In the first quarter of the 20th century, chronic and ‘lifestyle’ diseases overtook infectious diseases as the leading public health concern in developed countries. In Australia, as with many other countries, preventable diseases such as cardiovascular disease, cancer, obesity-related disease and chronic respiratory conditions, although unevenly distributed, account for as many as 90% of deaths. In contrast to health behaviourism, the socio-ecological model suggests that these diseases are influenced by lifestyle factors – particularly diet and physical activity – but that lifestyle is in turn strongly determined by the design of towns and cities, by education and employment and by the strength of community connections. Ultimately, much poor health is the result of disparities in governable social policies, and – to use Irving Zola’s river parable – even further ‘upstream’, by commercial interests and inequitable distributions of power and resources.

In 2008, the World Health Organization (WHO) Commission on the Social Determinants of Health was explicit about the importance of local government (LG) in improving public health. This raised expectations and endorsed LG to more aggressively improve social determinants. Both globally and locally, this has resulted in a better understanding that through the provision of social infrastructure – the facilities, structures and services that make a community more than just a collection of people – LG can play an important role to address a range of social determinants, thus improving health.

In 1998, The Victorian Government gave legislative recognition to the social determinants of health (SDH) in an amendment (Section 26) to the Health Act 1958. The amendment required each of Victoria’s 79 LGs to prepare a four-yearly evidence-based Municipal Public Health Plan. In 2004–05, a review of the Health Act resulted in the creation of a new Act, the Public Health and Wellbeing Act 2008 (hereafter referred to as ‘the Act’), which came into effect on January 1, 2009. Importantly, this new Act adopted the WHO’s definition of ‘wellbeing’ to incorporate the understanding that health is more than the absence of disease. The new Act also added requirements for the state to develop a Public Health and Wellbeing Plan (Section 49) and for municipal public health and wellbeing plans (MPHWP) to “have regard” to the priorities therein (Section 26). In the 2011–2015 State Plan, to which LG was working at the time of the research (a new 2015–2019 Plan was launched in 2015), the priorities took the form of Action Areas. These were: Continue to Protect the Health of Victorians, which

Abstract

Objective: The World Health Organization calls upon local government worldwide to play a greater role in improving public health by improving the social determinants of health. This research aimed to determine how local governments in Victoria, Australia, conceptualised their organisational efficacy to address public health with reference to their statutory obligations.

Methods: Sixteen in-depth interviews were conducted with Victorian local government health planners. Thematic analysis was used to determine the importance of state health priorities and the perceived organisational efficacy of local government to address health via social determinants.

Results: While there were disparities between state and local priorities for health, local government believes it can make an important contribution to improving health through ‘upstream’ approaches.

Conclusions: Victorian local government has strongly adopted the socio-ecological model of health and is aware of the important role that its diverse policy and program areas play in creating healthy communities. The Victorian State Government’s priorities, which adopted a more ‘downstream’ approach, were less influential.

Implications for public health: State governments’ priority settings should be responsive to local governments’ unique local knowledge of health priorities. There is value in legislating a social determinants role for local government, provided it is supported by state and national government policies that facilitate public health.

Key words: public health, local government, social determinants of health, organisational efficacy
have prepared for LG are intended to increase LGs’ confidence and capacity to improve the conditions in which community members are “born, grow, live, work, and age”, despite the influence of “macro-level societal forces that contribute to the (re)production of patterns in human health”.

Some important quantitative work has been done by Lawless et al. on the capacity of LGs in other states to address SDH. It showed that, generally, LG in NSW and SA is aware of and using SDH knowledge to inform their work. In Victoria, the research on LGs’ capacity to improve social determinants has focussed more on understanding the extent to which LG uses evidence and other forms of information to develop MPHWPs (see, for example). In regard to actions, the operational part of MPHWPs, some work has been done to assess MPHWPs for the extent to which they address particular health issues and their determinants (c.f. food security).

