School of Population Health

# Health in All Policies in Australian Local Government: A policy process perspective

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**Declaration**

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number SPH-88-2014.

Signature: 

Date: 1st December, 2021

# ABSTRACT

**Background and aim**:

Addressing structural determinants of health across policy areas, termed 'Health in All Policies', is an evidence-informed approach to address population wellbeing outcomes and has been propositioned in government for decades. There is limited empirical research internationally demonstrating the role of local government in adopting a Health in All Policies approach, despite claims that it is the most feasible tier of government to do this. The aim of this study was to explore the policymaking environment in relation to Health in All Policies in Australian local government. The study answered three research objectives: to identify the enablers and challenges in the existing healthy public policy processes in Australian local governments, to identify how the policy factors are different across various local government contexts and jurisdictions, and to explore how the Health in All Policies approach can be understood through the theoretical lens of political science.

**Methodology**:

This study employed a pragmatist epistemology, with a view to determine the practical possibilities for pursuing action of a Health in All Policies approach in Australian local governments. The study adopted an explanatory, sequential mixed method design, across two phases. Four theories of the policy process were embedded within the research design to deconstruct and describe the otherwise 'messy' policy process.

Phase one involved administration of a national online survey to elected members and employed staff across Australian local governments. The purpose of the survey was to understand and explain the existing factors influencing policy decision-making regarding health and wellbeing in local government. The online survey was distributed by email directly to management staff and elected members in local government across seven of the eight states and territories of Australia, inclusive of rural, regional, and city locations. The data were analysed using descriptive statistics and factor analysis to identify enabling and challenging factors influencing the local policy environment. Non-parametric testing was undertaken to compare local government across states/territories and geographical remoteness.

The purpose of phase two was to further explore the policy factors identified in phase one within a specific context. Phase two adopted a case study methodology, and used document analysis, individual interviews, and focus groups and observation/participation in a policy reference group within one of the case studies. Two regional councils were recruited as case study sites within one state jurisdiction. Interview and focus group data were themed using template analysis and triangulated with other case study data collected.

**Results**:

Enablers to Australian local government adopting Health in All Policies were strong personal and organisational obligations to act, a broad understanding of health and wellbeing, and a strong policy subsystem within local government that includes local leadership and support. Factors hindering the adoption of Health in All Policies included a perceived lack of coordination or support from higher tiers of government, limited staff and financial capacity, and lack of external lobbying putting pressure on the local policy agenda. Local governments in the state of Victoria, where municipal public health planning legislation has been mandated for some time, reported a more favourable policy environment, though not compared to all other states and territories. City councils reported a more favourable policy environment than their rural and regional counterparts, across nearly all factors in the policy process.

**Discussion**:

There are three key findings from the study. Firstly, the enablers and challenges in adopting a Health in All Policies approach in Australian local governments are similar to local governments internationally. This study contributes findings to the otherwise limited discourse regarding the role of policy actor values and beliefs, the role of media, events, and lobbying action in the local policy process. Secondly, city councils are in a more favourable position to adopt a Health in All Policies approach than regional and rural counterparts, which raises the impact of legislative environments and adequate resources to address health equity. Finally, the application of political science frameworks provides a suitable theoretical lens to describe key factors of the policy process that must be considered for Australian local government to successfully adopt a Health in All Policies approach.

**Conclusion**:

This is the first study of its kind to explore the policymaking environment in relation to Health in All Policies in Australian local governments. It is the first study to compare results across different geographically located councils, providing insight into the practices and policy decisions that can further exacerbate health inequities across metropolitan and rural populations. The meaningful application of political science frameworks adds to existing calls for future health promotion practitioners to gain a greater knowledge and understanding of the policy process to influence the policymaking environment in local government.

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## CONTRIBUTIONS OF OTHERS TO THIS STUDY

I would like to acknowledge supervisors and colleagues who have contributed to related research outputs:

### Related publication

**Lilly, K**., Hallett, J., Robinson, S., & Selvey, L. A. (2020). Insights into local health and wellbeing policy process in Australia. *Health Promotion International*, *35*(5), 925-934. https://doi.org/10.1093/heapro/daz082

*Contributions:*

- Jonathan Hallett, Suzanne Robinson and Linda Selvey, as supervisors of my PhD, contributed to the structure of the publication, reading of drafts and contributing feedback and suggestions for amendments.

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# ACKNOWLEDGEMENT TO COUNTRY

I would like to acknowledge the traditional custodians and owners of the land on which I live, work and play, the Gubbi Gubbi (Kabi Kabi) people, and pay my deepest respect to their ancestors and members of their communities, past, present, and to their emerging leaders.

I would also like to acknowledge that Curtin University holds a passion and commitment to work with all Australians and peoples from across the world, including First Nations peoples. I acknowledge that Curtin University works across hundreds of traditional lands and custodial groups in Australia, and with First Nations people around the globe.

## Table of Contents

# ACRONYMS

The following acronyms are spelt out in full when first used in the thesis and provided below as a reference point.

ACF: Advocacy Coalition Framework

ACT: Australian Capital Territory

ADEPT: Analysis of Determinants of Policy Impact

HIA: Health Impact Assessment

HiAP: Health in all Policies

HWB: Health and wellbeing

LG: Local Government

MSF: Multiple Streams Framework

NDIS: National Disability Insurance Scheme

NSW: New South Wales

NT: Northern Territory

PEF: Punctuated Equilibrium Framework

QLD: Queensland

SA: South Australia

SDoH: Social determinants of health

TAS: Tasmania

VIC: Victoria

WA: Western Australia

# LIST OF TABLES

# LIST OF FIGURES

# RELATED RESEARCH OUTPUTS

### Publications – Peer review

Lilly, K., Hallett, J., Robinson, S., & Selvey, L. A. (2020). Insights into local health and wellbeing policy process in Australia. *Health Promotion International*, *35*(5), 925-934. https://doi.org/10.1093/heapro/daz082

### Publications – Green open access

Lilly, K; Kean, B; Robinson, S; Hallett, J; Selvey, L.A. (2021): Factors of the policy process that influence local government to progress a Health in All Policies approach: scoping review protocol. *figshare*. Online resource. https://doi.org/10.6084/m9.figshare.14691414.v1

### Conference presentations

Lilly, K., Selvey, L., Hallett, J & Robinson, S. Health and wellbeing policy: perspectives from local government CEOs in Australia. 23rd IUHPE World Conference on Health Promotion. Rotorua, New Zealand 9-11 April 2019.

Lilly, K. Health Policy in Queensland Local Government: Health in all Policies? Australian Health Promotion Association 23rd National Conference, Perth, 2016.

# 1. INTRODUCTION

This chapter introduces the concept of Health in All Policies (HiAP) and provides an overview of the research problem, the significance of this study, along with the original contribution that this study will provide to the field of health promotion and those advocating for HiAP within local government (LG). The chapter outlines the research aim and objectives, with an explanation of how the research is designed to answer these. The chapter concludes with an outline of the structure for the thesis.

## 1.1 INTRODUCING HEALTH IN ALL POLICIES

Across the globe, including in Australia, there remains an unequal distribution of health amongst populations, based on unequal and unfair distribution of resources in power, services and immediate living and working conditions (Marmot et al., 2008). The role of health promotion as a discipline is to advocate, enable, and mediate action to address these health inequities (World Health Organization, 1986). The Commission on the Social Determinants of Health, established by the World Health Organization between 2005 and 2008, summarised and presented strong evidence that social, environmental, and economic determinants of health, sometimes referred to 'structural' or 'upstream' determinants, must be addressed if health promotion are going to achieve health equity outcomes (Marmot et al., 2008).

There are many determinants of health that contribute to population health outcomes, such as fair and consistent employment, affordable and safe housing, well designed urban planning, safe and healthy early childhoods, community-involved decision-making, affordable public transport, and universal healthcare (Marmot et al., 2008). Depending on how government policies address these health determinants, and the extent to which they are applied in a fair and distributive way, can have an impact on health outcomes across whole populations. Applied effectively, policies that address structural health determinants can minimise the unfair health outcomes, or health inequities, amongst population groups (Barry, 2021; Lucyk & McLaren, 2017; Marmot et al., 2008).

Health promotion practitioners and researchers have long advocated for health to be integrated into government policy (Bernier & Clavier, 2011). The integration of health amongst non-health sector policy has seen an ongoing and increasing acceptance within the field of health promotion, evidenced by various conference proceedings and declarations such as the Alma-Ata Declaration on Primary Health Care (World Health Organization, 1978), the Ottawa Charter for Health Promotion (World Health Organization, 1986), the Adelaide Recommendations on Healthy Public Policy (World Health Organization, 1988), the Jakarta Declaration on Leading Health Promotion into the 21st Century (World Health Organization, 1997), the World Health Organization 'Health for All' strategy (Antezana et al., 1998), and later in the European Health 2020 Strategy (World Health Organization, 2013).

HiAP is an approach that reinforces a systematic way to address policy decisions across sectors, driven by values of social justice and health equity and focussed on addressing a broad range of health determinants (Bacigalupe et al., 2010; Ollila et al., 2013). Central to HiAP is the recognition that many of these health determinants are influenced by sectors outside of traditional health services (World Health Organization and the Government of South Australia, 2010). HiAP is framed to assist policymakers outside of the health sector to consider their impacts, both positive and negative, on population health outcomes, during the development, implementation, and evaluation of policies, plans, and services. Therefore, HiAP is an approach that requires a whole of government commitment across all tiers of government, as well as across a range of sectors to improve health outcomes, including the involvement of private sectors and civil society (World Health Organization and the Government of South Australia, 2010). The approach acknowledges that policies in sectors such as education, housing, the environment, and transport can all have an impact, either positively or negatively, on HWB of populations (Ståhl et al., 2006).

The term HiAP was framed as part of the Finnish EU Presidency of 2006 (Ståhl et al., 2006). With the goal to further conceptualise the call to action for HiAP, the Government of South Australia invited delegates from around the world, including the World Health Organization, to advance the approach (Kickbusch et al., 2008). Resulting from this, HiAP emerged as a formal declaration by the World Health

Organization in 2010 (World Health Organization and the Government of South Australia, 2010). In 2011, the International Conference on Social Determinants of Health, through the Rio Political Declaration, reinforced a focus on cross-government action to address health inequities (World Health Organization, 2011). In 2013, the Helsinki Statement solidified HiAP as an agreed global call to action (World Health Organization, 2014).

