Municipal Public Health Planning in Queensland: achievements, barriers and implementation success factors.

Peter J Davey
Deputy- Director Centre for Environment and Population Health
Chair - Healthy Cities and Shires Network Queensland
Griffith University, Brisbane – Australia

ABSTRACT

Creating healthier and more sustainable cities requires new approaches to planning at the local level. Queensland Health, Local Governments and Griffith University have formed a working partnership to implement Municipal Public Health Planning (MPHP) in local government. Each city has its own culture and diversity, its own political and organisational barriers to planning, and changing health professional capacity. The Queensland Healthy City and Shires Network facilitates partnerships, research, training and learning environments with local government and community agencies that are developing and implementing participatory planning. Healthy cities and shires meet and compare their planning achievements.

Regional and town planning schemes provide consistency for major infrastructure and land development, and local government legislation now requires cities to determine social health needs. MPHP is identified as one of several community public health planning models trialed in this research. A practical ‘seven step’ MPHP process provides the framework for healthy cites needs based planning. This paper discusses the importance of a ‘platform approach’, where government and non-government agencies and community groups form a network and engage in the business of sustainable strategic health planning. The platform approach has 3 dimensions, Governance (long-term vision, layers of planning, industry support and regulation); a Platform (mechanism for agency networking, stakeholder forum, advisory committee, terms of reference, project management); and Implementation (local strategies and priority action areas, desired outcomes, communication process and evaluation). The research findings highlight the importance of the ‘platform approach’.

An Implementation Model has been developed to promote the actioning of strategies in community planning. In the model health strategies ‘link up’ vertically to higher levels of planning, and ‘link across’ horizontally to address gaps in agency planning, community group concerns and resident needs.

The paper will describe the research developed in evaluation of MPHP, including a summary of the qualitative evaluation methodology, results and findings of the study and a ‘Platform Approach’ to participatory planning and MPHP Implementation Model.

Key Words: healthy cities, municipal public health planning, partnerships, qualitative evaluation and strategic planning, health promotion implementation.

BACKGROUND

Increasingly people are making connections between the urban condition and the eco-crisis confronting the planet. There is an increasing realisation throughout the world of the need to respond to problems that threaten global and local ecosystems. A Healthy City is one where living conditions promote good health and a good quality of life. In order to create a healthier future for cities, communities have to become engaged in and influence city development and be part of the overall reform of governance that puts healthy environments and human development at the centre of concern.

The Healthy Cities Movement was initiated in the eighties by the World Health Organisation to address these concerns and implement the health promotion action areas of the Ottawa Charter in local community settings. At the same time the development of an ecological public health focused on such concepts as the promotion of equity, community participation, and collaborative partnerships, multi-sectoral approaches towards improving the health outcomes of communities. Creating healthier and more sustainable cities requires new approaches to community partnerships and participatory planning at the local level.
Each cities health plan is unique because each City has its own culture and diversity, its own political agendas and organisational capacity to respond to the global and local challenge. Local government in Australia is well placed to plan healthy cities as they are a democratic organisation, recognised as a legitimate facilitator for participatory planning, having political decision-making opportunities, a bureaucratic administration, economic and resource capacity and opportunity, a structure for community participation and is the level of government in Australia closest to the people.

In Queensland, a movement in local government to create healthy cities has been gathering momentum since 1997. Eighteen cities and shires in Queensland have developed Municipal Public Health Planning (MPHP) based on the WHO Healthy Cities Philosophy. MPHP can be described as both a product and a process. The product is a dynamic strategic planning document that guides future local health actions, while the process facilitates the development of partnerships and collaborations for change between local government and other stakeholders to identify and seek solutions. Figure 1 highlights the Seven Steps to MPHP.

In Queensland, MPHP is one of several Community Public Health Planning (CPHP) frameworks that have been trialed in communities. MPHP is the model specifically tailored to local government needs and structures, and the model is being improved with each research project experience.

**Figure 1 Seven Steps to MPHP**

**PURPOSE OF RESEARCH**

The purpose of this research was to evaluate the degree that partnerships or healthy alliances have contributed to effective health planning, to analyse the extent to which the aims of the MPHP projects have been achieved and investigate the extent to which the MPHP has been implemented. MPHP is a strategic planning process adapted from a business environment for a community setting. Strategic Planning has two stages, namely, an initial plan development stage (1 year), followed by a plan implementation stage (3-5 years).

The literature developed by WHO to promote Healthy Cities and MPHP does not address the fact that many health practitioners and agency staff lack skills and knowledge in strategic planning. The Healthy Cities Movement assumes that local government have the necessary organisational and management skills to develop partnerships and planning outcomes. Planning is complex and demanding. Here lies the weakness in the MPHP process, the issue of lack of skills and knowledge in participatory strategic
planning and limited organisational and human resource capacity can threaten the sustainability of planning projects. Multi-sectorial agencies work in partnership on developing a planning document. The planning process needs organisational capacity and individual support for the critical on-going MPHP implementation. Efforts are directed towards Stage 1 of the Plan itself but more effort is required to implement the plan and action strategies. MPHP project management teams concentrate efforts initially on the planning phase of the process.