More recently, an analysis of the actions in the 2013–2017 MPHWPs of the North and West Metropolitan Region of Melbourne (14 LGAs) was conducted for the way that state priorities and social determinants were addressed. It showed that councils were doing significant work beyond the explicitly addressed. It showed that councils were doing significant work beyond the explicitly defined priority areas of the State Plan, but that this was nevertheless an approach that was consistent with the WHO’s ambitions for LG in terms of addressing health’s social determinants.

Aim of this study

The present study aimed to collect and synthesise Victorian MPHPW planners’ qualitative views of their organisation’s efficacy to fulfils their obligations under the Act. The results complement recent research to provide an assessment of the extent to which LG in Victoria has taken on the WHO’s responsibilities for LG. Locally, the results will assist the Victorian State Government and the MAV to provide better, more targeted assistance and to engage in more effective advocacy on LG’s behalf.

Method

Semi-structured interviews were used to elicit LG health planners’ views of their organisation’s efficacy to improve public health. Specifically, the research questions were: 1) To what extent does LG “have regard” to the priorities in the State Health Plan?; and 2) How effective does LG feel it can be at improving social determinants by “identifying goals and strategies … for creating a local community in which people can achieve maximum health and wellbeing”? The interviews were conducted and analysed using seven steps: thematise; design; interview; transcribe; analyse; verify; and report.

‘Thematising’ involved the development of the research questions into a set of interview questions. This helped to ensure consistency between interviews, so that all topics of importance were covered and interviews were kept on track and to time.

The overarching research themes that were explored operationalised Van Vuuren and colleagues’ construct organisational efficacy. The interview questions elicited planners’ experiences of the development of MPHWPs, specifically, perceptions of their responsibility and capacity to successfully prosecute Section 26 of the Act to improve SDH.

Interviewees were the LG staff members most directly responsible for the development of the MPHPW. Stratified random sampling, using https://www.random.org, was used to select three interviewees from each outer-urban interface (including growth areas), rural and regional centres and (semi-) remote municipalities. One interviewee was also selected from each of four inner-urban municipalities (16 interviewees in total).

Potential interviewees were contacted directly by email (obtained by telephoning the council) and then by follow-up phone call. Three representatives who were initially contacted declined to be interviewed, and so other councils from the same groups were contacted.

The interviews took place between March and June 2015, at a time when councils were at the implementation and evaluation stages of the 2013–17 MPHPW cycle. Face-to-face interviews were conducted at participants’ workplaces, regional public libraries or in state government meeting rooms. All were audio recorded and signed consent was sought at the start of each interview (University of Melbourne Human Research ethics application 1443272.3). Key ethical issues addressed included the development of a plain language statement and consent form and the need for anonymity. The final four interviews yielded increasingly less new information, indicating no need for further sampling from the population.
The interviews were transcribed, then read while simultaneously listening to the interview recordings to correct any transcription inaccuracies. Interviewees were then provided with a copy of their interview transcript and asked to make any other corrections. No corrections were required by the participants. Next, thematic analysis was performed on the interview transcripts with reference to the research theme of LG’s organisational efficacy in health planning.\textsuperscript{12} Stage one of the analysis involved the transcripts being read twice while simultaneously listening to the recordings to search for data that could assist in determining interviewees’ assessments of LG’s efficacy to improve health, via ‘upstream’ or ‘downstream’ actions. Once data were identified they were categorised under nodes in NVivo10/11 that characterised LGs’ organisational efficacy, such as ‘capacity of LG’, ‘social determinants’.\textsuperscript{24} Next, data collected under themes were reviewed for verification and re-coded, if necessary, to ensure validity, then qualified into sub-categories via coding-on.\textsuperscript{25} For example, positive statements on LG’s capacity were grouped separately from negative statements within the theme ‘capacity of LG’. An initial report of interview results was sent to all interviewees allowing them to verify that quotes were accurately interpreted and appropriately anonymised. One participant requested that a quote attributable to her be paraphrased because she felt it identified her. This amendment was made without detracting from the results.