Whilst the conference in Helsinki in 2013 aimed to clarify the definition of HiAP (Ståhl & Koivusalo, 2020), Cairney et al. (2021) report an ongoing, vague definition within the HiAP narrative. The commonalities within the literature related to HiAP consider human rights, addressing 'upstream' determinants or social determinants of health (SDoH), through an intersectoral approach, and political commitment (Cairney et al., 2021). This study takes these definitions and underlying concepts of HiAP presented here as the basis for understanding the conceptual definition of HiAP.

## 1.2 RESEARCH PROBLEM

### 1.2.1 Limited empirical research in HiAP

Whilst there are a range of resources and tools available to support and guide the implementation of HiAP (Ritsatakis, 2012; Rudolph et al., 2013; Stone, 2015; World Health Organization, 2014), these toolkits likely appeal to stakeholders intent to learn more about HiAP and how to go about responding to the call for action. In addition, they assume there is already leadership in actioning HiAP and staff time and capacity (Rudolph et al., 2013). de Leeuw and Peters (2015) progressed this further to develop a checklist for practitioners to guide a HiAP approach. The authors devised a set of nine theoretical questions and prompts for policy developers to consider in approaching HiAP, depicted as 'juggling balls' in the policy process (de Leeuw & Peters, 2015).

However, Cairney et al. (2021) point out that HiAP is not a technical exercise, though moreso a political process. Of the 113 articles included in a systematic review of literature on HiAP, few studies explained HiAP through a focus on the policymaking environment (Cairney et al., 2021). Ironically, Lucyk and McLaren (2017) report that nearly half of the research (41.7%) on SDoH is intended for a

political decision-making audience. These studies contribute to the need for research to go beyond reporting the conceptual or theoretical elements that influence HiAP (e.g., cross sector collaboration), and expand the empirical contributions towards what is actually acceptable and happens in reality (Cairney et al., 2021; Shankardass et al., 2014).

### 1.2.2 Lack of research in policy processes

In order to understand the factors that influence a HiAP approach, it is necessary to understand policymaking processes. However, research and practice determining how policies are initiated, developed, implemented, and evaluated is not the linear process that health promotion practitioners may have previously considered it to be (Clavier & de Leeuw, 2013). In an early review of health promotion literature, Breton and de Leeuw (2011) conclude that research describing the healthy public policy process is limited, with few using political science theory.

The absence of political science theory in healthy public policy research has continued to be reported as a gap (Bernier & Clavier, 2011; Clarke et al., 2016; de Leeuw et al., 2014; Embrett & Randall, 2014), focussed on behavioural health or healthcare (Fafard & Cassola, 2020), or often reported superficially (Shankardass et al., 2012). Whilst the discourse of politics is growing within the field of health promotion, it still sits outside the mainstream of current health promotion research (de Leeuw et al., 2021; Fafard & Cassola, 2020). Studies in HiAP mimic this trend, with few informed by policy research, or alternatively continue to rely on simplistic policy cycle models (Cairney et al., 2021).

The science behind policymaking and the ways in which governments and policy actors make decisions has been debated for decades (Kuper, 2019). Defining the science of policymaking, or political science, began traditionally as a study of the state, although grew to recognise the range of policy actors in decision-making, and was re-envisaged as a study of politics (Kuper, 2019). The science of policy is best defined as " *concerned with understanding the decision-making processes of public and private institutions, and with assessing the significance of all knowledge for purposes of decision*" (Kuper, 2019, p. 172). This definition demonstrates that policymaking is complicated by the multiple diverse actors involved and wide range of seemingly irrational decision-making processes (Buse et al., 2012). It is this

complicated policy process that may be the reason policy action has proven challenging for health promotion (Bernier & Clavier, 2011; Breton & de Leeuw, 2011; Clavier & de Leeuw, 2013; Rütten et al., 2011).

A more nuanced term that bridges the gap between health promotion and political science is proposed as 'public health political science' (Fafard & Cassola, 2020; Greer et al., 2017) or 'health political science' (Kickbusch, 2013), the latter defined as '*the systematic and concept-driven field of study and development that encompasses actors, ideas, processes, and structures aimed at maintaining and/or resolving contested beliefs and priorities in allocating resources and capabilities for improving human and ecosystem health and well-being*' (de Leeuw et al., 2021, p. 3). Given that health political science is a call for a political lens to be adopted in the everyday practice of health promotion, it is well aligned to the goals of achieving HiAP (de Leeuw et al., 2021).

### 1.2.3 Lack of HiAP research at a local government level

Research demonstrating how or why HiAP is adopted is very limited across all levels of government (Cairney et al., 2021; Shankardass et al., 2014). In their review, Shankardass et al. (2012) found most cases or initiatives that had applied intersectoral action to health equity described policy processes at a national level (61%), and less at state/provincial level (38%) or local level (31%). Guglielmin et al. (2017) and Van Vliet-Brown et al. (2018) have both reported limited international research exploring a HiAP approach in a LG context.

## 1.3 SIGNIFICANCE AND ORIGINALITY OF THIS STUDY

This study is significant as it is one of the few empirical studies internationally and the first in Australia (to my knowledge) to specifically focus on the policymaking environment in relation to a HiAP approach in Australian LG. This study is the first in Australia to include the views of chief executive officers (CEOs) and elected members in identifying the factors that influence this policymaking environment. Whilst Australia is the setting for this study, the findings will be relevant both nationally and internationally.

In addition, this study has provided an original perspective, being one of only a few internationally that explore the policymaking processes related to HiAP using

political science frameworks as a theoretical lens. This study is the first in Australia to explore HiAP in LG applying political science as a theoretical lens. Based on the current research gap in describing HiAP as a policy process, health promotion researchers and practitioners may benefit from the application of political science frameworks to better understand and navigate the complex policymaking environment in LG.

## 1.4 Research aim and objectives

The aim of this study was to explore the policymaking environment in relation to HiAP in Australian LG. This was achieved by answering the following research objectives:

1. Identify the enablers and challenges in the existing healthy public policy processes in Australian LG.
2. Identify how enablers and challenges in the current healthy public policy process are different across various LG contexts and jurisdictions.
3. Explore how the HiAP approach can be understood through the theoretical lens of political science.

## 1.5 Research overview

A pragmatist epistemology was employed to the research, with a view to determine the practical possibilities for pursuing action of a HiAP approach in Australian LG settings. A pragmatist approach is adopted to explore why it is that local policy decision-making does, or does not, address determinants of health across a range of policy areas, within a broad understanding of the social, political, cultural and organisational environments in which the policy process exists (Creswell, 2014). Therefore, a mix of inductive and deductive reasoning supported the research process, with a deductive theoretical lens, combined with contextual information on the current policymaking environment and the perspectives of staff and elected members within the LG setting. Together, the research provided a meaningful level of inquiry as to how policy is created by those that experience it, and if theory can help to better understand the influence of the policy environment on local level decisions (Morgan, 2014).

Appropriately aligned to the pragmatist approach, the research employed an explanatory, sequential mixed method design, conducted in two phases to answer the three research objectives (Figure 1). Phase one (outlined in chapter six) involved a national, cross-sectional, online survey distributed via email to LG staff and elected members. The survey findings reported on the factors influencing the existing policymaking environment relevant to HiAP. The reach of the online survey to decision-makers across Australian LG allowed analysis of responses across different states or territories, as well as geographical remoteness.

Phase two of the research (outlined in chapter seven) employed a case study approach, reporting on the in-depth analysis of two LGs, both located in the same state of Australia. The findings of the case studies drew on interviews, documents and observation/participation in a LG policy reference group to gain further insight into the factors related to policy processes relevant to HiAP. Each of the phases were informed by a theoretical lens using three frameworks adopted from political science and one additional policy model tested in the field of health promotion. This culminated in a discussion of how the factors influencing the policy process in LG can be understood using political science theory. A further, in-depth explanation of the research design and methods is provided in chapter five.

The research findings will be of interest to a number of stakeholders groups, namely the health promotion and public health disciplines, along with LG staff that are advocating for an increased focus and priority for health equity amongst their local populations, by addressing determinants of health.

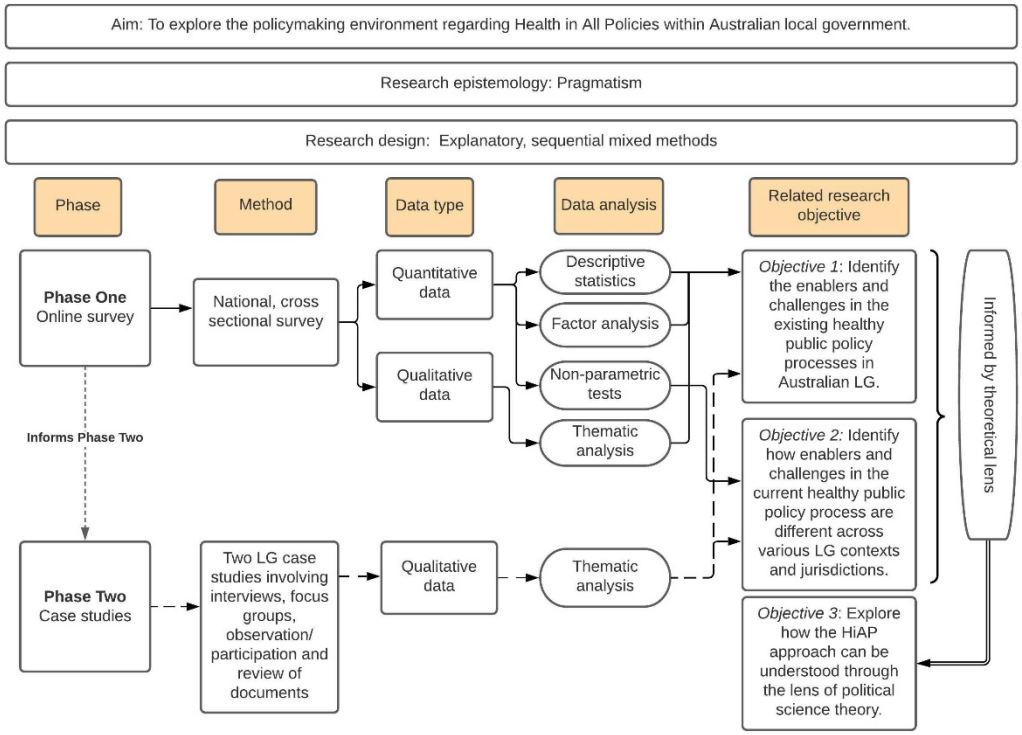


**Figure 1** *Overview of the research design, methods, data analysis and relevance to the research objectives.*

## 1.6 THESIS STRUCTURE

This thesis includes ten chapters.

