, guided by a new constituency (GCCHP, 1997, p.2; CHP Council
Minutes 17 April 1996). CHPs represent a combined response by state and local governments to introduce agency collaboration and promote intersectoral public health initiatives. MPHPs are consistent with worldwide trends in public health, the increased profile of public health issues in local governments and the community, and the response of governments to changing needs and concerns (CHP Council Minutes 17 April, 1996; Barker et al., 1998).

Chapman and Davey (1997) describe the formation of CHPs as involving the development of both a product and a process. In the context of a strategic planning document the term ‘product’ can be defined as:

- Articulating the community’s vision for a healthy and sustainable future
- Clarifying local government’s role in creating and maintaining healthy and sustainable environments at the local level, and
- Setting out clear goals, objectives and targets for meeting health priorities.

CHPs also involve a process of:

- Building new partnerships between levels of government and community organisations whose policies and programs affect the determinants of health (transport, environment, housing etc.)
- Helping key stakeholders to coordinate and understand and solve health issues, and
- Giving every opportunity at the local level to decisions regarding health.

The aim of the CHP was for Council to work collaboratively with other government and non-government sector service providers, community groups and individuals in order to positively influence the health status of residents and visitors, improve coordination and targeting of activities by organisations and individuals working for community health, expand opportunities for genuine participation by local communities in the decisions that affect their health, and define a new facilitators’ role for Council in planning for the health of the community.

The guiding principles of the plan, developed through consultation of the advisory groups with the PMT, included intersectoral collaboration (agencies), community participation (residents), equity in health, broad socio-ecological view of health, and evaluation and accountability. The framework sought to integrate key stakeholders in partnerships through consultative committee structures, including intersectoral working groups in the implementation phase. Barker comments that the sticking point was whether the planning process was structurally integrated into existing planning mechanisms so that information flowed to the other community plans. The rationale behind the CHP lies in its acknowledgement that socio-ecological health constitutes a vital component of the ‘New Public Health’ practice in modern industrialised cities. The GCCHP (1997) stated that the plan would form an integral component of the on-
going development of local strategic directions and would guide a combined whole-of-government and community approach to health advancement in the city.

7.4 Recognition of Gold Coast CHP in National Environmental Health Strategy

Figure 17 describes the case study under the title ‘Healthy Sustainable Gold Coast: A Community Health Plan for the Gold Coast’ (CDHAC, 1999). The National Environmental Health Strategy (CDHAC, 1999, p.14) referred to the GCCHP as an example of an intersectoral approach that reduces the barriers to agency participation and as a mechanism that helps the community to solve problems with local solutions. The strategy uses the Ottawa Charter for Health Promotion to build models of best practice, in which communities are supported to take control of their health. Healthy public policies are developed using community input, and environments are created which support community health.

The GCCHP was seen as developing an infrastructure that enables health promotion to take place (see CDHAC, 1999, p.14). The WHO (1986) Ottawa Charter for Health Promotion provided a foundation for the CHP and the plan is built around these principles. The CDHAC (1999, p.14) advocates that the community and appropriate stakeholder groups should be engaged at all levels in policy, standards and intervention decisions. The process of developing the participatory health plan at the Gold Coast is described step by step in Figure 17.
Healthy Sustainable Gold Coast: A Community Health Plan for the Gold Coast

The Healthy Cities and Shires Queensland, and Griffith University received a grant from the Queensland Health Department in 1994 to work with local government to improve the health of communities through the development of Municipal Public Health Plans. In 1995, the GCCC applied for and received an encouragement award. The award was offered by the Queensland Health Department to enable the Council to undertake development of the health plan. Local government is the level of government closest to the people and should be at the forefront of planning for enhanced health and well being.

The GCCHP was based on a concept derived from the World Health Organisation (WHO), the Healthy Cities Approach. The aim of the CHP was for Council to work collaboratively with other government and non-government service providers, community groups and individuals to:

- Positively influence the health status of Gold Coast people
- Improve coordination and targeting of activities by organisations and individuals working for the community’s health
- Expand the opportunities for genuine participation by local communities in the decisions that effect their health, and
- Define a new facilitators’ role for Council in planning for community’s health.

In developing this plan, the Council actively encouraged and facilitated community input. The plan recognises that cooperation and coordination are the prerequisites of success.

Process

The CHP consisted of several predetermined stages:

Stage 1: Preliminary Groundwork
Stage 2: Data Collection/Literature Review
Stage 3: Community Consultation
Stage 4: Strategy Development
Stage 5: Production of CHP
Stage 6: Implementation, monitoring and review

The plan has delivered many outcomes. These include: better collaboration and cooperation, between health service providers; creation of collaborative local solutions for public and environmental health issues; and collaborative community partnerships, through twelve community reference committees. The process has allowed for the identification and documentation of health needs, and contributed to better health outcomes, by enhancing funding opportunities. More importantly, health issues have been broken down into small, manageable projects scheduled to be completed over a three-year period.

The case study was prepared jointly by Griffith University and GCCC and published in Chapter 3 Strategic Management of Environmental Health, of the National Environmental Health Strategy.

Figure 17: Case Study Titled ‘Healthy Sustainable Gold Coast: A Community Health Plan for Gold Coast’
Source: National Environmental Health Strategy (CDHAC,1999, p.14)
7.5 Planning Process Evaluation – Steps in Developing the Plan

The case study will use the seven steps in the MPHP model as a framework to evaluate the process of planning. The project followed the guidelines for developing an MPHP, as outlined in Chapman and Davey (1997) and the local PMT adapted the MPHP model to suit its local organisational environment in the city. The process used in the development of the CHP evolved over the life of the project. A project executive led the project and the GCCC Project Officer facilitated it. Barker et al. (1998) report that initially the project worked through the seven steps sequentially. At the beginning of the project, six stages were planned; however, as the project matured a seventh step developed. After the first year Council found that there was continual movement backwards and forwards between the stages, so a more flexible process is desirable.

7.5.1 Step 1: Doing the Groundwork

A prerequisite for attempting to work within the Healthy Cities paradigm is the political acceptance and commitment of the mayor or elected representatives and the Council administration. This means that the top political level has to declare explicitly its support for both the practical development of the plan itself, and the changes in organisational culture that invariably result from such an undertaking (Barker and Yakimoff, 2001). The Council must be prepared to involve its residents and other non-traditional partners and go beyond the customary borders between professional and other sectors. The decision was made to confirm Councillor support for the plan through the organisation’s formal agenda process. A Council briefing that explained the work of Healthy Cities and Shires Queensland and the concept of a CHP was prepared by the Coordinator Health Protection and put before Council at its November 1996 meeting.

Council resolved that it should:

- Embrace in principle the concept of a Municipal Public Health Plan for the city
- Make application for an encouragement award of $5,000 to Healthy Cities and Shires Queensland for the development of such a Municipal Public (Community) Health Plan
- Appoint a Councillor to chair the project team, and
- Consider the provision of funding in the course of budget preparation for the 1996/1997 year.

Barker and Yakimoff (2001) advised that Cr Jan Grew, the then chairperson of Council’s Health and Cultural Services Committee, enthusiastically volunteered to chair the project team, and
that the plan then took its first, significant step towards becoming a reality. At around the same
time, private briefings were being conducted with the Council’s directors and senior managers
to legitimise the necessary degree of managerial support needed for the project. Securing
organisational commitment and awareness is a continuous process, to be undertaken not only
during the commencement phase but throughout the CPHP project. A variety of strategies were
used to build the interest of staff and their capacity to engage with the CHP project. These
included:

- Presentations to interested staff
- Circulation of health planning committee meeting minutes to key personnel
- Invitations to all Councillors to participate at project committee meetings
- Formal presentations for Councillors at monthly Council meeting, and
- Distribution of CHP information kits.

In summary, the internal communication processes in Council helped spread the information
about CHP via the following methods: in-house presentations delivered to staff, circulation of
committee minutes, extension of open invitations to Councillors to participate in project
committee meetings, formal update seminars to Council meetings and preparation of CHP
Information Kits (Barker and Yakimoff, 2001). To increase the profile of the CHP the project
used existing free-print media, firstly to announce the project and then to report on its progress
and actions. Other approaches involved:

- Address to a local Health and Cultural Expo
- Local shopping centres displays
- Gold Coast Show display
- Seminars for TAFE students, and
- Distribution of CHP promotional materials; eg library bookmarks.

All CHP information was disseminated to partners via the Working Party (WP) using an email
network and with regular meetings. The project officer attended the meetings of the other
agencies, reported by the agency representatives as a very successful approach.
The settings approach to population health can, at first, seem complex to newcomers to the project and does not lend itself to overly simplistic explanation or interpretation (Robertson, 1998; Chu and Simpson, 1994). Barker and Yakimoff (2001) noted that to the uninitiated, involvement in such projects can at first appear quite daunting. Healthy Cities and Shires Queensland project staff assisted with the conduct of training for all project participants, presented in the form of workshops and case studies. Throughout the project development period, training and professional development courses were delivered in areas such as community profiling, needs assessment and consultation techniques, group dynamics and meetings facilitation, strategy development, and plan implementation. Successful development of the project also required its partners to have a working understanding of the specific ‘Healthy Cities’ agenda of health promotion in its broadest ecological context.

In hindsight, the project managers advised that the task of raising awareness of the CHP and commitment to it was a slow and difficult process. Barker and Yakimoff (2001) reported serious staff anxiety over Council’s threatened de-amalgamation, which had the potential to derail the entire project. The new amalgamated GCCC structure allowed for the project to continue.

7.5.2 Step 2: Managing the Project

Figure 18 describes the structure of the CHP. The three-tiered committee structure comprised a Working Party, a Project Executive Committee and a Project Advisor Committee.

![Committee Structure Diagram](image)

Figure 18: Gold Coast Community Health Planning Project - Committee Structure

*Project Executive Committee*

The main role of the Project Executive Committee (PEC) has been to monitor progress, resolve organisational and community conflict and reduce inconsistencies during the course of the plan’s development. The PEC consisted of a cross section of senior Council, state government
and community representatives (Barker and Yakimoff, 2001). A Health Committee meeting held on 18 March 1996 minuted that the Chair of the Committee wrote to the Premier of the State asking for a State Government representative on the Project Executive Committee. The intention of the committee was to gain political commitment. The appointed members included the Chairperson, a Councillor, Director Community Services, Coordinator Health Protection, Director, Lifeline; a representative from Gold Coast Institute of TAFE and the Manager, Southern Public Health Unit Network, Queensland Health.

The PEC began by studying a section of the city, not the entire city area. The results of that study could be overlain as the CHP for the whole of the city (CHP Meeting Minutes 18 March 1996, p.2). A geographical area from Broadbeach on the coast to the Nerang and Beechmont hinterland, stretching east–west through the city, was chosen as the study area, this being regarded as representative of the city needs and the basis for more city-wide approaches to CPHP. At this meeting, the Committee agreed to use the WHO definition for health initially, but considered that the City needed a more holistic definition, as the WHO definition was outdated.

**Project Advisory Committee**

The recruitment strategy for the Project Advisory Committee (PAC) membership involved a process of identifying government and non-government agencies and other community stakeholders to assist with the planning. This committee would identify appropriate peak bodies responsible for the current and emerging health issues and then engage partners in the CHP process. The principal role of the committee was to clarify the priority public health issues from a variety of perspectives, facilitate the involvement of interested groups and individuals in the development of strategies, and participate in the plan’s implementation (Barker and Yakimoff, 2001). They list the stakeholders who have been involved in the CHP and recognise the diversity of representation across the sectors that influence health outcomes.

The 1997 CHP membership list is given below. Many more agencies participated in stages of the project. The list shows the level of ownership the process enjoyed across many specialist fields. The CHP is truly an intersectoral approach to health promotion, with an emphasis on partnerships and joint working, with local government as the primary driver.

The membership of this committee was very broad and consisted of representatives from the following:

**Intersectoral Agencies:**

- Health Chairperson (Councillor), GCCC
- Gold Cost Drug Council
- Community Health, Queensland Health
Gold Coast Council Staff:

- Project Coordinator
- Manager, Strategic Planning
- Social Support and Liaison Coordinator
- Coordinator Health Protection, and
- Minute Secretary.

*Project Working Party*

The Project Working Party (WP) was formed to drive the CHP. The WP comprised one full-time project coordinator and five part-time Environmental Health Officers within Council’s Community Health Services Directorate. Participants were largely self-selected according to their professional interests and their enthusiasm for the Healthy Cities and Shires Queensland concept. The membership of the WP was responsible for facilitating the progress of the plan day to day. The WP chose the geographical region to be studied in the pilot consultation, prepared the guiding principles and goals of the CHP and developed a community demographic health profile. The WP also designed the project’s logo.

The WP established a CHP Committee Management Structure. Barker and Yakimoff have explained that ‘in order to separate executive and technical functions, the WP decided upon a three-tier committee system to harness intersectoral and community involvement in the plan and provide a communication network’. Barker et al. (1998) reported that the three-tier committee system was complex and often a difficult task, with duplication occurring between the PEC and PAC. As a result of this perceived duplication and unclear committee roles and responsibilities, the Project Executive Committee members reduced their involvement in the CHP. A key factor
governing the success of the committees related to the Committees achieving the right balance in the organisation and structure of their meetings. Barker and Yakimoff advised in 2001 that when committee members met consistently and had well-defined agendas, including practical tasks, participation improved and real progress was achieved. Barker reported that the working party structure was cumbersome: it duplicated work and it became difficult to manage, because the Terms of Reference of each group were unclear. He noted that when members met regularly and had well defined agendas, including the allocation of practical tasks to agencies, and participation was high, real progress was achieved. These features are the foundation of good project management (Stoner et al., 1985).

During the development phase of the CHP the PAC facilitated the involvement of the agencies and community groups in strategy development and plan implementation and review. They also empowered another forty people to prioritise public health issues from a variety of community perspectives. Barker and Yakimoff reported that little governance and accountability were organised with the partner agencies in the project. No memoranda of understanding were developed between GCCC and the other agencies and this was a barrier to the success of the project.

The NPHP (2000, p.69) identified multiple accountabilities for organisations involved with MPH Plans. Partner organisations involved with the CHP at different levels of government, non-government or community groups have varying levels of accountability for the CHP strategies. The participating agencies in the CHP were not accountable for the implementing of the strategies in the plan. The CHP at the Gold Coast had no governance in place to formally require agencies to respond. All progress depended on informal agreements and networks. The project in its early stages prospered, even without agency accountability structures in place. People wanted to be involved; the needs of the agencies and community groups drove their involvement. However, in the latter stages of the project agency commitment reduced and the plan became more difficult to implement across the sectors.

A broader representation of professionals from Council and the agencies assisted with the CHP. PEC and PAC had a mix of political, managerial, educational and health professional groups, but the WP included only EHOs. The NPHP (2000) noted that a MPH process benefits from a broader set of skills than exists with environmental health or health promotion professionals; using town planners and social planners adds positively to the mix. Working parties should be broad based and include representation from all professional groups. This was seen as a limiting factor for the CHP at the Gold Coast and a barrier to the implementation and sustainability of the plan.
7.5.3 Step 2: Needs Assessment

The WP was committed to conducting a health-planning project with input from all agencies; yet more importantly, it set out to engage residents and community groups in discussion about health issues. Following a needs assessment these issues stood out as priorities:

- The community’s main health and quality of life concerns and current levels of satisfaction
- Gaps in health services and other community facilities
- Environment and health policy changes required to improve or promote the health of the community, and
- Strategies to reduce health inequities.

A comprehensive list of health issues was documented in the PAC minutes dated 30 April 1996. This list was prioritised and formed the basis of the strategies in the CHP. After examining community needs, the PEC considered it necessary to adopt and promote a concept of health which advocated a more holistic view of health and well being, not focusing on illness (see Council minutes 18 March 1996). The WP adopted a broad, socio-ecological view of health, encompassing physical, social and environmental health determinants to guide the needs assessment process. In addition, the WP felt it was essential to use a range of data collection techniques to establish and validate the broad range of community health issues (see PAC minutes 29 May 1996).

The needs assessment collected data from the following primary sources:

- An assessment of demographic profile information and existing community needs report and a review of the literature
- An examination of National Health Goals and Targets
- A community organisational mail-out survey sent to some 118 local organisations and community groups, and
- A community residential mail-out survey sent to 2000 householders.

Tsouros (1995) reflects that comprehensive city health profiles represent key products of Healthy Cities projects and provide the evidence and the credibility for serious efforts to promote health at a local level. They act as a basis for advocacy, for the setting of priorities and proven evidence of health issues. With direct access to data supplied by the Australian Bureau of Statistics (ABS), Council’s Research Unit compiled a demographic profile of the communities within the project area. Numerous existing community needs assessment reports from within Council and from other agencies added value to this process (see PEC minutes...
dated 30 April 1996). The GCCC also published a comprehensive Social Profile on its website and this document superseded the CPH Health Profile.

The community questionnaire was the key component of the needs assessment. Analysis of this data was carried out by the WP and was a time consuming task. The Project Advisory Committee members, as key informants, provided an initial list of priority community health issues. The questionnaire, which was developed by the WP with assistance from the PAC, was refined and then distributed randomly throughout the project area to some 2000 households, 118 community organisations and groups, and 124 visitors to local shopping centres. The survey collected both quantitative and qualitative data. The questionnaire had a significant reach across a broad range of respondents. To encourage participation in the survey, respondents were entered into a competition with the winners receiving a voucher for dinner at a local restaurant. The survey had a 21% response rate with 315 household-completed surveys, 25 community groups’ responses and 124 shopping centre face-to-face responses (see minutes of Focus Group Meeting 13 August 1996).

Some of the limitations of the survey included not reaching all agencies and community groups and under-representing certain sub-populations. For example, the youth group was underrepresented in the survey. The WP agreed that, in hindsight, the PAC needed to input more expertise to the design of the questionnaire, particularly to encourage ownership of the project by the many agencies and community groups in the Gold Coast. Feedback from agents and the community was needed, both for better access to information about health issues across the Gold Coast and to assist Council with future decision-making. A central access point for demographic health information had not previously existed prior to this project. The Council, through its community customer services outlets, was identified as being ideally placed to act as a central information source for health community services and facilities (GCCHP, 1997, p.11).

### 7.5.4 Step 4: Determining Priority Issues

The needs assessment conducted in the project identified 300 health issues. The Project Advisory Committee, assisted by the Working Party (WP), developed a health issue prioritisation method, which reduced the number of priority issues to 150. The method used the following prioritisation criteria: (adapted from Chapman and Davey, 1997 and PEC minutes dated 30 April 1996).

- Was the issue serious?
- Had the issue received previous actions by other agencies?
- What was the level of community interest?
• What was the degree of expertise within the Project Advisory Committee concerning the issue?

• What was the potential for collaboration?

Further to the initial prioritisation process, the PAC then rated the remaining issues as either highly significant across all sections of the survey, or highly significant based on the open comments section of the survey, or significant issues but low response, or national goals and target issues. A matrix was then created listing the individual issues under various health themes, classes, data collection sources, and assigned rankings. The issues were categorised into a matrix based on the following classifications in Figure 19.

<table>
<thead>
<tr>
<th>HS</th>
<th>The issues were highly significant across all sections of the survey. The issue received a high rating if listed also as a target in the National Goals and Targets document.</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>The issue was highly significant in the open questions section of the questionnaire.</td>
</tr>
<tr>
<td>L</td>
<td>The issues were significant but did not receive a high response frequency across all sections of the questionnaire.</td>
</tr>
<tr>
<td>M</td>
<td>This issue received an M rating if cited (not a target) in the National Goals and Targets document.</td>
</tr>
</tbody>
</table>

Figure 19: Priority Issue Classification Scale
(Source: PEC minutes dated 29 May 1996)

The data set was further reduced by numerical ranking of whole classes of issues according to their priority rating across all data sources. The PAC and WP concluded that it was a difficult task to prioritise a large complex set of interrelated health needs and recommended that the theme working parties developing the strategies should explore any other issues that didn’t become part of the final list of health priorities – in collaboration with the community groups concerns and subject to finding the resources to conduct more focus groups. The final list of core priority health issues is given below: these themes form the foundation of the GCCHP.

Twelve community health issues were identified during the CHP needs assessment process, resulting in a CHP being developed for the City, with the following themes:

• Access to Health Services and Information  
• Alcohol and Other Drugs  
• Community Safety  
• Disability and Mental Health  
• Environment Protection  
• Food Hygiene and Nutrition  
• Housing  
• Recreational Facilities  
• Rural and Hinterland Communities  
• Support for Ageing Persons  
• Support for Families, and  
• Transport.
7.5.5 **Step 5: Strategy Development**

Strategy development commenced with the Project Executive Committee meeting for a strategy development workshop. Intersectoral theme working groups (TWG) were formed for each of the themes identified in the previous step. A strategy development planning sequence was developed to assist with the process of articulating strategies for each theme. The capacity building template developed by the Project Co-ordinator contained three main sections: a) introductory material identifying CPHP first principles, modern conceptions of health and the project’s intended scope and goals; b) techniques for strategy development, detailing optional criteria for further issue prioritisation and clarification, ideas concerning research preparation, the Ottawa Charter framework for health promotion and the language of planning; and c) a sample Work Plan, documenting the key milestones by which the respective groups could gauge their progress.

In practice, many approaches were adopted by the various TWG to develop strategies in the plan (see PAC minutes 28 August, 18 September 1996). These approaches ranged from intersectoral consultation workshops to regular fortnightly meetings with key stakeholders and health professionals. TWG were provided existing data from the Health Profile. Several TWG competed action research to gain further insights into their respective health themes and their target community. As an example, the Rural and Hinterland Communities Focus Group conducted an additional and more comprehensive needs survey. This had responses from some 130 residents, over one third of the target population. A comprehensive list of specific recommendations for action, which engaged broad community support, was developed (see PAC minutes 13 November 1996).

The diversity of methodologies employed during strategy development resulted in a wide cross-section of the community being creatively involved in the planning for the future health of the City. It was estimated that some 300 people from agencies, community groups and residents participated in this step of the CHP process. It was beneficial to have such a broad spectrum of representation during strategy development; however, there were some barriers to progressing the CHP strategies.

Bringing together the many agencies, health professionals, direct service providers, community group representatives and residents was a positive process. However, a series of competing agendas emerged out of the process. The PAC and WP discovered that the organisational culture, member behaviour and professional and local language of Council and agency staff varied. This presented difficulties and differences in understanding, the not only of the CPHP processes, but of other competing plans such as the city’s town plan and local area planning, Council social planning and Councils transport planning. This was later to create enormous
time and resource implications for the WP, as the group attempted to integrate the various strategy approaches into a single ‘agreed-to’ document.

Finally, the TWGs provided the PAC with clear and concise objectives, strategies, action statements, project partners for each of the theme areas and this material was included in the collaborative CHP draft document in preparation for Step 6 of the process. The Project Officer from the Healthy Cities and Shires Office that was auspicing the MPHP Project with Queensland Health was reported as saying (see the minutes of the PAC meeting held on 11 February 1997):

The ongoing success of the CHP will be the collaboration of all key stakeholders and Council departments working in close liaison, she stressed the need to obtain political commitment for the strategies developed for inclusion in the draft CHP.

7.5.6 Step 6: Writing the Draft Plan

Final preparation of the draft plan was the responsibility of the WP. Following completion of the strategy development stage, a first draft of the plan was prepared by the WP for approval by PAC and the GCCC Health Committee. The writing of the draft plan consisted of a series of stakeholder consultations followed by redrafting and final editing. The WP completed the CHP, and then presented it to the intersectoral partners for comment, prior to the full Council meeting giving written endorsement. The plan was launched and promoted across the city. A formal signing ceremony was arranged by Council and attended by partner agencies and community groups. The GCCHP was successfully launched at the Gold Coast Council Chambers in early 1997.

7.5.7 Step 7: Implementation – Monitoring, Review and Evaluation

Implementation is the most important on-going component of MPHP. The role of an Implementation Committee (IC) was considered at the PAC meeting on 16 September 1997. The importance of a communication strategy ‘to highlight the significance of changes that are occurring because of the CHP, and to maintain health on the agenda’ was the key issue debated.

To facilitate the implementation of the CHP, the existing Project Advisory Committee and Working Party project management framework was retained, with some minor modification (see joint PEC and PAC meeting minutes 6 August 1997 and the IC minutes 21 January 1998). The PAC supported this approach, as it acknowledged the importance of maintaining key stakeholder involvement, trust and ownership during the implementation step. The PAC attempted to maximise the transfer of skills and knowledge acquired in relation to CPHP principles and processes as the project evolved from development to implementation. In the minutes of the PAC meeting held on 11 March 1997, the committee endorsed the concept of a
‘statement of intent’. This required agency partners to commit to the goals of the CHP, particularly collaboration, and assist with the on-going planning process and the implementation of strategies in the CHP. Quarterly IC meetings were scheduled for 2001, 2002 and 2003 with accountability for implementation of strategies equally allocated to Public Health Services, Social Health Services and Community Support and Infrastructure (see IC – Focus Group Meeting dated 15 November 2000).

Strategic planning processes require measurement of performance and evaluation. The monitoring of the CHP progress and annual review of the current and emerging strategies required specific information and reporting systems. PAC proposed to have quarterly monitoring of actions in progress, plus an annual review, and on-going process and outcome evaluation. Step 7 was an on-going process at the Gold Coast during the 3rd to 4th year of the Plan.

Figure 20 describe the CHP Implementation Committee Structure. An analysis of the Implementation Committee meeting minutes held between 21 January 1998 and 15 November 2000 found that agencies continued to report their progress on-agreed to activities in the CHP, and reported back to other members at the meeting. Nine implementation committee meetings were held during this three year period of implementation, with a range of 7 to 23 agencies (an average of 10 agencies), and between two and five Council staff, including the Committee Chair, attended meetings.

Figure 20: Gold Coast Community Health Planning Project - Implementation Committee Structure

Agency partners reported their implementation achievements and successes in the CHP to the IC. All agencies were supportive of this quarterly activities or progress reporting. The IC collated their achievements (status of strategy implementation) onto an electronic spreadsheet, and feedback this information to stakeholders (see IC minutes 15 November 2000). The CHP was not updated annually with these achievements. The IC decided to review and reprint the
CHP after a three-year period; removing completed strategies and adding new strategies, based on another round of needs assessment and strategy development.

Table 14 documents the issues and progress of strategy implementation in the CHP (Document CHP IC Minutes 17 May 2000; p.9).

Table 14: Progress of Strategy Implementation

<table>
<thead>
<tr>
<th>Issue</th>
<th>Total Projects</th>
<th>Completed</th>
<th>Not Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Service and Information</td>
<td>12</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Alcohol and Other Drugs</td>
<td>17</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Community Safety</td>
<td>9</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Disability and Mental Health</td>
<td>12</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Environment Protection</td>
<td>15</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Food Hygiene and Nutrition</td>
<td>26</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Housing</td>
<td>19</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Recreational Facilities</td>
<td>13</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Rural and Hinterland Communities</td>
<td>19</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Support for Ageing Persons</td>
<td>16</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Support for Families</td>
<td>11</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Transport</td>
<td>16</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>185</strong></td>
<td><strong>101</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>

Of the total 185 strategies/projects in the plan, 101 were completed, and 38 not completed. The remainder of the strategies/projects were ongoing. The IC analysed the Progress of Strategies/Projects over the three years, against three categories, namely: projects actioned by the community groups, projects actioned that were directly supported by Council, and projects actioned that involved intersectoral collaboration (illustrated in Figure 21).

![Figure 21: Progress of Strategy Implementation by Three Categories](source: CHP IC Minutes, May 2000, p. 9)
With the relative success of the GCCHP, in 2001 there was strong support to review the CHP, with an intention to add another three to five years to the life of the plan. Agency partners at the IC meeting on 17 May 2000 agreed to a new Implementation Model for the next three years of life of the plan. Figure 22 describes the proposed model. This model demonstrated three main areas of concern, based on the experience of the IC over the previous two years. They divided the main issues into public health, social health and community support and infrastructure. This enabled implementation of the 13 issues of concern to be shared across all partner agencies and Council departments. All agreed to continue the IC, but with a new reporting structure that enabled issues to be dealt with by Action Planning Committees for each category, who would report to the IC. These groups would replace the previous TWP. Council staff and interested agency partners continued to implement the remaining strategies in the CHP from 2001 onwards. However, Council questioned the sustainability of the CHP, mainly due to Council resources issues. Council continued to support the Healthy Cities approach and a fulltime Council CHP Project Manager continued to work with partner agencies to implement the plan.

Meanwhile the Council decided to have an independent review of the CHP. In 2002/2003 the GCCC funded a formal independent review of the CHP (via a tender process) to advise Council on how to build on the current progress and advise on future health and social planning activities.
7.6 Findings of External Review of CHP

An analysis of the Gold Cost City Council CHP was conducted in 2002 by external consultants. Aspects of this report will be introduced into the case study (ERM, 2002). The CHP Review developed a survey including several key questions (see IC minutes 2 November, 2000). Figure 23 lists the key questions proposed in the Review.

| Question 1 | Does the CHP remain the ‘best-value’ planning tool for progressing the city’s public health agenda? |
| Question 2 | To what extent can the key health strategies and objectives in the CHP become more fully integrated into Councils and partner agency corporate and other strategic planning processes, thereby strengthening intersectoral commitment to plan strategy implementation? |
| Question 3 | Can Council continue to increase its focus on public health initiatives and community development? Is this Council’s core business role? |
| Question 4 | To what extent is the CHP duplicating the work of other health planning initiatives within the region. Is there a need to realign or rationalise the project? |

Figure 23: Key Questions Proposed in the External Review

Barker noted in the external review report ‘Key Objectives of the Health Advisory Committee’ (see ERM, 2002), that:

The external review identified the important role of Council in CHP and highlighted the benefits for specific community projects and for budding partnerships with other agencies and the community, but indicated that the collaborative partnerships were stronger outside of Council and that internal Council departments needed to mirror that collaboration to make it successful.

The external report noted low stakeholder awareness of the broad definition of health demonstrated in the CHP project guiding principles. It also noted a greater need to enhance organisational commitment, increase resources, improve internal Council integration of planning, and define more clearly the roles and responsibilities of all internal and external partners to the plan. Insufficient feedback on the CHP achievements was a barrier to the success of the plan implementation. To remain current and useful, the agencies needed to communicate achievements to the PAC on a regular basis.

Barker and Yakimoff (2001) commented:

Not all strategies in the plan will be implemented concurrently, and in the passage of time may become redundant, it will therefore be necessary for those responsible for overseeing the implementation process, to periodically go back to the community and test the relevancy of the plan’s objectives and strategies, do some fine tuning or even overhauling issues as required.
The key point in this process is to keep the agencies and community groups and residents informed about the progress of the GCCHP. The feedback mechanism in the implementation stage of planning is vital to the sustainability of the CHP process. In response to this barrier to planning, the PAC developed an effective communication strategy to sustain the long-term interest in the plan.

In the minutes of the IC second Focus Group Meeting held on 15 November 2000, participants evaluated the CHP achievements and barriers to assist the external consultant in the review. Some clear outcomes of the external stakeholder evaluation were recorded in the minutes (see Table 15).

Table 15: Focus Group Evaluation Outcomes

<table>
<thead>
<tr>
<th>Achievements identified:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Created informal communication networks</td>
</tr>
<tr>
<td>Provided opportunities for improved partnership arrangements</td>
</tr>
<tr>
<td>Articulated joint goals and objectives as a group</td>
</tr>
<tr>
<td>Availed goodwill</td>
</tr>
<tr>
<td>Increased awareness of issues for Councillors and Council staff</td>
</tr>
<tr>
<td>Collaborative effort to maintain process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complementary – conflicting organisational planning:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues need to be incorporated in Agency’s strategic plan and Council’s Corporate Plan</td>
</tr>
<tr>
<td>Enshrine policies in legislation</td>
</tr>
<tr>
<td>Councillors lack ownership (sensitive issues can be too political)</td>
</tr>
<tr>
<td>Insufficient commitment sign-off</td>
</tr>
<tr>
<td>Improve links between Local and State Governments</td>
</tr>
<tr>
<td>Improve City wide strategy and policy development</td>
</tr>
<tr>
<td>Adopt as a core business activity</td>
</tr>
<tr>
<td>Involve key Council personnel (e.g. strategic planners etc)</td>
</tr>
<tr>
<td>Need to align the goals of planning for health with the principles contained within the Integrated Planning Act 1997</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes to model and resourcing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define Key Performance Indicators in relation to health issues</td>
</tr>
<tr>
<td>‘Value for money’ meetings and cooperative projects</td>
</tr>
<tr>
<td>Make sure what is perceived is realistically what is required</td>
</tr>
<tr>
<td>Outcome based funding with emphasis on sustainability</td>
</tr>
<tr>
<td>Whole of Community focus</td>
</tr>
<tr>
<td>Making the community responsible for their own health</td>
</tr>
</tbody>
</table>

Council decided to review its policy on project implementation and consultative approaches used previously to assess the feasibility of conducting further strategic health planning exercises.

7.7 Lack of Funding to Implement Planning Strategies

Gold Coast City financed the planning process and the administration of the implementation phase of the project. Council appointed a fulltime Community Awareness Officer to project manage the CHP. Also, when required, a second health professional from Council worked fulltime on delivering CHP outcomes.
Considering the project’s large scale, the health plan has been produced on a relatively modest budget. The $5,000 encouragement award provided by Healthy Cities and Shires Queensland proved useful at least initially; covering costs associated with hospitality, production of promotional materials and distribution of needs assessment survey forms. Barker and Yakimoff (2001) reported that, other than the printing fee for the final publication of the plan, the single biggest cost item from Council’s perspective has been that of implementation officers’ time. This was conservatively estimated to be in excess of 2,500 hours over an 18-month period.

The Gold Coast CHP has been a holistic plan for the community health activities of both the local Council and the broader city; Council facilitates the plan but there were no expectations that Council would fund all strategies. The plan’s rationale (see CHP, p.2) states:

Healthy and Sustainable Gold Coast: A Community Health Plan has been initiated by the GCCC in partnership with a number of other government and non-government agencies and community representatives to trial a cooperative approach to CHP and local governance.

The principal role of the Council has been to coordinate and facilitate the development of the plan, with assistance from these groups. The CHP seeks to provide a guide to whole-of-government integrated health advancement within the city. This approach can be the strength of the plan, but also the weakness, in that, without legislative support, progress is dependent on the strength of partnerships: as partnership change, progress can stop.

Looking to the future, many elements of the plan can be initiated immediately through a reorientation of existing resources or nominal additional support. On the other hand, several of the strategies will necessitate substantial preparatory effort and have implications for increased future resource allocation. Barker and Yakimoff (2001) commented that history would suggest that the ultimate effectiveness of any CHP’s ability to bring direct health improvements is likely to be proportional to the ongoing resources made available to it. Consequently an important challenge facing the plan’s implementers will be to secure, in what is likely to be an environment of great fiscal restraint, the sorts of strategy supportive budgets and programs that will enable full and effective implementation to proceed.

The other debate within Council is whether to integrate the CHP with other planning mechanisms which exist in Council. The Community Health Department in Council and the Town Planning Branch have planning processes that interface with social health determinants. There are several options: two possible ones include integration of the CHP (in the Environmental Health Branch) with the Social Plan in the Community Services Branch of Council; or integration of the CHP with the Local Area Planning process developed by the Town Planning Branch. The IC was concerned about the many layers of planning, and the need for other strategic action plans to inform the CHP. The IC proposed that the links between the
Regional Organisation of Councils (ROCS) and the Council Local Area Plan be recognised in future planning, and proposed the interface between complimentary internal Council plans depicted in Figure 24 (Personal communication with Barker, 2002). Planning information from Council can interface with the ROCS’ agenda; however, the integration of community health and local area planning would require significant Council internal departments restructuring and this approach has not progressed because of a lack of support from senior managers.

![Diagram](image)

**IMPROVED HEALTH OUTCOMES**

Figure 24: Integrating the Gold Coast Community Health Plan  
Source: CHP IC Minutes, May 2000, p. 12

### 7.8 Integration of CHP: Other Layers of Planning

Public health programs operate within certain policy and legislative frameworks at the state and local government level. Partner agencies and Council produce health outcomes, whether directly from health policy or indirectly as a result of aligned policy outcomes. This part of the case study explores the contribution of MPHP at the Gold Coast and the concept of integrated public health practice, a major aim of the CHP.

The National Environmental Health Strategy (NEHS), a Commonwealth Government initiative, recognised the value of participatory health planning (CDHAC, 1999). MPHP strategies in Council interact with other local government planning processes. At the State level, the Queensland Government Regional Framework for Growth Planning sets the stage for quality of life planning with 20-year planning projections. The Local Government and Planning Department requires local government to develop a town plan every six years. The Gold Coast CHP is a policy initiative of the GCCC, which supports the Corporate Plan and Operational Plan, a requirement under the LG Act. The LG Act requires an assessment of a wide range of community quality of life indicators; however, the LG Act and LGFS do not require Council to complete health needs assessment. It appears that health is defined more broadly in this Act, which weakens the position of health needs assessment. For health planning to have greater
impact, the Public Health Acts and Regulations should require annual health needs assessment. In Victoria, health needs and health impact assessment are mandatory for local government when formulating a MPHP. Other State policy on planning is managed by the strategic activities of the Community and Local Government Partnerships Group of Queensland Health, the Local Government and Public Health Services Protocol to promote public health planning in Councils.

Legislative reviews of the Health Acts and Regulation in Queensland in 1995 and 2004 called for comments from stakeholders concerning the introduction of mandatory MPHP in local government. Queensland Health’s Review of the Public Health Act did not recommend changes to the Act requiring all Councils to develop and implement MPHP. However Queensland Health has worked with the local government department to require Councils to include public health management matters in their three-year corporate planning cycle and the LGFS have been amended to include this clause.

The general lack of support from Queensland Health to mandate for MPHP state-wide, was based largely on lack of resources to fund such initiatives. The government asked who would pay for the development of state-wide community public health plans. In the place of a regulatory approach, Queensland Health funded a series of health planning projects to facilitate activities in communities in Queensland. A more detailed account of this approach appears in Chapter 3. In fact in Victoria in 2000, in order to take account of the dynamic nature of local government, and the fact that public health problems and priorities change over time, the State of Victoria’s Health (General Amendment) Act 1988 made provision for Councils to document their major public health activities in a public health plan (see Department of Health, Victoria, 1996).

Under the Act Section 29B:

Every Council must in consultation with the Chief General Manager (of the Department of Health and Community Services), prepare at three year intervals a municipal public health plan in Health (General Amendment) Act 1988.

The NPHP Report (2000, p.66) states that the Department of Human Services in Victoria requires Councils to consider national health priorities in the development of their plans. Barker and Yakimoff comment that there is still a dilemma at the Gold Coast regarding the definition of health and the Council’s role in public and environmental health. Barker and Yakimoff (2001) argue:

If a narrow view of health is the policy then Councils rely on the State Government to initiate health promotion programs only acting on health and environment services stimulated in legislation under their supervision, if a holistic view of health is held by Council (and is reflected in their policy) then Councils take on primary roles in settings-based health promotion. Unfortunately health promotion
initiatives identified in the CHP require funding support and the only way forward is to work collaboratively to obtain joint funding in the future if CHP is to be sustainable.

Barker and Yakimoff (2001) advised there was no evidence at the Gold Coast of the agency partners to the CHP adding their CPH Strategy commitments to their existing business plans, unless it was core business of that organisation. Further research is required to assess the impacts of CHP on the agency partners.

7.9 Learnings from Case Study

Interpretations and meanings from this case study are summarised in the table below. This process evaluation discovered a series of learnings from the CHP case study. Table 16 lists the process evaluation findings and learnings for this preliminary case study.

**Table 16: Gold Coast CHP Process Evaluation Learnings**

The CHP development stage of the planning process reached its target groups through successful community surveys, focus groups and strategy working parties:

Participants reported that the workshops were conducted in appropriate settings and facilitated well by University staff.

Participants were satisfied with the project structure and participatory methods used in the planning project including the following:

- Increased Councillors awareness of agency, community groups and internal council health programs
- The process created informal communication networks between council, agencies and community groups
- The process significantly improved collaboration and partnerships opportunities for agencies to address the social determinants of health, both within the health sector and outside of the health sector
- The process of the planning was the important factor [in comparison to the plan implementation stage] bringing agencies together to work in partnership
- The MPHP process clarified the role of council and partner agencies in health, family and environment matters, and
- Individuals (for the first time through MPHP) had an opportunity to become involved in health and environment service planning.

The process lacked capacity building of:

- Elected representatives in council, which reduced their involvement
- Partner agency staff, and
- Internal council staff includes social planners, strategic planners, community development, environmental and environmental health officers in comprehensive integrated planning (not all council planners involved in the process).

The community needs assessment process developed in Step 3 of the project could be improved by collecting data from across all suburbs not just a sample of suburbs

The CHP was evaluated prematurely: more time was required to assess the implementation impacts of the CHP and further impact evaluation is required to assess its effectiveness’
7.10 Conclusion

Chapters 2, 3 and 4 provided the theory that underpins MPHP, including issues of urbanisation, ecological public health, participatory planning theory and organisations and strategic planning. Chapters 5 and 6 highlighted the theory and practice of qualitative evaluation and the research methodology. The descriptive and evaluative case study approach in Chapter 7, provided an insight into the theory and practice issues for local government when establishing a MPHP. The case study was centred on the city of the Gold Coast, a city with both an increasing local population and facing the impacts of urbanisation and expanding international tourism. This chapter has examined a ‘local approach’ to MPHP (developed by a single local government), a city with a population of 400,000 residents that expands to 1 million during the peak tourism season, increasing demand on local government services and contributing to the health and town planning issues caused by urbanisation.

This case study examined mainly the development process of CHP. The learnings discovered in this case study assist with the design of the more comprehensive IQ to assess the implementation impacts of this MPHP project in Chapter 9. Key learnings from the case study will be discussed in Chapter 11. The following chapter, Chapter 8, documents the second case study in this thesis, examining the development phase of the of the Wide Bay ‘Regional Approach’ to Public Health Planning project, where two local governments worked in partnership with other agencies and citizens to improve their quality of life and health and environment services.
CHAPTER 8  
PRELIMINARY CASE STUDY AND PROCESS EVALUATION: WIDE BAY REGIONAL PUBLIC HEALTH PLANNING PROJECT

8.1 Introduction

This case study will describe the history of the Wide Bay Regional Public Health Planning (WBRPHP) Project, examine the process of MPHP, and comment on the initial implementation phase of the work. This case study will use the seven steps in the MPHP model as a framework for the case study in Section 1; in Section 2, the results of the preliminary process evaluation of the planning are described and discussed. Data has been collated from a review of published and unpublished papers; conference proceedings; internal Council reports; a content analysis of the minutes of the Executive Management Structure PMT; Council Reports; Project Co-ordinator internal reports to the PMT; minutes of the Implementation Committee; and results of the focus group meetings. At the end of this chapter, the meaning and interpretations of the findings of each stage of the planning process will be analysed and presented as process evaluation findings and learnings.