Results

Interview participants

Although each participant was the employee most directly responsible for the LG’s MPHWP, their positions ranged from officer to manager. Participants’ professional training was in environmental health (1 interviewee), health promotion (4 interviewees), community development (10 interviewees) and statutory planning (1 interviewee). All but one were female.

Adoption of State Health Plan priorities

Interviewees held mixed views about the influence of the State Health Plan on the determination of MPHWP’s priorities. A small number stated that the State Health Plan priorities were very important:

Yes definitely, because you would be silly to do a plan that stood alone, as (the State priorities) are where we are likely to attract funding from. (Interviewee E)

Others stated that while the State Health Plan priorities were used to guide MPHWP, they recognised that Action Areas also needed to be responsive to local needs. In some councils, a decision not to adopt a State Health Plan priority was made. In several cases, partner agencies had already prioritised, and were implementing, programs against Action Areas, and so LG considered itself better placed to lead efforts in other areas. For example:

… but then there’s actually quite a lot of activity that’s already happening and a lot of information that’s already around about skin cancer. (Interviewee E)

Such processes often resulted in a well-reasoned approach to the Act’s requirement to ‘have regard’ to the priorities of the State Health Plan, but with an eye to local concerns:

Did we look at it? Yes we did. Did we align with all of it? No. Did we align with those that were relevant to our community? Yes we did. (Interviewee B)

For other interviewees, the requirement to have regard to the State Health Plan was regarded more as a ‘tick the box’ obligation:

So, we met in our office. We went, “Oh what about the State health and wellbeing plan?” “Oh yeah, what about it?” “Oh, we’ve given regard to it, we’ve met our obligations under the Act.” (Interviewee F)

At the extreme, when asked whether the priorities played a role to influence the MPHWP, one interviewee responded, “Nothing. They did not play a role at all” (Interviewee H). She went on to suggest that this was because the prioritisation of issues relevant to LG in the State Plan was of low relevance to the LG area:

We were pretty shocked that gender equity and violence against women wasn’t in there. Which is a huge priority for the whole local government [sector]. (Interviewee H)

Although not called out as discrete issues for intervention, gender equity and the prevention of violence against women were included in the State Health Plan under ‘mental health promotion’ and, more recently, in amendments to Section 26 of the Act. However, these comments suggest that, at the time, at least some LG staff responsible for the MPHWP were either not especially familiar with the State Health Plan or did not regard it very highly. Indeed, a similar response was given by another informant who stated:

I think I’ve always felt it’s a shame that … maybe I’m wrong … that … the State Government don’t call out gambling as a key health and wellbeing issue, and the incredible impacts on communities. I think that would be great to have that called out or prioritised at a state level. (Interviewee I)

Such comments are indicative of a view held by the majority of interviewees that the Action Areas included in the State Health Plan are, at best, not exhaustive of the health-related issues that LG needs to consider locally, particularly when a social determinants lens is adopted.

Adoption of a social determinants approach

In contrast to interviewees’ ambivalence about the State’s priorities for health, all were of the view that health is significantly socially determined, and many took the view that virtually everything LG does plays some role in creating health and wellbeing. Indeed, all interviewees were critically informed by a socio-ecological approach to health and wellbeing with all of them aware of and many continuing to use EfH.\textsuperscript{26} For example:

We’re going to do basics like health [and] wellbeing, but it’s going to be great to have that called out or prioritised as an initiative for LG. (Interviewee F)

Consistent with this, several interviewees were also of the view that actions intended to address the upstream determinants of health were more efficient than downstream behaviour change programs and identified the importance of state government in this.

Until state government can work across these [EH] areas to create change from a systems perspective, you’re not going to see change at the local government area. (Interviewee D)

Indeed, when referring to SDH, many interviewees used, without prompting, Irving Zola’s river analogy,\textsuperscript{6} as exemplified by the following.