**Chapter one** has introduced the background and definition of a HiAP approach, along with an overview of the research problem, the significance and originality of this study and the research aim and objectives that will be answered in the thesis.

**Chapter two** further introduces the key elements required to achieve a HiAP approach and situates the context for this in the local level government of Australia. It introduces the definition of policy and the policy process and justifies why political science frameworks are important to apply when considering the policymaking processes in relation to a HiAP approach.

**Chapter three** is a scoping literature review outlining the current national and international research in local level policymaking environments, relevant to HiAP. The chapter synthesises the existing literature that describes factors that are enabling or challenging the policy processes in LG, relevant to HiAP. The scoping review

identifies gaps in the research regarding the understanding of the factors influencing a HiAP approach in LG.

**Chapter four** provides a descriptive overview of the frameworks informing the theoretical research lens. The chapter begins with a rationale for the use of political science theory, followed by a descriptive summary of four frameworks that will inform this study, including their respective strengths and limitations. The chapter ends with an explanation of how these frameworks inform the research design and interpretation of the findings.

**Chapter five** provides a detailed overview of the research design and how this is related to achieve the research aim and objectives. The chapter provides details of the methods taken in each phase of the research, including an overview of the participants, data collection tools, and procedures for data analysis and triangulation of data across the study.

**Chapter six** presents the results of phase one of the research, responding to research objectives one and two. The results of the national online survey, including both the quantitative and qualitative data, are analysed and presented, with consideration for the state or territory in which the LG is located and their level of remoteness. The results presented include respondents' understanding of HWB, the perceptions on personal and organisational priority given to HWB in LG, and to what extent they believe HWB is integrated in different policy areas. It provides details of a factor analysis, determining four key factors that play a role in the local HWB policy process. The results also report the additional themes identified through the qualitative responses that contribute to understanding challenges and enablers to the local policymaking environment of LG, in relation to HWB policy.

**Chapter seven** presents the results of phase two of the research, further responding to research objectives one and two. The results of phase two build on phase one, with a focus on the consideration of health determinants in LG policy. The results of the two case study sites are presented collectively, drawing on a more in-depth understanding of how and why LG does, or does not, consider health determinants in local policy processes.

**Chapter eight** is the first of two discussion chapters, providing an in-depth analysis of findings to research objectives one and two. The chapter presents a triangulation of the key factors influencing LG in adopting a HiAP approach, synthesised from both phases of the study. The chapter incorporates a discussion of where the study findings align or contrast to international literature on a HiAP approach in LG.

**Chapter nine** is the second of two discussion chapters in the thesis. The chapter responds to the third research objective, presenting the findings as interpreted by the theoretical lens applied in the study. The chapter culminates in a critique of the usefulness of the theoretical lens to health promotion and LG practitioners, policy advocates and researchers in understanding the policy process to inform a HiAP approach in LG.

**Chapter ten** concludes the thesis, summarising the key findings and insights in alignment to the research aim and objectives. The chapter discusses the strengths and limitations in the research design and experiences in the research process. The thesis concludes with recommendations for future practice, policy, and research.

## 1.7 SUMMARY OF CHAPTER ONE

This chapter has provided a brief introduction to the background and definition of HiAP, an overview of the research problem, the research aim and objectives of this study, as well as highlighting the significant and original contribution of this study to the field of health promotion. The next chapter explores the key concepts for this study, providing a more extensive discussion on the key elements required to achieve a HiAP approach, the context of Australian LG, as well as defining terms such policy, public policy, the policy process, and briefly outlining the role of political science in understanding policymaking processes.

# 2. BACKGROUND

The previous chapter provided a brief introduction to the concept of HiAP, an overview of the research problem, the aim and objectives of this study, and highlighted the significant and original contribution that this study will provide to the field of health promotion.

This chapter describes the key concepts and terminology pertinent to this study, including the key elements required for a HiAP approach and the context and role of Australian LG in addressing population health and wellbeing (HWB). The chapter concludes with a definition of policy and the policy process, and a rationale of why the research adopts theories from political science.

## 2.1 KEY ELEMENTS REQUIRED FOR HEALTH IN ALL POLICIES

As introduced in chapter one, HiAP is a systematic approach, encouraging governance structures across sectors that generate opportunities for policy solutions to benefit population health outcomes through addressing determinants of health (Freiler et al., 2013). Working collaboratively across different government departments, private organisations, and civil society is a key element to embedding health in a range of policy sectors and targets (World Health Organization, 2010a; World Health Organization and the Government of South Australia, 2010). HiAP is also reported to work best when there are clear mandates, processes to allow cross-sector collaborations, mediation between differing interests and agendas, clear processes for accountability, transparency, and participation, stakeholder engagement outside of government, the building of trust through practical cross-sector initiatives, as well as monitoring of progress and utilising the feedback into the policy process (World Health Organization, 2014; World Health Organization and the Government of South Australia, 2010). de Leeuw and Peters (2015) identified similar conditions required to enable HiAP to be implemented, or initiated, as part of a whole of government policy process, noting that these processes can happen simultaneously.

From experiences in California, USA, a practice-oriented guide for state and local governments identifies similar key elements such as intersectoral collaboration, and formal and informal structures that enable these functions (Rudolph et al., 2013). Formal structures, such as health impact assessments (HIA), are encouraged, to build

institutional processes for the consideration and assessment of health impacts of policy decisions made in all sectors (Ollila et al., 2013). Some evidence exists that HIAs are effective in raising awareness of health impacts, as well as influencing policy changes (Haigh et al., 2013). However, it is recognised that this shared and systematic approach to HWB relies heavily on political will and leadership, as well as having organisational structures in place (Ollila et al., 2013).

However, the intersectoral and systematic approach of HiAP challenges the structures of Australia's siloed government system. Literature findings support the difficulties of getting people in different sectors to work together and highlight that health promotion practice can seem quite vague and difficult for non-health sectors to deliver (Bacigalupe et al., 2010). There is also reported resistance from non-health sectors to take responsibility for HWB, or for any costs associated with health outcomes (Koivusalo, 2010).

Few formal government structures or mandates exist to adopt a HiAP approach, either in Australia or internationally (Barry, 2021). Most notably is the national Ministry of Social Affairs and Health in Finland and the Norwegian Public Health Act (2012), that both require municipalities to work collaboratively across sectors to address health determinants, along with one state jurisdiction in Australia (South Australia) that has a support unit to foster collaboration across sectors to consider health impacts (Ollila et al., 2013; Ståhl, 2018).

The national government in Finland mandated a HiAP approach for municipalities under their Health Care Act passed in 2010 (Ståhl, 2018). The legislation and international momentum of a HiAP approach in Finland, along with the systematic structures and processes within municipalities, has likely contributed to its success so far, noting that this requires expertise and capacity over the long term to achieve health equity outcomes (Ståhl, 2018).

Similar to Finland, the Norwegian government has had a long-term focus on health equity, and the latest Public Health Act passed in 2012 provides a mandate for municipalities to strengthen this approach through the use of HiAP (Fosse & Helgesen, 2017). The legislation focusses on whole of government responsibility for addressing health determinants, with the aim of reducing social inequalities in health

(Fosse & Helgesen, 2017). There is no similar, national approach to HiAP within LG in Australia, although legislation in some states provides direction on how LG should respond to municipal public health planning.

## 2.2 LOCAL GOVERNMENT IN AUSTRALIA

### 2.2.1 Functions of LG in Australia

LG, also known as councils or municipalities, is one of the three tiers of government in Australia, with LG being the closest tier to the community (Dollery et al., 2006; Ryan & Woods, 2015). The Australian Government is responsible for laws which affect the whole of Australia and largely hands over responsibilities for some matters such as health, law enforcement, transport, and education to the states and territories (Ryan & Woods, 2015). LGs are not a recognised tier in the Australian constitution, with their functions decided by each state or territory (Dollery et al., 2009; Ryan & Woods, 2015). As a result, LGs have a diverse range of responsibilities within each respective state or territory Local Government Act (Dollery et al., 2009), with decisions made by local councils able to be overruled by state or territory laws (Parliamentary Education Office, 2020). The Australian Capital Territory (ACT) has a different structure to the rest of Australia, with the normal functions of a LG delivered by the territory government (Dollery et al., 2009).

Structural reforms over the last century have seen a declining number of LGs in Australia, as they are consolidated and amalgamated over time (Ryan & Woods, 2015). There are currently 537 LGs in Australia (Australian Local Government Association, 2021). Whilst the classification of different LGs is quite complex, they are fundamentally rated as either city (urban/population over 1 million), regional (urban/population over 20,000 and high density/growing population), or rural or remote (population less than 20,000, low population density) (Department of Infrastructure and Regional Development, 2017).

The role of Australian LGs is quite narrow in focus compared to other countries (e.g., United Kingdom) (Dollery et al., 2009; Dollery et al., 2006; Ryan & Woods, 2015). LG in Australia is traditionally responsible for regulatory tasks such as building inspections, development approvals, and food safety inspections, along with responsibility for the provision of community services such as libraries, parks, and

open space recreational facilities (Meggarity, 2011; Ryan & Woods, 2015). LGs also often have responsibility for the development and maintenance of local roads and street infrastructure, pet controls, land care programs, and child and aged care services (Parliamentary Education Office, 2020; Ryan & Woods, 2015).

LG in Australia comprises staff that are employed to deliver a range of specialist and administrative functions, along with elected members voted in by community members every two to four years depending on the state or territory location (Meggarity, 2011). Elected members, led by a mayor or president (herein mayor), are responsible for making policy decisions and communicating policy decisions to their community (Meggarity, 2011). The capacity for LG to source income is limited, with some income from state and federal grants, though mostly through property rates paid by property owners and from public fines and services (Ryan & Woods, 2015).

Australian LGs are restricted by their demographic factors, ability to generate income, expenditure costs (e.g., infrastructure maintenance), the capacities and skills of elected members, and community demands (Sansom et al., 2012). For example, those in regional or rural locations often take on responsibilities usually supplied by state or federal tiers of government such as facilities for general practitioners (Dollery et al., 2006). Larger councils often have more staff and can hire specialists in their field, which is not feasible in smaller councils (Dollery et al., 2006). Given the diversity of LG and the constraints around generating income, LGs will always have their own unique characteristics (Dollery et al., 2006) and rely on higher tiers of government for fiscal capacity (Dollery et al., 2009).