8.2 Background to Wide Bay Regional Public Health Planning Project

A full list of the internal Council documents examined in this case study include:

- Minutes of Meetings
- Hervey Bay PMT Meeting 10 May 2002
- Fraser Coast Public Health Plan Minutes – 1 August 2002, 27 August 2002
- Hervey Bay and Maryborough Public Health Plans Combined Theme Working Party – 17 April 2002, and
In 1998 a partnership between Maryborough City Council (MCC), Hervey Bay City Council (HBCC) and the Central Public Health Unit Network (CPHUN), Queensland Health, was formed to develop two municipal public health plans (PHP). PHP reflect the local and regional health needs and clarify issues that impact on the quality of life of residents. The public health planning process would aim to facilitate the development of partnerships between local governments, other key government and non-government agencies and the community in creating and working towards a vision for a healthy and more sustainable community. In May 1998, the CPHUN-Wide Bay approached the HBCC and MCC to participate in a proposed public health planning initiative. Funding for this project consisted of AUD$20,000 from the CPHUN-Wide Bay and AUD$10,000 each from MCC and HBCC. Griffith University was engaged as consultants to manage the collaborative planning process (see Davey et al. 1999; 2001).

The approach taken was modelled on the WHO’s Healthy Cities Program, which advocates for the formulation and adoption of local public and environmental health plans. The HCM provided guiding principles for the project that essentially aimed to improve the quality of life in communities. The Approach introduced participatory strategic planning processes that identified priority health issues and encouraged agencies to work more collaboratively with communities in decision-making about health and environment outcomes. This case study is titled ‘Regional Approach – Local Implementation: Preliminary Findings of an Evaluation of a Public Health Planning Initiative in the Wide Bay Area’. A summary of the case study findings were presented to the 13th Australian Health Promotion National Conference – ‘Ecological Health Promotion: Living by Principles’ at the Australian Health Promotion Association at the Gold Coast on 5 June 2001 by the author of this thesis (see Davey et al., 2001).

There were three stages in the preliminary evaluation of the two public health planning projects reported in this case study (see Davey, 1999; Davey et al., 2001), included:

- Stage 1 - Preliminary Process Evaluation of Focus Groups;
- Stage 2 - Preliminary Process Evaluation of the Project Management Team, and
- Stage 3 - Preliminary Process Evaluation of the Theme Working Groups.

The steps in the participatory planning process will be discussed and the results and findings of each stage of the preliminary evaluation will be presented.

8.3 The Planning Process

As mentioned previously this section of the case study will use the ‘seven steps’ in the MPHP model as a framework for the analysis. The Wide Bay Public Health Plan 1999–2001 took 14
months to develop and was guided by a PMT comprising representatives from the lead and participating agencies. The Project developed a unique project management model underpinned by the guiding principles of the Healthy Cities approach. A Health Profile was developed for each Council area, based on an extensive literature review of all quality-of-life statistics and supported by a comprehensive needs assessment. A series of ‘Vision Workshops’ across the two communities launched the planning project. This included vision workshops with Councillors across Wide Bay together with the members of the PMT, and separate workshops in the cities of Maryborough and Hervey Bay.

Data collected from targeted Focus Group meetings highlighted a diverse range of health issues in the Region. PHP ‘Theme’ Working Groups were formed and some 100 agencies participated in developing the objectives, action strategies, responsible partners and lead agencies, timeframes and performance indicators in the PHP. There were seven steps to the Public Health Planning Model in Wide Bay. Each step will be briefly described. The steps in MPHP in practice overlap at times. However Steps 1 to 7 will be explained and highlighted as major building blocks to planning healthy and sustainable communities in Wide Bay.

8.3.1 Step 1: Raising Awareness, Preparing the Ground Work and Gaining Commitment

Initially, in any project there is a phase where the foundation stones are laid, and the innovators and developers of the project build and support the early stages of the process. In Wide Bay this involved creating a shared vision for quality of life across the two Councils by raising awareness and gaining commitment to the development of the plan and implementation of the strategies.

Awareness-raising activities included the conduct of a series of ‘Vision Workshops’ in each city. Vision Workshops were targeted at three groups:

- community groups and residents
- elected representatives and Council staff from both Councils, and
- members of the PMT formed to manage the PHP project.

Structured media releases were distributed to the local newspapers providing information about the planning project, and the local media promoted the vision workshops.

Community stakeholders and residents were notified through an advertisement in the local paper describing the project and inviting participation. Invitations were also sent to community groups in each city and the region, inviting the groups to participate in the public health planning process. The vision workshop was an educational process for the community, aimed at gaining
support to develop a comprehensive Public Health Plan. The Vision Workshops contained sessions on the WHO Healthy Cities approaches including the history of health planning. The definitions of health and environment were presented and discussed. The workshop explored the positive attributes of each city, provided health planning examples in other communities and allowed residents to provide input into their vision for their community. Residents were introduced to the MPHP theory and practice and the groups discussed the barriers to achieving each city’s vision.

The Vision Workshop Program in each city consisted of opening comments from the Mayor, followed by a presentation of the health planning experiences of a fellow City Councillor from another provincial city in Queensland. Staff from Griffith University – the research consultants to the PHP project – then conducted a structured interactive workshop. After the three initial presentations the community divided into groups to discuss the following questions:

- What are the positive attributes of your City?
- What is your Vision for the City?
- What are the difficulties in achieving the City Vision?

Group information was transcribed onto butcher’s paper and displayed to other groups. Groups reported their findings to the main group. The workshop facilitators then assisted participants to develop a common ‘Vision Statement’ for their city (see Table 17). The information was collated and used throughout the planning process: this method added value to decision-making about community attitudes, health and environment needs and services and the future vision of residents. In fact, the Vision Workshops provided a forum to gain commitment from the agencies, community groups and residents for the planning process. The good attendance at the Forums (over 100 agency staff, community group representatives and residents attended in Maryborough and 28 people participated at Hervey Bay City) demonstrated to Council elected representatives how important it was to involve communities in the participatory planning process. Table 18 provides examples of the feedback from the Vision Workshops held in Maryborough and Hervey Bay.

Table 17: Vision Statements

<table>
<thead>
<tr>
<th>Workshop Participants’ Vision Statements for each Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryborough</td>
</tr>
<tr>
<td>Hervey Bay</td>
</tr>
</tbody>
</table>
It was interesting to note that at the time of the Vision Workshops a debate was occurring about the hospital services in Maryborough being downgraded, and at the same time the State Government was funding more hospital services in Hervey Bay. Many residents at the Maryborough Workshop showed concern about the pending lack of hospital services in Maryborough and this debate bolstered the numbers of residents who participated in the workshop to the advantage of the project.

A workshop was also held for elected representatives and Council staff from both Councils to build capacity and knowledge of the process of health planning at both local and regional levels. The workshop developed a ‘Vision’ for their City and the Wide Bay Region. It was important to compare the opinions and attitudes of Council politicians and staff, agency representatives, community groups and residents. The MPHP process attempts to meet community needs with appropriate service provision and improved quality of life for residents. The vision workshop framework questions used with the community stakeholders and residents workshop were presented to this second workshop.

Elected Councillors and staff had a vision for their community that was very similar to the community stakeholder vision, with many of the same issues listed. This group were more skilled in expressing their view and articulating the priority health issues, compared to the community groups and residents. A major issue discussed within this group was the need for ‘good’ stable local government and a desire for on-going collaboration and interaction with residents. The participants highlighted the importance of a strong industry base in the region to promote sustainable employment and a vibrant economy, a need for strong local government management and the support and protection of the natural environment.

Both MCC and HBCC representatives recognised the many difficulties in achieving their City Vision. Difficulties included lack of funding, fragmented policy approaches, low growth rates, increasing local government responsibilities without additional funding, competing market forces, magnitude of the planning and implementation tasks to meet the Vision; and the need for greater cohesion in the community and community ownership of the problems.

A Vision Workshop was conducted for the members of the PMT. This workshop covered in more detail the processes of MPHP and raised the team skills in preparation for developing and actioning the PHP Project. The workshop collected information on the attitudes of this group and enabled the researchers to compare their level of knowledge with that of the agencies, community groups and residents and the Councillors and Council Staff.
Table 18: Findings from Wide Bay Community Stakeholders Vision Workshops

<table>
<thead>
<tr>
<th>Location</th>
<th>Positive Attributes</th>
<th>Vision for the City</th>
<th>Difficulties in achieving Maryborough’s Vision</th>
</tr>
</thead>
</table>
| Maryborough | Casual lifestyle  
Good education  
Climate  
Interaction between groups  
Affordable  
Clean environment  
Sense of community  
Friendly  
Local industry  
Mary River  
Opening for sports  
Proud of heritage  
Good health services  
Well located | Full employment  
No empty shops  
No violence  
Green environment  
Drug and alcohol free city  
Regional hospital  
Crisis accommodation  
No poker machines  
Cycle paths  
Improved public transport  
More industry  
Safe streets after dark  
Stable local internet provider  
Less crime  
Joint airport with Hervey bay  
Clean up Mary River  
Access to buildings for disabled  
More parks and gardens | Lack of finance  
Insufficient planning  
Resistance to change  
Lack of communication  
Lack of regional cooperation  
Community ownership of problems  
Self interest  
Too many departments and duplication  
Lack of volunteers  
Political distance  
Agencies not working together  
Difference in priorities across age groups  
Youth culture  
Community motivation |
| Hervey Bay | Sense of opportunity  
Access to sporting and other facilities and activities  
Capacity for tolerance  
Spirit of enterprise developing  
Community gives it a go  
Potential for tourism employment  
Support for youth  
Council attuned to community needs  
Good hospital  
No traffic lights  
Community spirit  
Friendly peoples  
Weather  
Good environment for elderly  
Training of Indigenous people | Safer traffic system  
Support for families in need  
Low crime rate  
Respite  
Choirs  
Community hall  
Healthy environments in schools, youth culture, home | Unemployment  
Attitudes  
Geographical isolation  
Lack of public transport  
Government and Council red tape  
Lack of continuity  
Political instability  
Lack of action  
Lack of financial resources  
Diversity in ideas |
In general, it was found that each workshop listed similar positive attributes of the Wide Bay Region, articulated a common broad vision for the two cities, and identified similar difficulties in achieving the City Vision. The PMT showed more concern for sustainable city practices and policy; reinforced the need for controlled land development; recognised the political agendas that were barriers to planning healthy communities; and listed funding, timeframes and lack of community cohesion around the issues and changing political priorities as difficulties.

The project vision statement developed jointly by Maryborough and Hervey Bay Cities was agreed as follows:

The Fraser Coast community values its lifestyle and national assets and by working together seeks to enhance the quality of life for all.

This had an emphasis on working together to improve quality of life and identified with regional boundaries of the Fraser coast, including the participating city boundaries. The vision statement was very suitable for a Healthy Cities approach to planning, as it has a broad-based definition of health and encompasses a wider regional context than that of the participatory planning.

8.3.2 Step 2: Managing the Project

The first step in managing the project was to engage project consultants and form an Executive Management Structure (EMS) comprising the Mayors from each City Council and the Regional Director of the CPHUN. A PMT was then established which reported to the EMS. The PMT defined and allocated project tasks and defined a project timeframe. Figure 25 (see Davey, Hauser &, Murray 1999) demonstrates the management flowchart that managed the development of the PHP project.

Figure 25: Wide Bay Regional Public Health Planning Management Model
The Public Health Planning Management Model had two layers of reporting, the regional PMT and the local City Council’s project teams. The PMT reported to the EMS. The PMT consisted of seven representatives across the Wide Bay Region and included three staff from the CPHUN-Wide Bay, two staff from HBCC, two staff from MCC and two academics from Griffith University. The Council Project Teams managed the local project in each City and included elected representatives, senior managers, environmental health officers, community development officers and administration officers. The project was coordinated regionally by the Health Promotion Specialist from the CPHUN-Wide Bay and facilitated by the Project Director and Project Officer from Griffith University.

**Guiding Principles**

The guiding principles of the PHP were identified and adapted by the PMT to include:

- Intersectoral collaboration
- Community participation
- Intradepartmental involvement
- Partnerships, and
- Working together to achieve the Shared Vision.

**Terms of Reference**

The PMT developed the following terms of reference (TOR) for the project and the City Council project teams:

**PMT:**

- To provide professional advice and local information
- To review and monitor the planning process and time frames
- To participate in collection and analysis of data
- To provide feedback to own organisation and the community
- To ensure intersectoral collaboration developing in the plan
- To act as a link between local government, key service provider and the community
- To participate in determining priority issues for the plan
- To participate in strategy development to address prioritised needs
- To oversee the writing of the plan
- To participate in the evaluation of the plan, and
- To establish a structure to ensure monitoring, review and implementation.

**City Council Project Teams:**

- To implement decisions made by the PMT
- To act as a link between the community and the PMT
- To conduct awareness-raising activities about the plan
- To analyse the data
- To gather data about health needs, and
- To co-ordinate strategy development through the theme working groups.
8.3.3 Step 3: Needs Assessment

The framework used for the needs assessment step included four stages.

*Gather Existing Information about Health Matters in the Community*

The Project Consultants published a Community Profile for each city with assistance from the PMT. The WHO recommends the health profile activity; the project consultants utilised the Health Profile framework published by the WHO (1994). The Health Profiles were collated from existing ABS and community statistics, agency and industry annual reporting, results from previous agency community consultation, and the findings from the community consultation conducted during the three awareness-raising ‘Vision Workshops’. The documents are referred to as the *Maryborough Community Health Profile 1999* and the *Hervey Bay Community Health Profile 1999*; each profile provided an update of the health of the city at that point in time, but also formed a benchmark for the quality of life of the city.

*Identify Priority Health Issues*

The PMT used the community profile to identify priority health theme areas and issues in each community. Health, environment, economic, social and cultural issues were prioritised and grouped into five key ‘theme areas’. These included employment, education and economic development; community safety; community and health services; liveable environment; and healthy lifestyles. The issues that were recorded at the series of vision workshops were collated and listed under each theme. Table 19 provides an example of the Hervey Bay themes and issues that were then used in the Focus Groups as the basis of further information collection.
### Table 19: Hervey Bay Themes and Issues

<table>
<thead>
<tr>
<th>Theme: Employment, Education and Economic Development</th>
<th>Theme: Community Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues:</strong></td>
<td><strong>Issues:</strong></td>
</tr>
<tr>
<td>Employment, Education and Economic Development</td>
<td>Alcohol and drug misuse</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Crime</td>
</tr>
<tr>
<td>Projected population and employment needs</td>
<td>Road safety</td>
</tr>
<tr>
<td>Industry diversification</td>
<td>Safe environments: home,</td>
</tr>
<tr>
<td>Education and training, levels and appropriateness</td>
<td>recreation, schools, public</td>
</tr>
<tr>
<td>Employment programs</td>
<td>spaces</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme: Community and Health Services</th>
<th>Theme: Liveable Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues:</strong></td>
<td><strong>Issues:</strong></td>
</tr>
<tr>
<td>Homecare/respite</td>
<td>Environment Management: identifying environmental values,</td>
</tr>
<tr>
<td>Mental health</td>
<td>monitoring, protection and pollution</td>
</tr>
<tr>
<td>Family support and counselling</td>
<td>Control</td>
</tr>
<tr>
<td>Arts and culture</td>
<td>Sewage treatment: effluent reuse</td>
</tr>
<tr>
<td>Drug and alcohol misuse</td>
<td>Water supply</td>
</tr>
<tr>
<td>Transport</td>
<td>Waste management: collection, disposal, reuse, reduction</td>
</tr>
<tr>
<td>Housing</td>
<td>Foreshore and coastal management</td>
</tr>
<tr>
<td></td>
<td>Open space strategy</td>
</tr>
<tr>
<td></td>
<td>Vector control</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme: Healthy Lifestyles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues:</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol, tobacco and other drug misuse</td>
<td></td>
</tr>
<tr>
<td>National and state priority issues</td>
<td></td>
</tr>
<tr>
<td>Suicide prevention</td>
<td></td>
</tr>
<tr>
<td>Sexual health</td>
<td></td>
</tr>
<tr>
<td>Food safety</td>
<td></td>
</tr>
<tr>
<td>Vector prevention</td>
<td></td>
</tr>
<tr>
<td>Personal lifestyles: reduction of risk factors</td>
<td></td>
</tr>
</tbody>
</table>

### Check Validity of Issues with the Community

The PMT was responsible for the preparation of the needs assessment, which included a series of open-ended questions around identified themes and issues (see Table 20).

#### Table 20: Community Focus Group Needs Assessment

<table>
<thead>
<tr>
<th><strong>Participants were Shown an Overhead of the Themes and Issues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 1</strong> Are there any issues facing people in this community that you feel do not fit into the identified themes and issues from the Vision Workshops?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Employment, Education and Economic Development Theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 2 (a)</strong> What do you think contributes to employment being an issue for the community?</td>
</tr>
<tr>
<td><strong>Question 2 (b)</strong> What do you think the community could do to address employment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community Safety Theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 3 (a)</strong> What safety issues do you think the community has?</td>
</tr>
<tr>
<td><strong>Question 3 (b)</strong> What do you consider to be the major injuries and accidents occurring in the community and what do you think causes them?</td>
</tr>
<tr>
<td><strong>Question 3 (c)</strong> How do you think the community could improve its safety?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community and Health Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 4</strong> What services do you think the community is lacking or what requires improving?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Liveable Environment Theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 5 (a)</strong> How does the natural and built environment impact on your life and health?</td>
</tr>
<tr>
<td><strong>Question 5 (b)</strong> How does the natural and built environment impact on your life and health?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Healthy Lifestyles Theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 6</strong> Health has been identified as including social, physical, mental and spiritual well-being: what prevents you or your community from having a healthy lifestyle?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>General Summary Questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 7</strong> Are there any other issues you would like discussed?</td>
</tr>
<tr>
<td><strong>Question 8</strong> What do you hope this Public Health Planning project will achieve for the community?</td>
</tr>
</tbody>
</table>
Focus Group meetings were organised across the cities and towns and specific health issues were targeted in each city. Tables 21 and 22 list the geographical areas and targeted health groups that participated in the needs assessment process.

Focus groups were conducted for approximately two hours, facilitated by the Project Consultants with assistance from the Project Coordinator from the CPHUN-Wide Bay. The Focus Group Program developed for both the Geographical and Target Focus Groups included:

- Introduction to the theory and practice of public health planning
- Description of the Healthy Cities and Shires: MPHP approach and PHP Project scope
- Discussion of the WHO definition of health in the context of traditional public health versus a holistic view of health and environment
- Understanding community needs assessment, and
- Comments on the nature of community participation in decision-making.

### Table 21: Geographical Focus Groups

<table>
<thead>
<tr>
<th>City</th>
<th>Location</th>
<th>Number Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryborough</td>
<td>Granville</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Tinana</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Maryborough Central</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Hockey Hall</td>
<td>17</td>
</tr>
<tr>
<td>Hervey Bay</td>
<td>Hervey Bay Central</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Toogoom</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Burrum Heads</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Howard</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>River Heads</td>
<td>22</td>
</tr>
</tbody>
</table>

### Table 22: Targeted Focus Groups

<table>
<thead>
<tr>
<th>City</th>
<th>Target Group</th>
<th>Number Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryborough</td>
<td>Young people</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Older people</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>People with a disability</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Aboriginal and Torres Strait Islander people</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>People from a non English speaking background</td>
<td>6</td>
</tr>
<tr>
<td>Hervey Bay</td>
<td>Young people</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Older people</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>People with a disability</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Aboriginal and Torres Strait Islander people</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>People from a non-English speaking background</td>
<td>6</td>
</tr>
</tbody>
</table>

The Geographical and Target Focus Group consultation process was based on a structured questionnaire on the ‘Theme Areas and Issues’ approved by the PMT from the three vision
workshops. Focus groups have a key role in this MPHP process and allow community input into the PHP through information exchange based around the ‘Theme Areas and Issues’.

The focus group questionnaire aimed to:

- extract opinions on broad health issues
- identify how current issues impact on the community
- identify priority areas for action by the agencies and community, and
- suggest solutions to address the issues.

In an open interactive environment focus group participants were asked the series of eight questions based around the five themes areas. Table 23 contains the methodology for the focus group questionnaire.

Information Collated and Media Release

Stage 4 involved the collation of the focus group results. The broad health issues were collated under each ‘theme area’. The results of the focus groups were fed back to the community for comment and ratification. The PMT prepared a media release of the conclusions of the needs assessment. This community publication enabled feedback from the agencies, community groups and residents.

8.3.4 Step 4: Determining Priorities

Community needs assessments produce a range of health issues that are too numerous to include: only priority health issues should be included in the PHP. To determine the health priorities from a large list of health issues, the project developed a prioritisation methodology: questions were proposed for each issue identified by the community profile, vision workshops, focus groups and working groups, to assist with determining priority issues (see Table 23).
Table 23: Methodology – Prioritisation of Issues

<table>
<thead>
<tr>
<th>How serious is the issue?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
</tr>
<tr>
<td>Question 2</td>
</tr>
<tr>
<td>Question 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the potential for collaboration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 4</td>
</tr>
<tr>
<td>Question 5</td>
</tr>
<tr>
<td>Question 6</td>
</tr>
<tr>
<td>Question 7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can something be done within the scope of the plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 8</td>
</tr>
<tr>
<td>Question 9</td>
</tr>
<tr>
<td>Question 10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are outcomes possible within available resources?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 11</td>
</tr>
<tr>
<td>Question 12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the cost of no action?</th>
</tr>
</thead>
</table>

The Working Groups used the identified themes and sub-issues, community comments from the Focus Groups and their professional insight to identify the priority issues. These questions were developed into a Prioritisation Matrix, which PMT and the Theme Area Working Groups used to prioritise the many health issues. These prioritised issues provide the foundation of the strategies in the PHP.

8.3.5  Step 5: Developing Strategies

Working Groups consisting of health professionals from the Councils, CPHUN-Wide Bay and other community agencies in the Wide Bay Region were formed around each theme area. The process of setting objectives, strategies, lead agencies, timeframes and performance indicators that related to the identified priority health issues was completed by the theme working parties. The theme working groups (TWG) were given the following tasks:

- set objectives related to identified priority issues
- identify possible strategies
- nominate and where possible gain commitment from lead agencies responsible for implementing strategies
- set performance indicators, and
- determine possible timeframes for implementing each strategy.

The Theme Working Groups met regularly over a one-month period to develop the comprehensive strategic direction for each prioritised health issue.
8.3.6  Step 6: Writing the Plan

The two cities each developed a unique Public Health Plan. The Theme Working Groups in collaboration with the PMT developed the action strategies for each Public Health Plan. To simplify the writing of the PHP, a strategic plan template was developed and completed by the Theme Working Groups for each sub-issue in each Theme Area. During the writing of the PHP several other tasks were completed, including:

- Members of the PMT prepared the introductory section of the PHP
- Council Project Teams edited the plan
- The PMT developed a process to formally engage the partner agencies as lead agencies for the strategies in the PHP. Letters were forwarded to some 100 agencies to gain commitment to implementation of the strategies agreed to in the plan
- The Councils forwarded draft PHP to all participating agencies and community groups for comment. The PMT requested agency commitment to participate in the planning implementation and asked agencies for any changes or alterations, and
- The PMT requested all partners to commit to a ‘Memorandum of Understanding’ to implement the strategies in the Public Health Plan

The final agreed-to Wide Bay Public Health Plans were officially launched separately in Maryborough City and Hervey Bay City. As the project was a regional approach, then perhaps cities could have come together for a regional launch of the plan. However, each Council formally recognised the document as part of the corporate planning process required by the LG Act. This gave legitimacy to a city-wide approach, with collaboration with agencies as required across the region.

8.3.7  Step 7: Monitoring, Review, Implementation and Evaluation of the Plan

The process of monitoring, review and evaluation has continued since the Public Health Plans were launched in Maryborough and Hervey Bay. A Monitoring, Review and Implementation Committee (MRIEC) was formed in January 2000. The aim of this Committee was to manage the implementation of the Public Health Plans in each City, with assistance from the CPHUN-Wide Bay. To facilitate this process the members of the PMT were reformed into the Monitoring, Review, Implementation and Evaluation Committee (MRIEC) which developed a TOR and agreed to meet every month to manage the implementation phase of the PHP Project and review the outcomes of the Public Health Plans in each city. This Group meets monthly and is chaired by the Senior Health Promotion Officer from Hervey Bay CPHUN.

In the development of the PHP there were initially five Theme Working Groups established in each city. The Theme Working Groups agreed to continue to meet every six months and feed back information to the MRIEC on the strategy implementation by agencies. This process was
reported as being too demanding on the time and resources of agency staff that were required to attend similar meetings in two cities across the one region. The TWG was restructured to the Theme Implementation Working Groups (TIWG). The MRIEC agreed to reduce the number of TIWG from ten to five across the region. The five regional Theme Working Groups now assist with the implementation of the two Public Health Plans. This structure allowed for continued networking of the intersectoral agencies while implementing the PHP within the region. This revised model reduces the need for agencies to meet separately in each Council area and allows the TIWG to take more of a Regional Approach to Implementation. Figure 26 describes the revised structure of the Monitoring, Review, Implementation and Evaluation of the Wide Bay PHP facilitated by the PMT and implemented by the TIWG.

This research has provided ongoing evaluation resources to the PMT, first to complete a preliminary evaluation, and then to develop a comprehensive process and implementation evaluation of the Wide Bay PHP. This evaluation will review the success factors for sustainable planning and make comment on how to overcome barriers to implementing the plans at a local and regional level. Each Theme Implementation Working Group has a lead agency identified to promote the activities of the Theme (adapted from see Davey, Hauser & Murray 1999).

![Image of the revised structure of the Monitoring, Review, Implementation and Evaluation Model used in Wide Bay](image-url)

Figure 26: Wide Bay Monitoring, Review, Implementation and Evaluation Model (see Davey, Hauser & Murray 1999)

Information was collected on progress of strategies in the PHP. Both the Maryborough City and Hervey Bay Public Health Plans were successfully launched in December 1999. Refer Figure 26 for the Monitoring, Review and Evaluation Implementation Model used in Wide Bay.
8.4 Preliminary Process Evaluation

The three stages in the preliminary process evaluation of the two public health planning projects, as previously mentioned, included:

- Preliminary Process Evaluation of Focus Groups
- Preliminary Process Evaluation of the PMT, and

The results and findings of each stage of the preliminary process evaluation will be presented and summarised in the findings of this chapter.

8.4.1 Preliminary Process Evaluation of Community Focus Groups

A process evaluation of two Community Focus Groups was conducted in February 1999 in Maryborough City. The Mental Health Targeted Focus Group (n=8 people) was evaluated at Maryborough City Hall in the afternoon and the Granville Geographical Focus Group (n=15 people) was evaluated at the Granville Community Hall in the evening.

The objective of the evaluation was to measure and check the activities of the project and its project quality, and assess if the PHP project was reaching the community (Hawe et al., 2004). Each group was asked a series of questions regarding the planning project reach, participant satisfaction, venue issues and planning content. Focus Group participants had an opportunity to discuss any positive and negative aspects of the PHP at the focus group and to provide suggestions for future needs assessment activities. Table 24 lists the Stage 1 process evaluation questions from community focus groups.

The process evaluation was conducted as an interactive workshop immediately after the conduct of the Focus Group. Individual responses were recorded on a white board and discussed with the participants. The responses to the questions were collated and analysed for key learnings.
Table 24: Community Focus Group Process Evaluation Questionnaire

<table>
<thead>
<tr>
<th>Planning Project Reach</th>
<th>Question 1</th>
<th>Level of understanding of the Project?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 2</td>
<td></td>
<td>Have we reached enough people/organisations?</td>
</tr>
<tr>
<td>Participant Satisfaction</td>
<td>Question 3</td>
<td>Comfortable with the focus group setting?</td>
</tr>
<tr>
<td>Question 4</td>
<td></td>
<td>Have you been listened too?</td>
</tr>
<tr>
<td>Question 5</td>
<td></td>
<td>Are participants open in discussion?</td>
</tr>
<tr>
<td>Question 6</td>
<td></td>
<td>Is the content of the workshop complex or too simple?</td>
</tr>
<tr>
<td>Question 7</td>
<td></td>
<td>Evaluation of the teaching by facilitator?</td>
</tr>
<tr>
<td>Venue Issues</td>
<td>Question 8</td>
<td>Like the venue?</td>
</tr>
<tr>
<td>Question 9</td>
<td></td>
<td>Easy access for people?</td>
</tr>
<tr>
<td>Question 10</td>
<td></td>
<td>Easy to get to?</td>
</tr>
<tr>
<td>Question 11</td>
<td></td>
<td>Timing of focus group appropriate / convenient?</td>
</tr>
<tr>
<td>Content Issues</td>
<td>Question 12</td>
<td>Are the Plan’s Themes relevant?</td>
</tr>
<tr>
<td>Question 13</td>
<td></td>
<td>Have the questions been relevant?</td>
</tr>
<tr>
<td>Question 14</td>
<td></td>
<td>Level of Interest?</td>
</tr>
<tr>
<td>Question 15</td>
<td></td>
<td>Presentation skills?</td>
</tr>
<tr>
<td>Question 16</td>
<td></td>
<td>Have you gained knowledge in participatory health planning?</td>
</tr>
</tbody>
</table>

**Community Focus Group Evaluation**

The focus group evaluation results were interpreted and key learnings include:

**Planning Project Reach**

- Participants advised the public health planning project had reached out to most agencies and residents in Maryborough and the project received a high level of interest; participants indicated the health planning was needed in their City.

**Participant Satisfaction**

- There was a reasonable spread of residents, government and non-government agencies represented both at the Mental Health Focus Group and the Granville Focus Group with a high rate of participation in the evaluation.

**Venue Issues**

- Workshop participants agreed that the workshop venue was suitable and that the Focus Group provided an opportunity to be listened to with regard to their priority health, environment issues, and community needs and services.

**Content Issues**

- Teaching and presentation skills of the facilitators, namely, the Project Coordinator and Project Consultant, were rated highly.
The focus group participants rated the workshops highly in respect of content and presentation of materials. Facilitators were scored highly for their ability to manage and communicate with participants in the workshops.

8.4.2 Preliminary Process Evaluation of the PMT

The public health planning PMT evaluation questionnaire is contained in Appendix B and the results are listed in Appendix C.

Compliance with Guiding Principles

The PMT strongly agreed that the project had set a framework for future intersectoral collaboration. Community participation had increased and partnerships were formed with many organisations. It was too soon to judge if organisations were working better towards a shared vision. However, organisations were working together on activities that added value to public health action. Prior to the project such collaboration was not evident. There were some interdepartmental ownership problems of the health issues noted, as well as problems with agencies committing time to the planning process. A senior manager commented that since the plan was developed ‘there were a large number of professionals now talking to each other, but the PMT had to ensure the PHP didn’t become a dust collector’.

Two Health practitioners from a government agency noted:

What’s been positive is the information sharing (between agencies) about what the other areas are doing, the PHP process was very well structured but some interdepartmental ownership problems that existed have been more highlighted by the PHP process.

and

This is a very positive process and purposeful exercise, it promotes the use of existing resources, reduces duplication and identifies where agencies should be focusing their human and financial resources.

A political representative noted that the attendance at working groups meetings could have been better, commenting:

People who attended the working groups who weren’t representing a particular agency or group found it difficult to be involved in the planning process; for that reason there were sometimes diminishing attendances at public consultation meetings: more community consultation is required in the future.

A health practitioner from HBCC commented:

This process has brought people together, particularly medical practitioners and others, and I believe the process has been worthwhile, community participation was offered but it is difficult to get large numbers to come along (to Focus groups).
Compliance with TOR

The PMT scored a rating of 7 to 8 on the majority of questions. This indicated the PMT members ‘agreed’ to ‘strongly agreed’ that the PMT provided professional advice, time frames were well managed, there was participation in data collection, feedback between organisations was high, there was a high level of collaboration, and links with Local Government and key service providers were strengthened. Strategy development was proceeding well and the prioritisation of issues was a beneficial process. The plan writing was reported achievable at that stage. PMT strongly agreed the Planning Process facilitation was well managed and scored the skills of the facilitators and Project Coordinator as nine to ten. PMT agreed that public meetings were highly successful; however, there was a need for more opportunities for engaging a greater number of community participants.

A political representative and a senior manager from HBCC agreed that the PMT attempted to meet the TOR of the Project and to involve all groups in the community planning process. A senior manager commented that the PMT functioned well, saying ‘Communication and discussion between members of the PMT have been open and co-operative and enabled the project to proceed satisfactorily and successfully’.

Health Planning Issues

The following are the responses to the PMT evaluation questions: a summary of key learnings from this section of the PMT evaluation:

- Attendance at public consultation meetings could be improved
- People participated freely
- Diversity of organisations represented, Indigenous groups not fully represented
- Project attempted to reach most groups
- Prompt and well written minutes produced
- Facilitators allowed opinions to be voiced
- Open communication and PMT cooperative
- Reaching service providers mainly
- Process brought people together
- Process timely and well organised
- Some departmental ownership problems
- Time commitment to process difficult
- Association with Griffith University added credibility to the process
- Positive and purposeful exercise, and
- Identifies what issues agencies should be focusing on.

The results indicate that there was general to strong agreement that the guiding principles and TOR of the project were being met. A political representative from Maryborough commented that the project wasn’t reaching all groups, with communication between allied groups being an issue: ‘Some groups are diverse and communication with the organisation is poor for that reason’.
A HBCC senior manager who is a member of the PMT advised: *The PHP is reaching the service providers mainly, there are not too many community members on the focus groups that I have been involved with, but the community has been consulted very well.*

The PMT minutes reported that the Seven Step PHP Model was beneficial to the process, health issues and strategies were well documented, and people could relate to the process as the process was user friendly. Not all groups wanted to be involved.

The project co-coordinator (Rhonda Noyes) from Maryborough noted: *There are groups who are not fully represented on the Working Parties, for example Indigenous and some consumer groups; this however has been a matter of choice for groups; I believe the PMT attempted to target all groups in the community relevant to the PHP.*

A health practitioner expressed concern when interviewed about the broad reach of the PHP: *Attempts are made to consider everyone’s point of view and needs but the scope of the plan and the limited resources will limit the plans outcomes*. A negative comment from a senior manager in response to a question on agencies being satisfied with the PHP process included, *‘Work had to be done to turn around some of the agencies on the Working Groups WHO saw the PHP as duplication of existing plans.*

### 8.4.3 Preliminary Process Evaluation of the Theme Working Groups

The Agencies Working Groups met four times over a period of one month to develop the priority strategies that laid the foundation for the Public Health Plan. As a sample, two of the Theme Working Groups were evaluated at their last meeting. The aim of the evaluation was to measure the activities of the program, program quality and who the program was reaching? Appendix D describes the survey questions. The Community Safety Working Group in Maryborough City (n=15) was evaluated along with the Regional Healthy Lifestyles Working Group (n=6), which had representatives from both Maryborough and Hervey Bay. The evaluation comprised three sections with eleven questions in total, was conducted in March 1999. Participants were asked if they strongly disagree, agree or strongly agree with the question along a rating scale of 1 to 10. Additional comments were also requested about the guiding principles and the process of Public Health Planning in the Region. Participants were asked to list four negative comments (if any) and four positive comments (if any). Appendix E and F highlight the responses.

*Compliance with Guiding Principles*

Both Theme Working Groups ‘agreed’ to ‘strongly agreed’ that the project had achieved intersectoral collaboration, community participation, and partnerships with many organisations.
It was too soon to judge if organisations are working better towards a shared vision; agencies in general stated more time was required to implement the plan and assess the outcomes. A member of the Healthy Lifestyle Working Group asked: *Will the PHP process combine community resources, provide awareness of participating organisations within the community and prevent duplication of necessary actions in the community?*

A health practitioner from HBCC commented strongly about community participation in the PHP process: *This project has been very well run. An honest attempt to consult the community on all levels has been completed. It is only limited by the reluctance of individuals to take part from the community. Young people were consulted and they felt they had their say.*

Medical practitioners from non-government agencies commented about expectations: *The amount of time given by Working Group members has now created an air of expectation; it will be up to both Councils to deliver on [and] the project brought the agencies together, but the process has created red tape and paperwork and no funds actually available for the program. How much will actually be achieved in real terms?*

An agency representative commented about the project reach: *A number of departments and government agencies were initially left out of the process but involved at a later stage of the PHP project for example, the Department of Local Government and Natural Resources, and a representative from Wide Bay 2020. The process allowed an officer like me to build a communication network, which will ultimately assist with efficient and effective planning and negotiation in the future.*

*Compliance Working Groups*

Both groups agreed that the Theme Working Groups provided feedback to the organisations they represented. They had ensured intersectoral collaboration in developing themes; that the process linked key service providers and the community; and the TWG had participated in prioritizing the issues. Some issues included:

- Some members were too focused on their own agendas
- Other members had difficulty keeping up with the process initially
- More awareness raising required
- Committed participants
- Minutes were timely, and
- The process gave an opportunity to express beliefs and ideas.
Health Planning Issues

Both groups scored questions in this section between ‘agree’ to ‘strongly agree’. The Planning Process was reaching target groups, some participants were not sure if the reach of the project was to all groups in the community. Participants strongly agreed that the facilitators were adding value to the process. The Community Meetings were rated highly both in Maryborough and Hervey Bay. Meeting venues rated as satisfactory. Most groups rated the participation process as eight to ten (8–10), strongly agreeing that there was an opportunity to participate in the process.

A summary of key leanings from the WG evaluation included:

- Some participants have their own agendas
- Agencies see the process as worthwhile
- Problems reconciling medical and CPHP models
- The process should start with outcomes, objectives are only one small part of planning
- Too early to assess plan outcomes, it needs time to implement
- Community members should evaluate the project
- Agencies were focused on the task but community groups had difficulty keeping up with the strategic planning process, and
- Meeting documentation was excellent and timely.

The PMT in Wide Bay delegated authority and planned jointly with the community to develop the health issues in the community; the intersectoral agencies developed the strategies in the plan. An agency partner on the WG made some significant comments about the planning process and implementation: Many of the issues discussed were already being dealt with under other plans and schemes. The WG need to focus on the gaps in between what is currently being done at all levels of government and in the community and industry groups; what needs to be done to ensure these plans are delivered, that they are effective and timely.

Councils have participated in writing grant applications to obtain funding for a Public Health Planning Liaison Officer who would primarily visit all agencies connected with the plan and engage in promotion of health activities and other health gains. The PHP in each city feed strategies directly to the corporate plans of Council, and this allows for a mechanism of reporting upwards to the Council Corporate and Operational Planning Processes and across to the business plans of participating agencies. The corporate planning processes are required by
the LG Act in Queensland and provide the budget cycles for funding strategies within communities.

The agencies that collaborated on PHP were formally asked in December 1999 to sign MOUs and agree to work together on implementation of the strategies. Of the 80 agencies that contributed to the PHP process, 35 signed MOUs and seven more signed letters of support. The remaining agencies contribute informally to the PHP, due to barriers in the local agency bureaucratic processes to signing any agreement with Councils. More work is needed here to build and maintain health and environment networks and partnerships in Wide Bay. Senior management turnover in agencies in Wide Bay is being investigated as one barrier to the planning process. Agencies questioned the future sustainability of the PHP and indicated that without resources the new strategies in the PHP will not be implemented.

The linkage between the PHP and the strategic business plans of the agencies that impact on the health of communities needs further understanding. There is a need to integrate the common strategies in the many layers of planning that occur in communities. The process of implementation was satisfactory in the first two years of the PHP, with many public health strategies being implemented as a direct result of the PHP project. The key informants advise that successful strategies were noted in the PHP update meeting minutes. An update from a PMT meeting (dated April 2000) described the themes in the Public Health Plan in Hervey Bay and mapped the strategies achieved as ongoing rather than commenced (see Table 25).

<table>
<thead>
<tr>
<th>Themes and No. of Strategies</th>
<th>% Achieved</th>
<th>% Ongoing</th>
<th>% Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Lifestyle (30)</td>
<td>37 (11)</td>
<td>37 (11)</td>
<td>26 (8)</td>
</tr>
<tr>
<td>Community Safety (25)</td>
<td>8 (2)</td>
<td>76 (19)</td>
<td>16 (4)</td>
</tr>
<tr>
<td>Community and Health Services (53)</td>
<td>8 (4)</td>
<td>68 (36)</td>
<td>24 (13)</td>
</tr>
<tr>
<td>Liveable Environment (45)</td>
<td>9 (4)</td>
<td>44 (20)</td>
<td>47 (21)</td>
</tr>
<tr>
<td>Employment, Education and Economic Development (26)</td>
<td>23 (6)</td>
<td>54 (14)</td>
<td>23 (6)</td>
</tr>
<tr>
<td><strong>TOTAL (179)</strong></td>
<td><strong>15 (27)</strong></td>
<td><strong>56 (100)</strong></td>
<td><strong>29 (52)</strong></td>
</tr>
</tbody>
</table>
As documented in the Facilitators Report, 28 November, 2000 for the Theme: Health and Community Services, the Project Officer from Maryborough advised that after a period of two years of PHP implementation the following strategies had received funding as a direct result of the PHP project process:

- Funding was received for Sexual Assault Service
- Funding was received for Fraser Coast Reconnect Youth Homelessness Project to employ a social worker and youth outreach worker
- Maryborough and Harvey Bay Disability Networks trialling merger to facilitate cooperation and information sharing between services in the district
- Pathways of Care – Youth Service Resource Directory
- Rumble in the Jungle Program — being held in Fraser Coast, and
- Continuing interest from Maryborough/District service/groups with interest in youth to work together on project.

A higher percentage of strategies were delivered from the regional theme working groups such as employment, education and economic development and healthy lifestyles; the liveable environment theme had the least success in achieving any progress on strategies outcomes in the plan. Due to the broad nature of several health issues like transport, youth services and disability services, several Working Groups were working on similar issues. One senior manager commented, ‘In hindsight it would have been opportunistic to bring the Working Groups together more regularly to discuss these common issues’. This issue of agency communication networks if not addressed can be a barrier to planning progress.

8.5 Plan Implementation Review Findings

The project established an Implementation Working Group over 2000 to 2002 that met every month to activate the many strategies in partnership with the agencies involved. A joint Project Officer was appointed part-time (from October 2001 to July 2002) to assist with plan implementation. PHP outcomes were monitored in both Cities over the two-year period: in 2002 at the end of the three-year planning cycle Hervey Bay City and Maryborough City reviewed the PHP. In a report dated March 2002 compiled by the joint City Project Officer for Hervey Bay and Maryborough Public Health Plans came the following recommendation:

In line with recent stakeholder comments and feedback and current best practice for planning frameworks and to ease the burden of the vast majority of stakeholders who work across the region and past the boundaries of each city, if the plans are to reflect the development of collaborative and progressive partnerships, then the adoption of one planning document for both communities is essential.
The project co-coordinator in 2002 reported in the Maryborough and Hervey Bay Public Health Plans final report that one of the major barriers faced by the Monitoring, Evaluation, Review and Implementation Team (MERIT) was the lack of resources, but commented that the process of PHP planning was extremely beneficial to the Region:

Participants have been challenged to step out of their ordinary way of doing business and communicate in a different way, stakeholders have been able to communicate across the sectors and the depth of knowledge of many service providers and government representatives has been enhanced, the PHP fulfils the new ‘whole of government’ approach with a renewed emphasis on collaborative partnerships.