Behaviour change is useful, encouraging behaviour change through literacy is useful, but without a supportive upstream environment it can be banging your head against the wall. (Interviewee B)

This was also well illustrated by one interviewee’s comment about the ineffectiveness of downstream actions. In this case, behaviour change programs related 2018 ONLINE Australian and New Zealand Journal of Public Health © 2018 The Authors
to healthy eating, when sections of the community were experiencing more systemic challenges:

_We have so much else going wrong that putting any sort of food on the table is a challenge, and getting the child fed and to school. What‘re they eating? It‘s just not a priority._ (Interviewee L)

When describing the extent to which MPHWPs adopted the SDH, one interviewee stated that policy areas such as education, housing and transport are “what make up the community’s DNA” (Interviewee G). Improving them for health equity therefore played a prominent role in development of the MPHWP.

Despite interviewees’ understanding of the SDH, there were some noted challenges associated with evolving the MPHWP to encompass such an approach. In particular, the consideration of councils’ capacity to have an impact on social determinants at the appropriate ‘entry point’ was an important criterion in prioritising issues to be addressed in the MPHWP. This is exemplified by the following statement:

_‘In the areas where, obviously, the data was really bad we thought, let’s put that into the Council plan. It sat there for little while and we looked at it and thought, ‘What can we actually impact? What can we do something around?’ That’s what stayed.’_ (Interviewee G)

One interviewee suggested that adoption of an SDH approach had drawn the focus of the MPHWP too far upstream, leaving downstream actions – for example, those undertaken by environmental health officers – out of the plan, and thus misrepresenting council’s totality of effort. Nevertheless, most interviewees felt that their council’s MPHWP was mostly successful in adopting and representing the council’s balanced approach to SDH. Such an approach included actions targeted towards all policy areas, albeit with a more upstream focus. Repeatedly, interviewees stated that because decisions in a broad range of policy areas determined health, LG had significant responsibility and potential as an agent of public health. As one interviewee stated:

_“Our roads, our footpaths, our children’s services, age and disability services, environmental health and agency management, waste management. You know? Basic stuff. Our environmental programs, our land care, our urban wetlands (are) all about health as well.”_ (Interviewee E)

This position is particularly well captured in the following response to the question of whether interviewees felt council’s capacity to act in health and wellbeing extended beyond health protection and health promotion:

_Absolutely! Yes, absolutely. The guy out there mowing the lawn has a health and wellbeing outcome, in my view, and by raising the guy mowing the lawn’s awareness of that he might do a better job about it and care more about it because he’s actually improving the social fabric._ (Interviewee B)

Despite councils’ strong adoption of a social determinants approach, several interviewees also stated that downstream behaviour change programs were more politically attractive. As one interviewee stated, councillors viewed behaviour change programs, as “the stuff that’s shiny” because they “can see it, they can sell it, they can tick it off” (Interviewee F). Many interviewees were aware of the need to continually educate councillors about the importance of addressing SDH and of the fact that the MPHWP needed to continually evolve.

_The comments a few years ago from our councillors were that, ‘We don’t do health; that’s not part of what we do’. But you breakdown the services within council, and we’re (very) much health and wellbeing focused._ (Interviewee M)

Other interviewees stated that the value of upstream was not always appreciated by all stakeholders. In particular, the ideas raised by community members during consultation sessions tended to be for downstream actions more than upstream. Interviewees hypothesised that this was because, over the years, community members have become familiar with public health taking the form of environmental health or behaviour change programs – “old-school” health promotion, as interviewee G called them – and, as a result, community members tended to reflect this view back during consultation. In this vein, interviewees indicated that the ongoing influence of council and community members meant that although there was an intentional effort to understand SDH and respond with more upstream effort, they might “never get away from” (Interviewee F) behaviour change programs.

The challenge of emphasising the benefit of a social determinants approach to other staff within council was not considered by interviewees to be as difficult. However, interviewees often stated that many council staff were focused on delivering services tied to funding. As such, they were focused on meeting their obligations under these funding programs, rather than how their actions might play a role in fulfilling a strategic plan, like the MPHWP.