There is limited emphasis placed on understanding the success factors needed to support the sustainable implementation of the MPHP. Organisations develop the plan as the main outcome of the project at the expense of continuing efforts to understand the complex issues involved in plan implementation. The old saying that we don’t want the plan to be “a dust collector on the shelf” can in fact be the reality of planning if an implementation model is not included in the MPHP from inception.

The wider research questions included: -
Do organisations build their capacity and management practices to engage adequately and legitimately in participatory planning?
Do organisations address agency and departmental governance measures to ensure the priority actions in the MPHP are implemented?
Does agency staff have the legitimacy and capacity to implement these actions? How can planning projects be sustained?

The research asked the following specific questions: -
Have the aims of the planning process been achieved?;
What are the achievements of MPHP initiatives in local government?;
What are the implementation outputs of the planning?;
Have the MPHP impacted on the organisations and communities where they have been developed?;
What are strengths and weaknesses of MPHP compared with other Public Health Planning models and frameworks in Qld?;
What are the barriers that prevent the MPHP from development and implementation?; and
What are the success factors and guiding principals for a sustainable MPHP implementation model?.

**METHODS - DATA COLLECTION and ANALYSIS**

A qualitative method was used and a Quality Evaluation Framework (see Figure 1) developed which included an ‘interviewing tool’ adapted from existing Healthy City theory and evaluation frameworks (see Speller, V., and Funnell, R., 1994).

![Municipal Public Health Planning (MPHP) Quality Evaluation Framework](image.png)

**Figure 1 Quality Evaluation Framework**
The research also examined the strengths and weaknesses of 7 other planning approaches in Queensland, and compared specifically the achievements, barriers and success factors for sustainable MPHP.

There were three phases of data collection. Initially, a Preliminary Evaluation with Case Studies was conducted in two local government areas in 1999. The reflections from this evaluation provided insight into designing Phase 11 of the study. Phase 11 was a Process and Impact Evaluation and included the conduct of 21 key informants in-depth interviews with stakeholders involved in MPHP from Hervey Bay City, Maryborough City and Gold Coast City in 2002. The key informants were selected from the following domains - political, executive management, management, practitioner, community organisation representative and partner. In Phase 11 of the data collection, and based on the findings of the first two phases, a Comparative Study was conducted in 2003. A comparison of 8 Public Health Planning projects and Legislative Frameworks state-wide included the conduct of 18 in-depth interviews and 3 focus groups with Managers, Practitioners and Partners.

The study examined several other Models that were being implemented in Queensland communities involving local and state government and other Planning Frameworks that have links to health but are driven by other state agencies in Queensland. These included:

- Community Public Health Planning Models
  1. Community Public Health Planning in Rural and Remote Areas Project;
  2. The Bowen Project (Bowen);
  3. Place Management (Place);
  4. Supportive Environments for Active Living (SEAL);
  5. Local Agenda 21 (LA21);
  6. Municipal Public Health Planning (MPHP);
  7. Towards 10 Year Indigenous Partnerships;
  8. Community Renewal

- Land Use, Development Planning and Legislative Frameworks
  9. Integrated Planning Act (IPA);
  10. Local Area Planning (LAP); and
  11. Regional Framework for Growth Management (RFG).

A full report of these findings can be found in Davey, P., Stewart, D., and Spork, H., (2003) Community Public Health Planning and Implementation Review - Report to the Qld Health Board of Management auspiced by Queensland Centre for Public Health, University of Queensland.

A theme analysis was carried out on the data sets, and the findings of the research described and discussed in light of the literature review.

FINDINGS and DISCUSSION

The MPHP experience has demonstrated varying degrees of achievements, barriers and success. MPHP has its origins in strategic business planning yet little evidence was found of sustainable organisational structures and procedures to support sustainable health planning and implementation. Local Government did provide initial training workshops to up-skill staff in planning techniques however more foundation theory is required.

MPHP barriers and success factors for sustainability included:

- Planning Models must suit community characteristics and needs, no ‘one-best fit’ model;
- Community organisation leaders ‘sign-off’ to the partnership;
- Select ‘3 Priority Actions’ driven by high level partnership Advisory Committee (AC) eg Healthy City Partnership Advisory Committee, agencies work on the other 100 actions simultaneously;
- Need legal support - Advisory Committees endorsed by law – eg Local Government Act;
- Need an Implementation Committee (reports to AC) that meets every three months to drive strategy implementation;
- Agencies report progress on implementation regularly eg Use web-site;
Network and partnership building is a priority to improve working relationships and deliverables;
- Committed politicians make a difference - MPHP is a political and bureaucratic intervention;
- Need representatives from the community at all stages of planning;
- Industry is part of the planning and can sponsor the project;
- Build capacity (HRM) of health professionals and agency staff to manage and engage in Healthy City Projects

The research concluded that an outcome of involvement in MPHP was an improvement in people, improvement in organisations and improvement in the planning models. For the planning to be successful partner organisations must address governance measures to ensure their strategic business plans reflect the agreed partnership responsibilities and priority actions in the MPHP and that agencies and staff have the legitimacy and capacity to implement these actions.