The report also made negative comments about the lack of investment on the PHP:

Without human and financial resources to keep the Plans alive many strategies only progressed because they were core business of stakeholders. The plans failed to evolve in the organic way intended due to this lack of resources.

At a meeting convened in Hervey Bay in March 2002 (attended by the researcher), the report findings received mixed support from the CPHUN project funders and key stakeholders, causing agencies to review their participation in the implementation of the PHP. It was recommended that a Fraser Coast Regional Public Health Plan be developed in the future to replace the joint PHP currently in operation, but planning governance, accountability issues, and future investment in PHP would be an unknown factor if a regional plan was constructed.

The funding of the joint project officer position finished in late March 2002. Councils and the CPHUN continued to implement strategies in the individual plans at a local level. The Regional Working Groups did not meet again. HBCC at the meeting indicated that, due to changing political environments with the appointment of a new Mayor, with organisation restructuring and appointment of senior management and other health practitioners and with the loss of funding for the Project Officer position, the priorities at the Council in regard to the PHP had changed. The PHP strategies were to be integrated into a new Social Plan proposed by HBCC and existing strategies integrated into this new approach with some matters could impact on the new State Government requirements of the Town Planning Scheme of Council in the future.

8.6 Learnings from Case Study

Interpretations and meanings from this case study are summarised in the tables below. This process evaluation discovered a series of findings from the PHP case study. Tables 26 list the process evaluation findings and learnings.
<table>
<thead>
<tr>
<th>Table 26: Wide Bay Regional PHP – Learnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MPHP process was developed at an appropriate time in this region enabling communities to participate in the health agenda.</td>
</tr>
<tr>
<td>The MPHP project was seen by partners as being well organised.</td>
</tr>
<tr>
<td>The PHP development stage of the planning process reached its target groups through successful community focus groups.</td>
</tr>
<tr>
<td>The Project Management Team (PMT) were satisfied with the program:</td>
</tr>
<tr>
<td>• Partner agencies were required to formally sign-off on strategy implementation and agencies reported on progress on core activities. Reporting of progress was considered an essential mechanism for change</td>
</tr>
<tr>
<td>• The PMT was renamed as the Monitoring, Review and Implementation Evaluation Committee (MRIEC) to implement the PHP. A large majority of the health strategies and core activities of the program were reported as being implemented in the first year of the plan, and</td>
</tr>
<tr>
<td>The PMT strongly agreed that the project had set a framework for future intersectoral collaboration. Community participation had increased and partnerships formed with many organisations.</td>
</tr>
<tr>
<td>There were interdepartmental ownership problems of the health issues agencies would not committing adequate time to the planning process.</td>
</tr>
<tr>
<td>Attendance at public consultation meetings could be improved</td>
</tr>
<tr>
<td>Even though there was diversity of organisations represented in the PHP, the Indigenous groups were not fully represented, this was a barrier to improving health conditions for this disadvantaged group.</td>
</tr>
<tr>
<td>Agencies were focused on the process and tasks, however community group representatives had difficulty keeping up with the strategic planning process methodologies.</td>
</tr>
</tbody>
</table>

### 8.7 Conclusion

The case study examined the development process of MPHP. The process and implementation of MPHP requires further research if this participatory planning model is to be effective and sustainable. This chapter documented the second preliminary case study in this thesis, examining the development of the Wide Bay Regional Public Health Plan where two local governments worked in partnership with other agencies and citizens. The descriptive and evaluative case study approach provides an insight into the theory and practice issues for local government when establishing a MPHP. The case study was initiated in a region with two competing cities, one with an increasing commercial centre and expanding tourism and the other with expanding rural and light industry. In each city urban sprawl from housing developments is placing demands on local and state government and NGO services and impacting on the quality of life of residents. This chapter has examined a ‘Regional’ MPHP Approach developed by a two local governments, with a combined population of 120,000 residents, namely Maryborough and Hervey Bay cities. The project has been described using a comprehensive case study.

The findings discovered in this case study will assist in the design of a more comprehensive IQ which is tested in the following chapter, Chapter 9. Chapter 9 will examine the implementation phase of MPHP projects in more detail.
CHAPTER 9 PROCESS AND IMPACT EVALUATION: TWO MUNICIPAL PUBLIC HEALTH PLANNING PROJECTS in QUEENSLAND

9.1 Introduction

This chapter presents the results and findings of 19 in-depth focused interviews conducted with Key Informants (KI) associated with the GCCHP project and the Wide Bay ‘Regional’ Public Health Planning (PHP) project. The chapter has two sections: Section 1 documents the results and findings of the evaluation of the CHP, while Section 2 documents the results and findings of the evaluation of the PHP.

The Implementation Questionnaire (IQ) developed for Phase 2 of the data collection to evaluate MPHP implementation was described in Chapter 6. The Questionnaires relevant to each project are contained in Appendix G and H. Table 27 describes the level of qualifications and experience of the KIs interviewed from both projects. The KI were well qualified, with the majority having university qualifications and half the group specialising in business studies. While 75% of the KI had experience in partnership building, strategic planning and community consultation, prior to the MPHP project only 20% had had experience in participatory health planning.

Table 27: Phase 2 Key Informants' Qualifications and Experience

<table>
<thead>
<tr>
<th>Qualifications and Experience</th>
<th>% Key Informants CHP and PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>18.75</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>50</td>
</tr>
<tr>
<td>Diploma</td>
<td>25</td>
</tr>
<tr>
<td>No formal qualifications</td>
<td>6.25</td>
</tr>
<tr>
<td>Business Studies</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56.25</td>
</tr>
<tr>
<td>No</td>
<td>31.25</td>
</tr>
<tr>
<td>Partnership Studies</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43.75</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
</tr>
<tr>
<td>No answer</td>
<td>31.25</td>
</tr>
<tr>
<td>Experience in Strategic Planning</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>75</td>
</tr>
<tr>
<td>No</td>
<td>18.75</td>
</tr>
<tr>
<td>No answer</td>
<td>6.25</td>
</tr>
<tr>
<td>Experience in Community Consultation</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81.25</td>
</tr>
<tr>
<td>No</td>
<td>12.5</td>
</tr>
<tr>
<td>No answer</td>
<td>6.25</td>
</tr>
<tr>
<td>Experience in Participatory Health Planning</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>60</td>
</tr>
<tr>
<td>No answer</td>
<td>20</td>
</tr>
</tbody>
</table>
Section 1 Evaluation of the Gold Coast Community Health Plan

9.2 Background

An IQ was developed for this phase of the data collection for this MPHP Project and is contained in Appendix G. A selection of key informant responses to specific indicator questions on whether the aims and main elements of the MPHP project were met and on the implementation impacts of the Gold Coast Community Health Plan (CHP) are presented in this chapter. Face-to-face focused in-depth KI interviews were held with a selection of politicians, managers, health practitioners and agency partners in the Gold Coast City project. KI signed an individual consent form and obtained organisational agreement to their involvement in the research. Each interview conducted by the researcher was completed within two hours, taped and then transcribed.

The IQ contained specific questions asked of the KI; their responses have been collated as the results and findings in this section of the chapter. The responses to these specific evaluation questions are examined to provide achievements and barriers for MPHP. The theme analysis was carried out on the results and findings and is discussed in Chapter 11.

9.3 Aims, Main Elements and Specific Questions from the CHP Project

This project had five aims, listed in Table 28, which are broken down into a number of elements and examined via a number of specific questions. The project executive, advisory committees and PMT developed the project aims jointly from their understanding of the goals of the HCM. The Healthy Cities and Shires Project that supported Queensland Health’s encouragement awards (see Chapter 7) also supported the aims. The five project aims were each assigned a process indicator number: PI 1 to PI 5, as listed in Table 28. For data organisation purposes in the IQ, each aim, main element and specific question was numbered. Appendix K contains a detailed list of the KIs interviewed, their category and allocated KI code.

Responses to questions were recorded and discussed below, with the comments considered to be relevant to the study recorded as quotations. A KI category has been assigned and noted adjacent to each quotation: Politician (P), Manager (M), Health Practitioner (HP) or Agency Partner (AP).
9.3.1 Intersectoral Collaboration

Levels of Collaboration

Q. Has the MPHP process invoked greater levels of collaboration between the government and non-government sectors and community groups?

Council lead agency collaboration is a positive approach to improving health promotion action and city governance. KIs interviewed across the four categories of politicians, managers, practitioners and agency partners agreed strongly that the MPHP process invoked greater levels of collaboration between all agencies. An elected representative commented that there was a high level of intersectoral collaboration between levels of government. A senior manager highlighted that intersectoral collaboration had been achieved, and other managers and practitioners indicated that it was a major factor in the success of the project.

A health practitioner stated:

HP1: Definitely, we had significant collaboration with the aged care in home disability, particularly with access to info and health services, and in environmental health and catchment management.

An agency partner noted:

AP2: Intersectoral collaboration [has] certainly started. A lot of organisations just talked to one another for the first time and it was more a consensual approach to enhancing community health in general. Community health in particular has been a big player in that and are now quite willing to work with other sectors. You never saw them before. The community health group worked exceptionally well.

Q. Has this collaboration been positive for your organisation?

KIs gave mixed responses to this question. Senior managers felt that the collaboration was very positive, project managers highlighted that the collaboration enabled the GCCC to be recognised as a lead agency, while health practitioners felt it was too early to assess the results of collaboration. Agency partners found collaboration to be very positive:
AP2: Certainly, yes. It raised a lot of awareness of housing issues, which a lot of people in the other sectors never saw housing as a social issue.

Q. Has there been increased activity in health promotion as a result of the MPHP process?

Responses to this question varied. The chair of the CHP initiative stated:

P1: Yes. In association with other groups there has been [an] increase [in] health promotion projects. With Queensland Health and with the people who deal with aged care in the community, they’ve certainly been more motivated through the planning project. Yes, it worked well.

Senior managers agreed that health promotion activity was on the increase, but other managers and a practitioner reported increases in health promotion activity. The project manager reported that the MPHP raised the community’s expectation that health services would be improved.

Shared Objectives and Group Purpose

Q. Did the MPHP process have an agreed set of terms of reference?

The project manager of the GCCHP advised that the project had an original ‘terms of reference’ (TOR) document. Other KI were aware of the project’s aims and TOR. A health practitioner mentioned that the TOR guided the aims of the project, and there was clear understanding of what was expected of the committee. The chair of the health planning committee stated:

P1: Well we certainly knew what our goals were and what we wanted to achieve. We may not have achieved all of them but we had to have a start.

Q. Did the working partners agree to the Aims of the planning process?

KI highlighted that the CHP Committee members agreed to a set of aims for the health-planning project.

The chair of the Health Committee stated: We knew what our aims were and from some one hundred issues discussed at the community focus groups some fifteen priority issues and sub-issues were selected as the foundation of the planning.

The agency partners all agreed that project aims were suitable for the MPHP project. The participative approach to developing the project TOR and aims is critical to group purpose.

Composition

Q. How did the project identify who should be involved? Describe your involvement in the MPHP?

Politicians, managers, practitioners and agency partners (referred to as ‘all categories’) were involved with the health planning projects as part of their organisational role and responsibility
within their representative organisation. The Health Committee chair at GCCC chaired the Healthy Cities Advisory Committee, which administered the MPHP at the local government level. During the interviews a politician commented:

P1: I’m the chairman of the CHP Committee. Because I am the chair of the Health Committee it falls under my role to [identify who should be involved].

A senior manager viewed the CHP plan as a microcosm of city governance and for that reason Council could legitimately engage in health.

M2: You define health according to local community characteristics; for example, climate and culture and you allocate resources based on needs. The CHP helps this process.

Another manager commented that to help achieve the objectives in the Council’s corporate plan there is a need to provide direction through the CHP; allocating roles and responsibilities to staff, and responding to community needs. The project partners in the CHP, formed themselves into individual working groups and sub-groups of the committee around priority issues. The Council invited representatives from all community sectors to join the project. An agency partner advised that their agency was invited because the Council identified their core function as a priority for the Gold Coast region. The agency partner stated:

AP1: There was an invitation to our community health service. Out of the original Council survey particular areas were identified and that’s why they invited the family group in, because supporting families was one area identified as a need.

Q. Was there a balance between Council representation and other bodies on the Steering Committees?

KIs noted that there was a mix of government, non-government and Council staff on the committee, with the community sector having the strongest numbers. This also included Council EHOs, engineers and town planners working together. The agency partners replied that the balance was right however there was a need for more political input from councillors across the city, not just the health committee chair:

AP2: Oh yes. The balance was right. We actually sometimes would have liked to see more elected representatives. We only had one, Jane Grew, who chaired it. And I often think it would have been good to have one or two of the other elected reps as guests to the regular meetings.

A practitioner noted that the balance of the Gold Coast CHP Steering Committee changed over time. Organisations provided staff to engage with the CHP project as part of the individual’s job role recognising organisational responsibility for health outcomes.

Q. Did the members of the Project have the skills, attributes and attitudes necessary for joint work?

The chair of the CHP Steering Committee argued: You can’t put pressure on agencies to collaborate... I believe that when you rely on people’s generosity to be part of that committee
it’s difficult to then say ‘now we’ll teach you how to do this’. There was recognition of a need to build all agency staff capacity to engage with MPHP. The chair of the Health Committee advised that partners had the basic skills, attributes and attitudes necessary for joint work, but on-going partnership training was required.

A manager supported this approach saying that stakeholders had moderate skills for joint work and there was no real training provided accept for the initial seminars on the process of MPHP, only the skills that the people had brought through experience and personal qualities to get things going (on the Steering Committee). A senior manager at the Gold Coast felt that there were skills for joint work with stakeholders including youth, the aged, and sport and recreation departments. A project manager at the Gold Coast stated that there was a broad range of skills on the committees and this added value to the partnership for planning: *We set out to have some firm committee rules that all opinions would be valued. We tried to change peoples’ attitudes to language, for example, no use of acronyms.*

An agency partner commented that there were positive attitudes toward joint work already in place because some members of the network were already loosely connected to Council planning initiatives; the family services network was loosely established and had the skills to be able to discuss their work in relation to the local government planning areas. An agency partner stated that on-going training in methods of agency and community partnership building was extremely important if the CHP was to be effectively implemented:

AP2: *In partnership building, no, some of them found it quite challenging. Other agencies were committed to it fully but it wasn’t happening and the Council wanted to help facilitate that. We needed more philosophical work: why you do partnerships, why partnerships produce better outcomes, some of the more holistic issues.*

**Q. Has a lead person from each organisation been identified to work with the alliance?**

KIs from all categories stated that a lead person was appointed from each partner organisations and that this representative played a key role as convenor of a particular theme or issue in the CHP. This was seen as a positive process, with the convenor not only communicating with their organisation, but also feeding back information to the Committees.

*Adequate Resource for Achieving Objectives*

**Q. Did the Project have an adequate budget to achieve its objectives?**

The chair of the CHO Steering Group stated that there was insufficient funding. Several other managers, practitioners and agency partners agreed that the project was seriously under-resourced; with the project manager stating that the project funding was satisfactory to achieve its aims, but there was a lack of resources to implement the plan.
Q. Has the project received additional sources of funding?

Council staff reported that Queensland Health had provided initial seeding funding and that agencies had contributed time and resources on specific strategies in the CHP. Additional funding of up to $100,000 had filtered into the CHP project since the initial $5000 received as an Encouragement Award from Queensland Health. The project manager stated:

HP1: On several occasions we got funding for implementation from the corporate sector, less than $100 000.

All agreed that additional sources of funding would be necessary to make the CHP project successful during implementation. The agency partners stated that the CHP document would assist with funding opportunities for future priority issues identified in the plan.

Q. Has the project identified a coordinator with appropriate skills to oversee the project?

Council and agency staff felt that the CHP project manager had the skills to oversee the project. All agreed that the skills of the project manager to facilitate joint work between agencies, communities and councils were a key factor in the success of the MPHP.

Q. Do participants contribute adequate time to the project?

The project manager stated that agency partners and council staff contributed adequate time, however one Council manager stated more internal integration of the CHP strategies within Council was required, stating: if the project manager was supported by another fulltime practitioner position, it would be a much more effective implementation process. If the CHP was more integrated with the Social Services Department of Council [then the other social planners carry 50% of the workload], the reach of the project would be much better.

Interdepartmental Involvement

Q. Has the MPHP increased collaboration between Council departments?

In general Council staff responded positively that collaboration between Council departments had increased since the CHP’s initiation. A Council manager advised that a significant project, the Transcord Adaptable Housing initiative, would not have been possible without the CHP. The project manager stated:

HP1: The CHP is a corporate issue not a directorate issue now. We have had interdepartmental collaboration in planning, environment and the transport department due to the CHP.

Agency partners noted that interdepartmental involvement within the Gold Coast council was beneficial and that from the CHP’s commencement other Council departments, including the
research department and several other sections of the Council, increased their involvement, including facilitation of the respite needs of families, which hadn’t occurred prior to the CHP being implemented. The CHP allowed council to take a broader view of health service delivery and respond to community needs, for that reason health council departments worked together breaking down interdepartmental barriers.

Q. Has the MPHP increased your knowledge of the roles of other departments in public and environmental health service delivery?

In general other council departments became more aware of the role of the environmental health branch in Gold Coast City Council. Two Council managers felt the CHP increased other agencies and department’s knowledge of the health agenda, with one stating the CHP was able to allocate resources to the priority area of need:

M5: Yes. I think some of the agencies waste resources and others are under-resourced and [there would probably be] a better outcome for the community if the resources were re-channelled via the strategies in the CHP.

The agency partners commented that agencies external to the Council gained a better understanding of how the Council operates because of the partnership activities of the CHP, with one agency stating:

AP1: We feel there is much more of a partnership between the community sector and the Council; it is much stronger. We’ve got much more confidence in approaching them and we know who to go to.

Q. Has the organisation of work practices been modified to accommodate MPHP strategies?

Senior managers at the GCCC stated that the environmental health branch’s work practices are changing and are now more closely related to the CHP strategies, and that a multi-disciplinary approach is now in place. One manager commented that work practices have changed as a result of the CHP with the environmental health branch now working with more non-traditional broader health roles and responsibilities.

Respondents all agreed that the CHP collects broad health information for improved decision-making within council. Some issues fall outside the ambit of the environmental health branch, however the CHP enables the branch to not only broaden its roles but to clarify its position on new and emerging community issues.
Partnerships (joint working, resource sharing, communication, teamwork, support)

Q. Describe the partnerships that have been formed during the MPHP process?

Council managers noted an increase in more formal partnerships with external agencies associated with the CHP. Agency partners agreed that better partnerships have been built with council and other agencies. As an example of this new collaboration one agency stated:

AP2: [There are] certainly more organisations to discuss housing issues with than before. You’ll increase the number of community health practitioners involved in housing. So a lot of across the sectors and across demographic boundaries could be dealt with. Coast Connect certainly took on board looking more closely at transport issues and other support services with other agencies from our legitimate involvement with the CHP in the Housing Network.

Q. Have all partners contributed to MPHP strategies?

Agency contribution to the strategies in the Gold Coast CHP has varied. The project manager advised that some agencies would only identify issues and advocate on behalf of their organisation, while other organisations would increase activity to sponsor more development based on their needs and capabilities. The project manager reported that agency contribution depended on the issue and particularly the personalities involved. It was important for organisations to select the most appropriate persons to work on collaborative health planning projects, people was a propensity for joint work would be more successful with the implementation of the CHP.

Q. Have the partners been prepared to compromise in order to resolve conflicts in priority issues?

A manager, a project manager and an agency partner all noted that there was little argument during information sharing activities of the CHP process priority issues. It was only when there was competition for resources between the agencies that conflict arose. A manager from the Council stated agency expectations had been raised that Council would increase health funding during the planning, when in fact the CHP was designed to engage agencies to take more responsibilities for broader health issues that was part of their agency portfolio. There was much discussion about the ownership of the CHP, whether it was a council or community plan. All agreed it was a community plan with shared agency responsibilities but facilitated by council. Conflict did arise when agencies sought to develop grant proposal funding for issues identified in the CHP outside of the established partnerships Advisory Committee structure.

Q. Have the strategies been agreed by each partner organisation?

The Gold Coast CHP had eighteen agency partners sign off to work in partnership on the CHP.
Q. Have working partners agreed to their responsibilities within the action plan?

In response to this question the project manager answered affirmatively, advising that the list of project partners and their contributions have been reported on a quarterly schedule through the coordinator, and that agency partners’ responsibilities were listed in the CHP.

Q. Does the Project review the process and achievements of MPHP and amend them as required?

The project manager advised that the progress of CHP’s strategies is monitored three monthly with the plan being reviewed after three years of operation.

Q. Does the MPHP project continually attract new members and keep its membership under review?

The project manager answered that there was no official review of CHP membership. Organisations and individuals could join and leave the Steering Committee as required. An agency partner stated that there was consistency in the membership of committees:

AP1: I’d say there’s been a fair bit of consistency with the key people like those that represent the different working parties but that doesn’t mean to say that within that sector there hasn’t been some new folk coming in because people’s roles change. But I think there has been enough consistency to keep things going. This turnover has not impacted on the sustainability of the process.

Q. Does MPHP act as a catalyst in generating new projects?

KIs agreed that the CHP acted as a catalyst in generating new health projects at the Gold Coast. The project manager reported that the CHP has been a success in imitating project work: ‘It’s a springboard and has made a big impact.’ A practitioner advised that the CHP was a catalyst for health projects.

Q. How did agencies and the community groups communicate in the process?

The CHP provided communication channels between all partners and the Council. The project manager had an active style of management using emails, phones, and meetings to communicate. Respondents noted a need for increased communication activity in the beginning of the CHP to sustain it, by using the free community newspaper and by promoting good news stories. A project manager suggested that they engage a prominent media personality to assist with communication and publicity for the CHP. On the Council’s communication methods a manager at the Gold Coast stated: If you work in local government and you work with something like a CHP, you have to be very patient when communicating the messages about helath. To be
successful you need to be better resourced and have much more receptive environment to deal with.

An agency partner advised that communication was increased and the CHP benefited from political support: The working parties were relatively autonomous to get on with their work and there were strong communication links through the project manager at GCCC who attended all the working parties. The opportunities for agencies to report back to the main group was an important form of communication. The chair of the Steering Committee, being the public figure, came to the events and there have been a lot of launches and events.

An agency partner reported that communication took place through the central role of the project manager: We were starting to work toward an email system at the end of it. The CHP needs an anchor and that anchor should be vested with Council.

A project manager reported that clear lines of communication were developed through the working party convenors. This allowed them to champion the CHP and assist the project manager with the CHP’s implementation.

9.3.2 Equity in Health

Issues for Equity

Q. Discuss how equity issues have been dealt with in the plan.

The elected representative at the Council gave an example of equity issues within a rural hinterland community that participated in the CHP. She stated that every Council division has the same amount of money but ‘if you don’t know how to get it then you don’t get the equity’. She also stated:

P1: When you talk about equity, I can give an example of people [like Del Savage from a hinterland community group] who have now had positive action from the CHP; in fact, new footpaths have been installed. In dealing with the Council the Hinterland Group know where to go to get this done, and now my people are able to access these facilities or get to where they want to go more easily. So I suppose there’s some equity in that.

A senior manager advised that equity issues for example were dealt with positively in the CHP in elderly and aged care, disability and youth services. A manager indicated that he was not aware if the CHP had triggered any policy change in the equity area, but stated that the CHP would ensure that other agencies would be brought together again for more effective cooperation on equity outcomes.
Special Needs Groups

Q. Have special needs groups’ requirements been addressed?

A senior manager advised that the CHP needed more awareness raising about special needs groups earlier in the project development stages. The project manager stated: *I have examples of special needs groups and equity issues in the CHP. Firstly, learning to have tolerance of individuals engaged with the CHP. Secondly, as examples, local police were asked to consider drug use as an illness issue, not a crime issue and work with council to solve these problems...We all agreed to be tolerant of the processes and this increased my respect for what the community is trying to achieve.*

An agency partner commented that residents needed more involvement in the CH Plan:

AP2: *I certainly think the CHP tended to deal with the upper end of town. Agencies received most support, although council did provide support to a couple of resident groups. I think the CHP would have benefited from more representation from residents’ groups, and assurance from Council that resident groups have an important role in the particular sector for input in future.*

9.3.3 Community Participation

Levels of Community Participation

Q. Did the project allow for community participation?

KIs advised that the level of community participation in the CHP was satisfactory. A politician was satisfied with the level of community participation. Several senior managers from the Council responded that there was satisfactory community participation. The project officer advised Council gathered resident opinions about a range of health topics through surveys conducted at shopping centres, supported by media in the local paper together with a media presentation.

One manager stated participation strategies require resources:

M4: *Community participation was] a lot greater than ever anticipated, in future we should resource more strategies that support community participation.*

Q. Have non-government community groups participated in MPHP?

Senior management at the Council stated that all sectors contributed to the CHP. A project manager advised that non-government groups formed sub-groups on a range of health issues and linked with the lead agencies on the Steering Committee. For example, neighbourhood groups formed a sub-group to report on crime issues. An agency partner felt that the community
influenced the CHP and that it was a very good first effort from Council. She stated: *I think the CHP should continue; it’s a must. It becomes a major document that assists NGOs, particularly in lobbying for funding, because it carries the clout of Council and politicians and that will give it credence. If community groups do their own little thing it rarely gets looked at. We did learn to meet new players in the government sector and it actually helped form quite good working relationships in some cases with them. To maintain energy in the Gold Coast region is quite challenging, the initiative has to happen reasonably quickly but it also has to be seen to have good outcomes, not just another talk fest.*

**Q. What influence has the community had on MPHP?**

KIs advised there was limited community’s influence on the CHP, as the plan did focus on agency collaboration followed by intersectoral action. Some issues directly were influenced by community group needs. One senior manager stated ‘GCCC had a strong commitment to the CHP with two Councillors committing their time’. The project manager stated that the community had no influence on the plan’s conceptualisation, but that the community had an opportunity to voice concerns outside the core business of the Council and provide comments on how well they were coping in the community, for example, with disabled children. Rural residents advocated for action through the CH planning mechanisms and were successful in improving local services.

**Q. Did the local community become involved in the needs assessment?**

A project officer advised that the community became involved in the needs assessment through the CHP community survey and focus groups on the special needs of communities. Few residents were engaged on the committees, the project was designed to engage government and non-government community agencies and groups, not focusing on individual residents.

*Empowerment and Decision-Making*

**Q. Has training been provided for participants?**

The project manager at the GCCC advised that the Healthy Cities and Shires Project Officer and other staff trained GCCC staff, working party convenors and committee members through training sessions and information seminars.

**Q. Did the project provide opportunity for input from agencies?**

Respondents indicated that several opportunities were provided for input from agencies at all levels of project meetings. Committee meetings were open to all interested persons and agencies representatives to allow discussion. The project officer gave monthly feedback to
agencies on progress on the CH Plan. The project manager passed on information about grants to agency partners so that they need not always look to the Council for funding and developed joint project proposals.

**Q. Did the project have clear decision-making processes in which community representatives were involved?**

The project manager advised that the committees had a clear process for decision-making with an appointed committee chair and each decision was minuted in the record of the meeting for actioning. The community played a part in the CH Plan strategy development. Theme groups that worked on the prioritisation of health issues and strategies and were provided opportunities for decision-making about what health issues were to be included in the CHP.

### 9.3.4 Broad Socio-Ecological View of Health

**Approaches to Determinants of Health**

**Q. Please comment on the broad approach of the plan to economic, development, social and environmental issues beyond disease-based models to encompass the social determinants of health.**

All categories of the KIs interviewed made positive comments on the broad approach of the CHP and its attempt to encompass the social determinants of health into Council planning. The chair of the Steering Committee argued:

P1: *I think to some extent...we have used the social determinants of health as a base because we’ve never undertaken a process like this before and we’d never worked as closely with people like Queensland Health and all of the sub-agencies of Queensland Health. So I guess we certainly do have a better understanding of the social determinants of health.*

A manager stated:

M4: *[There has been] some improvement in community participation, but the focus groups gave real direction for the Project. CHP was beneficial to people in the community, it was a broad view of health.*

Senior managers noted the link between health determinants and the town planning scheme at the Council:

M3: *There were economic and social views in the CHP process, particularly in the important links to the IPA.*

The practitioners stated that the Council’s role in the implementation of strategies to improve the social determinants of health had not been fully clarified and needed to be in terms of Council ownership of the social determinants of health. The agency partners felt that the social determinants of health needed to be addressed by the Council and that the CHP was assisting this policy change. An agency partner stated:
AP1: *I think the CHP addressed the Council’s core business and did a lot more, particularly for some of the social issues. Sometimes the Council can be focused on roads and sewerage and not that concerned about the social determinants of health, so I think the CPHP process helped promote social health issues. The Council is becoming better informed and it’s directing its social planning and social research units. I think the CHP and the LAP [local area plan] need to be integrated for each specific geographical area. I think that if those two planning processes worked together it would allow the social determinants of health to be satisfactorily addressed.*

*Traditional Core and Non-Core Business*

**Q. Does the plan address issues outside of the Council’s traditional core business? Is this appropriate?**

All agreed that the important mechanism of the CHP process was that it allowed council to work collaboratively with other agencies on the health needs of the community whether they were traditional or not. The traditional boundaries of council have though been widened greatly by the CHP and this is a positive feature of MPHP.

*Shared Ecological Vision*

**Q. Did the MPHP process provide for the development of a shared ecological vision in your community?**

A practitioner commented that the CHP had not captured enough of the imagination to claim that the plan had developed a shared ecological vision in the community, but it could in the future. Two agency partners noted that the CHP had a common vision for a better quality of life. An agency partner was prompted and asked ‘what do you think CHP’s shared vision was?’ She stated: *To see the CHP become an action document rather than it just sitting on the shelf. I think most people were committed to it, not just identifying the problems but addressing the results as well.*

9.3.5 **Evaluation and Accountability**

*Accountability*

**Q. How accountable is the Council to the community/agencies?**

All agreed that the council had accountability through the CHP to co-ordinate the planning activities on behalf of the partner agencies. The Chair of the CHP Committee and the project partners also had responsibility to meet the aims of the project.

**Q. How accountable are the agencies/community to the Council?**

KIs indicated the agencies were not accountable to the Council, but the Council expected the agencies to come across with strategy implementation. One agency partner reported that it was
difficult for Council to ensure that some of the agencies implement what they said they would implement in the CHP [as it was a partnership approach].

Q. Did the process identify partners’ responsibilities in the PHP, for example, strategies?

All agencies and the project officer confirmed that the CHP process identified partners’ responsibilities in the plan.

Q. Has the responsibility for activities in the MPHP been accepted by each participant?

In response to the question of agency partners accepting responsibility for strategies in the MPHP, a project manager at the Gold Coast stated that participating agencies had all agreed to implement their strategies identified in the CHP.

A practitioner was asked whether agencies had updated their own business plan to meet the strategy or action? He replied:

HP2: Community groups have incorporated these strategies from the CHP into their organisational strategic plans and activities. If some of the organisations who agreed to work on the plan didn’t reflect that in their own business plan it devalues the CHP.

Monitoring of Activities and Evaluation

Q. Did the process identify how to evaluate the work?

Various process evaluations were conducted on the CHP and authorised by the Gold Coast City Council. External consultants were engaged by the Steering Committee to review the CHP process and implementation.

Q. Did the process monitor the progress of activities?

The project manager advised that after CHP activities commenced a list of strategies was developed and monitored closely. Agencies reported progress to Council. An agency partner confirmed that agencies worked closely with the Council Steering Committee to document progress. A project manager advised that the CHP was evaluated based on the progress of activities in the CHP and agencies reported back to the steering committee quarterly, verbally or by a written report. A practitioner advised:

HP2: There was evaluation by measuring activity and reporting progress every three months.

Q. Sustainability of the Process

Respondents had clear views and opinions about ways to improve the sustainability of the CHP process. An executive manager at Council said: The main barrier for the CHP are that people
lack the organisational skills to operationalise the plan the Council needs to integrate the plan with the IPA. If you don’t have resources you have no legitimisation of the process— the plan sits on the shelf and doesn’t address needs.

The executive manager commented the CHP initiative needs to connect to the corporate plan to sustain its funding: The Council needs to translate the CHP into the operational plan otherwise there are no resources. GCCC doesn’t have an effective governance framework to link the CHP with the Corporate Plan. In summary, all agreed that the CHP is logical as a strategy within council, but to deliver on the corporate community health objectives of council one needs to continue to organisational align the CHP with agency and community expectations.

9.4 Implementation Impacts on Individuals and Organisations

9.4.1 Benefits and Support for MPHP (Political, Management, Practitioner)

Q. What do you think are the benefits of MPHP?

All categories identified networking as the key benefit of MPHP. Politicians agreed that the principal benefit was networking between the three levels of governmental and the non-government agencies.

P1: I think that probably the first benefit has been the networking opportunities between local government, state government and the private sector and the community, and it was quite clear from our initial meetings that those networks didn’t currently exist.

Politicians agreed that the other key benefit was that MPHP provided a very broad perspective that made it possible to address some concerns that had not previously been addressed. Managers noted that the main benefit was getting network interaction of disparate agencies involved in the city, that is, getting them together to discuss a broad range of topics and to improve health outcomes. The main feature that engaged organisations was the MPHP process. Managers responded that the MPHP process dealt with health issues outside the traditional elements of environmental health and this required more interdepartmental connections, but they still made health a priority for the agenda. A manager commented:

M2: Clear accountable goals for community health can be an indicator of our own performance [in balancing] priorities, and is the basic business in Council.

As a comparison the CEO of GCCC advised that Whitsunday City Council had benefited from articulating outcomes from their CHP process. It boosted skills and clarified organisational management frameworks as well as the critical issues, strategies, roles and responsibilities, organisational structures, people, resource allocation, budgeting, performance management and targets. All were placed into a governance framework. He said: Without this structure CHP is a mishmash. If you can’t articulate outcomes, the process is deficient.
Practitioners commented that MPHP was also a capacity building activity and professionally rewarding for those involved. Professionally and individually MPHP allowed practitioners to work with people at a similar level across different government and non-government agencies, extending skills, knowledge and experiences.

HP2: Professionally, if it’s done correctly there is the potential there for professional growth and development for the people involved in MPHP.

A practitioner commented that with MPHP the Council could work outside traditional roles to improve health. The Council could work in a facilitation role and would be well placed to make change by sharing resources and activities, and by having quality of life issues as a high priority.

An agency partner stated:

AP2: I think the CHP process was a very good recipe, I think it’s very community based. It certainly encouraged the Council to become involved in a lot more social issues that it hadn’t previously. But I would like to see more ownership of it by the elected members.

Q. What political support is provided for the MPHP during implementation?

The project manager commented that the Steering Committee Chair had high levels of enthusiasm in the beginning and cemented the process as chair. No state and federal politicians were engaged on the committee. Two other Councillors supported the CHP process with time but not with funding. A project officer said ‘Political support is important and, as an example, one Councillor, through the CHP, took an issue about crime and increased police numbers from the state arena’. A practitioner advised that ‘the chair of the CHP steering committee was reasonably supportive of it but not to the extent that any great budget or support came with it’.

Q. Has the MPHP increased political support within your organisation?

The project manager commented that the Steering Committee chair had increased her political support for health issues because of the community health plan. Other practitioner did not notice any increase in political support within the organisation as a result of the CHP. An agency partner stated that the CHP needed more political support from local state members, commenting that both Councillors and state politicians should be briefed and involved in the planning project.

Q. Is there management support for MPHP in your Council/organisation?

Senior managers at the GCCC all agreed that the Council management fully supported the CHP.

M4: Council is best placed to be the driver of the CHP because it is a consistent and sustainable entity. The CHP breaks down the reliance of and expectations on the Council from other agencies and residents for funding on matters that are non-core business.
A health practitioner managing the CHP at the Gold Coast agreed: *Executive level supports the CHP; they appreciate the need to forward plan and see the longer term benefits of health planning.* At the departmental level operational attitudes take precedence over forward planning; the linkages are poor between the operational plan and the CHP. The reason is accountability. *Projections in the CHP are sometimes unachievable and seen as a risk by management and staff trying to produce short term outcomes, so reactive methods are easier to demonstrate outcomes and are low risk.* You can always defend your use of time and your position being reactive, being reactive is perceived as more accountable and an easy way of working. *Not that it’s the only way, being proactive is the way forward.* Supporting this position a senior manager noted that council environmental health regulatory officers were not supportive of the CHP because the plan did not address the core environmental health issues in councils operational plan.

M5: *I think the CHP would increase its level of acceptance of the grass roots EHOs [environmental health officers] if the plan was more aligned to our core work.*

Agency partners had full management support to be engaged with the MPHP in both projects.

AP2: *Yes definitely, we had management support. Philosophically, at the time I was working with the housing sector, so with the Gold Coast Housing Network in particular we used the CHP to drive our organisational plan (we didn’t have a strategic plan). Now even at Connect the Coast, which is working with social isolation in older people, the CHP influenced part of the rationale behind the development of this organisation.*

9.4.2 Health Policy on the Agenda

**Q. What policy changes have resulted in your organisation as a result of the MPHP initiative?**

Policy changes that have occurred as a result of the CHP include incorporation of the CHP into the Council Corporate Plan. The chair said:

P1: *The fact that [the CHP] it’s become part of our corporate plan is in fact a significant policy change. We didn’t have it before and that’s what has happened.*

The project manager listed the following key examples of areas where policy change had occurred because of the introduction of the CHP:

- Adaptable housing
- Affordable housing
- Sharps management
- Drugs and alcohol
- Bin locations in parks
- Catchment management
- Environment protection and community involvement, and
- Storm water strategies.
An agency partner responded to this question:

AP2: Among the agencies, yes, we have seen significant policy change. We are seeing a much better linkage between the sectors towards health. Yes, for example, housing is now seen as a major health issue or outcome.

Q. Barriers to Successful Policy Implementation

KIs reported a range of barriers experienced in the development and implementation of the MPHP project in their city. Politicians expressed that their key concerns were time and having enough resources to implement the comprehensive community health plan. There were concerns about a general lack of funding for the MPHP. KIs indicated that there was inadequate funding in terms of both money and human resources to satisfactorily implement the MPHP, but that the process was instrumental in engaging the sectors in health action, with the money well spent. An elected representative and manager stated:

P1: The cost of doing this is so far and above the miniscule amount of money the State Government gives you to do that it’s just ridiculous.

M5: I’m comfortable with the process and see this process as being strength,. I think that any process that brings people together for effective dialogue is great.

The complexity of the CHP process was seen as a barrier by some KIs:

A politician expressed a view that the MPHP process was too complex, identifying too many strategies at one time, this approach was daunting for stakeholders, she stated:

P1: I would think that the barriers are simply the complexity of the CHP and the undertaking to produce a number of results in such a broad document as that. I think if you do something you need to be able to do it within a reasonable timeframe, and you need to have an expectation that you will have results to show on a regular basis. I think if I was doing it again I would do it in a manner that you completed one or two tasks at a time and had the results of those, and then started the next set of tasks.

Managers and practitioners expressed a range of comments about lack of budgets to implement the CHP, including the following barriers:

M4: [There is a] need to build strategies for CHP into the planning processes of all the other agencies and include a budget/resources. If the CHP strategies are not in the business plans of the agencies then we are just missing the point and wasting time going to meetings.

Several managers indicated that the access to funding to resource the new initiatives in the planning documents was the greatest challenge.

HP1: Resourcing and commitment of staff time has limited the outcomes of the CHP. The CHP distracts people from EH Branch’s main duties. The way the Council does business hasn’t changed because of the plan. For example immunisation doesn’t work through the CHP, and the EH branch so far don’t work with the agencies. The CHP is seen as another duty, therefore this extra work undervalues the plan. People don’t understand where it fits in; there is
resistance to it from the EH officers. But the interesting issue is that the activities of the CHP are more than we can do, much broader than the EH branch capabilities but it is organisationally dangerous to share the CHP with other branches. So for these reasons the plan does not advance as quickly as it should.

HP2: Concerns I have are the lack of training in project management. That’s quite obvious at the time there was a lack of that. Also there seemed to be a lack of integration and coordination across the Council.

Practitioners also reported challenges with regard to where the MPH plan should sit in the Council: for example should it be placed in the environmental health branch or at a higher level in the Council, so as to engage more departments in boarder planning agendas?

HP1: The manager of the EH Branch’s main concern is why do we have EH working in spheres which are not in our core business? This is a narrow view of legislation while more senior Councillors see a broad public health view but hard to fund positions outside of legal officers in EH Branch and this is a constraint for all of the Council.

A senior manager noted that Queensland Health tried to devolve more responsibility down to local government in terms of public health: Because state government can’t cope the Council is asked to do it. It never comes with any money or any resources. This is one of the barriers; there weren’t enough resources for the strategy development of the CHP and the implementation.

Senior managers had a more positive view of MPHP. There was conflict between senior staff who saw the broader positive traits of MPHP and the operational managers who dealt with the day-to-day organisational issues of lack of resources, lack of support and lack of direction.

There was widespread agreement between all KIs that the agency partners were fully supportive of the MPHP initiative and attended meetings and developed a network of interested health partners. At the Gold Coast all agencies signed off to work and made a commitment to work together.

AP1: [the signing-off process between their agency and the GCCC] saved my life seeing as this management process is critical. It offered a lot of safety to do our work because people within the community often have to take risks within their work, which is an unnecessary burden for us to have to carry.

KIs agreed that the non-government agencies benefited by being part of the MPHP committees. One project manager stated that NGOs need a vehicle to advance issues and the CHP provides this and they firmly attach to this process.
9.4.3 Health and Environment Activities

Q. What are the most inspiring examples of public and environmental health planning outcomes by Councils that you are aware of?

Chapter 7 lists the progress of strategies of the GCCHP in a table in detail. KIs reported a significant number of inspiring examples of planning outcomes during the projects. KIs at the Gold Coast commented that the planning process, through intersectoral working parties, gave agencies and community representatives opportunities to both collaborate and be part of the decision-making for health, placing their agency issues firmly on the health agenda. There was a sense of empowerment among the Advisory Committee members who had not been reached in other projects in the region. Comments by the Councillor from the Gold Coast highlight an example of good practice in community participation:

P1: I always think that one of the better things to happen was our representative from our rural and remote communities joined our meetings. She was probably one of the most exciting people in the room because she had now found an avenue to go into the Council to actually be able to voice the concerns of the people of Beachmont. She felt that they were very remote, very removed from the main tourist focus of the city and she just wanted to be there to talk, and to talk about things that concerned them. Now that may not necessarily have been the whole focus of the health plan, but to her that was absolutely vital and she was so thrilled that this had happened.