There’s a lot (of staff) who are providing service delivery purely . . . even though they play a key role in health and wellbeing, they’re delivering a service, connected to their funding provider too. It’s really hard to connect that. (Interviewee D)

The dedication with which all interviewees approached their role, particularly the opportunity they felt it afforded them to make a real difference to the lives of current and future residents of their municipalities, was notable. Indeed, the adoption of an SDH approach appears to have increased interviewees’ sense of responsibility as agents of health and wellbeing and to have been highly motivating. This is exemplified by the following extract:

_Personally, I get the most job satisfaction from pushing upstream rather than doing walking groups (for example) . . . it’s about when we’re not here, but how to set things up now for the future. . . . You’ve got people that enjoy the ‘now’ and want to see 100 people attend this and 100 people attend that. But I get more satisfaction from knowing that people are going to be able to not have to drive past 50 million fast food outlets on their way home in ten years’ time._ (Interviewee F)

**Discussion**

This study shows that while LG planners intimated the importance of equity, they more explicitly spoke of the value of working generally upstream using a systems-based, determinants approach to health, i.e. beyond environmental health, health education and health promotion. In doing so, this study complements and verifies the previous quantitative analysis of actions in MPHWPs,46 which also showed a leaning towards upstream actions, despite the risk of ‘lifestyle drift’ – the tendency for plans for tackling social determinants to ‘drift downstream’ towards health behaviourism in their implementation.57 Together, these studies help build a picture of Victorian LGs’ ambitions to influence public health, complementing the work done in other states.45

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The results also showed that during the 2013–17 MPHWP cycle, there were disparities between State and local public health priorities. This is exemplified by the extent to which LG felt obligated to have regard to the public health priorities of the State Health Plan.19 For some issues that appeared in the State Plan, a form of loose collaboration was implied,34 with LG identifying other organisations and agencies they deemed better equipped to lead certain initiatives. On other occasions, interviewees indicated that they had insufficient funding support from the State Government to develop actions against all Action Areas19. Indeed, while LGs can apply for program-specific grants, there is currently no funding provided from the state specifically to implement MPHWP. As a result, certain priorities were felt to be beyond the capability of LGs to address, and they developed few actions in those areas.

Such an approach suggests that the term ‘have regard’ allows LG to use discretion when adopting the priorities of the State Health Plan. To paraphrase Wylie and Blunt,58 to Victorian LG, ‘the words have regard meant no more than they say’. LG did not ignore the state priorities. Generally, they gave them the attention, thought and such weight as was considered appropriate. In doing so, they were likely to have benefitted from existing state-wide or NGO-run programs that addressed the Action Areas. But having done that, there was a feeling within LG that the opportunity cost attributable to not closely following the Action Areas was not significant enough to prevent them taking a more upstream approach than the State Plan put forward. Instead, this study supports previous work to suggest that LGs strongly adopt a social determinants approach in MPHWP,48 and feel that strategic or upstream actions are more efficient, equitable and economically beneficial than those that use health behaviourism. Despite having to work to the ‘relatively weak policy setting’62 set by the State,13 decisions to act upstream where possible were planners’ intentional response to the understanding that health and wellbeing are significantly socially determined and to a belief that LG was capable of ‘making a difference’. This approach was in turn influenced and legitimised by the 2001 document, EH.48

In summary, the Act’s emphasis on social determinants, along with EH, appear to have been more influential than was the 2011–2015 State Plan. It is noteworthy that despite the inconsistency between State and local plans, the approach taken by LG, described in recent research48 and elaborated upon in the current research, is consistent with the role described for it by the WHO’s Commission on the Social Determinants of Health.6 It is summarised in a modified version of the Action Areas from page 4 of the 2011–2015 State Health Plan19 (Figure 1).