### 2.2.2 Why focus on local government?

Australia provides universal access to healthcare, albeit in a complex governance structure (Australian Government Department of Health, 2019). Federal and state/territory governments have the primary responsibility for health, with priority on delivery of primary care services, funding and administration of public hospitals, management of pharmaceutical medicines, and responding to medical emergencies (Australian Government Department of Health, 2019). Given the priority on provision of health and medical care, these tiers of government are not able to address the complex nature of health determinants alone (Marmot et al., 2010; World Health Organization, 2012). Whilst many of the economic and social injustices

related to health equity lie with the responsibilities and powers of higher tiers of government in Australia, LGs also have a recognised role.

In the World Health Organization report by the Commission on Social Determinants of Health, it was acknowledged that LGs have a key opportunity to engage with community members at a grassroots level, which has a powerful role in creating a nexus between people and politics (Commission on the Social Determinants of Health, 2008). In 2012, the World Health Organization Regional Office for Europe published a report on the role of urban environments in addressing determinants of health, focussing in particular on the role that local tiers of government can have (World Health Organization, 2012). LGs are in a position to create opportunities for intersectoral action, by bringing together public, private, and charitable organisations to address local needs (World Health Organization, 2012). LGs are able to play a role in addressing local health determinants related to transport, air and noise pollution, access to local facilities, neighbourhood design, housing, employment conditions, availability of quality natural green spaces, and mitigating climate change (World Health Organization, 2012). LGs have opportunities to design urban environments to improve aesthetics and perceptions of community safety and have influence over community social connection and social capital, taking into account differing levels of advantage in society to address inequities (World Health Organization, 2012). For these reasons, LG is proposed as a feasible tier of government to address determinants of health (Burris et al., 2007; Collins & Hayes, 2013; E. Harris & Wills, 1997; Phillips & Green, 2015; Salmon & Whiteis, 1992; Wilson, 2004). However, to do this, LGs would need to take into account health considerations when they make decisions across a wide range of policy areas (World Health Organization, 2012).

### 2.2.3 Role of HWB in Australian LG

In Australia, all LGs have some role in population HWB under their respective LG or Public Health Acts, predominantly related to environmental health protections such as air and noise pollution, open space planning, animal management, and the provision of community services, and facilities such as libraries (Ryan & Woods, 2015). However, some LGs have legislative responsibilities to deliver further public health deliverables, such as in the states of Victoria, South Australia, and Western Australia (Table 1).

**Table 1** *Australian Local Government responsibilities in public health and addressing health determinants.*

| State or Territory | Public health responsibilities |
|---|---|
| **Victoria** | After commencing the process in 2001, the *Public Health and Wellbeing Act 2008* (Vic) of the State Government of Victoria legislates that councils must produce a public HWB plan. This can be a stand-alone plan, or public HWB priorities integrated into other council plans. Both approaches encourage collaboration across council departments. Local plans must respond to the state-level Victorian Public Health and Wellbeing Plan 2019-2023, which outlines four key priorities: climate change, healthier eating, active living, and tobacco-free living (Department of Health and Human Services, 28 August 2019). |
| **South Australia** | As of 2013, the *South Australian Public Health Act 2011* (SA) mandates LGs to prepare and maintain a regional public health plan that outlines strategies for promoting population HWB in their region. The regional public health plan, whilst flexible, aligns with the State Public Health Plan, with expectations of strategies for the protection, prevention, promotion, and progression of HWB, including consideration for the determinants of health (Government of South Australia, 2019). The current Local Government Community Health and Wellbeing Toolkit for South Australia focusses on State Public Health Plan, including a systems approach to smoking, nutrition, alcohol, physical activity, and stress (Government of South Australia, 2020). |
| **Western Australia** | The *Public Health Act 2016* (WA) sets out requirements for state and local public health plans. These became a legal requirement in 2021 for State Government and 2023 for LG (Department of Health, 2020). The local plans, whilst flexible, must align with the State Public Health Plan, applicable to locally identified needs. Examples provided include strategies to address environmental health, physical activity, nutrition, communicable disease control, mental health, tobacco control, and safe communities. |
| **Queensland** | There is no mandatory focus on HWB determinants. The public health responsibilities focus on regulatory laws including air and noise quality and management of natural resources (Local Government Association of Queensland, 2020) and some obligations for food safety under the *Food Act 2006* (QLD). |
| **Northern Territory** | There is no mandatory focus on HWB determinants. LG in the Northern Territory does not have urban planning or environmental health responsibilities that are required in other states and territories (Local Government Association of the Northern Territory, n.d.). The *Local Government Act 2008* (NT) outlines the roles of LG with broad responsibilities for wellbeing and quality of life. |
| **New South Wales** | There is no mandatory focus on HWB determinants. The *Local Government Act 1993 No.30* (NSW) outlines statutory regulations (e.g., waste management). |
| **Tasmania** | There is no mandatory focus on HWB determinants. The *Public Health Act 1997* (DPC TAS) outlines roles in immunisation services and air and water quality management. |

Since the 1980s, LG in Australia has seen an incremental transition from a ‘services to property’ to a ‘services to people’ focus (Dollery et al., 2006). Continually, community expectations of LG are rising, and higher tiers of government devolve some of their responsibilities to LG (Dollery et al., 2006; Kelly et al., 2009), a term commonly referred to as ‘cost-shifting’ (Kelly et al., 2009). This has contributed to

LGs experiencing a gap between expectations of what LG can deliver and existing resources (Ryan & Woods, 2015). As Grant and Drew (2017) note, the changing delegations and roles imposed on LG, often without funding, will continue whilst higher tiers of government have power over LG and roles and responsibilities between the tiers remain ambiguous. Over time, the flexibility of LGs to invest in their own policy areas of interest has also impacted their capacity (Kelly et al., 2009). For example, LG has seen a shift in responsibility towards more social issues (e.g., health, drug problems, accessible transport) and a more active role in development and planning, public health, and environmental management (Dollery et al., 2006).

## 2.3 Current practice of HWB in Australian LG

Since 2001, LG in Victoria has been legislated to develop or integrate public HWB actions into their responsibilities, aligned with the state-wide Public Health and Wellbeing Plan. Victorian LGs were supported with a toolkit, titled 'Environments for Health', that provided advice on how to develop, implement, and evaluate a municipal public health plan, giving consideration to the built, social, economic, and natural environment (State Government of Victoria, 2001). An evaluation of the toolkit found informants improved their understanding of the determinants of health and its influence on the LG approach to municipal public health planning (State Government of Victoria, 2011). The evaluation findings reported that the implementation of municipal public health plans varied across different councils (State Government of Victoria, 2011). More than a decade after implementation of the legislation, Alindogan (2017) assessed the content of all Victorian municipal public health plans and identified that while most LGs prioritised HWB actions aligned to the state-wide plan, such as physical activity, prevention of violence, and mental health, they also prioritised other areas. This included investments in community connectedness, local employment and economic growth, and environmental sustainability. Their study concluded that LGs include determinants of health as priorities in their planning. Paradoxically, many of the priorities that LGs are investing in are outside of the responsibility of the state health departments that oversee public health planning (Alindogan et al., 2017). This notion of LGs extending their actions beyond state health priorities is reinforced by Browne et al. (2019) who explored the views of municipal public health planners within Victoria,

concluding that LGs continued to address more ‘upstream’ approaches to HWB by addressing broader determinants of health than they were bound to do under the state’s Public Health Act 2008.

Outside of legislative mandates, various approaches have been attempted to improve population HWB at a LG level. These include Healthy Cities, Healthy Localities Projects, Municipal Public Health Plans, and traditional health behaviour programs, often managed by state or territory health departments (E. Harris & Wills, 1997). The federally-funded Healthy Communities Initiative program aimed to deliver local healthy behaviour programs between 2009 and 2013 (Department of Health, 2012). In Queensland, evaluation of the Healthy Communities Initiative reported that LGs in Queensland were able to deliver physical activity and nutrition programs, although they relied heavily on external funding. The program had no impact on integrated policy changes and minimal uptake of proposed HIAs (Local Government Association of Queensland, 2013). The experience in South Australia of the same funded program found that LGs were able to put in place a range of community-led and culturally appropriate actions to deliver on obesity programs, some at more structural policy levels (Jolley & Barton, 2015). However, when federal and state budgets were cut, the responsibility for health promotion was shifted to LGs to fill the gap left as state and federal governments disinvested (Jolley & Barton, 2015). Previous research suggests that while many of these funded programs or initiatives have benefits, and the intention of improving population HWB, addressing the broader determinants of health has been challenging (E. Harris & Wills, 1997).

In the latter example above by Jolley and Barton (2015), sustainability of the approach to HWB was stalled, despite the LG in question being formally committed to a Healthy City, as designated by the World Health Organization. This raises a question on the synergies between the Healthy Cities movement and HiAP and its uptake in Australia. The Healthy Cities program, after 30 years following the Ottawa Charter for Health Promotion (World Health Organization, 1986), has made the most promising progress in addressing the determinants of health at a local level, although its uptake in Australia is limited. Healthy Cities started as a World Health Organization initiative for regions to register to become a ‘healthier city’. Over time, the European division of the World Health Organization established more rigorous

guidelines and reporting stages to support the process and evaluation of the Healthy Cities Movement, and supported a shift towards addressing health determinants (Werna et al., 1999). Research, particularly for larger cities and those that have been involved for a long time, demonstrates some promising outcomes in policy considerations for health and to some extent HiAP (de Leeuw et al., 2015).

Following Europe's lead, various regions in the world have established their own Healthy Cities Networks, including Australia, which officially established an Australian Chapter of International Alliance for Healthy Cities in 2007 (although the website has not been updated since 2011)(Alliance for Healthy Cities, n.d.). The Alliance represents sustainable support in Australia after the Healthy Cities initiative was originally adapted from Europe in 1987. The main adaptation at this time was that LG did not lead the process in Australia, given that 'health' was seen to be a state or territory government responsibility (Baum et al., 2006). The pilot cities of Canberra, Illawarra and Noarlunga (now Onkaparinga) were coordinated by their respective state health services, with input from a range of stakeholders, including LG. Over time, this has changed, with Onkaparinga and Illawarra having established independent, non-government organisations to lead the Healthy Cities initiative, while LG is the lead amongst the six other cities registered in the Australian Chapter of International Alliance for Healthy Cities (Alliance for Healthy Cities, n.d.). Despite some progress in the region of Onkaparinga (Baum & Cooke, 1992) and Illawarra (Healthy Cities Illawarra, 2020), to date there is no further research on Healthy Cities in Australia and as demonstrated by the small number of registrations and recent updates from the Australian Chapter Alliance, there appears little interest in cities being formally recognised in this way. This raises the question of what drives or motivates a LG to become a healthy city, what it means for action in healthy public policy, and if it is any better to what other LGs are doing (de Leeuw et al., 2015). The answers to questions such as these rely on research focussing less on what LGs are doing and more on the how and why they are making these decisions. Lawless et al. (2017) previously recognised that little is actually known about how the concept of SDoH is considered in Australian LG.