Managers also highlighted the value of the MPHP process to make change in health policy.

M4: Any incremental improvement has to be of value, a base to build on. In the short term we see little change, but in the long term we see change. If we did a snap shot from the start of the CHP to the finish we see change. The ‘Pilot Transport Study’ was best practice.

A senior manager reported that the most inspiring examples of public and environmental health planning outcomes by Councils outside our organisation’s traditional role included:

- The sense of community that lower Beachmont residents have formed over the three years of the CHP
- The improved community transport for people with disabilities, and
- The introduction of the adaptable housing kit into the Council.

Other senior managers stated:

M3: The journey to the CHP is the valuable part as are the long term objectives for the following reasons: the CHP brings parties together, improves consultation with the community, increases actions of the working parties and the capacity building for the organisation is positive and this leads to good objectives in the plan.

The project manager stated there were improved health information services for social issues but the Council customer service focus distracted from the broad view in the CHP.
One manager stated that the organisation was not being reshaped towards CPHP, but that CPHP would be reshaped to suit the structure of his organisation: *This is one of the problems with planning tools, we are stuck in these local government structures and the CHP challenges traditional barriers. Instead of reorganising the Council to line up with the intersectoral CHP we try to manoeuvre the CHP to fit into the existing Council structures. Here lies the problem. The funding comes from Council so you have to work with the existing structure, otherwise you create silos and funding becomes a barrier for CHP.*

Practitioners reported many examples of inspiring health planning outcomes including the Life Options Expo at Broadbeach, which received good publicity for disability agencies and mental health issues. This joint exercise between Disability Services Queensland, Queensland Health and GCCC had good funding support due to the CHP initiative. GCCC CHP steering committee members advised that the Council did not report back to the agency partners enough and more efforts are required to provide feedback on outcomes to all partners.

One partner reported that the CHP improved the level of structural support for their existing family programs and this was positive for health outcomes.

**AP1:** *In the families support sector, we have produced a report on the current status of families. The CHP gave us more support both as a written document and as a presentation document. When we presented it to the community it was presented on behalf of the CHP and we were supported by the Councillors. Jane Grew, who was the Councillor for the CHP, presented the plan to the community, so we felt like we had the right sort of support to be able to do that.*

### 9.4.4 Best Practice Planning for Health

**Q. Have you any examples of the MPHP process integrating with other planning processes?**

The chair of the CHO Steering Committee said:

**P1:** *The project manager’s position has changed as this has consumed so much of his time. The CHP has also involved a number of other officers who were assisting. There has been an increase in their workload due to the plan.*

The Chief Executive Officer of the Council said:

**M2:** *The prime driver for the CHP is accountability, single point accountability. The coordination role of community health activities has improved. In the area of structural change the Council needs to mix professionals and develop job statements, the state government must allocate resources. In respect of organisational change the Council needs a best value approach as a valid structure. This needs incentives and the right accountable structures to get the right behaviour from staff.*

A senior manager in the Council responsible for the CHP noted:

**M3:** *There has been minimal change in the organisation from the CHP. Horizontal commitments are working regardless of where you sit in Council. The project manager has effective horizontal communication; the CHP has created awareness of the role of the plan in well being and quality of life. For environmental changes the CHP is core business of the*
Council, but maybe not shared by all Councillors or seen by the section managers as responsibilities...The CHP is a community plan; the allocation of responsibilities is broader than the Council. The Council is committed to coordinating the CHP. The Council has a legitimacy to coordinate the CHP that no other group has. In conclusion the process is what’s most important. The process of developing the plan is more important than the outcomes because the outcomes take time. It’s the collaboration and networks that are formed that are the key to success.

A project manager stated: The CHP is now on a plateau until outside organisations take the plan, and, more importantly, structurally within the Council. The Council is not responding to the preventive model in the CHP. Respondents across the categories replied.

A health practitioner provided two examples of best practice, stating:

HP1: I have two examples: The Integrated frameworks for social issues in local area planning (LAF) integrated well with the CHP, along with other planning like catchment engineering and planning for stormwater.

Two agency partners have noted that their agency is more confident in community health since working with the Council on the CHP: We’re more confident in reaching some of our accreditation standards when we know we are doing our business in collaboration under the leadership of the Council so we’ve changed our way of doing business in that sort of way. I think the infrastructure around the CHP needs to be strengthened so that as the work increases and flows on that we know that there are some support and facilities at Council for a bigger CHP secretariat.

The KIs across all categories indicated that MPHP was integrated into the corporate planning processes of the Council but had not been fully integrated into the town planning schemes.

A manager indicated that the town planners in the Council see the importance of the MPHP feeding information up to the town plan and getting grants to fund healthy projects. But other senior managers in the Council did not understand or appreciate MPHP. A manager noted the close linkages between the CHP and the operational plan at GCCC.

Another senior manager at Council stated:

M3: The future is in the link with the LG Act supporting health plans, and we need to link with other plans.

Q. What are characteristics of best practice community public health planning?

All categories of KIs interviewed felt that best practice related to the link between improved agency partnerships and intersectoral action and improved health outcomes. Senior managers at the Gold Coast said:

M4: Tangible outcomes are needed, however with CHP outcomes can take time and are not always tangible. Any health outcome is good, but must be quantified.

M5: The CHP brings people together. It brings people to the discussion table, the synergies it brings, bringing people together and making them talk. CHP is all about synergies and this is the best characteristic of health planning.
A best practice CHP is about improved collaboration with the Council, other government departments and community groups and increasing the level of funding for strategies.

From a governance perspective one agency highlighted that the Council had no formal control over decisions or actions taken by agencies outside of the Council, but could exert informal pressure over those processes through the CHP and this was a positive approach.

Q. How significant is MPHP compared with other planning initiatives in the Council/your organisation?

Politicians advised that the MPHP has raised awareness not only of health issues in the community but of the Council’s responsibilities for health and quality of life. Managers reported that MPHP was of equal value to Councils corporate plan and assisted the town planning schemes. Managers reported that the CHP at the Gold Coast was a significant management practice, that there was limited interdepartmental collaboration on the CHP and that it was less significant than the Council corporate plan because there was no legal basis for planning. A practitioner at the Gold Coast stated:

HP1: CHP was the first genuine attempt to plan ‘with’ and ‘for’ the community, compared to LA21 (which has had no outcome). The CHP locks the Council down to improving its practices with direct benefits. This process is about sharing outcomes for health.

Q. What is your overall assessment of the state of MPHP and practice within local government?

Councillors and senior managers at the GCCC commented that the current framework was flawed because the CHP wasn’t linked to an internal operational plan [in the environmental health department] and therefore had no consistent working budget. Others indicted the CHP is part of the corporate plan of the GCCC and this gives CHP more political legitimacy. This lack of budget for the plan and confusion over its governance and how it best fits into Council structures impacted on its success, they said:

M2: The CHP is a microcosm of a broader community-planning framework. The current framework is flawed. We need a CHP with community consultation, an environmental scan, risk assessment and opportunities identified on the CHP, operational plan and the budget.

M4: The Council is positive in its approach. The Council sees the benefits of the CHP because of the increased political advantage from working with other agencies.

M2: The failings at GCCC [may come because] if you don’t integrate the CHP into the operational plan so that you get a budget and resources the CHP falls over. If you don’t link strategies with resources allocation the CHP falls over.

A senior manager at the GCCC sees the CHP as a logical business plan for health.

M2: The CHP is a logical business principle to allocate resources from and measure where the risks are. There is a best practice element to a CHP but the process needs building blocks and a more solid framework. You need a framework to work within Council for community health
containing clear objectives, an action plan, accountable timeframes, resources, performance indicators within an integrated framework of the corporate plan and the operational plan within the organisational structure.

Agency partners who were collaborating on the planning project were positive about the overall assessment of the CHP. One agency partner thought the process was very good. It was developed as part of the community and therefore the community had ownership of it rather than the process being imposed from top-down. Another agency representative was very enthusiastic about the intersectoral planning being facilitated by the Council and saw Council involvement as significant in furthering implementation of strategies in the plan.

Q. Strengths and Limitations of MPHP

In general KIs felt the MPHP process was a very positive, beneficial process and MPHP moved Councils towards new understandings and better collaborations. Politicians commented that the strength of MPHP was that the process could be used to check and balance the agencies involved. Politicians complained that the state government did not provide enough funding to Councils to fund the MPHP initiative.

Several managers noted that MPHP was good for identifying gaps in services in the region and an effective planning tool:

M4: [The MPHP] identifies gaps in service provision from the holistic situation. If it works it locks in commitment from agencies to address service needs.

Weaknesses of the process included that it was under-resourced in implementing strategies, there was a concern about Council governance issues and staff accountability, and that the sign-off on activities was not at the political but bureaucratic level. Another threat to MPHP’s sustainability included the lack of commitment at the EHO officer level to the planning. One senior manager commented:

M2: Concern about issues of accountability as environmental health performance is critical to the continuance of the Gold Coast CHP. The Council needs to refocus from reactive to proactive measures in public and environmental health.

A health practitioner showed concerns about the fact that the Local Government Association of Queensland was supporting MPHP as a voluntary process, saying that an emphasis on CHP as a compulsory activity would improve sustainability of the plan. Asked if Queensland needs a law making CHP mandatory, a practitioner stated:

HP1: We need a law to make CHP compulsory, as a tool to plan, and we need mandatory requirements to report on the health of the community, for example, a state of health report. It would follow that it is important to have a broader definition of health to support the social and cultural issues that are now issues in local government.
Partners had a positive response to this question. Gold Coast agencies reported a very positive appraisal of the CHP. This included comments from the Gold Coast agency that reported a very vibrant involvement of agencies since the CHP was introduced, and that agencies found the CHP to be a very user-friendly document.

AP2: *I think it’s a brilliant document; very easy to use, a useable document. But I find it also gave me a good point of reference for identifying issues from other sectors outside housing, but that impacted on housing. For example, it gave us insight into general transport issues and education.*

In general the MPHP process was well understood and supported but the significant lack of monetary resources and human resources to implement the action strategies in the planning document was seen as a frustration by KIs. There was general consensus from KIs that the state government did not provide the necessary capacity building support to fully implement the MPHP. This lack of support threatened the implementation of strategies in the CHP and planning sustainability.

### 9.4.5 Infrastructure Change

**Q. What structural, organisational or environmental changes with a potential impact on the health of the target population have resulted from the MPHP activities?**

KIs summarised their thinking on the challenges for implementation the CHP strategies.

The chair of the Steering Committee concluded by saying that the plan was in place but some organisational issues weren’t resolved; managers’ job descriptions had not been updated to help with implementing the plan. The chair of the Steering Committee also found that CHP had a lower priority than the statutory town plan, but suggested the aim of the CHP was to feed information to the city’s corporate planning.

A manager at the Council stated:

M5: *I support the option of elevating the CHP to a corporate level so that everything is tied in from either the CEO’s office or city governance. [We] need to get the structure right initially for all planning projects, as the structure is important. Also if you have the right people in the right positions, and a good structure and process the CHP will be a success.*

All respondents agreed that there was increased knowledge about the structural role of the Council in public health and the role of the members of the Steering Committee. This was a major success of the CHP.
The project manager stated:

HP1: The CHP had some unanticipated spin-offs for Councils and the community: residents were empowered to take action, community participation increased, more weight in community opinion and community groups did not have to go to the local politician all the time but could work through the CHP.

A practitioner argued for the need to have indicators to monitor tangible outcomes in the MPHP:

HP2: The Victorian Health Department have indicators, and have now done a survey of the health of local authority areas. The report notes the cancer rates and asthma rates by local authority boundary. That’s a good start where they’ve got the State Government doing something meaningful with data for the local movement. The Council has to have indicators to assess tangible outcomes.

Q. Have there been changes in the attitude of interdepartmental agencies in Council in relation to the objectives of the project?

A senior manager responded:

M3: We have seen strong relationship building and commitment building in Council from the CHP.

An agency representative interviewed could not recall any changes to the Council:

AP2: In Council, no. The social research work of the Council is now doing a lot of work on housing in particular, and that has been very impressive. I think it would have been useful as a committee member for us to be told if the Council was doing that.

9.4.6 Skills Development

Q. What training has been provided to improve the MPHP participants’ knowledge and skills?

Regarding future training the chair of the Steering Committee noted that more training for staff in strategic planning was necessary. A practitioner commented that no training had been provided for the community residents on how to engage with the CHP process and this was needed. A practitioner noted that part of the strength was that the CHP was an exceptional community capacity building exercise.

9.4.7 Visibility and Media

Q. To what extent have the community agencies and residents been informed about this MPHP process throughout the planning stages?

All categories of KIs interviewed agreed that the media was an important component of the CHP. The chair of the Steering Committee noted that opportunities must be created to attract the media to planning processes. A manager at GCCC said that the media was not strongly involved:
There was a bit of promotion when the plan was developed and when it was launched, but there would have been very minimal since then. A project manager noted that he involved the media on a number of occasions and provided them with reports on activities. An agency partner stated:

AP2: I think they should have been told a lot more. It’s a very positive document and I was disappointed that a lot more wasn’t done.

The project manager advised that minutes were distributed from all meetings to agencies and a newsletter was planned in the future to disseminate information to the media.

9.4.8 Future Challenges

Q. Challenges for Implementation

The chief executive officer concluded that in respect of the implementation of the CHP councillors and managers need to allocate resources to CHP. A senior manager commented that it was difficult to find strategy implementation as the responsibility for the issues cut across several departments, he said:

M4: Branch responsibility in the CHP is split across several branches and the trick is to pull it together across branches...The GCCC in the past has been opposed to being engaged in community welfare, but the CHP assisted in promoting improvements in community health.

The chief executive officer of the Council cited a barrier to sustainable implementation stating that:

M2: There is no accountability recorded between the Council and the agencies. The CHP needs ‘sign off’ of accountability needed for clarity.

Other comments about future challenges included demonstrating evidence that change had occurred from the planning, improving communication structures, establishing base-line data and integrating strategies with other planning:

HP1: I support integration of all planning projects. We need to have filters for solutions, best fitting solutions for example, role clarification of all the committees. I had an example where the regional organisations of Council were asked to look at solving prostitution issues, but the needle disposal issue, which is linked with prostitution, was still to be dealt with by local Councils.

HP2: [Challenges for implementation include] establishing baseline data prior to the CHP, coming up with indicators of what they think community health is going to be, working with other programs and processes in the Council, such as our LA21 to try and marry those two up. Looking at some internal restructuring to facilitate the project work within the organisation generally would be of assistance.
9.5 Implementation Impacts on the Community

9.5.1 Plan Exposure

Q. How much direct contact has there been between the project and the community during implementation?

The project officer noted that, apart from initial focus groups that involve residents, the CHP focused on engaging agencies that represented the community. One partitioner stated that the community at large had little involvement, which was a barrier and as process that could be improved.

Q. What level of community participation has occurred during implementation?

A project manager sought community input on CHP strategies. A practitioner advised that residents received some feedback on activities through the agencies involved and via media releases by council. An example included the ‘Life Options’ program which was well publicised across the Gold Coast. It appears that the community is not being reached successfully during plan implementation.

Q. List what strategies have been funded or achieved since implementation commenced?

Over 80% of strategies were reported as implemented by the Project Manager. The following strategy was an example of a CHP strategy implemented across the sectors and outside of traditional areas of Council which impacted on the community:

M5: 1. Transcord car pass is a result of the plan. Transcord was there before the plan but the one-stop-shop and making people aware were new processes implemented from the suggestions of the CJP committees. Anything that improves the quality of life I see as having a bearing on environmental health or the well being of the community. People with disabilities being able to get around has to be a positive.

9.5.2 Residents’ Quality of Life

Q. Has MPHP had a direct impact on the residents’ quality of life since implementation?

A manager and practitioner at Council advised:

M5: The Beachmont Community group is working well through the CHP. It’s opened up doors for them. They know now where to go to. They’ve designed a park that people want, they’ve formed a neighbourhood watch group that also runs their CHP for them, they’ve improved the safety of the area by having a boardwalk footpath installed up one of the hills or mountains so that pedestrians don’t have to walk out in amongst the traffic or try and get onto the eroded shoulder of this drop off when a car comes past. So [the MPHP] channelled the group’s energy through this process. The chair of the community group was a great advocate for the community. When you talk about equity of services, it hasn’t solved all their problems but it’s certainly had some successes.
Well, yes the disability area [has improved]. The project manager has the Access Directory coming forward. It’d be hard for us to say that it’s been a negative for them.

9.5.3 Community Agency Strategic Plan

Q. Are the MPHP process or strategies in the plan part of the community agency strategic plans?

The chair of the CHP Steering Committee stated that agencies had included the CHP strategies in their business plans and this was part of the agreement to become a partner with council, she said:

P1: We have become engaged in a number of issues, which are probably better handled by the agencies involved in the CHP, for example, community safety. As Council has limited staff and limited resources it's appropriate that agencies identify their role and act on the strategies that they are responsible for.

When prompted, the chair advised there have been some visible positive outcomes:

P1: Look I think that given the resources and the input from people that we’ve had, I think we’ve made a very good success of what we’ve been doing with the CHP and I would be proud to say that we’ve worked on it together.

9.5.4 Community Agency Cooperation

Q. What changes have you noted in your agency as a result of the MPHP project?

Agency partners stated that the CHP has enabled their organisations to work legitimately with council and increased their professional capacity to plan collaboratively:

AP1: Because the local community organisations are very isolated in their local endeavours, to be brought together and sponsored by the Council with the CHP process makes a big difference.

AP2: Professionally it certainly enhanced my capacity. It’s a very good community capacity-building exercise for workers within the community and it certainly teaches them to work better with government departments.

Q. Has cooperation between the agency and Griffith University been beneficial?

KIs interviewed were positive about the University’s involvement in the CHP. Agency partners supported the University’s input into the CHP:

AP1: There have been some evaluations done by the University, and the times when you’ve [Peter Davey] come and brought information and gave the committee members access to other ways of looking at partnerships and knowing that partnerships are valued in many other sectors.

AP2: I think it was highly beneficial. I would see tertiary institutions being part of the community and they should contribute both professionally and corporately.
9.6 Achievements and Barriers to Effective MPHP

Table 29 presents the analysis of the KI responses from the evaluation of the Gold Coast City CHP, with a summary of whether the aims of the project were met: achievements and barriers to effective MPHP; Tables 30 and 31 document the implementation impacts on individuals and organisations and the community.
<table>
<thead>
<tr>
<th><strong>Intersectoral Collaboration</strong></th>
<th><strong>Equity in Health</strong></th>
<th><strong>Community Participation</strong></th>
<th><strong>Broad Socio-Ecological View of Health</strong></th>
<th><strong>Evaluation and Accountability</strong></th>
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<tbody>
<tr>
<td><strong>Levels of collaboration</strong></td>
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<tr>
<td>Council lead agency collaboration is a positive approach to improving health promotion action and city governance.</td>
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<td><strong>Shared objectives and group purpose</strong></td>
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<td><strong>Accountability</strong></td>
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<td>Participative approach to developing project TOR and aims is critical to group purpose.</td>
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<td><strong>Composition of working parties</strong></td>
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<td>Organisations provided staff to engage with CHP project as part of the individual’s job role recognising organisational responsibility for health outcomes.</td>
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<td>Agency and Council staff had only moderate experience in collaborative work.</td>
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<td>Good mix of Council and agency staff skills across committees and working parties.</td>
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<td><strong>Resources adequate to achieve its objectives</strong></td>
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<td>Insufficient funding for project from state level and local agencies human resources allocated by local Council adequate in plan development phase.</td>
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<td><strong>Interdepartmental involvement</strong></td>
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<td>Organisation of work practices by broadening job descriptions has occurred in Council to suit multi-disciplinary nature of agencies engaging in the project.</td>
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<td>Barriers between professional groups limit opportunities for joint work within Council.</td>
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<td><strong>Partnerships</strong></td>
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<tr>
<td>The CHP was a catalyst for partnerships in health promotion.</td>
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<td>Agency contribution depended on the issue and the personalities involved</td>
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<td>Clear lines of communication working parties will result in agencies championing the CHP and engaging in strategy implementation.</td>
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<td><strong>Issues for equity</strong></td>
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<tr>
<td>Minimal emphasis on equity issues in the planning.</td>
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<tr>
<td>Several projects demonstrated equity outcomes.</td>
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<td><strong>Levels of community participation</strong></td>
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<td>Residents invited to participate in health need surveys and workshops, progress on the CHP fed back to community.</td>
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<td><strong>Special need groups</strong></td>
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<td>Community action groups gained equal access to decisions making at meetings.</td>
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<tr>
<td>Councillors recognised the influence of participatory planning on achieving this aim.</td>
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<tr>
<td><strong>Empowerment and decision-making</strong></td>
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<tr>
<td>More involvement from residents and community groups in recommended in project committees and working parties.</td>
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<tr>
<td><strong>Approach to determinants of health</strong></td>
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<tr>
<td>Limited progress on social determinants of health, with silos in place with Queensland Health. Councilors, Council staff and agencies support this approach and the CHP will assist in future progress.</td>
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<tr>
<td>The CHP was assisting this policy change.</td>
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<td><strong>Traditional core and non-core business</strong></td>
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<td>CHP was not core business prior to the project, but to be effective Council needs to change to a community development focus to fully embrace the CHP, this requires integration of the activities of internal Council units.</td>
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<td>Local Area Plan (LAP) is core business has better geographical targeting, but limited community development compared to the CHP.</td>
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<td><strong>Shared ecological vision</strong></td>
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<td>Not achieved, but the CHP had a common vision for a better quality of life.</td>
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<td><strong>Monitoring of activities and evaluation</strong></td>
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<td>Progress of activities was monitored by agencies reported back to the steering group quarterly, verbally.</td>
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<td><strong>Other issues with process</strong></td>
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<td>Lack the organisational skills to operationalise the plan the Council needs to integrate the plan with the IPA.</td>
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<td>CHP is logical as a strategy but to deliver on Councils corporate objectives you need organisational alignment with community expectations.</td>
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<td>CHP needs to clarify organisational management frameworks: critical issues, strategies, roles and responsibilities and organisational structures, people, resource allocation, budgeting, performance management and targets.</td>
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<tr>
<td>Need a governance framework to articulate outcomes or the process is deficient.</td>
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<tr>
<td>The future is the LG Act supporting health plans with linkages to other plans.</td>
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</table>
Table 30: Gold Coast Community Health Plan – Implementation Impacts on Individuals and Organisations

<table>
<thead>
<tr>
<th>IMPACTS ON INDIVIDUALS AND ORGANISATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits of and Support for MPHP</td>
</tr>
<tr>
<td>• CHP increased political support for health agenda.</td>
</tr>
<tr>
<td>• CHP put health issues outside the traditional elements of environmental health and this transition required more interdepartmental connections.</td>
</tr>
<tr>
<td>• High executive level support for CHP, while health practitioner support was low, strategic managers see benefits.</td>
</tr>
<tr>
<td>• CHP provides clear accountable goals for community health this is a good process to indicate Council performance.</td>
</tr>
<tr>
<td>• Network interaction benefit of disparate agencies involved in the city to discuss a broad range of topics and improve health outcomes.</td>
</tr>
<tr>
<td>Health Policy on the Agenda</td>
</tr>
<tr>
<td>• CHP in the Corporate Plan as an key objective of Council.</td>
</tr>
<tr>
<td>• CHP generated several positive policy shifts.</td>
</tr>
<tr>
<td>• Improved linkages between sectors towards health outcomes.</td>
</tr>
<tr>
<td>• Inadequate funding major barriers to success in terms of both money and human resources to satisfactorily implement policy change.</td>
</tr>
<tr>
<td>• No budget for new broader view of health.</td>
</tr>
<tr>
<td>• Lack of commitment of general staff time has limited the outcomes.</td>
</tr>
<tr>
<td>• Sense of empowerment among the advisory committee members.</td>
</tr>
<tr>
<td>• Manoeuvre the CHP to fit into the existing structures, need to reorganising Council to line up with the intersectoral CHP.</td>
</tr>
<tr>
<td>• Prime driver for the CHP is single point accountability.</td>
</tr>
<tr>
<td>• Council needs to mix professionals and develop job statements.</td>
</tr>
<tr>
<td>Health and Environment Activities</td>
</tr>
<tr>
<td>• Significant number of inspiring examples of planning outcomes during the projects.</td>
</tr>
<tr>
<td>• Planning outcomes by Councils outside our organisation’s traditional role.</td>
</tr>
<tr>
<td>• Organisation was not being reshaped towards CPHP.</td>
</tr>
<tr>
<td>Best Practice Planning for Health</td>
</tr>
<tr>
<td>• CHP integrates well with other Council planning filling a gap with health data.</td>
</tr>
<tr>
<td>• Improved agency partnerships key characteristic of planning.</td>
</tr>
<tr>
<td>• Many strategies funded but the process continued to lack of human and monetary resources.</td>
</tr>
<tr>
<td>• CHP is significant compared to other plans by placing health on the agenda.</td>
</tr>
<tr>
<td>• Link between improved agency partnerships and intersectoral action and improved health outcomes.</td>
</tr>
<tr>
<td>• Overall the CHP was increased political advantage from working with other agencies.</td>
</tr>
<tr>
<td>Infrastructure Change</td>
</tr>
<tr>
<td>• Organisational change is required to accommodate the CHP – Council to take a best value approach as a valid structure.</td>
</tr>
<tr>
<td>• Structural change requires Council to mix professionals and clarify job statements to implement CHP.</td>
</tr>
<tr>
<td>• Integration of health, social and town planning in Council, driven by internal restructuring.</td>
</tr>
<tr>
<td>• Not all community groups incorporated strategies from the CHP into their organisational strategic plans and activities.</td>
</tr>
<tr>
<td>Skills Development</td>
</tr>
<tr>
<td>• Senior managers more supportive of CHP because of their understanding of strategic management compared to health practitioners.</td>
</tr>
<tr>
<td>• Increase in Council staff workload.</td>
</tr>
<tr>
<td>• Refocus from reactive to proactive measures which impacts on staff skills.</td>
</tr>
<tr>
<td>• Capacity building of EHOs required engaging their involvement in implementation.</td>
</tr>
<tr>
<td>Visibility and Media</td>
</tr>
<tr>
<td>• Council branch involvement is limited by the lack of policy on broader public health outcomes</td>
</tr>
<tr>
<td>• CHP had satisfactory visibility through promotion efforts of politicians and project managers</td>
</tr>
<tr>
<td>• Lack of media support due to limited reportable short-term outcomes</td>
</tr>
<tr>
<td>Future Challenges</td>
</tr>
<tr>
<td>• Modifying Council strategic management processes to assist with plan implementation not successful.</td>
</tr>
<tr>
<td>• Get the structure right for CHP and link to corporate plan.</td>
</tr>
<tr>
<td>• Develop a platform approach so agencies have community indicators to monitor outcomes as an evidence base.</td>
</tr>
<tr>
<td>• Develop equal partnerships in planning and share responsibilities for the CHP.</td>
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</tbody>
</table>
Table 31: Gold Coast Community Health Plan – Implementation Impacts on the Community

<table>
<thead>
<tr>
<th>IMPACTS ON THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Exposure</strong></td>
</tr>
<tr>
<td>• CHP focus groups reached small cross section of community residents.</td>
</tr>
<tr>
<td>• Limited exposure of CHP to residents.</td>
</tr>
<tr>
<td>• Project prioritised agency and community group involvement, not individual residents.</td>
</tr>
<tr>
<td><strong>Residents’ Quality of Life</strong></td>
</tr>
<tr>
<td>• Good evidence of direct impacts on quality of life in disability projects.</td>
</tr>
<tr>
<td>• Rural communities empowered by CHP process.</td>
</tr>
<tr>
<td>• Funding grants generated by CHP strategies improved outcomes in the long-term.</td>
</tr>
<tr>
<td><strong>Community Agency Strategic Plan</strong></td>
</tr>
<tr>
<td>• Limited number of agencies adapted their strategic business plans to include their organisations strategies in the CHP.</td>
</tr>
<tr>
<td>• Residents empowered to take action for health improvements.</td>
</tr>
<tr>
<td><strong>Agency Cooperation</strong></td>
</tr>
<tr>
<td>• Improves opportunity for agencies to work together.</td>
</tr>
<tr>
<td>• CHP was an excellent capacity building project for community groups.</td>
</tr>
<tr>
<td>• Highly beneficial to have university partner to facilitate planning process and capacity building workshops.</td>
</tr>
</tbody>
</table>
Section 2 Evaluation of Wide Bay Regional Public Health Plan

9.7 Background

An Implementation Questionnaire was adapted for this phase of the data collection and is contained in Appendix H. A selection of key informant responses to specific indicator questions on whether the aims and main elements of the MPHP project were met and on the implementation impacts of the Wide Bay Regional Public Health Plan (PHP) are presented in this chapter. Face-to-face focused in-depth KI interviews were held with a selection of politicians, managers, health practitioners and agency partners in the Wide Bay Project. KI signed an individual consent form and obtained organisational agreement to their involvement in the research. Each interview conducted by the researcher was completed within two hours, taped and then transcribed.

The IQ used to conduct KI interviews with participants of the Wide Bay PHP was described in the previous chapter. The IQ contained specific questions asked of the KI; their responses have been collated as the results and findings in this section of Chapter 9. The responses to these specific evaluation questions are examined to provide achievements for and barriers to effective MPHP. A theme analysis was carried out on the results and findings and is discussed in Chapter 11.

9.8 Aims, Main Elements and Specific Questions from the PHP Project

This project had five aims, which were developed jointly by the PMT from their understanding of the goals of the HCM. The Healthy Cities and Shires Project that support Queensland Health’s encouragement awards, detailed in Chapter 7, also supported the aims. The five project aims were each assigned a process indicator number: PI 1 to PI 5, as listed in Table 32. For data organisation purposes in the IQ, each aim, main element and specific question was numbered. Appendix K contains a detailed list of the KIs interviewed, their category and allocated KI code. A KI category has been assigned and noted adjacent to each quotation, as Politician (P), Manager (M), Health Practitioner (HP) or Agency Partner (AP). Key Informants (KIs) signed an individual and organisational consent form agreeing to their involvement in the research. Each face-to-face interview conducted by the researcher was completed within two hours. Each interview was taped, and then transcribed. Responses to questions discussed below. The comments considered to be relevant to the study are recorded as quotations.
Table 32: Wide Bay Regional Public Health Plan – Implementation Process Issues and Aims

<table>
<thead>
<tr>
<th>Implementation Process Issues</th>
<th>Aim</th>
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<tbody>
<tr>
<td>PI 1</td>
<td>Intersectoral Collaboration</td>
</tr>
<tr>
<td>PI 2</td>
<td>Community Participation in Decision-making</td>
</tr>
<tr>
<td>PI 3</td>
<td>Interdepartmental Involvement</td>
</tr>
<tr>
<td>PI 4</td>
<td>Partnerships</td>
</tr>
<tr>
<td>PI 5</td>
<td>Shared Vision</td>
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</table>

9.8.1 Intersectoral Collaboration

*Levels of Collaboration*

Q. Has the MPHP process invoked greater levels of collaboration between the government and non-government sectors and community groups?

The majority of respondents indicated that the WBRPHP process invoked greater levels of collaboration between all levels of agencies in the region. This collaboration was highest during the seven-step planning process, but decreased when the plan was being implemented. Politicians, managers and practitioners all agreed that the planning clarified the agencies’ roles in public health service delivery. An elected representative from Wide Bay answered that he felt the agencies now know how to develop a MPHP in collaboration with all agencies and community groups.

A senior manager stated:

*M7: The Mayor saw fit to contribute considerable time to go to all meetings. From a political point of view he saw the PHP process as being very important to get feedback from the community on a whole range of issues. The community don’t just raise health issues; they raise all sorts of issues.*

Practitioners’ comments included:

*HP4: Yes, [there has been greater collaboration,] particularly in the youth area, I think that has been a major outcome of the PHP*

*HP5: Yes, agencies are collaborating at planning meetings, especially when the project has had update meetings and agencies are talking together about strategies.*

*AP4: Yes, we’ve got very good partnerships. We contribute a lot to one another’s plans, particularly Queensland Health and the Council’s.*

An agency partner expressed that putting the plan together was good for collaboration between agencies.
Q. Has this collaboration been positive for your organisation?

All categories of respondents affirmed that collaboration had been positive for their organisations. A politician and several managers answered:

P3: Yes, because [Council staff] they now know how to really consult with the community.

M6: I think we know the officers better now and we're negotiating better with them now as we build up better relationships and trust.

M8: Yes, I think it has been positive for Councils. It's putting a face to a name and understanding more about the way that organisation might operate. Networking has a flow-on effect.

The practitioners and partners agreed that the networking generated by the HP process was very beneficial to future collaboration. Another practitioner reported that collaboration had improved between Hervey Bay City Council (HBCC) and the Queensland Health–Central Public Health Unit.

Q. Has the MPHP process increased health promotion activity?

There was a mixed response to the question of whether health promotional activity had increased as a result of the development and implementation of the PHP in Wide Bay. A politician reported there had not been enough activity, while a senior manager advised that health promotion activity had changed direction and activities were now based on the health needs that had been identified in the plans. Senior staff agreed that even though Queensland Health were driven by state-wide health outcome areas internally, the PHP needed help to prioritise what health promotion was necessary. Senior managers in local government reported some increase in activity around mosquito control programs.

*Shared Objectives and Group Purpose*

Q. Did the MPHP process have an agreed set of terms of reference?

All respondents participated in and were aware of an agreed set of terms of reference for the PHP project.

Q. Did the working partners agree to common aims for the planning process?

Respondents agreed that the working partners agreed to common aims for the PHP. A politician said that there was agreement on the aims of the project.
Q. How did the project identify who should be involved?

Respondents advised that the public meetings assisted in identifying project partners and the project team then sent invitations to identified partners who would assist the plans development. A manager stated:

M8: That [the idea of promoting the MPH plan by issuing of letters to agencies and community groups] was really from the public meetings, from the public consultation. The project team sent letters to all government departments, all agencies, all community groups asking for their involvement; it was just a blanket approach.

Practitioners were the driving force for MPHP to work more efficiently and effectively in communities.

HP3: I considered [the MPH plan] to be a model that would bring about better working relationships, partnerships, intersectoral collaboration across agencies and the community; where we could effectively look to address as many different health issues whilst also engaging many other key stakeholders in that process. I discussed this with my Health Promotion Unit and said ‘look I think this is the way we should be heading’, getting their support and then contacting those Councils and going from there.

Q. Describe your involvement in the MPHP?

Politicians, managers, practitioners and agency partners (referred to as ‘all categories’) were involved with the health planning projects as part of their organisational role and responsibility within their representative organisation. Each individual’s perspective of his or her involvement is relevant to the research and will be discussed below. A politician supported the concept of the public health plan and during the process attended seven of the forums that were held in various locations throughout Hervey Bay. He commented during the interviews:

P2: Basically the Environmental Health Manager at HBCC invited me to participate in the work. He was actually the one that changed my focus on what I thought health planning was. I didn’t think health planning was ‘health’, in as much as you have something wrong with you, but the impacts of whatever might be in the community and how that directly or indirectly impacted upon our health. The health planning process can change people’s attitudes about health action in a community.

Other elected representatives had past knowledge and experience in the WHO Healthy Cities approaches.

P3: I helped in the various planning stages [of the project], but I’ve always been an advocate of the ‘Healthy Cities’ concept. It’s always been our ambition to have a MPH plan.

A senior manager responded that the health promotion staff wanted to develop a local MPH plan and that this process had state health departmental support. There had been a policy shift
toward the new way of planning and it was built into council’s business plans. Involvement started with an approach from the Central Public Health Unit to councils to develop the MPHP. Funding and resources were provided to assist the Council to develop the MPHP.

Agencies became involved because the MPHP process offered opportunities to participate in decision-making about a range of health issues and bring people together. Agency partners were motivated by the planning process and commented:

AP5: We belong to Australian Parents for Drug Free Youth and part of the planning was to invite all government and non-government agencies to come to workshops and become involved in the health plan. I was extremely motivated. I could see that part of the plan had a lot of scope to it and so we participated in the plan. We made a number of inputs from our point of view into the plan, which were accepted as all recommendations were made Was there a balance between Council representation and other bodies on the Steering Committees?

AP5: Yes, I think agencies were all well represented in the PHP process.

Q. Did the members of the project have the skills, attributes and attitudes necessary for joint work?

Senior managers and practitioners advised that people invited onto the PMT and working groups had the necessary skills. One senior manager reported:

M6: I think at the time we had some very good people on that team, an epidemiologist planner, a health program manager—both had good skills in that area--so I think we had a good mix of skills.

HP4: I think with the health promotion background of Queensland Health and the involvement of Griffith University we did have the skills.

A senior manager at HBCC indicated that:

M7: Yes, I think in hindsight. You know, I did so much in getting Councillors there. I probably needed to do more and to really make sure that they were there at the initial session presented on PHP by Griffith University so they understood health planning. But you felt that there was more skills development or training or transfer of knowledge required for some of the Councillors and other managers across some of the other departments.

Q. Has a lead person from each organisation been identified to work with the alliance?

Respondents advised that a project manager had been appointed to the PHP project at the Central Public Health Unit, and each Council had appointed a project officer and senior manager to manage each city activity.
Adequacy of Resources to Achieve Objectives

Q. Did the project have an adequate budget to achieve its objectives?

KIs from government and Councils reported there was adequate funding to develop the plan, but future implementation funding had not been identified. There was a requirement to identify needs and then develop joint funding proposals for priority needs in the community. Senior managers at the Councils stated:

M8: Yes,[the encouragement award and council funding] it was adequate to actually develop the plan. I think MCC wouldn ’t have been able to put in much more than $10,000 with the size of our Council and our population of 26,000 residents.

M7: Yes, Hervey Bay contributed $40,000. The Council was very positive that Queensland Health provided $20,000. This was the carrot that was needed to get the PHP approved by the Council. I think also in terms of economies of scale it was beneficial to have two Councils working together on the project.

Practitioners and agency partners agreed that the monies were suitable for the development of the plan but implementation funding was lacking.

Q. Has the project received additional sources of funding?

KIs advised that the CPHUN and the two Councils provided implementation funding for a part-time project officer to manage the plan implementation. The senior managers were working with the PMT to secure a full-time project officer to drive the implementation. Senior managers from Councils said that the Council identified strategies in the PHP document and worked together to develop several grant proposals based on priority community needs in the PHP. A practitioner advised:

HP4: [Additional funds were received] only through grants for the strategies. A number of funding applications have been made to external bodies, for example, the ‘We Connect’ program for the youth ($500,000). I know that there are applications in at the moment for other funding sources.

Q. Did participants contribute adequate time to the project?

KIs advised that a project co-ordinator was appointed formally at the CPHUN. Both the HBCC and MCC had formally appointed project managers within the Council.

A politician from Maryborough City answered that staff had been appointed with appropriate skills to manage the project, but council and the agencies found it difficult to allocate sufficient time in a government environments with limited staff numbers and an increasing workload, she commented:
P3: No, I don’t think it was skills or a lack of skills. Some of the people involved just didn’t have enough time to devote to the PHP process.

Both Councils and the Central Public Health Unit contributed equally to plan and develop the project brief and engage the project consultants from Griffith University; however, during implementation contributions towards the planning process from councils varied, depending on the level of work associated with the particular health initiative that agencies were implementing. A practitioner stated:

HP5: I think you need more time spent on the PHP implementation, especially at the working party level. The working parties need to be involved in the PMT activities to see the whole plan instead of just one segment of the plan. The working parties couldn’t relate their outcomes in the context of the whole plan.

Queensland Health expressed a view that their staff were contributing as agreed throughout both the planning process and implementation stage. Both councils participated fully in the development stage of the planning, but after a 2-year period of implementation, councils decreased the amount of time staff spent on the PHP implementation, mainly due to human resource capacity issues.

9.8.2 Community Participation in Local Decision-Making

Levels of Community Participation

Q. Did the project allow for community participation?

All KIs agreed that there was a satisfactory level of community participation, including focus groups, working parties, and public meetings. The community are still involved, particularly through implementation working parties. There are also community representatives involved in the implementation working groups. One practitioner noted that the PHP has been more compatible with the agency participation compared to resident participation, stating: There’s been more emphasis on agencies, not necessarily on communities. It’s hard to get community members by themselves involved. If they are representing an organisation like a progress association or something like that it’s actually easier. I suggest that our committee should also approach community members, who have a known interest in an area. Another health practitioner advised the media was used to increase community participation:

HP5: Maryborough advised the public via ads in the local media, we ran telephone surveys, and the draft PHP document was left at different public access points for comments. There can be a skills level issue with residents’ involvement, like you involve community members [but] they might not be at the same skill level. So that’s a training issue and it mightn’t mean as much to them.
Agency partners agreed that the community had an opportunity to be fully engaged with the project. One partner stated:

AP4: Yes, the first focus groups were well attended [by residents], as well as the working parties.

**Q. Have non-government community groups participated in the MPH?**

KIs advised that a satisfactory number of non-government organisations (NGOs) participated in the planning process and contributed significantly by identifying a range of emerging community health needs.

**Q. What influence has the community had on the MPH?**

Politicians responded that the community drove the priorities issues in the PHP with their input into the public meetings and through the many community focus groups. A politician stated:

P3: *It was community input that drove the PHP.*

A senior manager from Maryborough commented:

M8: *I think the main influence has been the community in providing all of the aims and objectives and health needs for the PHP.*

Other managers and practitioners noted that the community had a lesser influence than government agencies, but certainly influenced the content of the PHP. Some emphasised the need to ensure that the groups did not become ‘single agenda organisations’, and that it was important to keep a balance between some of the groups.

M7: *The community had the opportunity and those that turned up, I think, went away quite pleased with the process. With all the workshops only in Howard the attendance was disappointing.*

Practitioners thought focus groups were very useful to help understand community perceptions of what issues needed to be addressed. For example, the community perceived that there was a high crime rate but the police statistics demonstrated a comparatively low crime rate. The community had a major influence on topical issues such as biting midges in Hervey Bay coastal areas.

**Q. Did the local community become involved in the needs assessment?**

KIs advised that the community in both Hervey Bay and Maryborough had a high level of involvement in Stage 3 of the MPH process: the needs assessment, which consisted of public
meetings, phone surveys and structured focus groups based on targeted health issues and geographical areas.