The main finding of the study was that it would be counter to the principles of ‘learning organisations’, to nominate a specific model as the most appropriate on a ‘one size fits all’ philosophy. Community public health planning practitioners, city management, community representatives, and other agencies working in collaboration need to select the approach and instruments that suit the specific planning situation, bearing in mind on one hand the nature of the community and the priority issues, and on the other hand the organisational skills mix and implementation resources available.

Figure 2: Integrating Community Public Health Planning in Queensland A ‘Platform Approach’

However, Figure 2 demonstrates the need for the agreed to strategies in the plan to be communicated and progressed ‘up’ (vertically) to higher levels planning frameworks; ‘across’ (horizontally) to community agencies and sub-populations of a similar nature; and to all relevant members of identified communities. The improved collaboration of agency staff and local government health and planning professionals would be seen to add value to planning and implementation processes in Queensland.

A ‘Platform Approach’ has been developed from the study and is currently being tested in local government (Kingaroy Shire and Gold Coast City). This approach emphasises the importance of both formal and informal partnership facilitation. The Approach provides a structure (managed by local government) or a level playing field where government, non-government agencies and community groups can formally agree to network and engage in health action on the same platform.
The approach seeks to improve organisational communication, build organisational and staff capacity and create legitimate collaborations (work on joint programs, grants, and fund raising) and sustainable health planning outcomes. The approach is described in the Figure 3.

![Figure 3 Example of a Sustainable Community Plan Kingaroy Shire - 2005](image)

The platform approach has 3 dimensions:

1. **Governance (long-term vision, layers of planning, industry support and regulation);**
2. **Platform Mechanism (for agency networking, stakeholder forum, advisory committee, enhanced communication, terms of reference, project management);** and
3. **Implementation (priority action areas, partners responsibility, desired outcomes, benchmarking and evaluation).**

The integrated model attempts to understand the health gaps and duplication of services in a community and overtime, improve health outcomes.

**CONCLUSION**

The research concluded that MPHP is complex and challenging and there has been many achievements for communities engaged in the process in Queensland. In the communities evaluated, project participants reported that the aims of the MPHP project were realised, with participants having improved networking opportunities, improved working partnerships - both within departments and across agencies and more program accountability. There was an increase in community participation in the health agenda and politicians were more focused on delivering health aims. 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 health outcomes.

In several communities there was a significant increase in funding for health projects as a direct result of priority action planning and agencies working in partnership. However, more emphasis is required to integrate health strategies into higher levels of planning eg Urban and Regional Planning and into the business plans of the other partner agencies.

MPHP has increased the level of health alliances formed between the agencies that were involved. The collaboration between local government and local agencies has improved significantly during the development and implementation stages of the MPHP. However, MPHP was difficult to sustain for longer than 3 years, this cycle linked closely with the political cycle for elected representatives in local
government. Several elected representatives and mayors saw healthy cities as a policy initiative that would increase their electoral support. MPHP needs political support to be effective; it cannot be only a bureaucratic process. Staff turnover significantly reduced the medium to long-term impact of MPHP. The high turnover of staff in agencies impacted adversely on MPHP outcomes.

The project management skills of the Project Officer managing the MPHP impacted directly on the success of the plan implementation. All members of the Advisory and Project Management Committees need on-going training and capacity building in strategic thinking and business planning, communication, project management and grant writing.

RECOMMENDATIONS

The success factors recommended for future MPHP include building individual and organisational capacity to strengthen strategic planning; improving governance and legitimacy for planning; sustaining structures and processes; formalising collaboration and partnerships; 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.

In summary, there is no one best-fit community public health planning model. Agencies working in partnership in local communities need to select the planning model and tools that suit the specific planning situation; bearing in mind the nature of the community and the priority issues, and on the other hand the organisational skills mix and implementation resources available. The research established that the MPHP Approach is most suited to local government environments.
REFERENCES


Brown, V. et al (2001), Grass Roots and Common Ground: Guidelines for Community-based Environmental Health Action, Occasional paper no. 2, Regional Integrated Monitoring Centre, University of Western Sydney


Hancock, Dr Trevor 2005, ‘Shaping Regional Health Development for a Healthier Future’, proceedings of the Shanghai International Forum on Healthy Cities 20-22 Nov 2005, China


Neuman, W.L., (2003) Social Research Methods – Qualitative and Quantitative Approaches, fifth edition, Allan and Bacon, United States

Smart State: Health 2020 – a Vision for the future -proposes a strategic vision for health and health care in Queensland in 2020


The National Public Health Partnership (NPHP) in its publication titled ‘ A Planning Framework for Public Health Practice (CHAC, 2000)

- Chapter 10 of Regional Outline Plan ‘Social Justice and Human Services’
- SEAL Manual and project documents
- CPHPRRAP Documentation and CD Rom, Queensland Health (2001)
- Ten Year Partnership Brochure (2002)
- IPA Act and Regulations
- Local Government Act and Regulations
- Cherbourg Ten Point Plan
- Yarrabah Partnership for Action


WHO websites on Healthy Cities Approach and Implementation, 2000