The examples above of current practice in Australian LG suggest that, particularly where legislation exists, there is some momentum to addressing health determinants.

However, the studies do not identify how or why decisions are made to invest, or not invest, in determinants of health, particularly outside of state and territory legislation for public health planning. Whilst there is some understanding of the role LG could have in addressing health determinants, along with resources to support LG to action these policy decisions, there remains very limited understanding of why, or what factors are enabling or challenging policy action. To better answer these questions, there is a need to understand the policymaking environment of LG, with a focus on how policies reach the agenda and are further developed, implemented, and monitored.

## 2.4 POLICY, POLICY PROCESS AND POLITICAL SCIENCE

Before research can begin to explore the factors in the policy process that impact on policy decisions, it is pertinent to consider what the term 'policy' means and how it relates to this study. In the information that follows, a definition of 'policy' is presented before the focus shifts to an introduction to the key factors in the policy process. This section will support the rationalisation of why health promotion practitioners and researchers need to better engage in an understanding of political science theories if advancements are to be made in influencing a HiAP approach.

### 2.4.1 Policy

Policy is often considered a written document or declaration that can be read and interpreted (Birkland, 2016). Examples of this include legislation, laws, administration, and planning documents (Birkland, 2016). However, the definition of policy goes beyond this, and may not be as formal as a specific written document (Bernier & Clavier, 2011; Birkland, 2016; Buse et al., 2012). One definition of policy is that it "*is a guide to action to change what would otherwise occur*" (Milio, 2001, p. 622). Extending on this, the term 'public policy' is defined as "*a statement by government on what it intends to do about a public problem*" (Birkland, 2016, p. 9). Weible (2018a) combines the definitions of many previous authors to define public policy as "*the deliberate decisions – actions and non-actions – of a government or an equivalent authority toward specific objectives*" (Weible, 2018a, p. 2). Hence, while written policies are important, any decisions that are made on actions, possibly unwritten or informal, or the deliberate actions that a government

takes, could be considered policy (Weible, 2018a). This study adopts the broadest definition, to mean any decision made in LG.

The term 'healthy public policy' is defined as "*policies that improve the conditions under which people live"* (Milio, 2001, p. 622). This includes policy related to safe and sustainable lifestyles and environments, such as housing, education, social services, and transportation (Milio, 2001). The definition of 'healthy public policy' is sometimes confused or used interchangeably with 'health policy', although the latter represents policy decisions related only to healthcare and health services provision (Buse et al., 2012). A further extension of the policy term, and the focus concept of policy adopted by this study, is referred to as 'health in all policies'. HiAP is a more explicit approach to achieving cross-sectoral, cross-governmental action through healthy public policy to address health inequities (Ollila et al., 2013).

### 2.4.2 Policy process and political science

Weible (2018a) defines the policy process as "*the interactions that occur over time between public policies and surrounding actors, events, contexts, and outcomes*" (pg. 2). The policy process is often referred to as a 'stages heuristic', which describes a series of seemingly logical phases from policy initiation through to policy evaluation (Buse et al., 2012; Sabatier, 2007). As a discipline, health promotion has largely relied on this rational policy framework to describe policy identification, formulation, implementation, and evaluation (Breton & de Leeuw, 2011; Buse et al., 2012). Cairney (2015) suggests that government practitioners continue to use this staged approach to the policy process due to its simplicity to comprehend. Although further to this, Weible (2018a) critiques that the policy cycle is only really problematic when it is used as the only way to perceive policy processes, ignoring the many interactions between policy stages and other factors that lie outside of its scope.

In light of this tendency to simplify the policy process, healthy public policy tends to be considered as an 'intervention' in a health promotion strategy plan with a focus on increasing awareness of research evidence or knowledge translation strategies (de Leeuw et al., 2014; Raphael, 2008). Carey and Crammond (2015) reflect on the problematic way health promotion practitioners create evidence on SDoH and believe that presenting this to decision-makers will initiate action. Most practitioners

and researchers, including in health promotion, are aware that the reality of policymaking is far less rational, though have little training in approaching the policy process in any other way (Breton & de Leeuw, 2011; Cairney, 2015). Numerous researchers have thus proposed for health promotion research and practice trying to influence action on determinants of health to better understand and navigate the policy process by utilising policy theory (Baum et al., 2019; Bernier & Clavier, 2011; Carey & Crammond, 2015; de Leeuw et al., 2014; de Leeuw et al., 2021; Fafard & Cassola, 2020; Greer et al., 2017).

What the stages heuristic approach does not highlight, but theories of the policy process do, is the inter-relatedness between factors that influence decision-making, such as the institutional or political environments; the beliefs, interests, or capacities of various decision-makers and the exposure to media and public opinions (Bernier & Clavier, 2011; de Leeuw et al., 2014). These influencing factors form the foundation of any policy theory, of which Heikkila and Cairney (2018) list as policy actors, institutions, networks or subsystems, ideas and beliefs, policy context, and events. Understanding these factors and how they inter-relate in the policy process helps to describe how and why policy is, or is not, being considered. For example, the need to understand all of the policy actors, or policy stakeholders, that are involved in decisions, how networks of actors and the relationships between them influence policy (Heikkila & Cairney, 2018), and who holds power or influence over decisions and policy agendas (Oneka et al., 2017). The policy process is also heavily influenced by the values, beliefs, biases, and political ideologies that each of the policy actors brings (Heikkila & Cairney, 2018; Oneka et al., 2017). This includes where their interests align with policy agendas, though also recognising that a lack of interest by key policy actors can be equally detrimental in influencing policy decisions (de Leeuw & Clavier, 2011).

Beyond policy actors, the policy context and environment is a key factor in the policy process (Heikkila & Cairney, 2018). This includes the history of the policy context, socioeconomic conditions, population demographics (Milio, 2001), geographical context, economy, social norms, and social cultures (Heikkila & Cairney, 2018). Policy environment includes the way media portrays social norms or the outcomes of political elections that demonstrate public opinions (Birkland, 2016).

It includes understanding that each 'institution' has its own norms, practices, and rules which determine how policy actors can interact in the policy process (Heikkila & Cairney, 2018), including how government systems, leadership, and resource capacity are considered in light of policy issues (Oneka et al., 2017).

In addition, the important role of events in the policy process is their ability to disrupt policy or create new opportunities for policy decisions, either via routine events (e.g., budget reviews) or unanticipated events (e.g., natural disasters) (Heikkila & Cairney, 2018). However, events may only be considered if a policy actor or decision-maker wants to pay any attention to them (Heikkila & Cairney, 2018).

The factors in the policy process outlined here begin to unravel the complexities involved in initiating and establishing a policy agenda. Hence the call for theories of the policy process to be prioritised in research. Theories from political science inform the theoretical lens of this study, to better understand the policy process of adopting a HiAP approach in the LG context. These theories and their application to this study are outlined in detail in chapter four.

## 2.5 SUMMARY OF CHAPTER TWO

This chapter has provided an overview of the key elements required for a HiAP approach and introduced the roles and responsibilities of LG in Australia in regard to public health and addressing health determinants across different jurisdictions. It has introduced a definition of policy, including the definition of HiAP in this study, and the factors associated with the policy process. The next chapter is a scoping review of the literature, synthesising the international research explaining the policy processes in relation to adopting a HiAP approach in LG and highlighting gaps in the current research.

# 3. LITERATURE REVIEW

## 3.1 INTRODUCTION

Chapter two introduced the key concepts and context for the research, namely the key elements required for a HiAP approach and the role of Australia LG in regard to public health across different jurisdictions. This chapter outlines a scoping review of the international literature that explores the known factors in the policy process that influence the adoption of a HiAP approach in LG to improve population health. The review identifies gaps in current knowledge which will ultimately guide and support this study.

An original narrative review of literature was conducted for this study in 2015 to synthesise the current literature and inform the research objectives and design. An increase in the research outputs on the topic since this time prompted the need for the review to be updated in 2021. As a result of this, a publication related to the results from phase one of this study is included in the review (Lilly et al., 2020: Appendix A). Where relevant, this is signposted throughout the chapter as a reminder of the existing evidence base and where this study contributes to fill this research gap.

## 3.2 SCOPING REVIEW METHODOLOGY

A scoping review was determined as the most appropriate type of literature review for this study. A scoping review was chosen to examine the extent of research applying both concepts of HiAP and the policy process, to identify gaps in the literature (Arksey & O'Malley, 2005; Munn et al., 2018). As acknowledged by Peters et al. (2015), scoping reviews are appropriate for addressing research objectives that go beyond a specific intervention or question, which is the case in this study given it is an exploratory approach across a number of key concepts (Peters et al., 2015).

The steps in conducting a scoping review were originally outlined by Arksey and O'Malley (2005) and have undergone refinements, most recently by M.D.J. Peters et al. (2020). The five key steps are 1) identify the research question, 2) identify relevant studies, 3) study selection, 4) charting the data, and 5) collating, summarising, and reporting the results. Whilst not as strictly bound to criteria

employed in a systematic literature review, these methods of a scoping review ensure that a structured, rigorous and transparent process is applied (Munn et al., 2018). A protocol was developed prior to completion of the scoping review and available as green open access (Lilly et al., 2021: Appendix B).

### 3.2.1 Purpose and background of the scoping review

The purpose of this scoping review was to establish an understanding of current knowledge regarding factors that influence a HiAP approach in LG, across different legislative and geographical contexts. The term HiAP was used explicitly in this review, along with terms that reflect the key conceptual elements of the approach, including addressing determinants of health to achieve health equity by working across multiple sectors (Ollila et al., 2013).