*Empowerment and Decision-Making*

**Q. Has training been identified and provided for participants?**

KIs commented that the project consultants had provided suitable training on the process of PHP to the PMT and to residents at public meetings held in both Council areas. However, one practitioner noted:

HP4: *I agree there was plenty of training in PHP processes. I think we needed more understanding of what the plan was going to achieve, its outcomes and how it might affect communities. This needed to be made clearer.*

**Q. Did the project provide opportunity for input from agencies?**

KIs advised that agencies were advised of the PHP processes and had full opportunity to be engaged with the project through invitations, public meetings, focus groups, the launch of the PHP, and process and implementation meetings. A partner agency was very positive about their input as an NGO into the PHP:

AP5: *We had some influence over decision-making in the PHP process. I thought that, for instance, if we wanted we could include a strategy. There was a mechanism that we could make applications to both Councils and say if Queensland Health didn’t want to do this but we [did want to], there was a process that we could take things on ourselves.*

**Q. Did the project have clear decision-making processes in which community representatives were involved?**

Senior managers reported that there were community representatives on the working parties during the PHP project and they participated in the planning process. He stated:

M8: *Yes, at the various meetings community members were involved. Residents provided the health issues that formed the foundation of the plans, [and] the working groups put together the strategies, timeframe and performance measures.*

M7: *Well, it was decided at the community forums that there would be constant feedback from each of the forums back to the working groups. The community representatives would be given copies of the draft plan so they could comment on it.*

Another senior manager reported that there was no conflict during the process in Maryborough saying, ‘I think everyone really agreed on everything that was submitted.’

Other KIs commented that, in general, there was no conflict in the PHP development process and that the community’s voice was equal to the other partners’. An agency partner found that some participants in the process had their own agenda. He said:
AP5: I wouldn’t say conflict but there were definitely people who had agendas. They strongly pushed their own agendas, but that happens in any of these things.

9.8.3 Interdepartmental Involvement

Collaboration Between Council Departments

Q. Has the MPHP increased collaboration between Council departments?

A politician from Maryborough commented that the PHP had increased collaboration between departments, particularly through the Disability Access Advisory Committee. Senior managers reported increased collaboration between the Community and Recreation Department and the Environmental Health Services Department and the Hervey Bay Strategic Planner developing the IPA requirements.

A practitioner reported several examples of increased collaboration between three Council departments, Community and Recreation Department, Roads and Construction and Environmental Health, as a direct result of the PHP process at Wide Bay.

Roles of Departments

Q. Has the MPHP increased your knowledge of the roles of other departments in public and environmental health service delivery?

In general KIs generally agreed that they had a better understanding of the role of the Councils and CPHUN in Wide Bay’s public health, health promotion and environmental health. However, an agency partner reported that the PHP did not improve his organisation’s understanding of Council operations, and more communication was required in this area.

Organisation of Work Practices

Q. Has the organisation of work practices been modified to accommodate the strategies in the MPHP?

KIs were very receptive to this question and gave a range of responses across the categories interviewed. A politician from Maryborough believed that MCC have an integrated approach to planning, including community input at all stages of the planning processes. She believed that PHP committees are ‘really excellent committees’. A senior manager from Queensland Health advised that the changing work practices influenced by the PHP are now included in their business plan. A senior manager from MCC reported that the introduction of the PHP had changed the Council’s priorities. A senior manager from Hervey Bay Council stated:
M7: We try and link our work with what’s in the public health plan. There’s more acknowledgement about how the issue fits with the public health plan, and how the other agencies need to be involved.

A practitioner commented that her job description had not changed with her changing role and that existing EHO’s were expected to do PHP work within their current portfolio. She advised that a new position would need to be created to fully implement the PHP.

9.8.4 Partnerships (joint working, communication and media)

Joint Working

Q. Describe the partnerships that have been formed during the MPHP process.

KIs agreed that the PHP process strengthened partnerships between the Councils, Queensland Health and other agencies, but the nature of the partnerships varied. Senior managers commented:

M8: Yes, I think we have a stronger partnership with Queensland Health–CPHU. Council has always had a relationship with them, a partnership with them, but we see a lot more of them now. There’s different objectives that we need to get together on…We are implementing the PHP and applying for funding on joints grants, we’re working together, we’re meeting each other more often than probably what we had in the past. We know what’s going on. The first twelve months of the development of the plan was more collaborative than this year, during implementation.

HP4: The major partnerships were between the participants of the Project Management team (PMT)…The PMT has demonstrated real integrity to work together in the future. I think they’re probably the main ones, particularly being on the PMT together.

Q. Have all partners made a contribution to the strategies of the MPHP?

All KIs indicated that there were varying levels of partnerships formed in the regional PHP project in Wide Bay. A senior manager noted that the HBCC contribution was a little stronger than Maryborough’s but believed Maryborough would still meet their obligations.

Q. Are the partners prepared to compromise in order to resolve conflicts in priority issues?

Key stakeholders agree there was some conflict in the planning process. One senior manager thought, however, that facilitators had the skills to avoid potential conflict. One senior Council manager stated:

M7: No arguing [occurred]. It was quite conciliatory the way the whole thing went. There was no one that was running their own agenda, the process was sound.
Health Practitioners mentioned that the planning process must recognise that there can be conflict between the partner agencies who previously competed for limited local funding opportunities and that it will take time for them to work together under this new partnership thinking in the WBRPHP; saying: Partnership need refining, with agencies noted that the fact that the strategies in the PHP were core business for their own agency, that they had their own budgets and had to implement in certain ways. They didn’t want to be led by the consultation outcomes or the general guidelines of developing the PHP. Part of it was they didn’t want other agencies interfering in their work, I think it could also be if they lose involvement in an issue they might lose funding, budgetary issues, might come in to it.

Q. Has each partner organisation agreed to the strategies?

Two senior managers stated there had been agreement to the prioritised strategies in the final planning documents in both HBCC and MCC through the working parties. There was a mixed response from agency partners to signing off on their responsibilities for the implementation of the PHP, particularly specific strategy sign-off via a memorandum of understanding (MOU). The issue was explained:

A senior manager from CPHUN advised that agencies have all signed a letter of support for the PHP, with some agencies having concerns about signing a more formal memorandum of understanding (MOU) detailing their responsibilities. However, some agencies were keen to have an MOU so as to legitimise the planning implementation process for their organisation.

An agency partner stated:

AP5: My organisation signed off on the strategies. The MOU process basically intended to show that you were responsible to the Council and that’s what I’m saying, because we’re not. We’ve signed up to do the things but there’s a lack of Council getting people together to check on the progress and outcomes.

Some agencies did not respond to requests to formalise their commitment to the strategy implementation. She stated:

I really think there could have been more work done in that area, in getting the agreement. Some agencies have come back and said ‘we can’t be the lead agents for that particular strategy, it’s not in our area’, or ‘we can’t do this’. There needed to be more work, training, education and awareness raising for those lead agencies so that they knew what they were getting into as well. It’s certainly been a positive as Council’s changing its approach nowadays about how it works with the community.

A practitioner advised that some agencies agreed to a letter of support for the PHP instead of agencies signing the more formal memorandum of understanding (MOU) with the Council to implement certain strategies in the plan.

Senior managers responded that it was difficult getting responses from a couple of agencies about their direction but most of them provided feedback and worked well together.
Q. Does the Project review the process and achievements of the MPHP and amend them as required?

The project manager advised that the Implementation Committee reviewed the strategies every three months, agencies responded by reporting on their progress on strategies in the PHP, and council collated activity into a progress report, published in the newsletter, he stated:

**M6: To monitor progress the Project Team sent out update report forms to the lead agencies asking them to let us know how strategies are progressing. We update the actual public health plan with their comments and then hold a public meeting with the working groups and all the agencies. Then, based on themes, we amalgamate the Hervey Bay and Maryborough actions. We’ve got five implementation theme groups, two common [two of the theme groups are responsible for regional issues] across the region, and three separate for each community.**

Q. Does the MPHP project continually attract new members and keep its membership under review?

A politician advised that the PHP coordinators and working parties attempted to generate interest from new agencies. A practitioner reported that the agency membership had attracted new members.

Q. Does the MPHP act as a catalyst in generating new projects?

Senior managers and practitioners have confirmed that the PHP acts as a catalyst to generate new health projects in Wide Bay. One practitioner stated that the ‘We Connect’ project funding was based on a collaborative submission by the youth organisations in Hervey Bay and Maryborough. Funding was also received for the ‘Falls in the Elderly’ project. The community agencies have been using the PHP as a tool to apply for funding for new projects and improve local community health.

Q. How did agencies communicate in the process?

KIs indicated that agencies communicated well through the working parties in the PHP development phase, however, the implementation phase needed to be re-structured to achieve on-going communication and improved strategy outcomes. In response to the question, Did agencies share information? - four KIs interviewed including politicians, senior managers and practitioners advised that there was no barrier to agencies sharing information and agencies were not guarded about sharing, making information available at working party meetings. The PHP was posted on the councils website, however a politician advised that the PHP project needed a web page to communicate progress on it actions. Senior managers thought that the existing six-monthly hardcopy newsletter that was widely distributed in the community was a good communication tool. KIs advised the health profile and PHP could be on placed on other agencies web domains for wider access and future input by the public. A practitioner stated:
HP4: The PHP is on the Council website. In Hervey Bay there is a local website called ‘Bay Connect’ that has been set up and information can be posted on that free of charge about activities, organisations. There needs to be a lot more community input in the next planning phase to maintain sustainability of the plan.

9.8.5 Working Together Towards a Shared Vision

Development of a Shared Vision

Q. Did the MPHP process provide for the development of a shared vision in your community?

A politician thought that the PHP had developed a shared vision of improved health in the community. A senior manager stated:

M6: I think at the meetings I was at a shared vision came through. Agencies valued the collaborative planning environment. I don’t think it was difficult for those groups to get a vision of what they want for their communities.

Practitioners noted that agencies who participated were introspective and examined what they were doing, their visions and goals and how they contributed towards quality of life. An agency partner agreed that the original PHP concept was about a shared vision for health: The original approach at the public meetings was about improving quality of life and providing a living planning document.

Accountability

Q. Did the process identify partner’s responsibilities in the PHP?

A politician, senior manager, and practitioner advised that there was a lead agent for each strategy and that they would identify a person responsible for each action within their business plans. Each participating agency identified the strategies that they were responsible for and reported on outcomes to the PMT every six months. Many PHP strategies were also contained in the partner organisations’ existing action plans.

Monitoring and Evaluation

Q. Did the process identify how to evaluate the work?

Politicians, managers and practitioners agreed that a process was developed to evaluate and measure the performance of the plan. A senior manager stated:

M6: Yes we did have an evaluation process, but we probably started to look at it toward the end of the process rather than building it in from the beginning.
Q. Did the process monitor activity progress?

KIs listed several activities that are a direct result of the PHP initiative in Wide Bay. As advised by the politician from Maryborough these included increased health action and networking between agencies, increased usage of the media and health publicity, increased immunisation programs and increased activity with the Access Advisory Committee. A Councillor from Wide Bay answered: Well you’ve got something to work with and to work for. You like the fact that it’s a document in Council…You should be able to read it and refer back to it all the time, a reference point for all health issues. You can check off what you’ve done.

KIs stated that activity progress was monitored every six months the program management team. A senior manager stated:

M6: Each six months actions in the PHP are updated, and that’s available on Council’s web site.

Q. Sustainability of the MPHP Process

A politician stated: Some agency heads didn’t understand in the early parts of the PHP process, some of the implications of the PHP for agencies reporting on key outcomes, so participation and sustainability of the planning process became an issue.

All categories agreed that the planning process was excellent but the long-term sustainability of the PHPs were subject to obtaining joint strategy funding and the CPHUN and both councils providing continuing project officer funding to project manage and implement the plan. In each case, the PHPs were community plans but facilitated by council, so Councils had the major responsibility to facilitate joint funding for its operation. Several comments were made about the sustainability of the MPHP from both project KIs. A manager in the Wide Bay project commented:

M7: I think what happened is that it is in the early days and I think [the MPHP] is starting to gain momentum. It was certainly on people’s minds when they were told that it would be part of the new Health Act, that it would be mandatory. But I think it is starting to take hold, and as more Councils do it the benefits we’ve seen will be taken on and it will widen the process.

9.9 Implementation Impacts on Individuals and Organisations

9.9.1 Benefits and Support for MPHP (Political, Management, Practitioner)

Q. What do you think are the benefits of having a MPH plan?

All categories identified networking as the key benefit of MPHP. Politicians agreed that the principle benefit was networking between the three levels of governmental and the non-
government agencies. Politicians found the other key benefit was that PHP provided a very broad perspective of certain concerns that had not been addressed previously. Managers noted that the main benefit has been achieving network interaction between disparate agencies involved in the city; getting them together to discuss a broad range of topics and improve health outcomes. The main feature that engages organisations is the MPHP process itself. Managers responded that the MPHP process dealt with health issues outside of the traditional elements of environmental health and that this required more interdepartmental connections, but it meant that health was the priority on the agenda.

M8: I think overall it is a health plan for the whole of the city. It’s pulling all of the various organisations, the participating partners, and the people in town, giving them a responsibility for the health of the community. And it’s also putting together a plan for the Council on their role and giving public health a greater emphasis.

Practitioners commented that MPHP was also a capacity-building activity and professionally rewarding for those involved. MPHP allowed practitioners to work with people, professionally and individually, at a similar level across different government and non-government agencies, extending skills, knowledge and experience. Other practitioners commented that MPHP provided an opportunity to assess community needs helping agencies improve the way they worked together and allocate spending. In relation to health needs and service gaps one practitioner stated:

HP5: I suppose it’s good in community development terms, if we can get people working together on shared issues and needs, which is going to have a more healthy outcome and be better for the community as a whole. You can actually start to address gaps in the community. You can actually avoid duplication of services and you can identify different needs and gaps and you can actually focus in on those priority areas.

Q. What political support is provided for the MPHP during implementation?

A Maryborough Council politician advised that the Council provided plenty of support for the PHP. Senior managers agreed that both Councils gave political support to the PHP project. A manager from the environmental health section at Hervey Bay stated that ‘Monetary support of $10,000 was provided by the Council, which is still a significant investment for the department of this size’. Practitioners stated that the mayors of each city were very supportive but other Councillors could have provided more political support to the project. One practitioner stated:

HP5: The MCC mayor is very supportive, he provides supporting letters.

An agency partner stated:

AP5: Councils were certainly on side. Both mayors, they didn’t want to get expectations too high due to budget constraints.
One issue that compromised its implementation in Hervey Bay was that an election was held and a new mayor took office, the planning cycles did not align with the political cycle. A senior manager said:

*I’m not sure about the new mayor of Hervey Bay’s support, but the outgoing mayor remained supportive. I’ve seen no evidence of the new mayor’s commitment yet. One of the things probably would be to do annual training and that would help to re-jig the enthusiasm among the mayors and the Councillors.*

**Q. Has the MPHP increased political support within your organisation?**

Politicians, managers and agency partners agreed that the PHP in Wide Bay had increased their own organisational support. One practitioner noted:

*HP5: It’s opened Council’s thinking in a sense that health is a bit broader than just clinics for immunisation and environmental health that health does take in the whole community. The definition of ‘health’ in the PHP is broad.*

**Q. Is there management support for MPHP in your Council/organisation?**

All KIs indicated that there was management support for the Wide Bay Regional PHP. The senior manager from Queensland Health commented that the mayors’ and CEOs’ support during the planning phase of the project was satisfactory but unfortunately this didn’t translate into funding for the appointment of a permanent full-time project officer position. The responsibility of implementing the Wide Bay PHP went to environmental health staff that were seconded from within each council. No new positions were created in councils to implement the PHP. This caused project management and workload problems.

*M6: The project officer position was lacking, and that’s where we are trying to get that project officer on board to drive the implementation. Where you’ve got an officer trying to do the implementation while they do their other duties PHP often comes too low down the list of priorities. So that’s a challenge there. With management support the Central Public Health Unit incorporated the PHP issues in the plan into their units business plan and we put a person against each of those tasks so you’d really have a project officer looking after the implementation of those plans now. Financially the PHP was supported and by providing staff to be involved in the development and implementation of the plan and it’s supported in the business plan. From governance point of view CPHU has placed the PHP in the internal Outcome Area Plans required by our central administration.*

*HP3: I think, in regards to management support, certainly from the PHU’s perspective there has been very strong management support. It’s been built into our outcome area and partnership area plans so it’s very much ingrained into what we are doing at a corporate level, our direction as such, which is filtering down to our local level. So we’re certainly living out what has been proposed strategically for our unit and I know that our manager of public health services through to our zonal manager and our unit manager are all very supportive of this process.*
In response to the level of management support for the PHP a practitioner commented:

HP3: Yes, environmental health staff were involved from both Councils. In fact they were, perhaps, leaders from both Councils if you like. We’re fortunate also in the public health unit that the coordinator of our unit is also the Director of Environmental Health so we had a key influence there. Our other EHOs were also involved at a working party level throughout the project as well, not all field EHOs were involved.

9.9.2 Health Policy on the Agenda

Q. What policy changes have resulted in your organisation as a result of the MPHP initiative?

The KIs collectively reported that health and environmental issues were now on the agenda as a direct outcome of the PHP, that community consultation had increased and that the Councils were consulting and communicating well with Council professional staff. Senior managers agreed that health was high on the agenda in the region as a result of the PHP initiatives. CPHP had also become a key initiative in both the ‘Communities and Local Government Outcome Areas’ in internal planning and the Local Government Association Protocol.

Practitioners reported that they were aware of policy change as a result of the PHP, stating:

HP5: There certainly have been some strategies from the PHP implemented. The youth network program is an example where a group of us actually listed [the] youth and services area for funding and we received over $300 000 over three years to pilot a youth network program. From that, too, the youth services are meeting again and it has brought people back together again to work on something.

New policies were enacted in the CPHUN to partly resource the cost of a project coordinator for one year, in fact $15,000 funding was allocated for the new implementation officer position. Councils were to also contribute towards this position, however only 1 year of funding was available. An agency partner noted that health was on the agenda with the introduction of the PHP but implementation of the strategies was the ongoing problem.

Q. Barriers to Successful Health Policy Implementation

KIs reported a range of challenges and barriers in the development and implementation of the MPHP projects in their city. Politicians expressed that their key concerns were not having sufficient resources to implement the comprehensive PHP. There were concerns about a general lack of funding for the MPHP. KIs indicated that there was inadequate funding in terms of both money and human resources to satisfactorily implement the MPHP and that the plan should have had a five year timeframe plan to allow more time to implement strategies.

M6: Well it’s clear now that the three year plan was too short a time to implement all strategies. We probably should have developed a slightly longer plan. I think four or five years is probably
a more sensible life for the plan with regular review. I think when the three years run out I don’t think there will be any challenge to re-do it, update the plans. Well, that’s the main challenge, keeping the implementation going. That’s where we see too many fall over. So far we’ve kept up to the schedules. The management group have been able to keep driving the implementation.

A senior manager was concerned about how staff turnover would affect the PHP and partner organisations, particularly the agency partners: Sometimes as much as fifty per cent new faces attended health planning implementation meetings. The challenge is to ensure that the core business of Council is in the PHP, not just in the Council operational plans.

HP3: Particularly in regards to the next five years there should be a continued investment in PHP. I think that the process has been started, the implementation is showing results. I think that it needs to be given time. Certainly not sort of decided upon that it’s not to progress beyond a three year period. I think a good evaluation should be done and undertaken by the Councillors. We need to agree on funding processes and in principle [there] needs to be that continued commitment towards it with a strong evaluation, and hopefully [its] successes and the achievements will speak for themselves and look to continue on with the planning process.

HP3: I think that in the initial awareness raising stages that if we could have reached those other departments within Council, the town planners and the engineers and so on, I think that would have been to the advantage of the project. I think also that at that stage it would have been great to be able to get on board and better inform some of the other government agencies and non-government agencies and the community, because they really didn’t come on board until the working party stage mid-way through the project.

Several managers indicated that getting funding to resource the new initiatives in the planning documents was the greatest challenge.

KIs debated the question of where the MPHP should sit in the Council: in the environmental health branch or at a higher level to engage more departments in boarder planning agendas. Senior managers tended to understand the broader opportunities and strengths of MPHP and felt the MPH Plan should be a high level planning process, while the operational managers, who managed the day-to-day implementation and organisational planning issues felt that the MPHP should be an operational level. The problem was that there was lack of resources, lack of community participation, and lack of direction for the MPHP implementation in its current state.

HP4: My main concern is that the community consultation or involvement seems to have decreased since implementation. Other than newsletters that are going out they don’t have any involvement.

There was widespread agreement between all KIs that agency partners were fully supportive of the MPHP initiative and attended meetings and developed a network of interested health partners. However, in Hervey Bay and Maryborough agencies were reluctant to sign off and commit resources to implement the plan. KIs agreed that non-government agencies benefited by being part of the MPHP committees. An agency partner commented that NGOs need more
time to engage with planning processes and that it takes time for them to integrate their involvement in their business agenda plans. She stated:

_The community welcomed the CHP with open arms and a lot of them tended to take on board more than what they could cater for at that time. Considering this was bought on in a hurry and we were asked to facilitate it all within about a three month space, a lot of agencies hadn’t brought it into their own work plans and that posed a big issue for a lot of agencies because it really stretched the workers._

9.9.3 Health and Environment Activities

Q. What are the most inspiring examples of public and environmental health planning outcomes by Councils?

Chapter 8 lists the progress of strategies implemented by the WBRPHP in a table in detail. KIs listed significant activities that are a direct result of the PHP initiative in Wide Bay. As advised by the politician from Maryborough these included increased health action and networking between agencies, increased usage of the media and health publicity, increased immunisation programs and increased activity with the Access Advisory Committee. A senior manager from CPHUN felt that health initiatives in their business plan had significantly increased. A practitioner stated:

HP5: *Everything’s always busy. The PHP certainly has meant that I facilitate meetings and take minutes, do reports, which is more time consuming. My role has changed; I am engaging more environmental services and the Environmental Health Department than what I would normally have._

An agency partner noted that there were more social health issues activities where once the ‘natural environment’ took priority in council planning. KIs reported a significant number of inspiring examples of planning outcomes during the projects. Through intersectoral working parties the MPHP process got agencies and community representatives to not only collaborate but to be part of the decision-making process for health, placing their agency issues firmly on the health agenda. There was a sense of empowerment among the Advisory Committee members that had not been reached in other projects in the region, practitioners stated:

P3: _There was consultation not only with the community but with professionals._

P2: *From the community consultation in the CHP and the seven focus groups I attended you got a feel for what some of the priority issues were and you were more confident in providing a service._

Managers also highlighted the value of the MPHP process to make change in health policy. Managers reported that the CHP had been the catalyst for an injection of funding into the communities for health projects, and that the most encouraging outcome was that the youth sector in WB were working together to get grants and improve the facilities for the local youth. The PHP was seen as the ‘key driver’ in understanding the role of the sectors in health and
particularly physical activity programs in Wide Bay, senior managers and health practitioners stated:

M7: I think that the key outcome of the PHP was getting a better understanding of what all the key agencies were doing. It was also interesting that you’d talk about an issue around the table and some of the key agencies would say ‘well we’re doing something on that’. It did seem like you could improve the resources of the public sector by these plans by just getting people together and communicating.

HP3: I certainly see that after the first twelve months that there has been an injection of resources into the communities of both Maryborough and Hervey Bay as a result of strategies in the plan. So that’s a very positive result as I see it. There are some good examples of an increase in the number of people that have taken up physical activity and exercise through the ‘Just Walk It Program’ for example. It’s an existing program that’s been introduced into these communities on a trial basis. There are now twenty walking groups happening that weren’t happening before, up to nearly 200 people walking now as a result of that that weren’t necessarily walking before.

9.9.4 Best Practice Planning for Health

Q. Have you any examples of the MPHP process integrating with other planning processes?

Politicians, senior managers and one practitioner advised that the PHP was integrated into the Town Planning Scheme in both Hervey Bay and MCCs under the requirements of the IPA. A politician answered: Yes, the PHP is integrated into the Town Plan, but should be a stand-alone. The PHP should be used more, and be able to be used for a reference document.

A senior manager from CPHUN advised: With the IPA process every IPA application that I review, the PHP and any future PHPs will be incorporated into the planning process.

One practitioner gave examples of shade creation strategies that linked to the Town Planning Scheme to the PHP. The KIs across all categories indicated that MPHP was integrated into the corporate planning processes of Council but had not been fully integrated into the Town Planning Schemes.

M6: I think there’s a need for the MPHP to integrate into other agency strategic plans but we are still in the early stages. That’s the implementation challenge. We’ve been pushing that all along, that these plans need to be used now, and [we must] try to get commitment from our partners to incorporate them into their business plans.

Another manager indicated that the town planners in Council could see the importance of the MPHP feeding information up to the town plan and getting grants to fund healthy projects. Senior managers however, in allied sections in council needed to be better briefed about the role of the PHP.
Q. What are characteristics of best practice community public health planning?

All categories of KIs interviewed highlighted that best practice relates to the link between improved agency partnerships and intersectoral action, and improved health outcomes. A manager and a health practitioner agreed on this point and stated: *The CHP is best practice because the planning has such broad intersectoral partnerships involved and...in that it’s giving the Council and community a plan for the future.*

HP4: *The PHP is about best practice teamwork, partners working together in partnership.*

Q. How significant is MPHP compared with other planning initiatives in the Council/your organisation?

Politicians advised that the MPHP has raised awareness of not only health issues in the community but of the Councils’ responsibilities for health and quality of life. Hervey Bay City used the PHP to provide information on health needs in the new town plan. Managers reported that the MPHP was similar to the Council Corporate Plan in that it assisted the decision making in the Town Planning Schemes, stating: *The challenge is now to integrate our MPHP plans into Councils’ other planning processes.*

Q. What is your overall assessment of the state of MPHP and practice within local government?

Politicians felt that not all Councillors understood the MPH plan’s intent. A Council elected representative stated that ‘Councillors from Wide Bay reported that the PHP was not being used enough as a best practice model, that other Councillors didn’t understand the planning process and weren’t as involved as first expected.’

P2: *In terms of improving the process I should have done a full talk to the Council right up front, but we’re always better in hindsight. In essence the two outlying Councillors thought the responsibility of the PHP was theirs, but certainly the local Councillors in the city itself had absolutely no idea, most Councillors didn’t realise how broad reaching the strategies in the PHP were.*

Agency partners collaborating on the planning project were positive about the MPHP.

AP4: *I think the fact that each of the Councils took it on board was significant. The fact that from a road safety point of view it has given us a head start, and we’ve actually taken on board the substance in it and we are using it. It’s not just dead information lying inside the document.*

Q. Strengths and Weaknesses of MPHP

In general KIs felt the MPHP process was a very positive process and beneficial and that it moved Councils towards new understandings of health services and better collaborations. However, the success of the planning varied between Council areas. Politicians commented that one of MPHP’s strengths was that the process could be used to check and balance the agencies involved. Several managers found the MPHP to be an effective planning tool, useful for identifying gaps in the region’s services. Agency partners were however critical of the slow
progress of the MPHP implementation. Wide Bay PHP agencies complained about the slow actioning of the strategies in the PHP. Comments from agencies in Maryborough and a regional agency included:

AP4: I think that the weaknesses were more evident with Hervey Bay than with Maryborough. Perhaps because Hervey Bay attempted to do more with the document than Maryborough did. But the endeavours that Hervey Bay had in identifying the major stakeholders and having the stakeholders take responsibility for the actions just didn’t come off. It really requires secretariat backup for these kind of things. Unless you’ve had people involved over a long period of time and they’ve developed ownership people won’t engage.

In general the MPHP process was well understood and supported but the significant lack of monetary resources and human resources to implement the action strategies in the planning document was seen as frustrating. KIs generally agreed that the state government did not provide the necessary capacity-building support to fully implement the MPHP. This lack of support threatened the MPHP’s sustainability.

9.9.5 Infrastructure Change

Q. What structural, organisational or environmental changes, which could potentially impact on the target population’s health, have resulted from the MPHP activities?

A politician from Maryborough agreed that the PHP had initiated levels of organisational change in Council particularly more environmental activities. A manager from Hervey Bay advised that the PHP didn’t operate for long enough to affect structural changes in the Council, a health practitioner stated:

HP5: Having enough resources is the issue, [we] didn’t have enough time to handle the three monthly updates required by the CPHUN. We have competing priorities with other roles, but [it would be better] if there was somebody here to actually drive the plan a little further and make contact with agencies and get people back on board, especially as it’s coming up to the cycle when agencies are doing their operational plans for the next financial year.

One senior manager advised that there was limited change as there was a lack of ‘someone concrete to just drive the PHP implementation in Council’. Another senior manager commented: The Council needs to ensure that the implementation phase of the PHP moves forward and is resourced. I think they need to do a lot more work in that regard. We discussed that in a staff meeting and said, ‘look it has to go forward and our project officer on staff will have to allocate the time’.

A politician in MCC said that the regional approach has not necessarily helped Maryborough to ‘own’ their health issues, and that each council would have taken more responsibility with a local approach to planning, stating: Health promotion is run from Hervey Bay CPHUN and you really need your health promotions officers here in Maryborough...because health promotion
officers need to be on-site. If you don’t live here you don’t know what we really need and know the attitude of the people. Hervey Bay is much different to Maryborough attitudes.

A practitioner supported the inclusion of the PHP as core business in the Council Corporate Plan.

Q. Have the Council interdepartmental agencies changed their attitudes in relation to the project’s objectives?

KIs interviewed advised that attitudes about the PHP’s importance had changed within their organisations. A senior manager observed that engineers and environmental health officers were working more closely together where historically there was little collaboration. He stated: The Manager of Maryborough is having some successes with collaboration among professional groups in Council because he has a pretty broad role with planning.

M7: Certainly from the planners’ point of view. It was pleasing to see how they acknowledged the PHP and the important role it will play in the Town Planning Scheme in Hervey Bay.

9.9.6 Skills Development

Q. What training has been provided to improve MPHP participants’ knowledge and skills?

A politician commented that more training workshops were required and that there should be only one person responsible for the Wide Bay Regional PHP implementation. An agency partner commented that more training would be beneficial for the PHP partners. A senior manager advised that training was conducted. He stated:

M6: During implementation we’ve kicked off a PHP ‘learning set’ within the Central Public Health Unit, a support group that encourage our colleagues who are interested in the process. We can share our successes and failures.

A manager from Hervey Bay indicated that while he gave two presentations to the Council management team about the objectives of the public health planning, he should have given similar training to lower levels in the organisation to improve grass root understandings of the PHP. Practitioners agreed that the initial training for the staff on the PHP PMT was beneficial but more understanding of the long-term planning outcomes would have been more relevant. One practitioner believed that the project teams’ training was perfectly tailored to their needs.
9.9.7 Visibility and Media

Q. To what extent have community agencies and residents been informed about MPHP processes throughout the planning?

KIs had a range of opinions on the extent that the public was informed about the PHP process including implementation. A politician working on the PHP in Maryborough City stated that more media usage was required in the PHP project. Another politician commented that the community were fully informed with the Council using the media well, particularly to highlight the disability initiatives. She advised:

P3: *During implementation of the PHP the existing working parties should be changed to an advisory committee. This approach will be highly visible in the community.*

Senior managers and managers agreed that more work must be done to make the PHP more visible and that this was the key responsibility of the project officer. Practitioners commented that during the PHP’s development the media usage and the launch was successful, but more work was necessary for the implementation stage. A practitioner note:

HP5: *I think it’s a Council responsibility to promote the plan, and some of the agencies can approach the media if they achieve positive outcomes.*

A senior manager stated that there could have been more media: *In Queensland Health’s respect media is pretty difficult with approvals you need but there certainly was some from us and from Councils, but I think it could have increased.*

A practitioner said: *The media was dealt [with] well up to the launch of the PHP but since then we’ve had limited media coverage.*

An agency partner said:

AP5: *For it to be successful and to get community support the PHP’s got to be in the media. The media is one of the most important assets of making a successful plan. Well, you can always have more. You can never have enough to get your message across to the community.*

9.9.8 Future Challenges

Q. Challenges of implementation

There were many comments about future challenges with implementation of the PHP:

M7 Greg C: *Implementation is always going to be a challenge: keeping the direction, keeping the groups interested and [knowing] where the resources are needed, and then being able to release them to do it.*
AP5: I recognise that it is not cheap but the benefits of the plan far outweigh the expenses to run the administration. We had some good people in the Council but they could only do what they did with the limited resources that they had.

A practitioner was asked to rate the PHP as to the plan achieving its aims, she answered:

HP5: Intersectoral collaboration? Yes, on a scale of ten I suggest seven or eight. We certainly got people talking and in some sense working together, maybe not to the extent the Council has. Community participation? If we are looking at the wider community, I think I’d probably rate that pretty low. I think we need to do more work on that so maybe two or three. Interdepartmental involvement, probably about an eight. Partnerships/ lead agencies / networking, a five and shared vision, I’d say, well we’re all looking for better outcomes and healthier communities so I’d maybe nine, I don’t think quite ten.

A newsletter was developed by the MREI Group and published in August/September 2000. The newsletter reported two successful grants in the area of Fraser Coast Youth Homelessness and Early Intervention Reconnect Program for three years at a value of $534 000. A second grant of $310 000 for three years was won by Maryborough Neighbourhood Centre to implement a Youth Networking project. Both grants are an outcome of the planning process and can be directly attributed to the community and agencies’ agreed-upon strategies in the PHP’s, and to the fact that both cities can demonstrate their needs, wants and health priorities to funding bodies. The PHP process provides clear information through its community profile and needs assessment steps. Partnerships formed in the planning process have also added value to further collaboration. More research is being completed around this important success story.

A practitioner concluded that the PHP’s key weakness was the lack of community input: As a process we need to extend the timeframes for strategy development. Even one more meeting would have been adequate. We have four meetings for each of the theme areas annually.

Senior managers noted that:

M6: I think that’s too early to tell. The agencies and partners are working better together to get grants and other funding. An example is the ‘injury grant’ that CPHUN are writing from the PHP strategies.

9.10 Implementation Impacts on the Community

9.10.1 Plan Exposure

Q. How much direct contact has there been between the project and the community during implementation?

All KI categories replied that contact occurred through the community and agency representing the implementation working parties, but more was required for the PHP implementation to be successful.
Q. What level of community participation has occurred during implementation?

The managers and practitioners noted that a PHP newsletter had been regularly circulated and contact was made with agency partners and community representatives when the PHP was updated every three months. While the first PHP update meeting seemed successful and had a lot of coverage, interest had waned by the second meeting. One practitioner commented: The only thing I can think of to make the PHP more sustainable during implementation is to hold a public meeting to explain what has been going on, what successes we’ve had and get their feedback on the way it’s sitting.

Q. List strategies that have been funded or achieved since implementation.

In the facilitator report, ‘Theme: Health and Community Services’ (28 Nov 2000), the Maryborough project officer advised that after a period of two year from the project’s commencement the following strategies had been achieved:

- Funding was received for a sexual assault service
- Funding was received to employ a social worker and a youth outreach worker for the Fraser Coast Reconnect Youth Homelessness Project
- Maryborough and Harvey Bay Disability Networks trailing merged to facilitate cooperation and information sharing service in the district
- ‘Pathways of Care Youth Service Resource Directory’ was initiated by CPHU-YPAR
- The ‘Rumble in the Jungle Program’ was held in Fraser Coast by CPHU-YPAR, and
- There was continuing interest from Maryborough/District service/groups with interest in youth to work together on projects.

A higher percentage of strategies were achieved in the regional theme working parties, that is, Employment, Education and Economic Development and Healthy Lifestyles. The Liveable Environment Theme had the least success in achieving any progress on strategies in the plan, while a number of health issues stretched across several theme areas because of the broad nature of the themes.
9.10.2 Resident Quality of Life

Q. Has the MPHP impacted directly on the quality of life of residents since implementation?

Politicians, managers and practitioners felt that agency partners were more aware of the organisations’ roles in public and environmental health due to the PHP initiative. One Councillor stated:

P3: Yes, the partners understand Council’s role a bit more. They don’t hesitate to contact us if there is any need. The network is stronger but it could be a lot stronger.

A practitioner commented:

HP5: At the update meetings the agencies actually learnt what other departments were actually doing. This was valuable. Information networking is certainly important. We get to know what each agency is actually doing and what their roles are.

A politician stated:

P3: Yes the PHP has impacted in terms of Town Planning requirements.

Managers had a mixed response. CPHUN managers reported that ‘there were definitely impacts on the community from the PHP and we know more about what agencies and community groups are doing.’ Another manager noted that it was too early to be able to say if there had been positive impacts on the quality of life of residents. A practitioner stated:

HP5: The PHP hasn’t touched the community in that sense, it hasn’t impacted on Joe Blow in the street. It’s been more at that community and government service level rather than the actual community. There’s been impacts from successful grants applications, bringing money to health issues.

KIs commented that quality of life changes are hard to measure and that in three to five years there should be some improvement in youth outcomes. One senior manager replied that ‘community attitudes about quality of life would be measurable after three to five years.’ A manager from Hervey Bay noted:

M7: Not yet. There’s going to be some strategies that are quick wins...and that was something that was important for the sustainability of the PHP.

HP5: I’d like to see the PHP staying within Council at the moment, but over time it should be more community owned.
9.10.3 Community Agency Strategic Plan

Q. Is the MPHP process, or are strategies in the plan, part of the community agency strategic plan?

A politician stated that it was very important for agencies to include their PHP activities in their strategic plans, but not all agencies had achieved this in Maryborough. A senior manager from CPHUN advised though that the majority of agencies across the region included the strategies in the PHP in their organisations plans.

In summary politicians, senior managers of CPHUN and agency partners advised that the PHP is a key component of their organisations’ core business. A senior manager from the CPHUN stated:

M6: I think Queensland Health has moved towards the participatory approach. There has been a big shift in Queensland Health’s thinking. If you don’t move in that direction these days you’re a dinosaur.

9.10.4 Agency Co-operation

Q. What changes have you noted in your agency as a result of the MPHP project?

A senior manager and health practitioner responded that the PHP brought about change:

M6: I think it’s really enforced that social definition of ‘health’. It makes you think much more broadly about what health is and what we’re doing in health, whereas we weren’t trained to really think that broadly, it’s given us some legitimacy to expand the boundaries.

HP4: [I’m] more aware of other agencies in the area. I’ve developed contacts within those agencies that I can call on for information and feedback, but I feel good about it myself.

A practitioners interviewed believed that cooperation had improved between agencies, but more work was needed.

HP5: Under different strategies within the plan there might be several partners that are listed that don’t talk to one another. They might be doing things and working towards a strategy but they’re not actually working together and again that’s a co-ordination thing. A lead agency is not actually taking on their role...I think the relationships between professional groups in Council have improved. Certainly, without the PHP there would not have been anything happening otherwise.

In summary, Partnerships have improved across professional groups working on the plan, but as one politician pointed out: Professional group are working well together under the PHP all due to the plan that’s facilitated the collaboration.

Q. Has cooperation between the agency and the University been beneficial?

The facilitation by Griffith University was seen to be very helpful to the PHP project.
9.11 Achievements and Barriers to Effective MPHP

Table 33 describes the analysis the KI responses from the evaluation of the WBRPHP project via a summary of Process Issues: achievements and barriers to effective MPHP; Table 34 documents in the implementation impacts on individuals and organisations and communities.
Table 33: Wide Bay Regional Public Health Plan – Implementation Process Issues: Achievements and Barriers

<table>
<thead>
<tr>
<th>Inter-sectoral Collaboration</th>
<th>Community Participation in local decision-making</th>
<th>Interdepartmental Involvement</th>
<th>Partnerships</th>
<th>Shared Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of collaboration</strong></td>
<td><strong>Level of community involvement</strong></td>
<td><strong>Collaboration between Council departments</strong></td>
<td><strong>Joint working</strong></td>
<td><strong>Development of a shared vision in community</strong></td>
</tr>
<tr>
<td>Process invoked greater levels of collaboration between all levels of agencies in the region.</td>
<td>Satisfactory level of community participation, including focus groups, working parties and public meetings.</td>
<td>Better understanding of the role of the Councils and CPHUN in Wide Bay in public health, health promotion and environmental health.</td>
<td>PHP process strengthened partnerships between the Councils, Queensland Health and other agencies, but the nature of the partnerships varied.</td>
<td>PHP had developed a shared vision of improved health in the community during the process of developing the plan.</td>
</tr>
<tr>
<td>Collaboration was highest during the seven-step planning process, but decreased when the plan was being implemented.</td>
<td>The community are still involved with implementation working parties.</td>
<td>Integrated approach to planning and community input at all stages of planning processes.</td>
<td>Staff turnover in all agencies is the weaknesses of the project.</td>
<td>Implementation of the PHP decreased after two years.</td>
</tr>
<tr>
<td><strong>Shared objectives and group purpose</strong></td>
<td><strong>Empowerment and decision-making</strong></td>
<td><strong>Changing roles of departments</strong></td>
<td><strong>People drove the process there were cultural differences between agencies, the PHP acted to dissolve differences through joint work.</strong></td>
<td></td>
</tr>
<tr>
<td>Planning clarified the agencies’ roles in public health service delivery.</td>
<td>Initial skills training by project consultants was beneficial on the process.</td>
<td>PHP included in Council and many agency business plans.</td>
<td><strong>Resource sharing</strong></td>
<td></td>
</tr>
<tr>
<td>The networking was quite positive and a key issue, health promotion activity was now based on the health needs that had been identified in the plans and activity was increasing.</td>
<td>More understanding required of what the plan was going to achieve, its outcomes and how it might affect communities.</td>
<td><strong>Organisation of work practices</strong></td>
<td>Agencies reluctant to be guided by the PHP needs due to possible impact on current and future budgetary issues and impact on their core business.</td>
<td></td>
</tr>
<tr>
<td><strong>Composition of working parties</strong></td>
<td><strong>Conflict emerged during the Project, caused by people strongly pushing their own agendas.</strong></td>
<td><strong>PHP changed the Council’s priorities.</strong></td>
<td>PHP is a good planning tool for activities for the next three years.</td>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td>Multi-sectoral approach to working parties and committees.</td>
<td></td>
<td>Job descriptions did not reflect changing roles until the creation of a new position: this was poor job practice.</td>
<td>Newsletter was most efficient communication tool.</td>
<td><strong>Accountability</strong></td>
</tr>
<tr>
<td>Health practitioners were the driving force for MPHP to work more efficiently and more effectively in communities.</td>
<td></td>
<td></td>
<td>Agencies reluctant to sign MOUs and commit formally to the strategies</td>
<td>Letter of support from partner agencies needed for the PHP to implement certain strategies in the plan</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td><strong>Conflict emerged during the Project, caused by people strongly pushing their own agendas.</strong></td>
<td><strong>Monitory of activities and evaluation</strong></td>
<td></td>
<td>Lead agency for each strategy identifies a person responsible for each action within their business plans</td>
</tr>
<tr>
<td>Practitioners and agency partners had suitable plan development funding, implementation funding was lacking.</td>
<td></td>
<td>Activities were reported by agencies and collated by Council every three months, this process fed back information to all committees.</td>
<td><strong>Monitoring of activities and evaluation</strong></td>
<td>Plan updated every six months from progress reporting of agencies.</td>
</tr>
<tr>
<td>People had the skills but lacked the time to devote to the PHP process.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Table 34: Wide Bay Regional Public Health Plan – Implementation Impacts

**IMPACTS ON INDIVIDUALS AND ORGANISATIONS**

**Benefits and Support for MPHP**
- Increased networks between three levels of government and community agencies.
- The process of planning increases intersectoral collaboration.

