August 2016

The Municipal Public Health and Wellbeing Plan (MPHWP) Benchmarking Project

Executive Summary

The project aims were to identify: 1) the nature and the success of the priorities and actions in the 2009-2013 round of MPHWPs and the factors that contributed to their success or otherwise (selected to enable retrospective analysis); 2) indicators that can be used to determine success and track progress across selected action types included in the plans, and governance strategies that would increase the likelihood that these actions are implemented successfully; and 3) key strategies and actions that will enhance successful implementation of current and future MPHWPs plans.

The methods used to fulfil these aims included stakeholder engagement, content analysis of the 14 MPHWPs (2009-2013) and one place-based plan, interviews, and a workshop involving Council planners.

In terms of the nature of key actions in the 14 MPHWPs, the majority, 74% targeted the community in general. Actions focused equally on young people (8%), people of low socioeconomic status/disadvantaged/homeless (8%), and internal local government operations (6%). Fewer focused on the groups defined by gender/sexual orientation, Aboriginal and Torres Strait Islanders, the aged, CALD groups, disease based population groups, health services (non-target group specific), new arrivals and people with disability.

The majority of policy/issue areas being addressed focussed on the broader determinants of health e.g. natural environment/resource efficiency (9%), crime and safety (9%), public open space and facilities (8%), education and employment (6%), transport (5%), housing (3%) and economic development (2%). This is likely to be a reflection of the efforts by DHHS over the past decade on promoting the Environments for Health Framework in Municipal Public Health Planning. Actions that focussed on social cohesion and democracy (12%) included such activities as developing partnerships, representation on committees, and building community capacity.

Fewer actions focussed on individual health and behaviours (17% in total). Of these, most focussed on promoting physical activity (30%), and healthy eating (30%), followed by drug and alcohol use (17%), gambling (12%), and tobacco use (5%). In terms of 'type of actions', the predominant category was delivering a new program or service (23%). This was followed, by the development or implementation of a strategic plan, reorientation of existing services/ service improvement, and continuing or expanding on an existing service/program, advocacy, and research (8-16%).

In terms of the success of actions, a large proportion of MPHWP actions had no data on implementation and therefore progress on these actions was unknown. This was largely due to three Councils that had not evaluated or could not easily retrieve evaluation or performance related data for 98% of the MPHWP actions. Of the 10 Councils that did provide evaluation and reporting data, seven provided close to 100% coverage of MPHWP actions.

Of those actions for which data was available 52% have been implemented fully and were completed by the end of the MPHWP period. A further 19% were fully implemented and were ongoing at time of interview. Of those actions that were advocacy-based, 17% and 13% were only partially implemented and were continuing or had been discontinued at time of interview, respectively. Almost a third of all actions concerning the development or implementation of a strategic plan were partially implemented or continuing at time of interview. These strategic plans tend to have a life span of three-four years, and continued implementation beyond the term of the MPHWP is not unexpected, though it would have been expected that all had been developed. While 54% of actions requiring the reorientation of services/service improvement were fully implemented, one quarter was partially implemented and ongoing at time of interview.

A number of factors were identified during the interviews as having influenced the successful implementation of MPHWP actions. These include who was responsible for an action, partnerships, clarity and visibility of the action, interest in the topic, integration of the MPHWP with the wider Council plan, Councillor, regional and central government support, resourcing, timing and readiness, alignment (line of sight) with priorities, and feasibility of the action. Recommended strategies to promote the enabling factors or address the barriers to implementation, and ways in which evaluation of MPHWPs could be enhanced were informed by the interviews and workshop. These are summarised in Table 1 in the main report.

The Appendix includes a suggested set of indicators. These should be considered in conjunction with other outcome related indicators including those that DHHS (central office) is leading the development on - to measure the progress towards achieving the outcomes of the Victorian Public Health and Wellbeing Plan (VPHWP). The main body of this report summarises the findings from the content analysis, interviews and workshop, which together, informed the development of these recommendations.

By the Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne for the North Metro and West Metro Health, Department of Health and Human Services (DHHS)