Since the commencement of this research in 2014, two similar scoping reviews were identified, both first published in 2017. Following is a summary of these reviews, concluding with how this proposed scoping review is different to each of them. Guglielmin et al. (2017) focussed on the challenges and enablers to LG implementing HiAP, resulting in the inclusion of 23 peer review articles and four government documents in the review. Studies were included from 2002 to 2016, written in English and in a LG context where HiAP was being implemented in response to a national mandate. Articles were included where LGs were implementing HiAP or aiming to achieve population health outcomes through addressing other similar concepts, such as health inequities. Studies involving higher tiers of government were included, though only if LG was also involved. Van Vliet-Brown et al. (2018) conducted a scoping review to identify research gaps in how HiAP is utilised in municipalities. The review included a wide range of sources dated between 2006 and 2015, including from peer review articles, commentaries, policy documents, government information sources, conference abstracts, posters, and presentations, resulting in a total of 27 sources. The scoping review reported primarily on recommendations for successful implementation of HiAP, along with challenges and enablers for LG to adopt HiAP. Sources were included only if they specifically used the term ‘health in all policies’, solely in the context of LG, and were written in English. Further inclusion and exclusion criteria were not made explicit in the published article.

This scoping review has some similarities to these previous reviews, such as including sources only in English, located in the LG context, and focussed on HiAP. Similar to Guglielmin et al. (2017), search terms extended to include concepts related to HiAP, and where LG are involved alongside higher tiers of government. This scoping review also differs in the following ways. It includes the use of different databases that represent a broader interdisciplinary context, an update of sources up to early 2021, and a broader and more in-depth focus on the policy process across a range of legislative contexts at a local level of government. This review includes all factors related to the policy process, not only including implementation of HiAP, but also investigating factors that influence policy agenda setting, development, and evaluation of the HiAP approach. The review is nuanced in its specific interest in the differences across varying geographical and political contexts of LG, as well as the application of theories to explain the policy process. As a result, the scope and scale of research included in this review builds on previous work and is broader in scope, and provides a more recent account of the research. Primary sources included in the previous scoping reviews are also included in this literature review, where they are relevant and meet the inclusion criteria.

### 3.2.2 Identify the research question

A research question should clearly align with the objective of the scoping review and the Participants, Concept and Context (PCC) framework (M.D.J. Peters et al., 2020). In this review, the research participants are not relevant, as the research is conducted in the setting of LG, rather than referring to a defined population group. The context is specified as the tier of government at a local level, often termed 'local government' or 'municipality'. The concept, HiAP, represents an approach to healthy public policy that is underpinned by addressing structural determinants of health across a range of sectors to achieve greater health equity (Bacigalupe et al., 2010; Ollila et al., 2013). Based on the understanding of the concept and context to be researched, along with the aim of this study, the research question proposed for the scoping review was:

- What are the factors in the policy process that enable and/or challenge LG in initiating, implementing, or evaluating a HiAP approach to achieve health equity?

Additional sub-questions of interest include:

- Are these policy factors different across various LG contexts and jurisdictions?
- How does the literature related to HiAP approaches in LG apply theories from political science?

### 3.2.3 Identify relevant studies

Identifying relevant studies involves determining the types of sources to be included, and restrictions imposed (M.D.J. Peters et al., 2020). Due to language and resource constraints, sources had to be written in English. The articles sourced were published between 2001 and 2021. Both academic peer-reviewed research articles and grey literature were included in the search, as appropriate to the scoping review process (Arksey & O'Malley, 2005; M.D.J. Peters et al., 2020). It was also considered appropriate to include government reports and thesis dissertations, as the concept of HiAP is relatively new and the academic literature may not capture all of the information that best informs this research topic. Opinion pieces or debates were considered in the review, although literature reviews, newspaper reports, and conference abstracts were excluded.

A search for relevant literature using keywords was undertaken as an initial scan, using several electronic databases in consultation with a university librarian. This initial scan of literature is important to establish key terms, judge the extent of the current research, and ensure a comprehensive coverage of relevant literature (Arksey & O'Malley, 2005). The databases Proquest, Scopus, and EBSCO were chosen for their relevance to health and social sciences, and their multidisciplinary nature, including health, politics and humanities. The database search terms were constructed in reference to the PCC framework (M.D.J. Peters et al., 2020), using terms such as ‘local government’, ‘council’, ‘municipality’, ‘HiAP’, and ‘healthy public policy’. The initial scan of the literature highlighted the synonymous use of terms around HiAP such as ‘determinants’ and ‘health equity’. These terms were sometimes used with and sometimes in the absence of the term HiAP. The term ‘healthy public policy’ returned a large number of articles that were irrelevant, mostly related to healthcare services and therefore removed. To minimise the number

of irrelevant sources within Proquest, the full term of 'policy process' was utilised instead of 'polic*'. Adjustments to the search terms were made as a result of this initial process. The final search terms are outlined in Table 2, along with the final search strings for each database and their results in Table 3.

**Table 2** *Key words and search terms used for scoping literature review.*

| Participant/ Context/ Concept | Key Terms | Alternative terms included |
|---|---|---|
| Context | Local government* | "Local council", Municipality, "city government" |
| Concept 1<br>AND | Health in all polic* | "determinants of health" or "health *equit*" |
| Concept 2 | "polic*" | "policy process" |

**Table 3** *Databases used in the review, search string and limits, and number of sources then included in the review (after removing duplicates).*

| Database | Search string used | Limits | Number of sources |
|---|---|---|---|
| Proquest | ("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health inequit*" OR "health equit*") AND ("policy process") | Year: 2001 - 2021<br>Language**:** English<br>Sources**:** Dissertations & Theses, Scholarly Journals and Reports | 593 |
| Scopus | ("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health *equit*") AND ("polic*") | Year: 2001 - 2021<br>Language**:** English<br>Sources: Articles and Reviews | 208 |
| EBSCO | ("local government" OR "municipality" OR "local council" OR "city government") AND ("health in all polic*" OR "determinants of health" OR "health *equit*") AND ("polic*") | Year: 2001 - 2021<br>Language: English<br>Sources: Academic Journals, Journals, Dissertations | 234 |

A manual scan of references of included sources was also undertaken. This additional search strategy is considered useful to ensure both a comprehensive approach to the review and to extend beyond the limited number of articles sourced during the database searches (Peters et al., 2015). Articles that met the inclusion criteria (see section 3.2.4) for the review were included.

### 3.2.4 Study selection

A decision-making flow chart for criteria on eligibility of sources was established prior to the review of literature (Table 4). The first inclusion criteria ensured that the

study was located with the LG context. This included instances where higher tiers of government were involved, but only considered relevant where the role of LG was clear. Secondly, the source had to refer to HiAP or a related concept. Sources that did not explicitly or clearly define the definition of health they were referring to (e.g., public health) were included. Sources that focussed on behavioural determinants or healthcare settings were excluded. Finally, the inclusion of sources had to describe at least one factor of the policy process.

Articles were excluded if they discussed policy content analysis or policy impacts, rather than factors related to the policy process. Given the expected dearth of literature in the area, articles were included from all countries to expand the learnings of a HiAP approach. There was some obvious overlap with the research on intersectoral collaboration and HIA as a concept. This research was included where it met the research inclusion criteria, but not sought out intentionally.

**Table 4** *Decision-making flow chart for determining inclusion of sources.*

| | Include | Exclude | Examples for exclusion |
|---|---|---|---|
| Is the study/case study focussed within the LG setting (either solely or in conjunction with other tiers of government)? | Yes | No | Set in State or Federal tiers of government<br>Set in local healthcare settings or community-based organisations<br>Not in any particular context |
| Does the source refer to HiAP or a related concept, e.g., health inequities? | Yes | No | Focus on biomedical or lifestyle factors e.g., physical activity |
| Does the source describe the policy process (e.g., getting policy onto political agenda, factors enabling or challenging the development or implementation of policy)? | Yes | No | Discusses content in policy documents or policy impacts/outcomes |

Citations for all identified sources were exported to an Endnote X9[1] library and duplicates removed. The remaining sources were exported to Rayyan[2] software to allow for the first stage of review. The titles and abstracts were assessed by two reviewers, using the inclusion/exclusion flow chart as a guide (Table 4). The sources identified for full text review were entered into an Excel spreadsheet and assessed by

[1] Clarivate Analytics™, US, 2018.

[2] Mourad Ouzzani, Hossam Hammady, Zbys Fedorowicz, and Ahmed Elmagarmid. Rayyan-a web and mobile app for systematic reviews. Systematic Reviews (2016) 5:210, DOI: 10.1186/s13643-016-0384-4.

two reviewers, noting the reasons for exclusion of sources during regular meetings. A PRISMA flow chart provides a summary of the relevant sources identified at each stage of the scoping review (Figure 2).

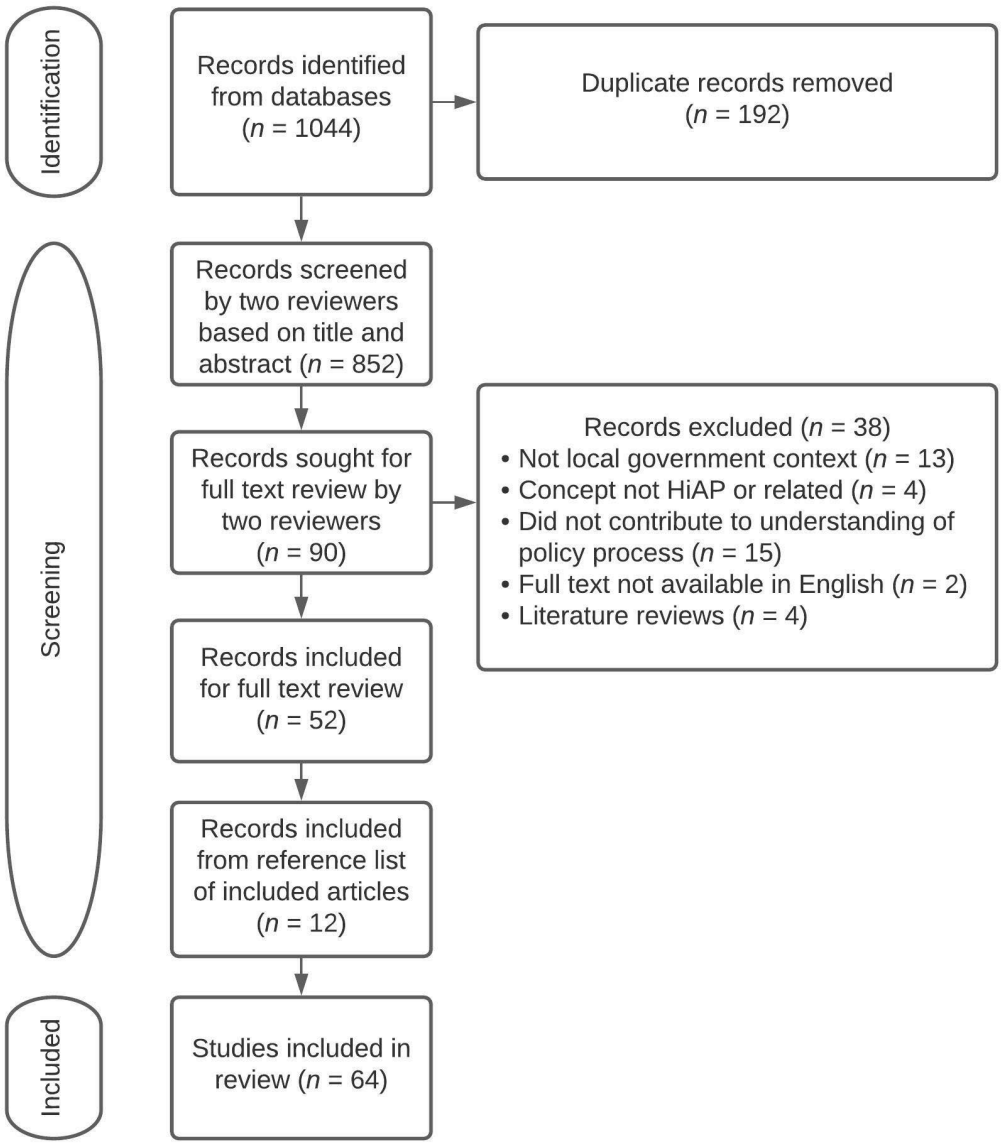


***Figure 2**: PRISMA flow chart detailing the number of sources included at each stage of the review process, including reasons for exclusion at full text.*