**Political Support**
- High level political support across the region during first year of implementation.
- Management and professional support from all levels of agencies placed health firmly on the agenda.

**Health Policy on the Agenda**
- Broad perspective of health concerns not previously addressed by other planning.
- Community consultation empowered the interest of professionals in Council.
- Limited policy change in organisations to sustain the health movement.
- PHP clarified what the agencies were achieving.

**Organisational Change**
- After two years of implementation insufficient human resources to implement the strategies in the PH Plan.
- Agency partner staff turnover impacted on plan implementation.
- Lack of investment in PHP to engage project managers was a critical factor.
- Conflict between executive managers and health practitioners over operationalising the plan.
- Agencies needed more time to integrate PHP strategies in their strategic business plan.

**Health and Environment Activities**
- Increased health promotion action and networking between agencies collaborating on plan implementation.
- PHP a key driver and catalyst injecting funding into communities for health projects.
- Sense of empowerment in the advisory committee participants from the HCM not reached in other projects in the region.

**Best Practice Planning For Health**
- Strategies in PHP integrated into town planning schemes of participating cities.
- Best practice characteristics relates to linkages with broad agency partnerships and improved health outcomes.
- PHP as significant as the corporate plan and feeds health data to the town plan.
- Regional approach had economy of scales for resources but ownership by individual Council significantly decreased and impacted on sustainability of plan implementation.
- Planning approach allowed by a check and balance on agencies performance.
- A main weakness was State government not proving capacity building support to fully implement the plan.

**IMPACTS ON INDIVIDUALS AND ORGANISATIONS (continued)**

**Infrastructure Change**
- Health planning gathered momentum in first two years but an overall assessment of implementation found lack of commitment between Councils and limited project staff.
- The Environmental host organisations did not restructure or implement any organisational change their departments to allow for the implementation of this broad public health plan.
- Lack of project driver in Councils.
- There was an increase in environmental programs as a direct result of the plan.

**Skills Development**
- Learning set developed by CPHUN during implementation was instrumental in progressing capacity building for health planning across departmental.

**Visibility and Media**
- Media worked well with health promotion staff to promote PHP launch and programs.

**IMPACTS ON THE COMMUNITY**

**Plan Exposure**
- More contact with community groups and residents required during implementation phase.
- Three monthly newsletter effective communication tool.
- Over 2 million in funding for community projects as result of the PHP, this would directly impact positively of health service provision and lead to health outcomes.

**Residents Quality of Life**
- Residents and community groups more aware of public and environmental health issues since introduction of PHP.
- Increased confidence by residents to communication with Council over health issues.
- Health impacts are measured over medium to long term timeframes, making outcomes difficult to demonstrate.

**Community Agency Strategic Plan**
- In most cases the core business of community groups was in the PHP however limited success with other agencies including strategies in their business plans.

**Agency Cooperation**
- Agencies were accepting of the broader determinates of health and the opportunity for collaborative action.
- Facilitation and capacity training by the neutral university partner was considered as positive to planning approach.
9.12 Conclusion

This phase of the research described and examined the responses of KI participating in two MPHP projects. The EF developed and described in Chapter 6 was tested with participants of the Gold Coast City CHP and the WBRPHP project. From the meanings and interpretations discovered from the qualitative data, the research then documented the achievements and barriers of the MPHP process and implementation for each project. Chapter 10 presents the findings of Phase 3 of the data collection. It analyses and compares the strengths and limitations of municipal public health planning to other community public health planning and legislative planning frameworks. The themes developed from the combined findings of Chapter 7, 8, 9 and 10 are discussed in Chapter 11.
CHAPTER 10 COMPARATIVE ANALYSIS of COMMUNITY PUBLIC HEALTH PLANNING: MPHP STRENGTHS and LIMITATIONS

10.1 Introduction

This chapter presents Phase 3 of the data collection. It analyses and compares the strengths and limitations of municipal public health planning (MPHP) to selected community public health planning (CPHP) models and legislative planning frameworks (LFP). There are two sections of data findings. In Section 1, the results, findings and interpretations are examined from 17 in-depth focused interviews of key informants (KI) conducted with managers, health practitioners and representatives of agency partners. Section 2 describes and discusses the findings of the document mapping of selected CPHP models and LPF in Queensland. The collated findings of this chapter are presented later in this chapter in a table of MPHP strengths and limitations (see Table 38).

10.2 Background

The Community Public Health Planning Review (CPHPR, 2003) commissioned by Queensland Health addressed the reported lack of cohesive and coordinated approaches to community public health planning (CPHP) across Queensland (see Davey, Stewart and Spork, 2003). The CPHP models and LPF examined in the CPHPR are listed in Table 35.

<table>
<thead>
<tr>
<th>Community Public Health Planning Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Public Health Planning in Rural and Remote Areas Project (CPHPRRAP)</td>
</tr>
<tr>
<td>The Bowen Project (Bowen)</td>
</tr>
<tr>
<td>Place Management (Place)</td>
</tr>
<tr>
<td>Supportive Environments for Active Living (SEAL)</td>
</tr>
<tr>
<td>Local Agenda 21 (LA21)</td>
</tr>
<tr>
<td>Municipal Public Health Planning (MPHP)</td>
</tr>
<tr>
<td>Towards Ten Year Indigenous Partnerships</td>
</tr>
<tr>
<td>Community Renewal</td>
</tr>
<tr>
<td>Legislative Planning Frameworks</td>
</tr>
<tr>
<td>Integrated Planning Act (IPA)</td>
</tr>
<tr>
<td>Local Area Planning (LAP)</td>
</tr>
<tr>
<td>Regional Framework for Growth Management (RFG)</td>
</tr>
</tbody>
</table>

The review aimed to develop a shared vision for health planning within Queensland Health, but strove also to engage other agencies to invest in CPHP in the future. The review, which commenced in 2003, was led by the researcher while employed at the Queensland Centre for Public Health (QCPH), Griffith University. The results of the review were published in a government report (Davey, Stewart, Spork, 2003); the findings were presented in a seminar to the board of directors of Queensland Health. The CPHPR recognised the importance of working
across the sectors, rather than restricting the data collection solely to the health sector. Hence the stakeholders interviewed were employed across sectors involved with health planning, from the departments of health, state development, community engagement, local government and planning and housing.

Key informant (KI) survey data came from 17 focused in-depth interviews with a broad group of stakeholders state-wide in 2003, conducted by the researcher. The relevant findings of the Community Public Health Planning Review (CPHPR) – where it relates to MPHP – are then presented to support this discussion. Elements of the data from the KI interviews and the conceptual mapping of selected CPHP models and LPF conducted in the review will be extracted and discussed. Interviews were conducted by phone by the researcher (with equal assistance from one other academic staff at the QCPH) during June 2002. Table 36 details this breakdown by each category of KI interviewed while Appendix K lists the full details of KIs.

<table>
<thead>
<tr>
<th>Categories</th>
<th>M Manager</th>
<th>HP Practitioner</th>
<th>AP Agency Partner</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Participants</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>17</td>
</tr>
</tbody>
</table>

The added value of examination of this information is that this time the majority of KI are in executive and senior decision-making positions across a broader range of state-wide government agencies: the findings are therefore more representative of the opinions of higher level decision-makers and health policy advocates. The first set of KI interviews (see Phase 2 of Results and Findings) examined mainly local and regional agency staff opinions. Each interview ran for approximately one hour, with interview data recorded by note taking. Approval was obtained from Queensland Health to use the original transcribed data in this research. The conceptual mapping instrument developed by Davey, Stewart and Spork (2003) is presented in Appendix I. Information on the selected CPHP and LPF was extracted from this source for use in this discussion. The outcomes of the three regional workshops conducted in the CPHPR (see Davey, Stewart and Spork, 2003) have not been included in this study; these outcomes dealt with internal Queensland Health processes and were considered not to be relevant.

This Phase 3 examination will add to the body of evidence already obtained from the case studies and KI surveys conducted in Phase 2 of this research. In light of the literature review, this section contributes both the perspectives of managers, health practitioners and agency partners engaged in CPHP statewide and the salient features of CPHP, with an emphasis on examining the strengths and limitations of MPHP. The literature review in Part 2 and the key
learnings described earlier in the research case studies (Chapter 7 and 8) assisted the development of the survey framework used in the CPHPR.

As early as 2002 the following 10 question topics were formulated by the researcher for the CPHPR from this research base, these included:

- Awareness of and involvement with CPHP
- Knowledge of best practice elements of CPHP
- Key learnings
- Overall assessment of CPHP
- Future challenges and barriers
- Preferred models
- Health impacts from CPHP, and
- Other agencies that should be involved in CPHP.

10.3 Section 1: Findings of State-wide KI Interviews on CPHP and LPF

The analysis will follow the order of the ten questions above. Firstly, the level of awareness of community public health planning models and legislative frameworks varied across the KI categories of manager, practitioner and partner. In general, managers were aware of the majority of CPHP models in use in Queensland, both within Queensland Health and in other agencies. Managers were also aware of the commonalities and differences between models and understood their strengths and limitations. Most practitioners were familiar with only one or two CPHP models, with their experience tending to be limited to one preferred model – in most cases, the model they had developed or worked with in their own community. Practitioners had a limited understanding of the broad range of CPHP models used by Queensland Health and other agencies. Partners were mostly unaware of the CPHP investment that Queensland Health had made in community planning, but were knowledgeable on other planning state-wide processes, for example, Community Renewal, IPA, and Regional Framework for Growth Planning. In general, partners agreed that Queensland Health should disseminate information to other agencies on their health planning initiatives, and develop formal structures to enable other agencies to engage in this activity. Partners also felt that Queensland Health should become involved with regional planning frameworks and should engage in all aspects of regional health planning.

The Department of Local Government and Planning was not well informed of CPHP Models in Queensland Health. As expected, external agencies had less knowledge of CPHP in Queensland Health than did other categories. However, overall there was support for cross-agency planning workshops to inform sectors about health outcomes. In general, there were many and varied planning models being implemented across Queensland, with a high level of involvement in health planning across all categories of managers, practitioners and partners. The agency partners, however, were less informed of CPHP, as evidenced by the following comments:
AP8: There was not a lot of involvement in public health planning. I have not heard of any of these models.

AP6: Not involved in community public health planning processes in Queensland directly, mayors get involved in Regional Planning Advisory Committees (RPAC) and can put Health on the agenda, the future is regional planning engaging the health sector.

CPHP, having been initiated from Queensland Health, has unfortunately not engaged at all with the State Department of Local Government and Planning’s Regional Planning Advisory Committee (RPAC), and this appears to be a major deficiency in their partnership approach. If health planning is to be integrated with other planning mechanisms then RPAC appears to be lacking information on community health needs. Key informants were asked questions about their awareness and involvement in the CPHP models and, specifically, what they found to be the strengths and limitations of MPHP compared to the other CPHP models.

An executive manager reported that MPHP’s strength was engaging local government as a viable stakeholder to drive the planning process, particularly since local government was historically an action group. A weakness identified was that local government might not represent everyone, to a point where local government can be seen as bogey people. Other comments that local government was more sustainable and better positioned to manage health planning included:

M9: Local government is a more sustainable structure, a structure that will always be maintained, although there are some surfacing tensions between local government and community groups wanting to set up alternative form of government. As local government develops and grapples with social issues in the fullness of time they will enhance the social infrastructure evolution of supra process and this will be positive for social issues. Queensland Health needs to make the call as to what is the correct approach for planning. Our current Director General of State Development accepts local government as representative government, so let them do planning, LG politicians do what they should, MPHP is needed.

In general, managers expressed support for a variety of CPHP models in Queensland, because of the diversity of communities and organisational capacities in provincial towns, regions, towns, and rural and remote locations. KIs agreed that each model had strengths and limitations, and it was considered important to address each community’s needs and develop a tailored planning model, rather than to impose a template on communities, as supported in this view:

MP9: We need a series of planning models; don’t go down the preferred model track. Models should meet a series of quality standards, and we need to recognise the diversity of communities and not impose one model for all.

Secondly, there was support for a whole-of-government approach to planning and the need to gradually integrate planning strategies into the IPA. There was criticism of Queensland Health for not becoming an active partner in existing regional planning frameworks. The Department of Local Government and Planning representative (AP6) commented that the future is regional planning where health can engage. It was also noted that Queensland Health should encourage
any planning models that provide health information in local areas, and that this information should be disseminated to the regional planning frameworks. Health Practitioners were informed of best practice issues, but only around their preferred model. They appeared to criticise models they were not directly involved with.

A collation of elements of best practice included:

- The ability of the model to build capacity/skills/knowledge/awareness
- The level of community engagement
- The level of governance and legitimacy
- Plan sustainability
- The levels networking
- Planning process design and adequate needs assessment
- Project management capability
- Model’s ability to interact with other planning initiatives both horizontally and vertically
- Monitoring of costs of planning, and
- Evaluation.

KI commented that Queensland needs holistic, state-wide planning, because current planning does not balance economic and environmental matters, and has difficulty coordinating and integrating the social dimensions of planning. With respect to the horizontal and vertical integration of strategies between planning processes and land use frameworks, one agency partner felt that best practice depends on information on strategies communicating up to higher levels of planning, and the key role was to manage vertical and horizontal relationships, at the nexus of the community group, this approach will create change.

A health practitioner said:

HP8: Best practice requires intersectoral action, the IPA is a master planning framework. We need a strategic framework and we need community engagement.

In general KIs commented that MPHP had best practice features (only one KI disagreed). KIs commented about best practice MPHP in the KI interviews, stating MPHP provides a broad reach of agency inputs and involvement with the community. However KIs agreed that trust and goodwill need to be built up, and that MPHP needs to focus on issues of concern to be effective in the community. A partner noted: there is a lack of integration and communication between the various health silos; it’s do the best you can locally, then come back to health to support future progress.

Linkages to other projects could be improved and would add value to MPHP. MPHP needs to be accountable, reporting to the Regional Managers Forum (RMF) and informing other departments of progress. Health practitioners had varied responses to the elements of best practice MPHP:
M6: The [MPHP’s] strengths lie mainly in partnerships and the opportunity for community participation. The benefits include a greater council profile in the community. The weaknesses of MPHP include the level of commitment required, the time resources required.

HP8: I was involved with MPHP in the early days because of concerns about surveys of ratepayers. I was very involved with community renewal and SEAL, subsequently my enthusiasm for MPHP has cooled, partly because circumstances have changed: the policy and regulatory governance environment has changed. MPHP days are over, I find the word lead agency unnecessary: planning should be about partnerships.

These comments demonstrate the variability of responses and personal experiences with CPHP. Practitioners demonstrated a liking for their own planning initiatives, and criticised other CPHP processes. Health promotion officers competed across regions over funding for best practice CPHP.

The issue of key learnings was high on the agendas of managers, practitioners and partners when discussing their experiences with CPHP’s significant impacts on their organisation. In general, most felt the CPHP to be a resource-hungry process but considered it a priority investment. There was general consensus that lessons learnt from the planning models were being passed onto the organisation and community, particularly by the CPHPRR project. Some planning models, particularly the MPHP model, developed awareness-raising workshops to improve the skills of project managers, agencies and communities. However, it was noted that there is a lack of integration and communication between the various health silos.

KIs commented as follows:

AP6: More resources are required to develop plans and policy at State Agencies to coordinate CPHP. There is no coherent position to bring agencies to the table in making regional plans. We need mechanisms for local government to engage with IPA and the regional development of planning matters. Local government must integrate and coordinate needs.

M6: The CPHPRR projects passed on learnings. They did this well, they focused on maintaining the project on the ground, communicated learnings to organisations and Queensland Health staff, and fed learnings to management. The department was able to adapt to new way of working, so that it was not just planning, but disseminating of information.

AP6: The more Queensland Health participated in regional planning, the more successful they were.

AP13: In the CPHPRR Project we work on the horizontal (community level), but depend on the vertical (other planning processes in government); the key role is to manage vertical and horizontal relationships, at the nexus of the community group. This will create change. Need to build learnings on Organisational Change: establish learning networks across all levels of government and discuss what the learning processes for service sectors communities/practitioners/managers are. The actual outcomes need Govt versus community driven responses.

It appears that models that work in communities have certain strengths, and their key learnings should be recognised and tested in other communities. However, the lack of investment in
training and support for project implementation, compared to other allied agency investment, is supported by the following comments evidenced in the data.

M1: There was no core set of training from universities on CPHP and very little respect for community development or radical social work when planning.

AP8: The Queensland Government injected 82.5 million dollars into community renewal for three years for fifteen places to make CR sustainable. Training is needed with any CPHP model and so is leadership development for skills capacity building.

KI were asked the following question: As a [manager / practitioner / agency partner], what are the key learnings about your involvement in community public health planning? The responses relating particularly to MPHP, the focus of this section, include:

M9: The challenge is clearly for MPHP to take a broad view of health. The weaknesses: Are we getting to the people we want on board to help plan? In some large local governments you don’t get the people involved that you need to be involved.

M11: MPHP has been very beneficial and the Gold Coast appears from an external evaluation to have done very well. There is a need to communicate the MPHP successes better.

M11: Governance issues need improving, that is the types and levels of planning (local, regional, corporate, state). We should advocate for a whole-of-government approach, with Local Government placed well to implement MPHP.

A key learning established from the interviews was the importance of involving the University sector in the facilitation and training of staff engaged in MPHP. Many managers and practitioners agreed with one manager’s observation that there is not enough training in health planning. We need to make EHO more equipped for health planning. Educate them on how to manage planning processes.

Comments included:

M11: Agencies with MPHP should utilise the universities as facilitators; in this role, planning processes have been more effective, for example, in performing as a mediator between local government and state government. The notion of ‘partnerships’ gets away from the idea of ‘big brother’ and also develops the transfer of expertise. Place management and Community Renewal do not seem to be so well integrated with university expertise.

AP6: MPHP would be effective as a tool to provide health information to regional planning with local government. The clearer and more available the health information in a community, the better the local government will be able to communicate and implement the planning scheme.

HP3: MPHP has engaged environmental health people, but we need to have strategic planners and key government agencies involved also. The future challenges are in multiple planning processes that need to be better integrated. MPHP may have been the forerunner to other models and it seems to have taken a bit of a beating although this may reflect personalities and model prejudice.
The key informants gave a mixed assessment of the state of CPHP. Some respondents felt there was a need for skills training for all staff and community members engaged in CPHP. Respondents felt that health planning was evolving, and that state-wide structures for regional planning had improved significantly in recent years, providing a more sustainable structure for disseminating and actioning local strategies (that were government departments’ responsibilities). It was reported that a whole-of-government approach is now possible across the State, and that the IPA and town planning schemes of local government could integrate with the outcomes of local CPHP initiatives. The majority of people expressed a view that Queensland Health should continue to invest in CPHP across the state, but with greater collaboration from local government and other agencies that could influence health outcomes.

The following responses were documented regarding the question of the KI overall assessment of the state of community public health planning and practice within Queensland:

M9: Plenty of health planning activity, but no evidence of improvement in health outcomes; we need this to happen, need an information system established, and need indicators associated with the project.

M13: It is very important for local governments to be engaged in the process, as they have such a significant impact or influence on the local environment (for example, through active transportation, active recreation and green paths).

KIs responded similarly when prompted about having a series of planning models or one model that fits all circumstances – as one commented:

AP13: We need a flexible set of planning values and a workforce that can understand the complexity of the circumstances, rather than one model fits all communities. I suggest the need for a series of planning models, don’t go down the preferred model track. Queensland Health needs a series of quality standards to be met by Models, recognising diversity of community and not one model for all.

Resourcing issues were addressed by KI. Most KIs indicated a lack of resourcing for strategies in the plans; the need to define local governments’ role in MPHP; and the need to define training, education, and mentoring opportunities, as there is not enough training in health planning. There is a need to make EHOs more equipped for health planning and to enable this group to manage the process and planning implementation issues. MPHP needs more governance for sustainability. Finally, local government needs project management skills, to understand how the planning process works, how to promote sustainability of the project and how to allow the strategies in the plan to inform council’s long-term strategic planning. An agency partner agreed:

AP6: Local government has a facilitating role in planning. There are a wide range of interests; we need holistic state-wide planning. There is currently an imbalance between economic and environmental matters, the social dimension of planning are hard to coordinate and integrate;
health planning is then not comprehensive. Queensland Health has no legislation to allow this to occur.

Finally, all KIs noted that plan implementation is difficult without investment in planning, and the challenge is to continue to engage community members with no initial concrete benefit for communities, asking communities to give up time and effort with little reward.

KI were asked to summarise the major issues, challenges and barriers associated with community public health planning in their region; one responded:

AP9: Queensland Health should take a leadership role. It can’t expect local government to engage in community health planning unless it provides leadership and a framework to assist councils with this investment in the future of healthy communities.

The key issue to overcome is the planning sustainability issue. The question often proposed by KI was What can be done to sustain CPHP? KIs suggested local and state government agencies need new ways to work with other agencies; they need to find new ways to negotiate with other agencies and try to put in place proper governance to do cross-sectional activity. At the same time, agencies should improve engagement processes across communities. All agreed it is becoming more difficult to engage communities; one KI summarised this issue well: voices are hard to find. Finally, KIs agreed that there was need for more diversity and broader representation of the local community on Planning Committees and for better project reach.

Compared to CPHP, the MPHP process could be improved by:

- Improved communication of information to other layers of planning
- Improved investment and funding
- Better coordination of activities
- Improved leadership and direction from Queensland Health, and
- Supporting legislation for local government to engage legitimately with participatory planning.
One KI noted:

HP8: There are systemic problems; there is a real need for good governance structures. There is a real fear about this. Under the IPA, local government is required to take a key governance role. The solution lies in improved project management capability.

Most KIs supported the employment of a project officer to sustain MPHP initiatives during implementation, one stating: One key issue that needs to be addressed is the frequent personnel staff changes in agencies. Associated with this, is the need for on-going training and support. Councils cannot sustain the actioning of MPHP without suitable investment. It is clearly necessary to employ a project officer to sustain a CHP.

There were comments that many communities consider that they are over-consulted and that future planning initiatives need to consider short and long-term outcomes to meet, on one hand, a need for local political agendas to show early wins and, on the other hand, regional planning requirements for long-term planning.

In general, managers in Queensland Health did not favour one particular model, but preferred a suite of community public health planning models. Most practitioners had experience with only one model, and some practitioners showed support only for the model that they developed personally. All agreed that a ‘tool kit’ of CPHP models listing their features, strengths and limitations, would be beneficial for managers and practitioners when choosing a model for a
community. Most managers and practitioners supported having a series of planning models, rather than a preferred model.

Respondents identified a need for a series of guiding principles or quality standards for each model. In doing this, Queensland Health could recognise the diversity of communities, rather than taking a ‘one model fits all’ approach. Respondents thought that participatory planning models that engaged and involved citizens in decision-making should be used. The review also found that organisations needed governance arrangements to action the plans and strategies.

Several overall findings emerged. There was general support for a model identifying practice points and key learnings, but not for a preferred model. It was noted that all models analysed demonstrated that community engagement and agency partnerships were conducive to improved health outcomes in communities. As well, there was a desire for Queensland Health to be able to participate in other planning processes, not always as the primary driver. The major finding was that there was support for a series of planning models: that most managers and practitioners advised not to take a ‘preferred model’ approach. KI comments included:

M13: Need to use those parts of the various models which are functional for the specific community/job in hand. Need an approach which provides some ‘early wins’ to build resources and confidence.

AP13: Engage people as citizens, primarily use ‘participatory models’, involving people in decision-making have governance arrangements and it’s naive to make assumptions that all people want to be involved in such complexity of planning.

A KI informant made positive comments for future effective and sustainable planning that are of interest to the research findings:

AP6: The Regional Planning Advisory Committee (RPAC) shows a way forward, with local level planning schemes being the mechanism for local integration and coordination. The challenge is for agencies to be made aware of and to use it to progress initiatives. The IPA has a framework, but how it works in a voluntary and cooperative basis is the challenge. We need better strategies to engage and disseminate information and plans.

The MPH process was reported as resource intensive, more so than both Queensland Health and Council initially realised.

There was a low level of awareness of the health impacts of the Queensland CPHP models. Most participants advised that there must be a more comprehensive evaluation of the investment in planning. Some Councils reported improvement in a range of issues where increased funding had been a final result of the planning exercise. There was agreement that a major positive impact of CPHP was increased collaboration and networking across the sectors and within the organisations that have contributed to the planning: this would produce improved health outcomes.
KI reported several health impacts from MPHP. The following comments demonstrate these achievements:

HP3: *It is clearly possible to observe health impacts from MPHP, however there is a lack of quality evaluation data in this area. Also the budget often only runs for as long as the project is implemented. The ‘Just Walk It’ project in Hervey Bay and Maryborough is still active and the physical and social benefits are clear.*

In summary, all participants agreed that the broader the participation in CPHP, the better the chances for increased health outcomes. There was agreement that Local Government would have an increasing role in health planning in the future, and had legitimacy for this planning, in the light of the IPA and ecological sustainable development in communities. There was a view that Queensland Health should become more engaged with other planning processes, and not always be the lead agency for health planning.

Participants agreed that the LGAQ Protocol needed to be implemented over time. Linkages with the Department of Local Government and Planning and their Regional Framework for Growth Planning, with Queensland Housing and Community Renewal should urgently be established across the State, as this approach would guarantee health issues at a local level becoming entrenched in land use planning at a regional and state-wide level. There was support for capacity building for Queensland Health and local government staff, to enable their engagement as equal partners at both horizontal (across agencies and communities) and vertical (up to higher decision-making in government) levels, as well as with other structures and processes that impact on health planning and strategy implementation.

10.4 Section 2 Document Analysis – CPHP and LPF Strengths and Limitations

The results and findings of the conceptual mapping of selected documents highlight the features of selected LPF and CPHP models. These findings, given in this section, include the following CPHP models and LPF:

- Local Agenda (LA21)
- Municipal Public Health Planning (MPHP)
- Community Public Health Planning Rural and Remote Area Project (CPHRRAP)
- Supportive Environments for Active Living (SEAL)
- Community Renewal (CR)
- *Integrated Planning Act 1997 (IPA)*
- Local Area Planning (LAP), and
- Regional Framework for Growth Management.

By comparing MPHP to these frameworks and models the salient features observed could guide more effective and sustainable MPHP implementation processes. Part 1 of the thesis reviewed
the literature on the following frameworks: IPA and SEQ Framework for Growth Legislative Planning Regional and Local Area Planning (LAP) and CPHP Models namely, LA21, MPHP, CPHPRRAP, SEAL and Community Renewal (CR). As discussed in Chapter 2, not all CPHP models were examined in this study: the frameworks and models reviewed were competitive or complimentary planning initiatives being implemented in communities simultaneously with MPHP. Patton (1987) commented that a certain amount of data could be omitted without impacting on a focused and comprehensive description of the findings: on this basis, three models – the Bowen Project, Place Management and Indigenous planning – have not been analysed in this chapter. As well, these models are not as relevant for this study, as their implementation is not the sole responsibility of local government.

Table 37 describes an analysis of the key features of CPHP models, including their history and context, the purpose of the model and its strengths and limitations. The data were obtained from the conceptual mapping conducted by the researcher during the CPHPR (2003). Appendix I contains a copy of the conceptual mapping framework used in the analysis.
<table>
<thead>
<tr>
<th>Models and Frameworks</th>
<th>History and Context</th>
<th>Purpose of Model</th>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Agenda 21</strong></td>
<td>Post ‘Earth Summit’ 1992, in late 1990s integrated into several city plans.</td>
<td>Planning to achieve sustainable development via social/economic development; resource management; major group participation; implementation.</td>
<td>Integrated planning into Councils’ Corporate Plans. Links to other local plans to pursue ecologically sustainable development.</td>
<td>Limited focus on health – seen as an outcome of environmental sustainability; limited to Council-oriented policy areas.</td>
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<td><strong>Municipal Public Health Planning</strong></td>
<td>Built on ‘Healthy Cities’ principles and WHO ‘Health for All’ strategy; since early 1990s. Modified for Queensland Local Government as the key driver.</td>
<td>To build collaborative partnerships between stakeholders at the local level to address factors affecting health in the community; to plan and implement more efficient/effective public and environmental health services and conditions.</td>
<td>Promotes political commitment; community participation; and concentrates on intersectoral/intergovernmental collaboration. Has been taken up by a substantial number of local governments in Queensland and Victoria.</td>
<td>Comprehensive health profile developed, limited evaluation undertaken; community works with high agency involvement at structured workshops. Concerns re shifting health responsibilities from state to local levels, funding of strategies key collaborative action.</td>
</tr>
<tr>
<td><strong>Community Public Health Planning Rural Remote Area Project</strong></td>
<td>Started 1998, three year project with 14 rural remote communities; Queensland Health funded, looking for a new model of service delivery. Based on participatory action research theory and practice from WHO.</td>
<td>Empowerment of rural and remote communities, capacity building, to facilitate change and developing structures.</td>
<td>Flexible, locally driven and needs based; well resourced; community control over local public health activities.</td>
<td>Three year project; requires reform of governance; transferability of the model to other locales; Indigenous involvement.</td>
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<tr>
<td><strong>Supportive Environments for Active Living</strong></td>
<td>Integrated planning related to physical activity in local areas, since late 1990s Eagleby pilot project.</td>
<td>Strategic framework to provide a basis for coordinated whole-of-govt and community action for creation, enhancement and sustainability of environments that support active living.</td>
<td>Improved integrated planning aligned to IPA and driven by regional managers forum, sound governance. Community participation and program development to increase participation in physical activity. Innovative community engagement processes. Needs to be trialled in other communities, not just Gold Coast City.</td>
<td>Evaluations needed to determine effectiveness of multi-strategy framework; limited to a focus on physical activity; community vs government-managed initiative unclear.</td>
</tr>
<tr>
<td><strong>Community Renewal</strong></td>
<td>Community Renewal (CR), a Queensland Housing initiative developed in 14 communities state-wide; well supported by local government and well funded by State Government.</td>
<td>Focuses on infrastructure improvements targeting communities that have an identifiable sense of community or identity to improve, engages local suburbs in decision-making.</td>
<td>Well-structured capacity building processes, strong focus on governance and signed-off activities between community committee leaders, agency heads and the responsible state minister, robust evaluation phase.</td>
<td>Little emphasis placed on social health; community action plans far too broad; limited sectoral linkages formed.</td>
</tr>
<tr>
<td>Models and Frameworks</td>
<td>History and Context</td>
<td>Purpose of Model</td>
<td>Strengths</td>
<td>Limitations</td>
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<td><strong>Integrated Planning Act 1997</strong></td>
<td>1999 legislation to achieve ecological sustainability by coordinating and integrating planning at the local, regional and state levels.</td>
<td>IPA objective is to have all future land use development in Queensland comply with 10 broad state planning policies (eg. air pollution; public and environmental health planning)</td>
<td>Political and policy support at State level; all Departments and LGs involved; has fostered a breadth and depth not seen before in planning at the local level. Focuses on triple bottom line (integrated planning; State involvement; community engagement)</td>
<td>Recent development means that there is little evaluation of impact on community public health; some concern that the ‘land use’ focus will outweigh the community involvement focus.</td>
</tr>
<tr>
<td><strong>Local Area Planning</strong></td>
<td>Built on Australian Local Govt Association (ALGA) Manual – 1993, requiring an action plan to coordinate and integrate all Council programs in a given area; part of IPA legislative frameworks</td>
<td>A detailed planning instrument that provides a comprehensive framework for the development/use of a local area.</td>
<td>Allows conversion of broad strategic planning principles and objectives into detailed area-specific guidelines; requires an action plan; attempts to coordinate and integrate all LG programs in a given geographic area.</td>
<td>Emphasis mainly on infrastructure planning and implementation with relatively little community development, partnership and ownership. No published outcomes/performance evaluations.</td>
</tr>
<tr>
<td><strong>Regional Framework for Growth (SEQ2001)</strong></td>
<td>Focus on South-East Queensland in the early 1990s using a whole of government approach; similar frameworks now in 6 other Queensland regions.</td>
<td>To establish the responsibilities of state/local government agencies to facilitate collaboration on agreed priority planning actions.</td>
<td>Strategies on transport, air quality, economic development, regional services, landscape, and cultural issues delivered; community health planning is not a direct focus but is subsumed in ‘social justice and human services’</td>
<td>Lack of coherent integration of these regional frameworks into a whole-of-government and community response to maintaining and improving overall quality of life.</td>
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(Source: adapted from Davey, Stewart and Spork, 2003)
10.5 Summary of Strengths and Limitations of MPHP compared to other CPHP

This section focuses on analysing the strengths and limitations of MPHP compared to other CPHP models and to LPF.

LA21 is a model tested by several local governments in Queensland. This process has not developed well in Queensland, compared with several pilot projects in other Australian states, although several LA21 pilot projects were underway in Queensland at the time of this review. This process emphasises ecological sustainable development (ESD), promotes environmental improvements (sustainable energy, recycling and water conservation) and attempts to facilitate integrated planning. LA21 has minimal focus on traditional public health activities. The emphasis on sustainable development is the salient point used in this planning methodology. Other models analysed did not refer to ESD as a foundation principle.

Municipal Public Health Planning (MPHP) emphasises the importance of local government as having a pivotal role in improving the health of communities. The process is well documented. It focuses on building health and environment agencies’ capacities to collaborate, in order to improve the delivery of preventive health services. The MPHP process emphasises the importance of working within existing political systems, structures and boundaries to increase funding opportunities for identified community needs. Agencies and community working parties identify, document and prioritise health needs, and develop strategies that form the foundation of the Health Plan. This model has been most successful in provincial cities in Queensland. It has also been applied to rural communities and has had most success where there is positive political support.

The Community Public Health Planning Rural and Remote Areas Project (CPHRPRRAP) is a model focused on smaller rural communities and has delivered well-structured capacity-building approaches for health, with formalised ‘partnership’ arrangements. The process is managed by Queensland Health staff, who appoint an auspicing body to host the project within the community. Local government can be appointed to host the project. This model has many positive features, including its emphasis on capacity building at the local level, the development of learning circles for all stakeholders, and community funding, which is available at the beginning of the project, with allocation responsibilities connected to the local Steering Committee. This model is focused on rural communities in western Queensland. Participants and practitioners have reported it to be a quality health-planning model.

The Supportive Environment for Active Living (SEAL) project creates quality community engagement activities, and engages other planning projects at the suburb level, to use physical activity as an entry point to community planning. The project has innovative community needs
assessment processes, using rapid appraisal techniques; communities are brought together to a local event (for example, a food festival), where trained staff members collect needs assessments data. This reduces the time required and expense associated with data collection, without reducing the reliability of the community inputs. The project has good documentation, placing a high priority on vertical linkages with other layers of planning required by the IPA, and on local government legislation, the Regional Managers Forum. This project has been trialled in certain disadvantaged South-East Queensland suburbs only and needs more exposure to test its sustainability. In summary, at a suburb level and at a specific issue level, the SEAL Project has many positive features to ensure more sustainability for local area planning. This project has innovative community consultation practices. The well documented manuals and policy approaches will assist communities and agencies to better implement local strategies. The model is closely aligned with LAP and could be integrated with LAP to reduce duplication of effort at a local level.

*Community Renewal* (CR) is a Queensland Housing initiative developed in fourteen communities state-wide. This project is well supported by local government and well funded by the State Government compared to the other models. The project has well structured capacity building processes in place, engages local suburbs in decision-making, and has a strong focus on governance between community committee leaders, agency heads and the responsible state minister. These three parties prior to monies being allocated for community improvements sign off all committee decisions. This model’s weakness is that it focuses on infrastructure improvements, for example, beautifying streets and community safety, and places little emphasis on the social needs such as addressing drug abuse or family breakdown. CR has had a robust evaluation phase. The model was developed in several Indigenous communities, with one community not being able to agree on how to spend the allocated monies. For this reason, priority health actions were delayed. However, in rural and remote areas the CPHPRRAP has been supported as the preferred model, providing best practice examples of community engagement and capacity building. This model provided upfront funding to communities and further evaluation is required to assess future sustainability of the process. Community Renewal, an initiative of Queensland Housing, is considered the best example of a community planning model developed and implemented by a state agencies other than Queensland Health. In summary its focus is built around renewal of suburban infrastructure, with less emphasis on determinants of health.

*Regional Framework for Growth Planning* (RFGP) is managed by the Department of State Development and has a twenty-year vision for quality of life across regions. Queensland Health contributes to RFGM planning, but does not act as the primary driver. The Department of State Development works across regions to develop long-term infrastructure plans. These plans link
over time with local government town planning schemes and other state agencies’ plans. They are integrated legitimately with local government through the IPA. This planning can be considered higher order planning and provides the foundation for future infrastructure initiatives.

The *Integrated Planning Act (IPA)* regulates town planning, sustainable development and land use in Queensland. *IPA* and *Local Area Planning (LAP)* are intrinsically linked. LAP takes a suburb-by-suburb approach to improve local conditions and is part of the town-planning schemes required of councils in the IPA. LAP provides a structure for local community input into planning for future community needs. This has helped the concept of ‘health’ to be better understood, beyond the social context, gaining acceptance on the planning agenda. Local area plans focus on the impacts of development by managing the problems of increasing population within local authority boundaries in Queensland.

LAP strengths are that its planning mechanisms have gained legitimacy within acts and regulations. It has also helped to bring about sustainable governance, ensuring that each local government in Queensland practises environmentally sustainable principles, while planning and developing communities. The process has good links to regional planning at a state level, and has input from the Regional Organisations of Councils (ROC). Impacts from planning decisions are considered across the boundaries of adjoining local government authorities. LAP allows for input from other planning processes through good governance and a legitimate structure. Its limitations include prioritising infrastructure development without considering social needs, and lack of priority for addressing local health services. Furthermore, its community engagement process seems largely restricted to public meetings early in the process of planning, with limited opportunities to comment on the developed plans.

The CPHPR recommended that, instead of supporting a preferred CPHP model, each planning model should identify practice points and key learnings. Managers in Queensland Health did not favour one particular model, but preferred a suite of community public health planning models, suggesting that a CPHP ‘tool kit’ highlighting the strengths and limitations of each model would be very beneficial for future CPHP. The review (see Davey, Stewart and Spork, 2003) did support health planning at a local government level, and recommended that local government engage fully with the whole-of-government agenda and other planning processes that demonstrate an integrated process. It also concludes from the review that agency partners need to be made more aware of CPHP in Queensland so that they will engage as a major stakeholder.
10.6 Summary of MPHP Strengths and Limitations

In summary this chapter aimed to analyse the MPHP process in comparison with other statewide participatory planning processes, documenting its strengths and limitations. Managers statewide expressed support for a variety of CPHP models in Queensland, because of the diversity of communities and organisational capacities in provincial towns, regions, towns, and rural and remote locations; however, MPHP was the model the majority of executive managers considered most suited to local government. It was agreed that local government provided opportunities for agency and community participation and is therefore the most sustainable structure of government to continue participatory health planning. Local government will have an increasing role in health planning in the future, and has legitimacy for this planning, both in the light of ecological sustainable development and the requirements of the IPA.

MPHP introduced the HCM, partnership thinking and the social determinants of health within local government settings. MPHP significantly improved agency collaboration during the planning process; during implementation, however, it required not only more governance structures within local government, but also improved capacity building of the people involved with planning or project management and better integration with other layers of planning. MPHP was affected by staff turnover in the agencies [as staff left agencies there was limited handover of planning knowledge to new staff]. More investment was required to fund the strategies in the plan, and this constraint was reported as the most difficult barrier to effective planning. Interestingly, health practitioners tended to have experience with only one model, and were biased towards using only that preferred model. This research is interested in the capacity building issues for people engaged with participatory health planning. The strengths and limitations of MPHP compared to other CPHP and LPF are described in Table 38.
Table 38: MPHP Strengths and Limitations

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>The HCM changed the policy approach of Queensland Health to support participatory planning, namely the MPHP process in local government.</td>
<td>Social issues (poverty, homelessness, mental health issues etc.) are not well handled in the MPHP process.</td>
</tr>
<tr>
<td>MPHP model has features most suited to local government settings [compared to other CPHP models]</td>
<td>MPHP takes time, sometimes years, to show outcomes so political support is difficult to maintain across election cycles.</td>
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<tr>
<td>MPHP emphasises the importance of working within existing political systems and has successfully engaged political commitment from elected representatives in local government</td>
<td>MPHP needs:</td>
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<tr>
<td>MPHP has demonstrated that it is part of the whole-of-government approach to improving quality of life.</td>
<td>• Improved communication of information to other layers of planning</td>
</tr>
<tr>
<td>MPHP engages local government as a viable stakeholder to drive the process.</td>
<td>• Improved investment and funding</td>
</tr>
<tr>
<td>MPHP uses existing community agencies, groups and residents, and supports their efforts.</td>
<td>• Better coordination of activities by project officers</td>
</tr>
<tr>
<td>Empowerment is a key issue and strength of MPHP – must work ‘with’ people, not ‘on’ people.</td>
<td>• Improved leadership and direction from Queensland Health,</td>
</tr>
<tr>
<td>The strengths lie mainly in partnerships and the opportunity for community participation.</td>
<td>MPHP is very resource intensive, with no upfront funding for strategy implementation compared to CR.</td>
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<td>The health profile developed within the project deliverables has a strong focus on social determinants of health and places health issues on the agenda [no other model develops health profiles]</td>
<td>MPHP limitations are that its planning mechanisms have not gained legitimacy within acts and regulations [compared to LAP], therefore long-term sustainability of MPHP is a problem:</td>
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<tr>
<td>One major benefit is a greater council profile in the community.</td>
<td>• No legislation to mandate for MPHP in Health Act and IPA like LAP</td>
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<td>Strategic management practices in LG are recognising the need for community participation processes: MPHP provides that vision.</td>
<td>• No legislative standards to link MPHP to corporate plan and town plan</td>
</tr>
<tr>
<td>Capacity building of staff and participants through project committee training is satisfactory.</td>
<td>• No formal MOU or ‘sign-off’ by higher-level decision makers in agencies to act on local strategies [CR has this strength].</td>
</tr>
<tr>
<td>MPHP increases community confidence to engage in health issues; expectations also grow and people feel that they should be involved – there is a greater sense of having a ‘right’ to be involved.</td>
<td>• The process needs people committed to partnership approaches.</td>
</tr>
<tr>
<td>University partnerships assist with plan development.</td>
<td>The process requires stronger communication and reporting linkages to regional planning at a state level and the Regional Organisations of Councils (ROC).</td>
</tr>
<tr>
<td>The voluntary nature of MPHP [compared to a mandate] improves council ownership and more open partnerships, but sustainability of the plan is compromised if there is no supporting legislation for local government to engage legitimately with participatory planning.</td>
<td>After the plans have been developed, the implementation remains a difficulty, particularly getting continued support from both government and non-government agencies.</td>
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Limited capacity building processes, not as strong a focus on governance [compared to CR] |

Agencies did not support signed-off activities with council |

Limited evaluation of each stage of process |

No shared responsibility for action between community committee leaders, agency heads and the responsible state minister. |

The budget often runs only as long as the project is being implemented, so project officer positions are not sustainable.
10.7 Conclusion

This chapter presented Phase 3 of the data collection. It analysed the strengths and limitations of municipal public health planning in comparison to selected CPHP models and LFP. A matrix of key learnings from the analysis of the findings was presented in a table of MPHP strengths and limitations (see Table 38). Figure 27 summarises the data collection methods in Chapters 7, 8, 9 and 10. The figure also describes the process for Chapter 11 theme analysis. Chapter 11 will present the central themes of the research and discuss the collated findings from Phases 1, 2 and 3 of the data collection.
CHAPTER 11  DISCUSSION and RECOMMENDATIONS

11.1  Introduction

This chapter will discuss in detail the major findings derived from the study that are useful for effective and sustainable implementation of future MPHP Plans. Drawing from the literature review and the analysis of case studies and key informant interviews, seven themes have emerged as important elements for successful implementation of MPH Plans. This chapter will initially discuss each of these elements including: agency collaboration and community participation, capacity building, organisational issues, governance and legitimacy, layers of planning, investment in planning and sustainability of MPHP models. Second this chapter will present the two major recommendations of the study. The first recommendation consists of a comprehensive set of success factors for MPHP indicating the salient features to improve the effectiveness and sustainability of future planning projects. Success factors are targeted towards significantly improving the capacity of people to engage in MPHP, build organisational capacity to implement MPH Plan strategies and improve the features of the MPHP model itself. The second recommendation details an Implementation Management Model for MPHP – a comprehensive approach for local government to implement and manage future MPH Plans in partnership with agencies and community groups from a common platform.