Figure 1 shows the original three Action Areas of the State Health Plan19 and adds a fourth area, ‘Address social determinants’, which was absent from the original version. Also shown is the level of priority LG placed on each area according to this and previous research. It shows that, more consistent with the Act than with the priorities of the State Health Plan, LG considered social determinants to be the highest priority and an area in which it could be efficacious.20,54

As the level of government closest to the people,20,60 LGs have unique experience of public health priorities as they manifest at the community level. Therefore, while there are advantages to LG receiving guidance from (i.e. ‘having regard to’) state-level priorities, communities must also ‘make their own decisions, based on assessments of health needs and resources at their own levels’;61 i.e. determine the areas in which they can be efficiently effective. An important implication of LG not feeling significantly beholden to state priorities for health is that it would be beneficial for state health departments to be aware of and responsive to LGs’ perception of its priorities and efficacy in public health. This could be enabled via state health departments consulting closely with LG about its priorities, or, in the case of Victoria, via a four-yearly review of the disparity between state and MPHWP priorities. In Victoria, the State Government has recently acknowledged LG’s locally responsive approach to public health and this has resulted in a shift in the priorities described in the current (2015–2019) State Health Plan. Specifically, the current plan makes reference to the findings of previously research68 to acknowledge that although councils responded to many of the State’s priorities for public health, many LGs … … noted that their contributions to the health and wellbeing of their communities go beyond the priorities listed in the first plan. Additional areas included in some council plans were problem gambling, community safety, immunisation, land-use planning and family violence.21
In Victoria, the State Government’s acknowledgment of local priorities is a commendable response to the research and is suggestive of State Government’s increasing recognition of LG’s potential to improve social determinants.

Limitations
This study is not without limitations. Interviewees were the staff directly responsible for the development of the MPHWPs and so it is perhaps unsurprising that they self-report being well-informed and committed to the socio-ecological model of health. Additionally, although stratified sampling using organisational geography was used to identify interviewees, this study did not explore the influence that context played on interviewees’ perception of organisational efficacy. Finally, the sample is relatively small (16 interviews), which limits the generalisability of results. This analysis used a novel approach for exploring interviewees’ perceptions of their organisation’s efficacy, i.e. their organisation’s ‘belief in itself’, complementing previous research on the actions in MPHWPs. While organisational efficacy is an established construct in organisational psychology and was anticipated to be useful for exploring LG’s capacity to address SDH, the fact that MPHWPs are a statutory requirement and are well-supported by advisory and instructional documentation. There is, however, a risk that legislating a role for LG to address public health by improving determinants will bring with it a cost-shifting, or even legitimisation of state or national governments’ divestment of some of their responsibility for public health. Although LG is the level of government closest to the people, ultimately, its effectiveness as an agent of public health has limits, as there are many health-determining issues that are beyond its jurisdiction. Even for countries that legislate and support local health planning, state and national governments must continue – and indeed increase efforts – to improve the socio-economic, cultural and environmental conditions that determine health. For example, there is a role for partnerships of LGs to advocate up to state and national governments for healthy public policies that result in benefits trickling down to local communities. It is hoped that this will assist governments at all levels to more equitably allocate responsibility for public health, so that each jurisdiction is given the tasks in which it can be most effective. In Australia, this should take the form of the State and Commonwealth Governments actively working to ensure that health and equity are priorities in all policy decisions within their remit, from taxation and trade, to the regulation of local industries, so that each meaningfully contributes to improving health for all.

Conclusions
This research suggests that, consistent with the Commission on Social Determinants of Health’s recommendations for LG internationally, LG in Victoria has a high level of organisational efficacy to improve community health and, in many cases, is attempting to ‘punch above its weight’ to improve social determinants. If LG’s potential as an enthusiastic and locally savvy agent of public health is to be maximised, it will need continued support from state government. This should be in the form of adequate resourcing and training of LG councillors and support from the North-West Region of the Victorian Department of Health to GB; and a National Health and Medical Research Council Principal Research Fellowship (grant number 1004900) to BGC.

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