Data extracted from each source included year, country, level of government(s), key concept of focus, research aim, methods, participants, applied theory, application of

political science theory, key findings, and comparison of different contexts. Study limitations were also noted, although not formally assessed for quality. A summary of extracted data from the literature is provided in Appendix C. From the extracted data, themes of the policy process outlined in the literature were determined through a process of coding in NVivo[3], conducted by two reviewers.

### 3.2.5 Charting the results

The literature review intentionally sourced research over the span of 20 years, though most articles were published since 2012 (Figure 3).

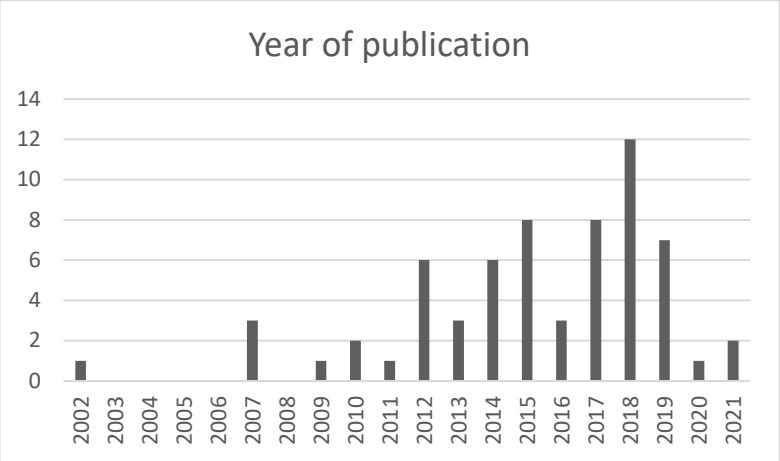


**Figure 3** *Year of publication of included sources.*

A majority of the research was located in European countries ($n$ = 46), particularly research conducted in Scandinavian countries of Norway, Netherlands, Denmark, and Sweden ($n$ = 31) (Figure 4). A 2021 debate piece is the only Australian source directly related to the concept of HiAP in LG. An additional ten articles focussed on empirical research in Australia, one of which is a publication related to this study. McCosker et al. (2018) and Lilly et al. (2020) were the only Australian studies to apply a theory adopted from the field of political science. The participants included in the Australian empirical studies included LG staff, planners, and management, who mostly had public health responsibilities. McCosker et al. (2018) included participants outside of LG, including government advocates in higher tiers of governments, NGOs, and the private sector. The paper related to this study is the only empirical study in Australia that includes the perspectives of elected members,

[3] QSR International Pty Ltd. NVivo Versions 11 (2015) and 12 (released 2018). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

managers across different sectors and the views of LG CEOs. Data were collected by empirical studies from within the state of Victoria (*n* = 6), NSW (*n* = 2), SA (*n* = 2) and WA (*n* = 2), except for the paper related to this thesis study, that also included QLD, TAS, and the NT. No studies included the ACT.

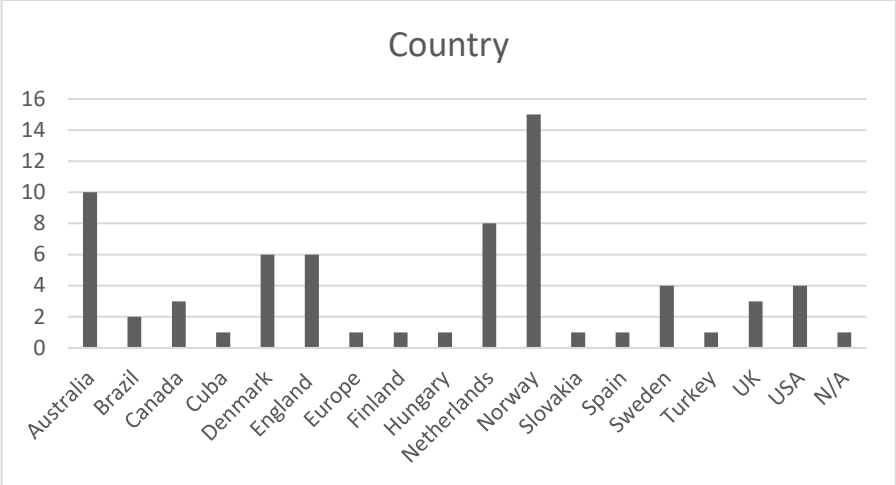


**Figure 4** *Country where data collection was undertaken (some countries were included in multiple case study articles and hence there are more represented here than number of articles).*

The LG setting was the sole focus of 59 of the articles. Five articles spanned across multiple tiers of government, though included LG. HiAP was the sole focus of 21 of the articles, with most of these from Norway (*n* = 12). Six of these Norwegian articles were derived from the same funded research project on addressing health determinants amongst families with children. Other key concepts included health equity or equality (*n* = 13), determinants of health (*n* = 9), SDoH (*n* = 9), and others less defined such as public health, health promotion or healthy planning (*n* = 14). The terms 'health inequalities' or 'social inequalities' were referred to in some studies and interchangeably on occasion with 'social inequities'. It was determined that all of these studies, by definition, were actually referring to 'health inequities', given their focus on addressing structural determinants of health to address population health disparities. Therefore, herein, the term 'health inequities' is used.

Eleven of the studies referred to political science theories in their research (see section 3.2.8). A summary of the sources based on level of government, focus on

HiAP, the application of political science literature and the Australian context are outlined in Figure 5.

Of the 64 studies included in the review, 13 discussed findings based on different geographical or political contexts regarding enablers or challenges to addressing HiAP or a similar concept. Some studies intentionally included samples of case study sites or LG participants across a mix of different contexts, though results were not presented as such (e.g., see Browne et al., 2019; Exworthy et al., 2002; Mundo et al., 2019).

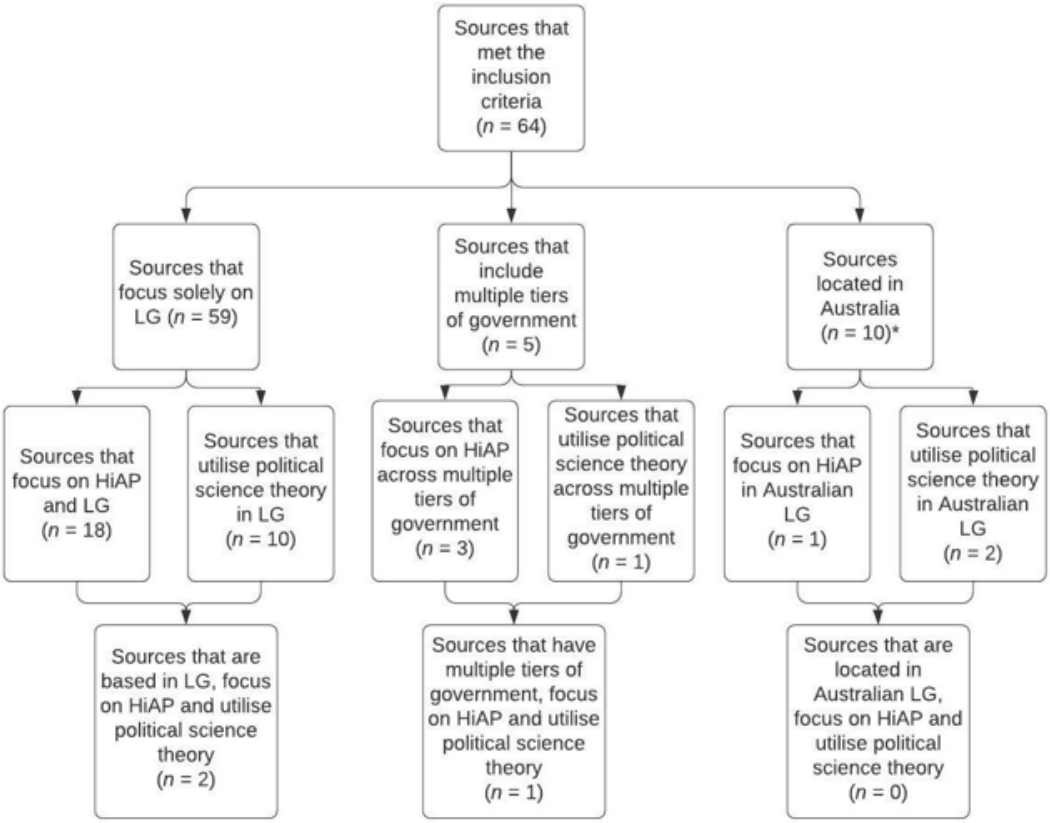


**Figure 5** *Summary of literature that meets inclusion criteria, highlighting focus on role of LG, focus on HiAP, use of political science theory, and overview of the research in the Australian context.*

**Australian studies within the 64 included sources*

### 3.2.6 Scoping review findings

This section is presented in sequence of the scoping review questions. It commences with the factors that enable and/or challenge LG in undertaking a HiAP approach to achieve population HWB outcomes. This is followed by what is known of the

influencing role of LG context, and to what extent the literature has applied theories of the policy process.