11.2  Discussion of Major Findings

The major findings emerged from a collated analysis of the results of Phase 2 of the thesis. These include discussion on the following elements: agency collaboration and community participation, capacity building, organisational issues, governance and legitimacy, layers of planning, investment in MPHP and sustainability of MPHP models.

Agency Collaboration and Community Participation

Intersectoral collaboration was a project aim common to both MPHP projects, and included aspects of partnership, joint work and interdepartmental action. This aim contained several elements including the level of collaboration, shared objectives and group purpose, composition of working parties and the adequacy of resources. Both projects demonstrated that the MPHP process improved levels of collaboration between the host local government and agencies (either government or non-government), which improved health promotion action and strategic planning governance. Collaboration was highest during the seven steps of planning and decreased during the first two years of the MPHP implementation. Improved Council and
agency collaboration was a result of a common agreement to improve the quality of life of residents via the MPHP process. Practitioners and agency partners had suitable plan development funding, but implementation funding was lacking which reduced opportunities for collaboration. MPHP does clarify the needs of communities and through partnerships it creates opportunities for joint grant writing. This did occur in both projects bringing several large funded grants to councils that would not have previously been successful without the participatory planning structures in place. MPHP was seen as a planning tool that had a vision and focus on health (that no other planning instrument demonstrated) and directed activities for the next three years towards health services improvement; compared to corporate plans and their annual operational plans, with broader quality of life issues, and the Integrated Planning Acts: Local Area Planning was dedicated to land use development. This argument alone supports the need for regulation to support a mandate for MPHP, subsequent financial resourcing and accountability for health services by state and local government, the process does engage the stakeholders necessary for integrated service delivery (NPHP, 2000). As Cassidy indicated (2005) even the most effective program faces two challenges: maintaining or expanding its capacity and sustaining its effectiveness, these issues are dependent on adequate resources.

The Gold Coast Community Health Plan (CHP) project was instrumental in establishing a partnership approach to health service delivery, improving knowledge of Council and agency roles in public health and increased their commitment to health. The CHP was a catalyst for partnerships in health promotion with agency contribution dependent on the issue and the personalities involved. The planning projects clarified the agencies’ roles in public health service delivery in all cities, which assisted in reducing duplication of services and programs between agencies. The development of formal partnerships was a key aim of the Gold Coast CHP Project. These partnerships need to be formalised for more effective and sustainable strategy implementation. The composition of working parties in the planning included a multi-sectoral approach to committee’s structures, which provided opportunities for staff to engage with the CHP project as part of the individual’s job role, recognising the organisational responsibility for health outcomes. A success factor of the process was to ensure that there was a good mix of council and agency staff skills across committees and working parties.

The principal challenge for the future of the GCCHP will be to build on the success associated with the plan’s development and strategy implementation to gain further commitment by Council, other government and non-government agencies and the community. The positioning of the CHP within Councils organisational structure and its functional relationship to departments within council is the challenge for the plans future sustainability and success: healthy governance structures need clarification for voluntary plans (Plans with no legal mandate in state legislation). The Gold Coast CHP is logical as a strategic management activity
but to deliver on Councils corporate community health objectives you need organisational alignment with the corporate plan and the internal department planning in council and with community expectations.

In summary, all partners who saw the need to address the social determinants of health more broadly supported the MPHP. All partners need to continue to work together in the future to create a more healthy and sustainable Gold Coast. Association with a university added credibility to the process. In general the process of planning was seen as more important than the implementation initially, and was the catalyst for improving collaborative and partnerships.

The approaches of the HCM and MPHP in Wide Bay were supported by all partners who saw the need to address the social determinates of health more broadly. The planning phase of the WBRPHP project increased collaboration between Council and the three levels of government, non-government agencies and community groups, however during the implementation the degree of collaboration between each Council and the CPHUN; and between Council and partner agencies reduced. In the PHP the stages of the planning process facilitated shared objectives and a group purpose. The Wide Bay PHP process strengthened joint working and partnerships between the Councils, Queensland Health and other agencies, but the nature of the partnerships varied from signed-off formal agreements, to letters of intent to work together, to agencies working in collaboration on grant writing. People formed partnerships and drove the process, however there were cultural differences reported between agencies, and the PHP acted to dissolve these differences through joint work. Agencies were reluctant to be guided by the PHP as a day-to-day operational plan due to the impact on their core business in their agency strategic plan and both current and future budgetary issues. The Wide Bay PHP process brought people together, however it was too soon to judge if organisations were delivering improved health outcomes. Organisations were working together on activities that added value to public health action. Prior to the project such collaboration was not evident. The participative approach to developing project TOR and aims is critical to group purpose. The WBRPHP project newsletter was most efficient communication tool used by each project.

In the WBRPHP health practitioners were the driving forces for the MPHP project and enabled more efficient and effective partnership work. There were limited resources to achieve the aims of the planning and insufficient funding from state level and local agencies reduced Councils’ ability to appoint the human resources necessary to adequately plan the development phase. Interdepartmental involvement was critical to the process. The organisation of work practices by broadening job descriptions had occurred in Council to suit multi-disciplinary nature of agencies engaging in the project. Clear lines of communication in working parties will result in agencies championing the CHP and engaging in strategy implementation. During the implementation of
the PHP, the degree of collaboration between each Council and the CPHUN and between Council and partner agencies reduced.

Both projects aimed to improve community participation in public health planning. This aim incorporated levels of community participation including empowerment and decision-making. Levels of community participation in both projects increased during the process. Gold Coast residents participated in health need surveys and workshops and progress on the CHP was fed back to community. In Wide Bay, there were satisfactory levels of community participation were found in the PHP including focus groups, working parties and public meetings. More involvement from residents and community groups is recommended in future project committees and working parties. Initial skills training by project consultants were deemed beneficial to the process. More understanding is required of what the plan was going to achieve, its outcomes and how it might affect communities. In Wide Bay, conflict emerged during the community consultation caused by members of the community strongly pushing their own agendas.

Both projects aimed to have a broad socio-ecological view or shared vision of health. This aim contained three main elements including approach to determinants of health, traditional core and non-core business and a shared ecological vision. There was limited progress on social determinants of health, with silos in place with Queensland Health. Councillors, Council staff and agencies support this approach and the CHP will assist in future progress. The CHP was assisting this policy change. CHP was not core business prior to the project, but to be effective Council needs to change to a community development focus to fully embrace the CHP, this requires integration of the activities of internal Council units. Local Area Plan (LAP) for example is core business in council has better geographical targeting, but limited community development compared to the MPHP. A Shared ecological vision was not achieved in either project, but the CHP had a common vision for a better quality of life. The PHP had developed a shared vision of improved health in the community during the process of developing the plan. The MPHP process acted as a catalyst to generate new health projects in communities, but the implementation of the shared vision decreases over time.

The organisation of work practices was different in each Council. Staff turnover in all agencies is the weaknesses of the MPHP project, and many other projects in government. In the CHP job descriptions were broadening to include the MPHP project activities and changing Council’s priorities (based on needs assessment); however in Wide Bay job descriptions did not reflect changing roles, and new position were not created quickly enough: this was poor strategic management and organisational behaviour. Confronting this important management issue would be considered a success factor for future MPHP. In Wide Bay there was a changing roles of
departments generated by MPHP with the PHP included as a core Council planning process and many agency business plans were adapted to include the activities of the MPHP.

Both projects aimed to monitor and evaluate the progress of the participatory health planning. The main elements of this process evaluation included accountability, monitoring of activities and evaluation other issues with process. First there was no formal accountability of the agencies to the Gold Coast City Council, this made the CHP ineffective. Not all community groups incorporated strategies from the CHP into their organisational strategic plans and activities. Organisations who agreed to work on the plan need to reflect that in their own business plan otherwise the CHP devalues. Second, Activities were reported by agencies and collated by Council every three months, this process fed back information to all committees. Progress of activities was monitored by agencies reported back to the steering group quarterly, verbally. Both plans were updated every six months from progress reporting of agencies. Last, the other issues with process included concern for a lack of organisational skills to operationalise the plan within each council and integrate the plan with the IPA.

The focus groups conducted in Gold Coast City and the two cities in Wide Bay were evaluated highly by residents and demonstrate the need for more comprehensive community participation. Implementation impacts from MPHP included specific responses about Plan Exposure, residents’ quality of life and the outcomes of the planning including other community agency strategic action. Respondents all agreed that more contact was required with community groups and residents during the implementation phase. The Gold Coast CPH implementation activities had less exposure to residents compared with the extensive public consultation over the entire process of planning in Wide Bay. However both projects prioritised agency and community group involvement, over individual resident involvement in the design of the planning projects. A surprising finding was the increased confidence reported by residents from each community to communicate with Council over health issues, this in itself is a very positive achievement of MPHP projects and a core issue in the WHO HCM. In both communities the three monthly newsletters was seen as an effective communication tool for councils and Queensland Health – CPHUN to connect with community residents and agencies.

The Strengths and Limitations of MPHP compared to other CPHP models and legislative planning frameworks need discussion. In the early nineties, the HCM changed the policy approach of Queensland Health to support participatory planning; namely the MPHP process in local government. Empowerment is a key issue and strength of MPHP requiring individual and organisations to work ‘with’ people in communities, not ‘on’ them (see Chapman and Davey, 1997). The strengths lie mainly in partnerships and the opportunity for community participation. University partnerships assist with MPHP plan development.
The benefit of MPHP is the greater council profile in the community as a direct result of the structured seven-step planning activities of the planning project. A significant weakness identified was that even though agencies supported strong partnerships; the signed-off partnership approach was not supported by the agencies, mainly due to the lack of funding to support the plan strategies. MPHP is a voluntary planning approach, agencies would from more significant formal partnerships if MPHP was a legal requirement of either the Health Act or IPA. Finally, the evidence points to the MPHP process needing a governance framework to articulate partnerships, and health impacts or the process is deficient. While MPHP addresses the priority health issues, develops strategies, roles and responsibilities and organisational structures, but is deficient at building the capacity of people, allocating resources and budgeting, monitoring performance and managing targets – to be effective future MPHP local and state governments needs to clarify their organisational strategic management processes and fit participatory health planning into sustainable frameworks.

**Capacity Building**

Organisational capacity comprises an important set of factors that influence program capacity and sustainability, including the ability to manage operations successfully over time, run programs in conformity with performance criteria and implement and complete existing and new strategies (Cassidy et al., 2005) Investment in organisational and individual capacity building is required in both projects in the areas of partnerships, governance, accountability, integrating layers of planning, media advocacy, grant writing and program evaluation. A priority issues identified was to build skills and knowledge of social determinants of health with competing Council professionals, including town planners, social planners, community development workers, EHOs, senior departmental managers. Secondly capacity building with community groups and residents empowered their involvement in the MPHP.

Skills development is an important success factor for effective MPHP. MPHP increases Council staff workload as health was refocused from reactive to proactive measures. The project management structures for example in the development phase of the Gold Coast CHP project were of good quality, members of the various project committees attended capacity building workshops to prepare for the steps of the planning. The Wide Bay PHP achieved a satisfactory level of capacity building for the public, community groups, and PMT working parties. More capacity and skills were needed tough to drive the implementation of the public health plans across the region, particularly with community groups. Agencies agreed the WBRPHP project was a positive and purposeful exercise, and the partnership approach taken by Councils and state government (with joint funding arrangements for the project) was viewed as a positive way forward for building the capacity of staff to engage with participatory health planning.
While mayors and Councillors chairing the health committees wanted to improve resident services at a local level, other Councillors showed little support, this reduced the impact of the PHP within Council. Council senior managers were reluctant to have more health responsibilities devolved to their departments mainly because of monetary constraints and the lack of capacity to implement the process. The inability of Councils and the state government to appoint a full-time project manager during the project implementation phase impacted on the capacity of the MPHP projects to achieve implementation outcomes.

The strength of MPHP was that the process did provide initial capacity building activities for staff and participants through project committee training. This model builds the capacity of internal department in council, staff in agencies and community groups and residents and supports their efforts. On-going capacity building of EHOs and health promotion officers is required so they can engage adequately in MPHP implementation. Queensland Health – CPHUN developed learning sets during MPHP implementation and this capacity building approach was instrumental in progressing skills and knowledge for health planning across departments. However, a weakness of the MPHP was that social issues like poverty, homelessness and mental health issues were not dealt with well in the MPHP process. Certainly participants agreed that the projects needed improved communication of information to other layers of planning, improved investment and funding, better coordination of activities by project officers and improved leadership and direction from Queensland Health. Compared with the Community Renewal Process though, MPHP had limited capacity building processes. MPHP through its public meetings and workshops does increase community and agency representative confidence to engage in health issues, expectations also grow, and people feel that they should be involved – there is a greater sense of having a ‘right’ to be involved from this WHO approach based on the HCM.

**Strategic and Organisational Issues**

The MPHP was an initial strategic catalyst injecting funding into communities for health projects. The MPHP as a strategy did increase health and environment activities during the implementation phase. There were a significant number of inspiring examples of planning outcomes from the projects, which met strategic objective of the council and agency partners. However a percentage of the new strategies in the MPHP were outside of Councils traditional organisations’ role. The CHP at the Gold Coast also put health issues outside the traditional areas of the environmental health department and this transition required broader interdepartmental connections for the plan to be successfully integrated. The Councils departments were not being reshaped or restructured to allow internal departments to engage staff or resources to address these emerging issues.
The MPHP process failed to create enough organisational change in Council and participating agencies to fully support the plan implementation; after two years of implementation insufficient human resources were allocated to implement the strategies in the MPH Plans. MPHP does provide clear accountable goals for community health and this is an indicator of council performance, but resourcing programs in the strategic plan is a major deficiency. WHO (2000) suggest that this argument cannot be used in an economic environment with scarce and competing resources, and that partnerships for health promotion action are the way forward. In reality in Australia there is funding available, but the lack of a mandate for MPHP as compared to other planning mechanism limits its management and political support in local government. From a strategic perspective until MPHP is a legal requirement it will have limited resourcing. There was however evidence of an increase in networking and health promotion action between agencies collaborating on plan implementation; so continued and increased levels of resources would have seen the delivery of an effective MPH Plan.

There was limited project staff to manage the MPH Plans implementation, this was a serious organisational issue. Internal organisational staff infrastructure is critical to the success of future MPH Plans, the three-year plan needs a council approved annual operational plan based on need with linked budgets to be effective. Staff turnover in the agency partner organisations also impacted negatively on networking and ownership of the MPH Plans in the theme working groups. The high level executive support for MPHP was contrasted against low health practitioner support; interestingly the strategic managers in both organisations could clearly see benefits of MPHP compared to health practitioners. Turnover of senior staff in one of the Councils in Wide Bay significantly impacted on the progress of planning, this resulted in disagreement about planning philosophies; as the new senior staff appointed did not support the existing Healthy Cities approaches and favoured other planning models. In these circumstances for sustainability of public policy and programs Councillors who are responsible for the planning projects advisory committees needed to exercise more control, to lessen the impact of changing staff attitudes. But agency partner staff turnover also impacted on plan implementation; in many cases the key agency decision maker did not attend the MPHP advisory committee so less senior staffs were asked to give commitment to issues outside of their responsibility. A critical factor that impacted on effective MPHP was the lack of investment in MPHP to engage permanent project managers. In summary, health planning gathered momentum in first two years and achieved significant milestones, but an overall assessment of implementation found a lack of commitment by Councillors, senior staff and the process was limited by a lack of project staff.

In Wide Bay the findings indicate that there was general agreement that the guiding Aims and TOR of the WBRPHP project were being met, but the indecision about the most appropriate project structure, either a regional (two Councils working together with economy of scales with
a joint project officer and regional committees) or local approach (Councils working independently, with local staff) halted the progress of strategy implementation. Local mayors and Councillors were very supportive of the PHP, but were at times reluctant to show leadership for health planning across the region. This was a response (based on past negative experiences) to state governments devolving responsibilities and tasks to their level of government without adequate funding or resourcing. The benefits of MPHP included increased political and professional support from all levels of agencies in both projects, which placed health firmly on the agenda. There was high-level political support for MPHP across the Wide Bay Region during first year of implementation, but this declined as resources decreased.

In respect of MPHP placing health on the agenda, the CHP was formally part of the Gold Coast Councils Corporate Plan, this was seen as a key strategic objective in Council and generated several positive policy shifts (but there was not enough policy change to sustain the health movement) and improved linkages between council and other sectors. However inadequate funding was the major barrier to implement policy change. MPHP gave a sense of empowerment to the advisory committee members and community consultation empowered the interest of professionals with in Council, prioritising their work functions and activities.

From an organisational capacity building point of view council needed to multi-skill their professionals and develop appropriate job statements to manage the allocation of staff time to participatory planning. However, the CHP at the Gold Coast had satisfactory visibility through the promotion efforts of politicians and project managers, but there was a lack of media support due to limited reportable short-term outcomes from the planning. The Wide Bay Councils involved the media in all stages of the MPHP. Media worked well with health promotion staff to promote the MPHP launch and programs.

Strategic management practices in LG are recognising the need for internal council, agency and community participation processes, the strength of MPHP is that the model provides that vision. Finally, MPHP takes time to implement and sometimes years to show outcomes, so political support is difficult to maintain across election cycles.

**Governance and Legitimacy**

Politicians and executive managers in both councils advised that MPHP needs a legal mandate in the Local Government Act with support for formal reporting mechanisms to link strategies to other higher order planning in the council and at a state government level. Interestingly health practitioners were more concerned with health promotion action through partnerships at a local level, rather than advocating for a formal planning framework. The Gold Coast CHP preliminary case study found that with no statutory requirement for council to have a CHP, the support by Councillors and senior staff to resource the planning process plan reduced over time.
rendering the plan ineffective after two years of operation. From a governance and legislative perspective, there was a demonstrated need to align the aims of CHP with the principles contained within the IPA. There was support for CHP to report legitimately to the Council Corporate Plan, and a legislative requirement for this process is critical to effective planning. Queensland Health could also require mandatory needs based participatory health planning in the Public Health Act, similar to the Victorian Health Act. The key learnings from the process evaluation conducted in Chapter 9 for Wide Bay PHP found local government has a significant contribution to improving the social determinants of health, however without legislative requirements mandating MPH the PHP plan implementation was at a stalemate with state government over resourcing issues.

There is an argument for mandatory health planning (Public Health Act requiring each council to have a 3-5 year MPH Plan) to provide legitimacy for local government to engage fully in the Wide Bay Regional PHP. There was no mandatory requirement for Councils to have a MPH Plan, this was seen as a barrier to effective and sustainable planning by participants of the Wide Bay project. The problem is that Council has a coordinating role in health planning when using a MPHP model but has no formal planning governance for control of other agency decision-making.

The local approach to MPHP at the Gold Coast City (facilitated by one local government with local residents, health agencies and community groups) was an effective and efficient process design. Councils and Queensland Health could promote ownership of the plan by all partners and the community. There was indecision about the most appropriate approach, either a regional (two Councils working together with economy of scales with a joint project officer and regional committees) or local approach (Councils working independently, with local staff) halted the progress of strategy implementation; as the two communities had similar needs but different priorities, and there was limited funding available for project staff. The regional approach to MPHP [that involved two adjacent councils working together] significantly reduced the duplication of processes and activities, but impacted negatively on the ownership of the planning process by elected representatives and council staff. Local mayors and Councillors were very supportive of the Wide Bay PHP, but were at times reluctant to show leadership for health planning across the region. This was a response (based on past negative experiences) to state governments devolving responsibilities and tasks to their level of government without adequate funding or Resourcing. The results indicate that there was general agreement to strong agreement that the project aims and TOR of the WBRPHP project were being met. This positive function of MPHP was recognised by executive mangers interviewed but Advisory Committee members were nonchalant and unaware of this strategic feature of participatory planning. The regional approach to MPHP in Wide Bay was not considered best practice. It did have initial
economy of scales in committee structures and Resourcing benefits but this was overshadowed by the decreasing ownership by individual Council, which significantly decreased with this project structure, impacted on sustainability of plan implementation.

The WBRPHP project for geographical reasons experienced difficulty connecting with the state governments - regional framework for growth planning, (which had a presence in the region but was positioned in an office in another city) which reduced the opportunity to place strategies into other higher layers of planning for actioning with appropriate funding. The project did not prioritise the connections between the public health plan and the town and corporate plans in Council; this reduced the impacts of the longer-term health planning outcomes.

One strength of MPHP compared to other CPHP models is that it engages local government as a viable stakeholder to drive the process. For that reason MPHP is more focused on health outcomes, as it is co-ordinated by environmental health departments within council [where town planning departments co-ordinate participatory health planning, health issues have a lower priority to land use development]. The MPHP model has features most suited to local government settings [compared to other CPHP models] MPHP emphasises the importance of working within existing political systems and has successfully engaged political commitment from elected representatives in local government. The current voluntary nature of MPHP [compared to a mandate] may though improve council ownership and more open partnerships, but sustainability of the plan is compromised if there is no supporting legislation for local government to engage legitimately with participatory planning. A major weakness of the planning is that thee is no shared responsibility for action between community committee leaders, agency heads and the responsible state ministers to sign-off legitimately provide proper governance and accountability for planning implementation.

Layers of Planning

More effort was required by project committees to communicate with other planning mechanisms in the Gold Coast Council including the town plan. The strategies in the CHP needed to inform the many layers of planning both internal and external to Council: as a priority, health issues needed to be incorporated in Council’s Corporate Plan, and Integrated Town Planning (IPA driven) and Local Area Planning processes; and responsible partner agency’s strategic plans. There was support for integrating the GCCC CHP with other layers of planning within Council, particularly LAP, however the silos between professional groups and narrow internal Council department structures and budgets prevented this approach, impacting on the viability of the CHP. The PHP from both cities in Wide Bay integrated strategies with their corporate and town plan, however there was limited integration with the other layers of urban planning and decision-making processes in the region, for example, state-based Wide Bay
Regional Framework for Growth Plan, Regional Managers Forum and ROCs. Opportunities to report and communicate health needs of the cities to other planning activities in the region were not effectively and routinely done.

The most important feature of any Municipal Public Health Planning Model is that the Model has built in mechanisms to address a ‘whole of government approach’ to planning. This infers strong linkage with the IPA and Regional Planning Frameworks, the LG Act, the local Town Planning Schemes, Council Corporate Plans and the Regional Framework for Growth Planning. MPH was found to be the most suitable planning model for local government but the process needs structural improvement.

Figure 28 demonstrates a way forward to improve communication between the many layers of planning in local and state government and partner agencies.

For effective MPH planning and on-going implementation of strategies, programs and activities in the MPH Plan health actions need to link both horizontally with community residents, community groups and the legislative requirements of the IPA – Town Planning Schemes, and vertically to other planning mechanisms including the Whole of Government – Regional Framework for Growth Management Planning initiatives and other agency networks and business plans that have implications for creating healthy and sustainable communities. This would involve more resources to link with national and state government and other
legitimate planning forums, including the Regional Managers Forum of State Agency Managers, the Regional Organisation of Councils, working through Queensland Health and the LGAQ Protocol, and industry: to work collaboratively in the future. This approach will ensure local health needs are placed on the agenda of the organisations responsible for funding such initiatives, provide for information flow to other higher order planning mechanisms and allow a participative approach to rolling out new participatory health planning initiatives. The main strength of MPHP is that the model has demonstrated to councils and other agencies the significant contribution of a whole-of-government approach to health planning to improve quality of life in cities and shires in Queensland.

Investment and Planning

MPHP projects increased the levels of activities centred around the health agenda which in turn then required further investment for identified strategy implementation. The health profile developed within the project deliverables has a strong focus on social determinants of health and places health issues on the agenda, no other model completes a health profile indicator with as extensive evidence-base for health promotion.

The Gold Coast CHP was resourced satisfactorily in the development phase of planning, however there were limited investment in human and economic resources for strategy implementation. The project was successful in applying for grant monies for several priority strategies identified in the CHP. Agencies didn’t incorporate the strategies from the CHP (that they were responsible for) into their own organisations strategic management planning cycles, so funding was not allocated for new staff to manage the project implementation or strategy implementation.

Both the Maryborough and Hervey Bay PHP were resourced satisfactorily in the development phase of planning; however, there were limited investments in human resources for strategy implementation. The project did generate over $2 million of increased funding in the early stages of implementation as a direct result of the initiative. Local government politicians’ criticism of the lack of state government funding was an appropriate assessment of the situation. In the short-term significant funding flowed to the priority strategies in the WBRPHP project, however after a period of 2 years, as agency collaboration decreased, funding decreased. The relationship between these two factors demonstrated by this evaluation is a convincing argument for investment in collaborative partnerships for health.

Sustainability of the Planning Implementation

The Gold Coast City CHP was not sustainable over time due to a range of reasons: first, the complexity of participatory planning made decision-making time consuming; there was a lack
of human and economic resources invested in the CHP implementation; Councillors required short-term results to demonstrate their achievements to their organisation and constituents; and many of the health strategies in the CHP had medium to long-term outcomes; Councillors and senior staff reduced support for the CHP and moved on to other initiatives, as the MPHP process didn’t fit the expedient political cycle of local government. A large majority of the strategies and activities of the program were reported as being implemented in the first two years since launching the plan. There was no mandatory requirement for Council to have a MPH Plan, this was seen as a barrier to the sustainable planning.

In respect of the WBRPHP, there was an identified need for a joint full-time project officer to facilitate the implementation of both plans if a regional approach to planning is continued, otherwise each Council should work independently sustaining their PHP with local staff. The high level skills and experience of the project officer add significantly to MPHP effectiveness and its sustainability.

Need to develop implementation processes to provide Council with a mix of short to medium term and long-term outcomes to align with the realities of political cycles and residents demands, this would facilitate continued and legitimate political support from Councillors in an environment of competing interests. In summary, there was a lack of organisational strategic management and governance structures in both local government and Queensland Health (at the time of planning) to allow politicians, management and health practitioners to legitimately provide continuing support for participatory health planning. Partner agencies however showed continued support for broad-based planning approaches to quality of life improvement and the inability to harness this cooperation reduces the sustainable life of MPH Plans.

Respondents agreed that the planning outcomes should be integrated with other Council planning, thereby filling a gap in the city health data. The PHP made significant contributions to both Maryborough and Hervey Bay Councils’ Corporate Plans. For the first time health data was supplied legitimately to the town plan. Strategies in PHP integrated into town planning schemes of participating cities. Overall the MPHP increased political advantage from working with other agencies. This planning approach also provided a check and balance by Council on the participating agencies performance. This is an important management issue, allowing an opportunity for council to monitor state agencies and NGO’s that should be accountable to local residents. A main weakness of MPHP was that state government agencies attended Implementation Committee meetings but didn’t fully support a local coordinated effort to implement the plan strategies in each participating city. The strategies of the MPHP needs to be embedded in the core strategic actions pans of the collaborating agencies and senior decision-makers need to participate in the planning as well as project officer level staff. Agencies needed
more time (3–5 years) to integrate MPHP strategies in their strategic business plan; organisational realignment of aims and objectives cannot occur in 1–2 years.

11.3 Recommendations of the Study

11.3.1 Success Factors for Effective MPHP

The following ‘success factors for effective MPHP’ are presented in Table 39. The comprehensive success factors were discovered from this research and indicate the salient features to improve the effectiveness and sustainability of future MPHP projects. The success factors cover both the achievements and barriers to the effective implementation of MPHP, but are targeted towards significantly improving the capacity of people to engage in improved MPHP mechanisms, build organisational capacity to implement MPHP strategies and build the features of the planning model itself.

The matrix uses the themes of the research discussed in this chapter and maps the success factors for future MPHP against three organisational domains identified in the discussion of the major study themes in this chapter, these include:

- Building the individuals’ capacity to engage in MPHP
- Building the participating organisations and community capacity to engage with MPHP, and
- Improving the features of the MPHP model.

In summary, success factors from the study, included: building individual and organisational capacity to strengthen strategic planning; improving governance and legitimacy for planning; strengthening an understanding of organisational behaviour and its impact on successful planning while sustaining organisational structures and processes and; formalising collaboration and partnerships; establishing a commitment to investment in implementation; integrating the layers of planning cycles and addressing the on-going challenge that organisational barriers present for sustainable MPHP.

From these success factors the research has developed a management model for local government to implement a more effective and sustainable MPHP model. The research found that there was an identified lack of capacity building in the projects to date. There was a need to build capacity and improve people’s planning skills, improve capacity in the participating agencies/organisations and improve the features of the MPHP model. For the planning to be effective, partner organisations must address governance measures to ensure their strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the
MPHP; and agencies and staff must have the legitimacy and capacity to implement these actions.

Success factors are detailed for each theme in the matrix and represent the specific elements in health planning that need attention from health planners and project management teams while engaged in the process of development and implementation of best practice MPHP. The success factors for MPHP identified from the research provides future direction for health planners and their implementation will guide more effective and sustainable MPHP Plans.
Table 39: Success Factors for Effective MPHP

<table>
<thead>
<tr>
<th>INDIVIDUAL SUCCESS FACTORS</th>
<th>ORGANISATIONAL AND COMMUNITY SUCCESS FACTORS</th>
<th>SUCCESS FACTORS FOR PLANNING MODELS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Building the individuals’ capacity to engage in MPHP</strong></td>
<td><strong>Building the participating organisations and community capacity to engage with MPHP</strong></td>
<td><strong>Improving the features of the MPHP model</strong></td>
</tr>
<tr>
<td>Build skills in local and state government staff, and agency and community representatives to improve networking. Collaborate across other all levels of government. Engage as individuals in other planning models.</td>
<td>Develop rules of engagement between internal departments in Councils Work collaboratively for funding of planning outcomes. Local government to engage formally with RFGM, RMF and ROC.</td>
<td>Develop formal MOU between all agency partners in advance of strategy implementation. Design models that engage with the State Regional Managers Forum. Select strategies that benefit from promote agency collaboration. Engage senior managers as representatives on health advisory committees.</td>
</tr>
<tr>
<td><strong>COLLABORATION and PARTNERSHIPS</strong></td>
<td><strong>CAPACITY BUILDING</strong></td>
<td><strong>ORGANISATIONA L ISSUES</strong></td>
</tr>
<tr>
<td>Universities upgrade participatory planning curriculum in management, town planning, environmental health and health promotion programs. Develop key learning circles on CPHP statewide with politicians, managers, health practitioners and agency partners. Community development and health planning training for elected representatives in local government.</td>
<td>Supportive environments for CPHP. Continuation of funding support from Queensland Health for participatory health planning.</td>
<td>Facilitate a strategic management approach to MPHP. Role clarification of Queensland Health and agency partner representatives. Develop a proxy voting system for representatives of agency partners to increase commitment to attendance at MPHP committee meetings.</td>
</tr>
<tr>
<td><strong>GOVERNANCE and LEGITIMACY</strong></td>
<td>Queensland Health to continue to support CPHP state-wide with smart partnership funding opportunities for LG for priority strategies. Build supportive environments for Health Planning, including organisational structures friendly to MPHP. Formalise Health Advisory Committees as legitimate LG committees as per LG Act.</td>
<td>Expand job descriptions to include activities with MPHP. Need to encourage leadership in participatory planning by elected representatives.</td>
</tr>
<tr>
<td></td>
<td>MPHP to link formally as a ‘health needs tool’ to provide priority social health infrastructure and land use planning needs to the state governments (twenty year) Regional Framework for Growth Planning.</td>
<td>Sign-off of strategy implementation funding by Minister for Health, elected representatives and health advisory committee representatives.</td>
</tr>
<tr>
<td>LAYERS OF PLANNING</td>
<td>INDIVIDUAL SUCCESS FACTORS</td>
<td>ORGANISATIONAL AND COMMUNITY SUCCESS FACTORS</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------</td>
<td>---------------------------------------------</td>
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<tr>
<td></td>
<td><em>Building the individuals’ capacity to engage in MPHP</em></td>
<td><em>Building the participating organisations and community capacity to engage with MPHP</em></td>
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<td></td>
<td>Improve budgetary timeframes to fund planning strategies and actions.</td>
<td>Recognise national health priorities.</td>
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<td></td>
<td>Improve grant writing skills.</td>
<td>State departments to link business plans to avoid duplication of health outcomes.</td>
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<tr>
<td>INVESTMENT IN PLANNING</td>
<td>Invest in Queensland Health staff in short courses in the process and implementation of participatory health planning models.</td>
<td>Link with local government protocol.</td>
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<td></td>
<td>Continue to invest in learning circles across the regions.</td>
<td>Evaluate each stage of planning.</td>
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<td></td>
<td>Promote tertiary training in CPHP e.g. needs based qualitative analysis.</td>
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<tr>
<td></td>
<td>Invest in short courses on IPA components and other legislative frameworks.</td>
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<td></td>
<td>Provide training and ongoing support for communities that participate in PHP.</td>
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<tr>
<td>SUSTAINABILITY OF PLANNING MODELS</td>
<td>Reduce high staff turnover in agencies at regional level.</td>
<td><strong>Reduce silos between departments.</strong></td>
</tr>
<tr>
<td></td>
<td>Provide incentives for staff to be engaged with MPHP.</td>
<td><strong>Reduce silos between departments.</strong></td>
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<td></td>
<td>Develop skills and knowledge in planning models.</td>
<td><strong>Reduce silos between departments.</strong></td>
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<td><strong>Reduce silos between departments.</strong></td>
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<td><strong>Reduce silos between departments.</strong></td>
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</tbody>
</table>
11.3.2 Implementation Model: Need to Strategically Manage MPHP

There is a need to build capacity and improve people’s planning skills, improve capacity in the participating agencies/organisations and improve the features of the MPHP model. For the planning to be effective, partner organisations must address organisational behavioural issues and planning governance measures to ensure both that their strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the MPHP and that agencies and staff have the legitimacy and capacity to implement these actions. The implementation management model developed in this thesis when applied to future MPH Plans requires an annual reporting mechanism, which provides community accountability to the planning for local government and its partner agencies. The effective implementation of a MPH Plan will in time lead to healthy and sustainable communities. At a local government level, particularly in provincial cities in Queensland, MPHP has many strengths: there is an opportunity to refine the local and regional approaches to participatory planning studied in this research. The MPHP process has seven flexible steps: this flexibility has been identified as an important feature of this framework, particularly when applied across communities with varying characteristics. The emphasis on agencies working in partnership provides opportunities for joint project funding and a sharing of resources.

Several weaknesses of MPHP may impact on its sustainability, particularly the voluntary and informal structure and processes inherent in the HCM model. Having no legislative mandate for local government to address the social determinates of health creates a subsequent lack of funding to implement priority strategies identified by the collaborative process. The conclusions of the study detailed in the previous chapter included a comprehensive matrix of success factors and provided the foundation for the development of an implementation model for effective and sustainable MPHP.

The ‘Implementation Management Model for MPHP’ developed in the study (Figure 29) provides a comprehensive project and governance structure for effective MPHP. This approach to participatory health planning has three dimensions, namely Healthy Governance, a Platform Foundation and a focus on Implementation action.

Healthy Governance includes three main aspects: a long-term planning vision, the need to identify and meet national health goals and targets in the planning and the recognition of the many layers of state and regional planning, supported by local industry and regulation to provide a mandate for MPHP in the Public Health Act. The approach needs ‘planning governance’ measures in each partner agency and particularly in the organisation that facilities the platform: local government. Healthy governance measures include improved organisational
governance; improved communication processes between agencies and local government; programs for building organisational and staff capacity to engage with participatory planning; and legitimate and productive health alliances. Effective MPHP will be an outcome of ‘healthy governance’.

A Platform Foundation is a mechanism to sustain agency networking and promote formal signed-off partnerships on a partnership platform where agency and community groups implement the MPHP as a legitimate local stakeholder forum (supporting the health advisory committee and supported by a multi-sectoral Project Management Team with agreed-to committee terms of reference to enhance communication and reporting). The research demonstrated the need for elected council representatives (local councillors) to engage fully with MPHP: this political support is critical to future positive MPHP outcomes. To sustain the support of politicians, Project Management Teams must demonstrate short to medium term ‘wins’ or evidence of best practice. The Project achievements must be visible to the community and the media must be engaged in the promotion of the process and program implementation.

The earlier model developed by Chapman and Davey (1997) was more hierarchical, giving health-planning responsibility solely to local government – the platform approach implies equal responsibility between community agencies for the health needs of communities.

Implementation focuses on the actioning of strategies in the MPH Plan within an organisational context: health planning projects (and subsequent actioning of strategies) requires a greater appreciation of the impact of organisational behaviour and strategic management (of individuals, agencies and community groups) on improving planning success; the development
of formal and informal alliances for health to action strategies in collaboration; six-monthly Health Forum and Advisory Committee meetings supported by a funded project officer engaging with stakeholders; and in particular those strategies with several priority action areas based on the capacity of the healthy alliances and the available funding. An interactive web-site (including a newsletter and stakeholder data base) is recommended to facilitate communication between stakeholders. Such a web-site is also suitable for reporting the progress of the agency strategy implementation, and informing all stakeholders of health impacts. Joint grant writing is a significant outcome of MPHP. A process and impact evaluation is also built into the model and feeds back success factors to the Health Advisory Committee and agencies.

11.4 Conclusion

This chapter documented specific success factors for effective MPHP and documented an Implementation Management Model, supported by comprehensive evidence, as a way forward for the development and implementation of future MPH Plans. The success factors for effective MPHP were articulated in this chapter as the first recommendation of the thesis. The implementation model to improve the effectiveness of MPH Plans constructed from the collated findings of the research, was presented as the significant and second recommendation of the thesis. The major recommendations of the thesis fill the gap in the body of knowledge about how to effectively implement and strategically manage MPH Plans. The thesis discovered that effective implementation of MPHP will contribute to more healthy and sustainable communities. This discussion will allow for the study conclusions to be accurately documented in Chapter 12.
CHAPTER 12 CONCLUSIONS

12.1 Introduction

This thesis examined municipal public health planning and implementation in local government in Queensland focusing on the achievements, barriers and success factors associated with three planning projects. The study argued that the WHO Healthy Cities approach: municipal public health plans compared to other participatory planning models has been an effective strategic health planning process for local government. The planning process has placed health on the agenda in communities through partnership approaches between agencies, but the implementation and subsequent sustainability of the MPH Plans could be significantly improved. This final chapter will sum up the findings of the thesis with concluding remarks and provide implications and directions for future research.

12.2 Conclusions from the Study

There is an increasing realisation throughout the world of the need to respond to problems that threaten the environment and the quality of life of cities and communities. In Part 1 of the thesis the global challenges for health, for which local responses could assist in improving quality of life for residents, were discussed and need investigation, particularly in terms of how participatory health planning can be a positive organisational and community planning instrument for change.

This research has been based on a need to gain further understanding of how local governments can respond, through sustainable health planning, to the impacts of urbanisation in their community. This study examined and analysed the gap discovered in the body of knowledge relating to the effective processes and implementation of MPH Plans in local government in Queensland, through its focus on process and impact evaluation of two existing MPHP projects.

Each city has its own culture and diversity, its own political agenda and organisational capacity to respond to these global and local challenges. Creating healthier cities requires new organisational and strategic management approaches to health planning at the local level. To create a healthier future for cities, relevant agencies and residents must become engaged as partners in planning, and influence decision-making about health services and land use.
development. Local government is central to this planning and could make improvements towards healthier cities.

The literature reviewed in the thesis in Chapter 2, 3 and 4 discussed issues such as ecological public health and Healthy Cities approaches as well as partnerships for health promotional and MPHP, and explored the relationships between the governance of MPHP and the conceptual linkages with modern organisational management theory and practice and strategic planning responses. The World Health Organisation (WHO) initiated the Healthy Cities Movement in the 1980s, to implement the health promotion action areas of the Ottawa Charter in local community settings. The development of an ecological public health emerged, and introduced such concepts as the promotion of equity, community participation, and collaborative, multi-sectoral approaches towards improving the health outcomes of communities.

In Australia, the Commonwealth Government funded a National Healthy Cities Program in the early 1990s, and the Queensland Government responded with small grants to local government to develop and implement Healthy Cities approaches like MPHP in state and local government. Since then, eighteen cities and shires in Queensland have developed MPHP based on the WHO Healthy Cities philosophy. While the process helps local government and other stakeholders to develop partnerships and collaborate, the product of the planning is a dynamic strategic planning document that guides future local health actions. MPHP is only one of several community public health planning (CPHP) models to have been trialled in communities across Queensland. It is, however, the only model specifically tailored to local government. Local government is a democratic organisation, possessing political decision-making structures, and is supported by a bureaucratic, professional and technical administration. The organisation has economic and resource capacity and supports community participation and so is well placed to facilitate healthy and sustainable communities. Local government in Australia is the most suitable level of government to plan and build future healthy and sustainable cities, through structural mechanisms like MPH Plans.

The literature review concluded that generally MPHP projects are more effective when intersectoral collaboration across governmental and non-government agencies is in place, when local resources are mobilised instead of depending on external funding, and where the need to build local capacity to manage resources has been addressed. The literature indicated several barriers that reduce the effectiveness of MPHP implementation. In relation to political, managerial and organisational barriers, there is a sense in the literature that politicians, city managers, agency decision-makers and health and environment professionals working in national and local organisations may, for a range of reasons, contribute to the problems of an
unhealthy city (because of their inability to work jointly on holistic health issues), rather than working together across the sectors solving the problems. Local government and agency staffs responsible for health planning require a variety of health promotion skills to be effective planners. These include not only health promotion project skills but also, more broadly, knowledge and experience in partnership facilitation, strategic planning and organisational management. The factors described in the literature as contributing to the effectiveness of healthy cities projects (and MPHP) include agency collaboration, strong political support, community ownership and demonstrated outcomes.

Many studies have reviewed the success of this health planning process, usually applying process evaluation, but in most cases have not articulated the implementation outcomes. Here lies the gap in the evaluation of MPHP (Davey et al., 2001b: 2003). Minimal impact evaluation has been conducted on the implementation of Healthy Cities – MPHP projects. Firstly, for any health program it is vital to establish whether the goals of the MPHP projects have been reached. If the goals are being reached, then the program is performing. Secondly, the relationship between increasing agency collaboration and more effective planning is unclear, yet the Healthy Cities rhetoric supports this approach. Lastly, the issue of individual and organisational capacity to implement the plan has not been widely reviewed in previous studies and warrants further analysis. This research analyses the factors that threaten the effectiveness and viability of MPHP projects. The researcher concluded that although, MPHP process evaluation has been conducted, there are few impact evaluations published, and outcome evaluations were non-existent.

The research used a qualitative process and impact evaluation in the study design, described in Part 2 of the thesis. Grounded theory techniques allowed for an exploration of meanings and interpretations from the key informant responses. The research asked the question – what are the achievements of, barriers to and success factors for MPHP in local government? The study used a qualitative research method with initial case studies, then a process and impact evaluation method examining two MPHP projects in Queensland, followed by an analysis and comparison of MPHP in relation to other community public health plans and legislative frameworks. The thesis used a triangulation approach to methods of data collection, firstly developing an evaluation framework examining MPHP through case studies, using document analysis techniques; then conducting impact evaluation on two MPHP projects, using an Implementation Questionnaire (IQ) for this phase of the research; and lastly, comparing the features (strength and limitations) of MPHP to other CPHP models. The research tested the IQ on the two MPHP projects, determining whether the aims of the MPHP projects had been achieved and analysing the extent to which the MPHP had been implemented. The research examined the two stages of
planning: the initial plan development stage over a one-year period followed by the plan implementation stage, usually over the next three to five years.

In part 3 of the thesis, phase 1 comprised the writing of two case studies from document analysis and observations of the researcher made in 2001. The first case study described the GCCHP project, reporting on the planning process and implementation outcomes. The second case study, (Wide Bay Preliminary Evaluation: Regional Approach to Public Health Planning with Local Implementation Case Study), described the joint Maryborough City and Hervey Bay City MPHP Project.

Phase 2 of the data collection, conducted in 2002, consisted of a more in-depth analysis via the development and testing of a comprehensive evaluation, using the IQ, of the same two MPHP in Phase 1. This required the conduct of in-depth interviews with 17 key informants (KI) involved locally with the projects. The KI were categorised as Politicians, Managers, Health Practitioners and Agency Partners. MPHP is also compared to selected community public health planning (CPHP) models and legislative planning frameworks (LPF) in Phase 3 and was discussed in the context of the themes of the research and success factors for effective MPHP. A matrix in Chapter 10 demonstrates the strengths and limitations of the MPHP process.

From the theme analysis of data conducted from Chapter 7, 8 and 9 the research discovered that MPHP is complex and challenging. Communities engaged in the MPHP process in Queensland have achieved planning activity and progress. In the communities evaluated, project participants reported that the aims of the MPHP project were realised: participants had improved networking opportunities, better working partnerships and more program accountability, both within departments and across agencies. Community participation in the health agenda increased and politicians became more focused on delivering health services. Agencies participating in the MPHP process had gained a clearer understanding of the roles of each agency in health promotion, and this was favourable for intersectoral collaboration. In several communities funding for health projects increased significantly as a direct result of priority action planning and of agencies working in partnership. However, more emphasis is required to integrate health strategies into higher levels of planning; for example urban and regional planning, and into the business plans of the other partner agencies.

The thesis analysed whether the aims of the three MPHP projects studied were met and whether agency partnerships were improved. It found that project managers had difficulty meeting all the aims of their MPHP projects. However, intersectoral collaboration significantly improved during the process of developing the MPHP and continued for approximately two years of the implementation stage. The process of MPHP was considered as important as the outcomes of
planning. Also a comparison of the features of MPHP to other CPHP models during the study provided a range of effective success factors that could be tested on future MPHP processes.

Looking more closely, it can be seen that partnerships processes were improved during the MPHP, particularly as the network of agencies gained ownership of the process and developed trust with their new agency partners. Unfortunately, in respect of the first issue, when plans became under-resourced both financially and through lack of human resources (dedicated project staff and strategy implementation), the main aim – of agency and interdepartmental collaboration – declined further. MPHP has increased the activity between health agencies involved. The collaboration between local government and partner agencies improved significantly during the development process and implementation stages of the MPHP. Key informant reported that the process of planning is equally as important as the implementation phase, with both phases enhancing agency joint work. However, MPHP was difficult to sustain past the development phase of the project, for longer than a three-year implementation period.

Community participation was satisfactory during the planning process; in particular, the MPHP approach adopted in Queensland recognised that agencies and community groups represent the residents, and ensured that individual residents were well represented in the initial health profile and health needs assessment stage of the process, rather than merely later on in strategy committees. This appeared a suitable community engagement process. It is recommended that more research is required to assess the effectiveness of citizen involvement in all stages of MPHP.

Local government and agency professionals do not have the resources and therefore the subsequent capacity to implement all the strategies in the MPH Plan. However, the successful level of strategy implementation indicated that the partnerships formed during the planning process and implementation phase were a catalyst to health action. MPHP requires legitimacy through a mandate in the Public Health Act and the Local Government Act in Queensland to enable the provision of adequate budgets. The thesis recommends that regulation in the Public Health Act with linkages to the Integrated Planning Act and the Local Government Act is necessary to provide the planning governance, with supporting budgetary processes, for local government to legitimately develop and implement future MPH Plans. Sustaining participatory health planning contributes to healthy communities.

The broad sociological view of health that demands linkages with health and environment settings reached a satisfactory level of awareness across stakeholders; however, structural and organisational barriers impeded further progress regarding the social determinates of health. Longer periods of implementation are required before a proper assessment of this aim can be measured. Interdepartmental joint work has been difficult to achieve in each of the MPHP
projects, with professional barriers reducing the opportunity for integration of planning strategies. The aims of accountability and evaluation have not been well advanced during the projects: scarce resources were channelled to strategy development and joint grant writing as a priority, rather than improving these aims. This change of focus to aims of accountability and evaluation needs to become more important in this implementation environment.

Mayors and elected representatives perceived ‘Healthy Cities approaches’ as a health policy initiative that linked the many agencies and citizens. MPHP needs political support to be effective; it cannot be a bureaucratic process only. Staff turnover significantly reduced the medium- to long-term impact of MPHP: in particular, the high turnover of staff in agencies impacted adversely on MPHP implementation outcomes. In general it was a significant finding that the level of project management skills of the Project Officer managing MPHP projects directly affected the success of the plans implementation. This supports the need for structured training and capacity building for staff involved with MPHP. Members of the Advisory and Project Management Committees also need on-going training and capacity building in partnership building, strategic thinking and business planning, communication, project management and grant writing.

A model highlighting the need for MPH Plans to communicate with other layers of planning was constructed from the research findings in Chapter 11. It detailed the complexities of the many layers of planning in communities that require improved communication channels so health needs in MPH Plans can be interpreted by other levels of planning and decision-making bodies. The Model describes having structural communication mechanisms in place, so that health strategies in the MPHP can ‘link up’ vertically to inform higher levels of planning; and ‘link across’ horizontally, to address gaps in the strategic business plans of other agencies, community group concerns and residents needs. The organisational structure of each participating local government was not realigned during the implementation phase of the MPHP project to allow for more integrated interdepartmental planning practice: this aspect needs to be further considered.

The major findings supported more effective future municipal public health planning and implementation and included: building individual and organisational capacity to strengthen strategic planning; improving governance and legitimacy for planning; strengthening an understanding of organisational behaviour and its impact on successful planning while sustaining organisational structures and processes and; formalising collaboration and partnerships; establishing a commitment to investment in implementation; integrating the layers of planning cycles and addressing the on-going challenge that organisational barriers present for sustainable MPHP. From these findings the research has developed a management model for local government to implement a more effective and sustainable MPHP model. The research

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concluded there was an identified lack of capacity building in the projects to date. There was a need to build capacity and improve people’s planning skills, improve capacity in the participating agencies/organisations and improve the features of the MPHP model. For the planning to be effective, partner organisations must address governance measures to ensure their strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the MPHP; and agencies and staff must have the legitimacy and capacity to implement these actions.

The research discovered that the MPHP process and implementation was successful in clarifying the role of agencies in the delivery of public health services, significantly increasing agency partnerships. During the implementation phase, as a direct result of the planning process of the MPHP, there was evidence of improved funding opportunities for strategies identified by stakeholders. However, the high turnover of agency staff, and the lack of capacity building by the project team, with politicians and agency partners, presented barriers to planning. The study concluded that MPHP has strengths and limitations compared to other CPHP models, but that it has features most suited to local government.

The recommendations of the study in the final chapter, Chapter 12 recognise comprehensive success factors and present an effective implementation model for strategically managing MPHP. This model emphasises the importance of healthy governance, a platform approach and a focus on sustainable implementation processes. The implementation management model provides direction for effective project management structures, where government, non-government agencies and community groups agree to form healthy alliances, facilitating both formal and informal partnerships on the same platform. From the common platform, politicians, managers, health practitioners and partner agencies communicate, network, and engage in health action with organisations and residents.

The research demonstrated the importance of political and organisational support and the need for both the mayors of councils and elected council representatives (local councillors) and the local government organisation to engage fully with MPHP: this political support is critical to future positive MPHP outcomes. To sustain the support of politicians, Project Management Teams must demonstrate short- to medium-term ‘wins’ or evidence of best practice. The project achievements must be visible to the community and the media must be engaged in the promotion of the process and program implementation.

There was a demonstrated need to monitor medium to long-term planning outcomes and demonstrate evidence of improved quality of life. There is then the need to strategically manage MPHP implementation and develop a platform approach to sustain participatory health planning partnerships between Council, partner agencies, community groups and residents having a
shared responsibility for health. MPHP is very resource intensive, with no upfront funding for strategy implementation compared to other planning projects [see Community Renewal (CR)].

MPHP limitations are that its planning mechanisms have not gained legitimacy within acts and regulations [compared to Local Area Planning (LAP)], therefore long-term sustainability of MPHP is a problem:

- To be effective and sustainable the MPHP process needs individuals and organisations committed to partnership approaches
- MPHP needs legislation to mandate for it in an integrated way in the Local Government Act, the Public Health Act and IPA
- Need legislative standards to link MPHP to the Local Government Act and the IPA Corporate Plan and Town Plan respectively, and
- no formal MOU or ‘sign-off’ by higher level decision makers in agencies to act on local strategies.

The MPHP process for it to be sustainable requires stronger communication and reporting linkages to regional planning at a state level and through the Regional Organisations of Councils (ROC). After the plans have been developed the implementation remains a difficulty, particularly getting continued support from both government and non-government agencies. This is in contrast to planning mechanisms that have regulatory support, which are sustainable because they become mainstream activities with annual budget support in local government.

In summary, firstly, intersectoral collaboration, in particular via signed off formal MOUs between local government and agency partners, promoted the effective implementation of MPHP. Secondly, local governments were not successful at building their organisational capacity and strategic management practices to engage adequately and legitimately in the governance of MPHP, although the capacity of the project managers to engage with stakeholders was significantly increased. Thirdly, the majority of partner organisations did not have appropriate strategic planning measures to ensure their agencies’ strategic business plans reflected the agreed-to partnership responsibilities and priority actions in the MPHP. It is recommended that these wider aspects of strategic business planning be recognised within further MPHP implementations.

12.3 Future Challenges for Implementing Effective MPHP

Councils may need internal restructuring to integrate health, social and town planning departments in Council, if MPHP is to be sustainable. This infers organisational infrastructure change, the environmental health departments in council that hosted the MPHP projects organisations did not restructure or implement any organisational change in their departments to allow for the implementation of this broad-based public health plan. A solution would include
both manoeuvring the CHP for example, to fit better into the existing structures, while at the same time reorganising Council departments to line up with the intersectoral CHP. This is a challenge; the WHO HCM suggests that healthy cities policy needs positioning in the Mayors office, as an umbrella over all internal departments, not within a specific lower level department. Until this occurs in Queensland it may be difficult to effectively administer MPHP.

MPHP implementation needs more efforts on formalising partnerships between agencies on a common platform approach, so agencies have equal opportunities in planning and share responsibilities for implementation. In most cases the core business of community groups were in the plans however there was limited success with some agencies to include the agreed to strategies in their own business plans.

What was significant with the MPH Plans reviewed was that residents’ services improved as a direct result of the MPHP projects. Best practice examples include the positive impacts on quality of life in disability projects at the Gold Coast, with rural communities empowered by the CHP process engaging fully with local government to meet their identified needs. Funding grants generated by the CHP strategies improved outcomes in the long-term. Over 2 million in funding for community projects as result of the Wide Bay PHP, this directly impacts on the provisions of more effective health service provision and leads to health outcomes. However as health impacts are measured over medium to long-term timeframes, this makes outcomes directly related to the MPHP projects difficult to demonstrate. This affects the on-going management support and sustainability of the planning.

In summary, there are future challenges for implementing MPHP. First council strategic management processes to assist with plan implementation were not successful and need modification. There was an urgent need to get the structure right for MPHP within councils and legitimise linkages to the corporate plan. Several respondents suggested that councils develop community indicators to monitor the outcomes of participatory planning to establish an evidence base, however the research established that impact evaluation is a more effective tool to monitor the outputs of MPHP. The thesis concludes that effective implementation of MPHP will lead to healthier communities.

12.4 Implications of Research and Future Direction

An effective and sustainable implementation model to strategically manage MPHP in the future was presented in this chapter. The research outcomes in the previous chapter included a matrix of success factors for effective MPHP based on individuals, organisations and improving the MPHP model. Recommendations from this study are designed as a guide to improve the implementation of future MPHP mechanisms in local government in Queensland. The
evaluation framework developed for evaluating MPHP projects in this thesis could be tested in other local governments both in Australia and internationally.

MPHP skills training and improving the capacity building training methods for planning and implementation of MPH Plans is critical to the success of future MPH Plans and must focus on the needs of the all levels of organisations including individuals, community group representatives and agency partners engaged in local and state government. The research concluded there was an identified lack of capacity building in the projects to date. There was a need to build capacity and improve people’s planning skills, improve capacity in the participating agencies/organisations and improve the features of the MPHP model. For the planning to be effective, partner organisations must address governance measures to ensure their strategic business plans reflect the agreed-to partnership responsibilities and priority actions in the MPHP; and agencies and staff must have the legitimacy and capacity to implement these actions. Further research is required to redesign the MPHP model utilising these findings and demonstrate MPHP capability in different local government areas, particularly communities impacted upon by urbanisation. There is an emerging need to engage industry partners in MPHP.

The major findings of this thesis centred around the following elements: building individual and organisational capacity to strengthen strategic planning; improving governance and legitimacy for planning; strengthening an understanding of organisational behaviour and its impact on successful planning while sustaining organisational structures and processes and; formalising collaboration and partnerships; establishing a commitment to investment in implementation; integrating the layers of planning cycles and addressing the on-going challenge that organisational barriers present for sustainable MPHP. From these findings the research has developed success factors and a management model for local government to implement a more effective and sustainable MPHP model.

The thesis recommended that regulation in the Public Health Act be developed with linkages to the Integrated Planning Act and the Local Government Act. As indicated in the conclusions, this would be necessary to provide the legislative planning governance, with supporting budgetary processes, for local government to legitimately develop and implement future MPH Plans. Further research into the impacts of the prescriptive nature of this regulation is required.

This MPHP implementation management model can help guide the implementation and sustainability of not only participatory health planning but also generic healthy cities projects, not only in Australia but elsewhere in the world. Further research is required into improving political and community inputs into participatory health planning, and testing action research methods for healthy cities projects.
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## Appendix A: MPHP Projects Funded by Queensland Health and Local Government

<table>
<thead>
<tr>
<th>Project and Partners</th>
<th>Brief Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Pilot projects Round 1 (funding $10,000 grant)</strong></td>
<td></td>
</tr>
<tr>
<td>Brisbane City Council</td>
<td>CHP 1996–1999 developed and in 1999 reviewed by consultant, strategies rolled up into Corporate and Operational Plans of Council with suburb- by-suburb Health and Safety Committee part of Local Area Planning Process. Initial seed funding by Queensland Health $10,000. Developed in 2003 in the Healthy and Active City Strategy.</td>
</tr>
<tr>
<td>Banana Shire Council</td>
<td>Plan Implemented, Evaluation and review of first three 3-year plan in 2000. Initial funding from Queensland Health $10,000.</td>
</tr>
<tr>
<td>Cairns City Council</td>
<td>Plan Implemented, Evaluation and review of first three 3-year plan in 2000. Initial seed funding from Queensland Health $10,000.</td>
</tr>
<tr>
<td><strong>Pilot Projects Round 2 (funding $5,000 grant)</strong></td>
<td></td>
</tr>
<tr>
<td>Livingstone Shire Council</td>
<td>First 3-year plan still in implementation, monitoring and reviewing strategies in 2000. Seed funding from Queensland Health $5,000.</td>
</tr>
<tr>
<td>Burnett Shire Council</td>
<td>Initial $5000 funding Plan still in draft. In 2000 there is a plan to re-establish process. Funding from Queensland Health</td>
</tr>
<tr>
<td>Cambooya Shire, funded $1000 by Healthy Cities and Shires in 1998</td>
<td>1998–2001 MPHP completed and being implemented. Seed funding from Queensland Health $1000</td>
</tr>
<tr>
<td>Boonah Shire Council</td>
<td>1996–1999 Developed and Plan implemented. Seed funding from Queensland Health $5,000.</td>
</tr>
<tr>
<td>Bamaga Community</td>
<td>Awarded encouragement award but project didn’t commence due to a similar Commonwealth Infrastructure project starting.</td>
</tr>
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<td><strong>Projects initiated after initial Queensland Health encouragement awards finished</strong></td>
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<td>Hervey Bay and Maryborough Cities with CPHUN-WB</td>
<td>Launch of plans in Dec 1999. Queensland Health, CPHUN funding and funding from each Council.</td>
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<tr>
<td>Kilcoy Shire Council</td>
<td>Launched Plan in 2000</td>
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<tr>
<td>Kolan Shire Council with Queensland Health, CPHUN Wide Bay</td>
<td>Joint funding from Shire Council and Queensland Health Launched in 2001</td>
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<td>Coloola Shire, Gympie</td>
<td>Developed a Community Development Plan with a Health Determinants Plan, funded partly by Sunshine Coast PHU, Queensland Health, launched in 2001</td>
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<tr>
<td>Logan City Council with Queensland Health Public Health Unit and Griffith University</td>
<td>Joint funding from City Council and Queensland Health Logan Public Health Plan launched in 2003</td>
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<tr>
<td>Townsville City Council</td>
<td>Launched Healthy City Plan 2003 (TCC, 2003) Member of the Alliance for Healthy Cities (see Davey and Murray, 2003)</td>
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<tr>
<td>Rockhampton City</td>
<td>Launched Rockhampton CHP 2003</td>
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<td>Kingaroy Shire Council</td>
<td>Kingaroy Shire Sustainable Community Strategy 2006 in draft at May 2006</td>
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Appendix B: Project Management Team Evaluation Survey

SECTION 1: Evaluation of Compliance with Guiding Principles
This section attempted to gain an understanding on how the aims of the project were being met.

Question 1  Intersectoral collaboration has been achieved in the process of planning?
Question 2  Is there a high level of community participation in the process?
Question 3  Is there a large number of departments and organisations involved in the process?
Question 4  Partnerships among organisations have been improved as a result of the process of PHP e.g. potential for resource sharing, teamwork and support amongst organisations?
Question 5  Organisations are working better together to achieve a shared vision as a result of the process of PHP?

Comments:
List negative comments about the guiding principles and the process of PHP in the Region.
List positive comments about the guiding principles and the process of PHP in the Region.

SECTION 2: Evaluation of TORs

Question 1  The PMT has provided professional advice and local information?
Question 2  The PMT has reviewed and monitored the plan’s process and time frame?
Question 3  The PMT has participated in collection and analysis of data?
Question 4  The PMT members have provided feedback to their own organisation and the community?
Question 5  The PMT has used intersectoral collaboration as a strategy in the development of the plan?
Question 6  The PMT has acted as a link between local government, key service providers and the community?
Question 7  The PMT has participated in prioritising issue/s in the plan?
Question 8  The PMT has not participated in strategy development?
Question 9  The PMT will oversee the writing of the plan?
Question 10  The PMT has a role to participate in evaluating the plan?
Question 11  The PMT has a role to establish a structure to monitor and review the plan?

Comments about the Terms of Reference of the Project:
List negative comments about the PMT meeting the TOR of the Health Planning Process in the Wide Bay Region.
List positive comments about the PMT meeting the TOR of the Health Planning Process in the Wide Bay Region.

SECTION 3: Health Planning Issues

Question 1  Is the PHP process reaching the target groups? If not, describe the parts of the community not being reached.
Question 2  Not all parts of the program are reaching all parts of the target groups?
Question 3  Are all participants satisfied with the PHP Process?
Question 4  Are all the components of the project of good quality?
Question 5  The project officer from Griffith University has facilitated the project to a high standard?
Question 6  The Project Coordinator from CPHUN has coordinated the process to a high standard?
Question 7  The initial ‘Awareness Raising Training Workshop’ conducted by Griffith University added value to understanding the process of planning in a community?
Question 8  The initial Community Vision Workshop in Hervey Bay was important in the process?
Question 9  The initial Community Vision Workshop in Maryborough was important in the process?
Question 10  The meeting venues have been unsatisfactory?

Any other comments may be provided here.

# the following scale was used to gauge responses
Strongly disagree………………………………..Agree…………………………………………Strongly agree
1…………2…………3…………4…………5…………6…………7…………8…………9…………10
Appendix C: Results of Project Management Team Evaluation Survey

March 1999 (n=7)

This table lists the data from the survey distributed during the development of the planning process:

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SECTION 1: Evaluation of compliance with Guiding Principles

This section attempted to gain an understanding of how the aims of the project were being met.

Question 1    Intersectoral collaboration has been achieved in the process of planning?
Question 2    There is a high level of community participation in the process?
Question 3    There is a large number of departments and organisations involved in the process?
Question 4(a) Partnerships among organisations have been improved as a result of the process of PHP?
Question 4(b) There is potential for resource sharing, teamwork and support amongst organisations?
Question 5    Organisations are working better together to achieve a shared vision as a result of the process of PHP?

Comments:
List negative comments about the guiding principles and the process of PHP in the Region.
List positive comments about the guiding principles and the process of PHP in the Region.

SECTION 2: Evaluation of Attitudes of Members in Theme Working Groups (TWG)

The TWG has provided professional advice and local information?

Question 1    The TWG has participated in collection and analysis of data?
Question 3    The TWG members have provided feedback to their own organisation or community?
Question 4    The TWG members have collaborated in the development of the themes?
Question 5    The TWG has acted as a link between key service providers and the community?
Question 6    The TWG has participated in prioritising issues in the plan?

SECTION 3: Health Planning Issues

Is the PHP process reaching the target groups? If not, describe the parts of the community not being reached?

Question 1    Is the (insert Theme Working Group) reaching all agencies and community groups in this process of collaboration?
Question 3    Are all participants satisfied with the PHP Process?
Question 4    Are all the components of the project of good quality?
Question 6    The Project Officer from Griffith University has facilitated the project to a high standard?
Question 7    The Project Coordinator from CPHUN has coordinated the process to a high standard?
Question 8    The initial Community Vision Workshop in Hervey Bay was important in the process?
Question 9    The initial Community Vision Workshop in Maryborough was important in the process?
Question 10   The meeting venues have been unsatisfactory?
Question 11   There has been an opportunity for a high level of participation as a TWG member at meetings?

Any other comments may be provided here.

# the following scale was used to gauge responses
Strongly disagree.......................... Agree..............................Strongly agree
1…………2…………3…………4…………5…………6…………7…………8…………9………10
Appendix E: Results of Process Evaluation of Theme Working Groups  
– Community Safety

March 1999 (n = 15) This table lists the data from the survey to agency representatives WHO participated in the development of the PHP

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### Appendix F: Results of Process Evaluation of Theme Working Groups – Healthy Lifestyles

March 1999 (n=6) This table lists the data from the survey to agency representatives WHO participated in the development of the PHP

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353
Appendix G: Phase 2: Gold Coast Community Health Plan Questionnaire (IQ)

DATA COLLECTION INSTRUMENT

Key Informant Detail:

TIME: 
PLACE: 
NAME: 
CURRENT POSITION: 
EMAIL: 
PHONE NO: 
FAX NO:

Key Informant Background:

1. What is your educational background?
2. What are your qualifications?
3. What experience do you have with strategic planning?
4. Have you studied in business planning?
5. Have you experience in community consultation or studied this method?
6. Have you studied partnership building in communities?
7. Have you had experience in health planning before this MPHP process?

______________________________________________________________________________________________

Interview Method: In-depth face-to-face interview
Interview Participants: Key informant’s perspectives i.e. political, manager, health practitioner, agency partners
Interview Questioning: Implementation Questionnaire - Process and Implementation impacts
Prompt Questions: Other questions may be used as required to prompt more specific interview discussion
Interview Duration: Interviews approx. 2 hours in length
Data Recording: Interview data will be recorded through a tape and note-taking and then transcribed
EVALUATION OF PROJECT AIMS (PA-GC)

Aims of the Gold Coast CHP:

<table>
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<td>Equity in Health</td>
<td>Community Participation</td>
<td>Broad socio-ecological View of Health</td>
<td>Evaluation and Accountability</td>
</tr>
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</table>

Intersectoral Collaboration
Levels of Collaboration
- Has the MPHP process invoked greater levels of collaboration between the government and non-government sectors and community groups?
- Has this collaboration been positive for your organisation?
- Has there been increased activity in health promotion as a result of the MPHP process?

Shared Objectives and Group Purpose
- Did the MPHP process have an agreed set of terms of reference?
- Did the working partners agree to common goals and objectives for the planning process?

Composition
- How did the project identify WHO should be involved?
- Describe your involvement in the MPHP?
- Was there a balance between Council representation and other bodies on the Steering Committees?
- Did the members of the project have the skills, attributes and attitudes necessary for joint work?
- Has a lead person from each organisation been identified to work with the alliance?

Resources adequate to achieve its objectives
- Did the project have an adequate budget to achieve its objectives?
- Has the project received additional sources of funding?
- Has the project identified a coordinator with appropriate skills to oversee the project?
- Do participants contribute adequate time to the project?

Interdepartmental Involvement
- Collaboration between Council departments
- Has the MPHP increased collaboration between Council Departments?
- Roles of departments
- Has the MPHP increased your knowledge of the roles of other departments in public and environmental health service delivery?
- Organisation of work practices
- Has the organisation of work practices been modified to accommodate the strategies in the MPHP?

Partnerships (joint working, resource sharing, communication, teamwork, support)
- Describe the partnerships that have been formed during the MPHP process?
- Have all partners made a contribution to the strategies of the MPHP?
- Have the partners prepared to compromise in order to resolve conflicts in priority issues?
- Have the strategies been agreed by each partner organisation?
- Have working partners agreed to their responsibilities within the action plan?
- Does the Project review the process and achievements of the MPHP and amend them as required?
- Does the MPHP project continually attract new members and keep its membership under review?
- Does the MPHP act as a catalyst in generating new projects?
- How did agencies and the community groups communicate in the process?
Equity in Health
Issues for equity
Discuss where equity issues have been dealt with in the plan?
Special need groups
Have the needs of special needs groups been addressed?

Community Participation
Levels of community participation
Did the project include participation from the community?
Have government and non-government community groups participated in the MPHP?
What influence has the community had on the MPHP?
Did the local community become involved in the needs assessment?
Empowerment and Decision-Making
Has training been identified and provided for participants?
Did the project provide opportunity for input from agencies?
Did the project have clear decision-making processes in which community representatives were involved?

Broad Socio-Ecological View of Health
Approaches to determinants of health
Please comment on the broad approach of the plan to economic, development, social and environmental issues beyond disease-based models to encompass the determinants of health?
Traditional core and non-core business
Does the plan address issues outside of Council traditional core business? Is this appropriate?

Shared Ecological Vision
Did the MPHP process provide for the development of a shared ecological vision in your community?

Evaluation and Accountability
Accountability
How accountable is the Council to the community/agencies?
How accountable are the agencies/community to the Council?
Did the process identify partner’s responsibilities in the PHP? e.g. strategies
Has the responsibility for activities in the MPHP been accepted by each participant?
Monitoring of activities and evaluation
Did the process identify how to evaluate the work?
Did the process monitor the progress of activities?

IMPLEMENTATION IMPACTS ON INDIVIDUALS AND ORGANISATIONS (II-GC)

Benefits and Support for MPHP (Political, Management, Health Practitioner, Agency Partner)
What do you think are the benefits of having a MPHP?
What political support is provided for the MPHP during implementation?
Has the MPHP increased political support within your organisation?
Is there management support for MPHP in your Council/your organisation?

Health Policy on the Agenda
What policy changes have resulted in your organisation as a result of the MPHP initiative?
List Barriers to success

Health and Environment Activities
What are the most inspiring examples of public and environmental health planning outcomes by Councils that you are aware of?
Best Practice Planning for Health
Have you any examples of the MPHP process integrating with other planning processes?
What are characteristics of best practice community public health planning?
How significant is MPHP compared with other planning initiatives in Council/in your organisation?
What is your overall assessment of the state of MPHP and practice within Local Government?
Strengths and Weaknesses

Infrastructure Change
What structural, organisational or environmental changes which have a potential impact on the health of the target population have resulted from the MPHP activities?
Have there been changes in attitude of interdepartmental agencies in Council in relation to the objectives of the project?

Skills Development
What training has been provided to improve the knowledge and skills of the participants involved with MPHP?

Visibility and Media
To what extent have the community agencies and residents been informed about this MPHP process throughout the planning stages?

IMPLEMENTATION IMPACTS ON THE COMMUNITY (II-GC)

Plan Exposure
How much direct contact has there been between the project and the community during implementation?
What level of community participation has occurred during implementation?
List what strategies have been funded or achieved since implementation commenced?

Quality of life of the residents
Has the MPHP impacted directly on the quality of life of residents since implementation?

Community agency strategic plan
Is the MPHP process or strategies in the plan part of the community agency strategic plan?

Agency cooperation
What changes have you noted in your agency as a result of the MPHP project?
Has cooperation between the agency and the University been beneficial?
Appendix H: Phase 2: Wide Bay Regional Public Health Plan Implementation Questionnaire (IQ)

DATA COLLECTION INSTRUMENT

Key Informant Detail:

TIME:
PLACE:
NAME:
CURRENT POSITION:
EMAIL:
PHONE NO:
FAX NO:

Key Informant Background:

1. What is your educational background?

2. What are your qualifications?

3. What experience do you have with strategic planning?

4. Have you studied in business planning?

5. Have you experience in community consultation or studied this method?

6. Have you studied partnership building in communities?

7. Have you had experience in health planning before this MPHP process?

Interview Method: In-depth face-to-face interview
Interview Participants: Key informant’s perspectives i.e. political, manager, health practitioner, and agency partners.
Interview Questioning: Implementation impacts
Prompt Questions: Other questions may be used as required to prompt more specific interview discussion
Interview Duration: Interviews approx. 2 hours in length
Data Recording: Interview data will be recorded through a tape and note-taking and then transcribed
EVALUATION OF PROJECT AIMS (PA-WB)

Aims of Wide Bay Public Health Plan

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<tr>
<td>Intersectoral Collaboration</td>
<td>Community Participation in Decision-Making</td>
<td>Interdepartmental Involvement</td>
<td>Partnerships</td>
<td>Shared Vision</td>
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Intersectoral Collaboration

Levels of Collaboration
- Has the MPHP process invoked greater levels of collaboration between the government and non-government sectors and community groups?
- Has this collaboration been positive for your organisation?
- Has there been increased activity in health promotion as a result of the MPHP process?

Shared Objectives and Group Purpose
- Did the MPHP process have an agreed set of terms of reference?
- Did the working partners agree to common aims for the planning process?

Composition of Working Parties
- How did the project identify who should be involved?
- Describe your involvement in the MPHP?
- Did the members of the project have the skills, attributes and attitudes necessary for joint work?
- Has a lead person from each organisation been identified to work with the alliance?

Adequacy of Resources to Achieve Project Aims
- Did the project have an adequate budget to achieve its objectives?
- Has the project received additional sources of funding?
- Has the project identified a coordinator with appropriate skills to oversee the project?
- Did participants contribute adequate time to the project?

Community Participation in Local Decision-Making

Levels of Community Participation
- Did the project allow for community participation?
- Have non-government community groups participated in the MPHP?
- What influence has the community had on the MPHP?
- Did the local community become involved in the needs assessment?

Empowerment and Decision-Making
- Has training been identified and provided for participants?
- Did the project provide opportunity for input from agencies?
- Did the project have clear decision-making processes in which community representatives were involved?

Interdepartmental Involvement

Collaboration Between Council Departments
- Has the MPHP increased collaboration between Council departments?

Roles of Departments
- Has the MPHP increased your knowledge of the roles of other departments in public and environmental health service delivery?

Organisation of Work Practices
- Has the organisation of work practices been modified to accommodate the strategies in the MPHP?
Partnerships (joint working, communication and media)

Joint Working
- Describe the partnerships that have been formed during the MPHP process.
- Have all partners made a contribution to the strategies of the MPHP?
- Are the partners prepared to compromise in order to resolve conflicts in priority issues?
- Has each partner organisation agreed to the strategies?
- Does the Project review the process and achievements of the MPHP and amend them as required?
- Does the MPHP project continually attract new members and keep its membership under review?
- Does the MPHP act as a catalyst in generating new projects?
- How did agencies and community groups communicate in the process?

Working Together Towards a Shared Vision

Development of a Shared Vision
- Did the MPHP process provide for the development of a shared vision in your community?

Accountability
- Did the process identify partner’s responsibilities in the PHP?

Monitoring of Activities and Evaluation
- Did the process identify how to evaluate the work?
- Did the process monitor activity progress?

Sustainability of the MPHP Process

IMPLEMENTATION IMPACTS ON INDIVIDUALS AND ORGANISATIONS

Benefits and Support for MPHP (Political, Management, Practitioner)
- What do you think are the benefits of having a MPH plan?
- What political support is provided for the MPHP during implementation?
- Has the MPHP increased political support within your organisation?
- Is there management support for MPHP in your Council/organisation?

Health Policy on the Agenda
- What policy changes have resulted in your organisation as a result of the MPHP initiative?
- Barriers to Successful Health Policy Implementation

Health and Environment Activities
- What are the most inspiring examples of public and environmental health planning outcomes by Councils?

Best Practice Planning for Health
- Have you any examples of the MPHP process integrating with other planning processes?
- What are characteristics of best practice community public health planning?
- How significant is MPHP compared with other planning initiatives in the Council/your organisation?
- What is your overall assessment of the state of MPHP and practice within local government?
- Strengths and Weaknesses of MPHP

Infrastructure Change
- What structural, organisational or environmental changes, which could potentially impact on the target population’s health, have resulted from the MPHP activities?
- Have the Council interdepartmental agencies changed their attitudes in relation to the project’s objectives?

Skills Development
- What training has been provided to improve MPHP participants’ knowledge and skills?

Visibility and Media
- To what extent have community agencies and residents been informed about MPHP processes throughout the planning?
IMPLEMENTATION IMPACTS ON THE COMMUNITY

Plan Exposure
How much direct contact has there been between the project and the community during implementation?
What level of community participation has occurred during implementation?
List strategies that have been funded or achieved since implementation.

Quality of Life of Residents
Has the MPHP impacted directly on the quality of life of residents since implementation?

Community Agency Strategic Plan
Is the MPHP process, or are strategies in the plan, part of the community agency strategic plans?

Agency Co-operation
What changes have you noted in your agency as a result of the MPHP project?
Has cooperation between the agency and the University been beneficial?
Appendix I: Phase 3: Conceptual Mapping of Documents: Reviewing Framework

| DOCUMENT / PROJECT: ____________________________________________ |

| 1 | Historical Context and Background |
| 2 | Local Context / Location |
| 3 | Organisational Context / Funding and Promoting Body |
| 4 | Global Model Derivation / Orientation |
| 5 | General Principles / Best Practice Elements e.g. |
| | o Intersectoral Collaboration / Partnerships |
| | o Relationship Between Health and Environment |
| | o Breaking Down Territories |
| | o Equity |
| | o Sustainability |
| | o Putting Health on the Agenda |
| | o Community Participation |
| | o Industry Involvement |
| | o Access to Health Services |
| | o Reorientation of Health Services |
| | o Building Healthy Public Policy |
| | o Strengthening Community Action |
| | o Developing Personal Skills |
| 6 | Links to External Policy, Legislation, Charters |
| 7 | Governance (Internal) |
| | o Legitimacy and authority through internal government / departmental / organisational directives, legislation etc |
| 8 | Level / Type / Process of Agency Involvement and Partnership |
| 9 | Purpose of Model |
| | o Goals, Aims, Objectives |
| 10 | Target of Model |
| | o Specific Population, Community, Group, Individuals |
| 11 | Intended Health Determinants and Impacts |
| | o Individual, Social, Ecological |
| 12 | Planning Process |
| 13 | Implementation Process |
| 14 | Evaluation / Assessment Process |
| 15 | Consultation Methods |
| | o Levels, Types and Process of Community Engagement |
| | o Levels, Types and Process of Agency Involvement |
| 16 | Resources and Costs |
| | o Training |
| | o Support |
| | o Sustainability |
| | o Evaluation |
| 17 | Limitations and Gaps in the Model |
| 18 | Success Factors |
| 19 | Barriers to Success |
| 20 | Key Learnings and Outcomes Generated from the Model (to date) |
Appendix J: Phase 3: CPHP and Comparisons to MPHP Key Informant Interview Survey

Interview Method: In-depth and open-ended questionnaire by phone interview.
Interview Participants: Key informants perspectives i.e. manager, health practitioner, agency partners.
Interview Questioning: 10 main questions represent the general areas of interview exploration.
Prompt Questions: Other questions may be used as required to prompt more specific interview discussion.
Interview Duration: Interviews approx. 45 – 60 mins in length.
Data Recording: Interview data will be recorded through note-taking and then transcribed.

AWARENESS
What community public health planning models are you aware of that are happening in Queensland / happening within your work arena?

INVOlVEMENT
Describe your involvement in community public health planning processes in Queensland.

BEST PRACTICE
What do you think are the elements of a best practice community public health planning model? Provide a specific project / model example.

KEY LEARNINGS
For you as a [manager / practitioner / partner with Queensland Health], what are the key learnings about your involvement in community public health planning?

ASSESSMENT
What is your overall assessment of the state of community public health planning and practice within Queensland?

FUTURE CHALLENGES / BARRIERS
For you as a [manager / practitioner / partner with Queensland Health], what do you think are the future challenges and / or barriers to community public health planning?

PREFERRED MODEL(S)
Which model/s of community public health planning would you prefer to use and why?

HEALTH IMPACTS
Do you think that the community public health planning that has been happening in Queensland to date, has resulted in health impacts. If so, what impacts have resulted? If not, why not?

OTHER AGENCIES FOR CONSULTATION
What other agencies do you think should be consulted in this review of community public health planning processes?

MISC
Do you have any other comments on planning processes and issues which you would like included in this review?
## Appendix K: Key Informant Matrix

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<th>Phase 2 Wide Bay PHP 2002</th>
<th>CPHP and MPHP 2003/2004</th>
<th>Position and Organisation</th>
<th>Comments</th>
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<td>Health Committee Chairperson, GCCC(GCCC)</td>
<td>Councillor</td>
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<td>Bill Brennan</td>
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<td>Mayor</td>
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<td>Ann Millar</td>
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<td>Health Committee Chair, MCC</td>
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<td>Sophie Dwyer</td>
<td>Sophie Dwyer</td>
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<td>Manager, Environmental Health Unit, Queensland Health</td>
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<td>Dale Dickson</td>
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<td>CEO, GCCC</td>
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<td>Colette McCool</td>
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<td>Executive Manager Community Health Branch, GCCC</td>
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<td>John Cohan</td>
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<td>Manager Environmental Health Branch, GCCC</td>
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<td>Ric Williams</td>
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<td>Coordinator Environmental Health, Environmental Health Branch, GCCC</td>
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<td>M6</td>
<td>Mal Price</td>
<td>Mal Price</td>
<td>Mal Price</td>
<td>Director, CPHUN Wide Bay, in Bundaberg, Queensland Health</td>
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<td>Greg Crisp</td>
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<td>Manager, Environmental Health Services, HBCC</td>
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<td>Jeff Bacchi</td>
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<td>Director, Planning and Environmental Health, MCC</td>
<td>Project Director</td>
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<tr>
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<td>John Scott</td>
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<td>State Manager, Public Health Services, Queensland Health</td>
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<td>David Strain</td>
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<td>Manager, CPHUN, Queensland Health</td>
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<td>David Logan</td>
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<td>Manager, Southern Public Health Unit Network, Brisbane Southside, Queensland Health</td>
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<tr>
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<td>M12</td>
<td>Jacqui Lloyd</td>
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<td>Director, Health Promotion Services, Tropical Public Health Unit Network, Townsville, Queensland Health</td>
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<td>Ross Spark</td>
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<td>Manager, Tropical Public Health Unit Network, Cairns, Queensland Health</td>
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<td>Bryan Barker</td>
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<td>Community Awareness Officer, GCCC</td>
<td>Project Manager, GCCCCHP</td>
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<td>HP2</td>
<td>Mike Yakimoff</td>
<td></td>
<td></td>
<td>Environmental Health Officer, GCCC – assist with coordination of CHP</td>
<td></td>
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<tr>
<td>19</td>
<td>HP3</td>
<td>Darren Hauser</td>
<td></td>
<td></td>
<td>Health Promotions Officer, CPHUN Wide Bay, in Hervey Bay</td>
<td>Project Manager, Wide Bay PHP</td>
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**Codes**
- KI – Key Informant
- P – Politician
- M - Manager
- HP - Health Practitioner
- AP - Agency Partner