### 3.2.7 Factors that enable and/or challenge a HiAP approach in LG

Sixteen themes represent the factors that enable or challenge LG to initiate, develop, implement or evaluate a HiAP approach, each presented as its own subheading.

#### *3.2.7.1 Understanding of health*

The research findings on how the term 'health' is understood or defined in LG is mixed. The term 'health' is considered broad in scope (Hoeijmakers et al., 2007), perceived as complex, and difficult to define (Synnevåg et al., 2018b). Some studies reported that decision-makers had a good understanding of the broad range of policies that impact health (Browne et al., 2019; Collins & Hayes, 2013; Hendriks et al., 2015; Lilly et al., 2020). However, Lilly et al. (2020) report that only 6.5% of LG survey respondents communicated that 'all policies' impact on HWB. Fosse et al. (2019) reported that few decision-makers were aware of the social gradient in health and Mundo et al. (2019) found a lack of understanding of upstream health determinants amongst public health officials located within LG, along with a lack of clarity on the role of LG to address them.

Lawless et al. (2017) found that while staff with public health responsibilities were moderately familiar with the broader concept of the determinants of health, nearly half still agreed that lifestyle choices affect health outcomes more than other factors. Other research supports these findings, reporting that whilst there is some understanding of health determinants, LG decision-makers continue to rate individual lifestyles as having a high influence over health (Collins, 2012; Morrison et al., 2014). Health was also seen as a separate problem to social issues, therefore more likely to result in a behavioural approach to health problems (Holt et al., 2017).

Some authors report mixed findings within the same study, with the understanding of public health or HiAP meaning different things to each LG studied (Marks et al., 2015; Synnevåg et al., 2019). In addition, both Canadian and Australian studies found that non-metropolitan council decision-makers were less familiar with the broader health determinants (Collins & Hayes, 2013; Lawless et al., 2017).

It was often reported that the understanding of health inequities or public health planning was not shared amongst decision-makers within LG (Bagley et al., 2007; Dhesi, 2014; Morrison et al., 2014; Morrison et al., 2015). Where there was shared understanding, this created a more systematic and multi-sectoral approach to public health (Lillefjell et al., 2018). Regardless, understanding of health equity and determinants of health did not always determine priority given or actions taken (Collins, 2012; Didem et al., 2012).

#### *3.2.7.2 Level of policy priority*

Across studies, the level of LG priority given to health inequities, determinants of health and intersectoral action is mixed. Amongst municipalities of Vancouver in Canada, 44% reported prioritising health inequities (Collins & Hayes, 2013). A similar finding was found by Fosse and Helgesen (2015), whereby 43% of Norwegian municipalities reported health inequities as a goal in 2011, and in 2014, 48% of municipalities reported living conditions as their main priority. Municipalities in Barcelona also report mixed findings, with most politicians agreeing health inequities is a high priority, though staff and political opponents disagreeing it is a priority for the city council (Morrison et al., 2015). However, Morrison et al. (2014) report that most decision-makers across Europe reported health inequities as a high priority.

Other studies have found high levels of priority given to addressing intersectoral action (Holt, Rod, et al., 2018), HWB policy (Lilly et al., 2020) and action on the SDoH (Browne et al., 2019; Lawless et al., 2017). Factors enabling health inequities to remain high on the political agenda include highlighting the political and economic benefits, creating a sense of urgency (Storm et al., 2014) and the motivation to improve health outcomes for citizens (Hendriks et al., 2015).

Fosse et al. (2019) found that Norwegian municipalities gave low priority to SDoH, with most prioritising individual mental health issues. This is a common theme across the research with priority given to behavioural and lifestyle programs (Collins, 2012; Collins et al., 2007; Dhesi, 2014; Fosse et al., 2019; Tallarek née Grimm et al., 2013). Several reasons for this arise from the research, including lifestyle programs being more politically attractive (Browne et al., 2019) or determinants of health being perceived as outside of the control of LG (Dhesi, 2014; Morrison et al., 2014).

In addition, a low level of priority is given to addressing health inequities by staff in other policy sectors (e.g., housing), making collaboration across sectors challenging (Storm et al., 2016).

Many factors challenge the priority given to health inequities and determinants of health. This includes a 'crowded' policy agenda (Exworthy et al., 2002; Van Vliet, 2018), lack of perceived urgency (resulting from lack of performance measures) (Exworthy et al., 2002), competing with issues such as healthcare (Collins, 2012; Marks et al., 2015), competing with legislative issues such as food safety (Bagley et al., 2007), lack of power or opportunity to respond (Lawless et al., 2017) and competing with nationally funded programs that concentrate on national priorities (Fosse et al., 2019). One of the ways that LG have dealt with the high number of priorities is to integrate them into a range of programs and strategies already being invested in. Although caution is raised that this could result in a 'tick and flick' exercise for LG (Van Vliet, 2018).

Politicised decision-making was a challenge raised by a few studies, with conflict over gaining short term wins for a few, versus long term population gains for many (Marks et al., 2015), political ideologies that favour economic gain (Kokkinen, Muntaner, et al., 2019), and the recognition that long timeframes are needed for public health action do not match short term political election terms (McCosker et al., 2018).

In Norway, Hagen et al. (2018) report that larger and less central municipalities were more likely to make decisions prioritising fair distribution. This is consistent with findings that larger Norwegian municipalities tend to prioritise living conditions (Fosse et al., 2019; Hagen et al., 2017), and that smaller municipalities prioritise lifestyle issues (Fosse et al., 2019). Overall, this study found that city councils are more likely to report HWB as a higher priority than are regional councils (Lilly et al., 2020).

#### *3.2.7.3 Champion*

There was agreement amongst the literature that a policy entrepreneur, champion or knowledge broker was a critical factor to progress local policy on health inequities (Exworthy et al., 2002) or determinants of health (Guldbrandsson & Fossum, 2009;

Jansson & Tillgren, 2010; Langeveld et al., 2016). It was considered more successful if policy entrepreneurs had power (Guldbrandsson & Fossum, 2009; Helgesen et al., 2017; Jansson & Tillgren, 2010), political connections (Guldbrandsson & Fossum, 2009), negotiation skills (Guldbrandsson & Fossum, 2009), a background in policy agenda setting (Langeveld et al., 2016), ability to develop local health profiles (Helgesen et al., 2017), or sheer persistence (Guldbrandsson & Fossum, 2009).

In their network analysis, stakeholders expected municipalities to facilitate the policy (Hoeijmakers et al., 2007). However, whilst municipalities remained central to the policy networks, the authors found no evidence of a policy entrepreneur (Hoeijmakers et al., 2007). In the Australian context, Lilly et al. (2020) also found that the majority of councils did not report a local champion, or any internal lobbying action. On the contrary, another Australian study found that healthy planning and active living advocates, located within and outside of LG, played the role of policy entrepreneurs (McCosker et al., 2018).

#### *3.2.7.4 Cross-sector relationships*

##### Internal collaboration

Intersectoral collaboration in LG received mixed findings, with a sufficient level of cooperation reported in some research (Lilly et al., 2020) and lacking in others (Morrison et al., 2015; Pettman et al., 2013). Holt, Waldorff, et al. (2018), in their analysis of documents of Danish municipalities conclude that there is discourse around intersectoral action, though no specific actions to achieve this, something they refer to as a 'rationalised myth'. The argument is that LGs like the idea of working intersectorally more than implementing it.

Local intersectoral working groups have evolved in Norway, with fluctuating proportions of how many municipalities have them and who is involved (Fosse & Helgesen, 2015; Fosse et al., 2019; Helgesen et al., 2017). The latest surveys in 2017 indicate that 72% of Norwegian municipalities have established working groups, with up to 56% now involving chief executive officers (Fosse et al., 2019). This is in addition to the voluntary employment of a Public Health Coordinator (PHC) within each municipality to support local implementation of cross sector public health plans (Fosse et al., 2018; Hagen et al., 2018; Tallarek née Grimm et al., 2013). Whilst not all municipalities have employed a PHC, this has increased over time from 74% in

2011 to 85% in 2014 (Fosse & Helgesen, 2015; Helgesen et al., 2017), noting that the majority had a PHC prior to it being encouraged by the Public Health Act in 2012 (Hagen et al., 2018). Some factors likely limiting the effectiveness of the role of the PHC have been reported, including that only 22% are employed full time (Fosse et al., 2018), 46% are reported as working under the direction of a medical officer (Tallarek née Grimm et al., 2013), while only 27% are employed in a more cross-cutting position within the chief executive office (Helgesen et al., 2017). Notably, the size of the municipality, access to revenue or political profile were not associated with employing a PHC (Hagen et al., 2015), nor the focus on health equity amongst municipality policies (Hagen et al., 2018).

Horizontal collaboration, was found to be higher in urbanised municipalities in Cuba (Spiegel et al., 2012). However, Pettman et al. (2013) found that horizontal cooperation for health promotion is lacking across Australian LG departments, particularly in larger councils. In contrast, the results of this study found that city and regional council respondents were more likely to report sufficient cooperation during policy development than rural counterparts. Small municipalities in the Netherlands had positive influences on intersectoral collaboration as they tend to know one another, although other challenges as they are often limited in resources and capacity (Hendriks et al., 2015).

The research highlights the complexities of intersectoral collaboration to address health inequity or health determinants. Enabling factors include support by management (Steenbakkers et al., 2012), perception of being cost-effective and efficient (Holt, Rod, et al., 2018; Holt, Waldorff, et al., 2018), good relationships (Storm et al., 2014), previous positive experiences with collaboration (Storm et al., 2014), support from all levels of bureaucracy (Holt, Carey, et al., 2018), shared interests (Storm et al., 2014), shared objectives and measures for public health action (Jansson & Tillgren, 2010), and shared goals for a project, rather than for an issue such as health, and having someone to coordinate and support the collaboration (Storm et al., 2016).

Putting less priority on ‘health’ was seen as facilitating more collaborative action, as health was not considered important for many departments (Hoeijmakers et al., 2007; Synnevåg et al., 2019), particularly for sectors with legislative responsibilities

(Hendriks et al., 2015; Storm et al., 2016). This is consistent with findings that sustaining cross-sector action was challenging where 'health' remains the policy problem for addressing determinants of health (Exworthy et al., 2002; Hoeijmakers et al., 2007). Focussing on other issues was seen as more successful to engage different sectors, for example prioritising living conditions (Hagen et al., 2017; Holt et al., 2017), social sustainability (Scheele et al., 2018), or keeping the strategy 'vague' (Holt, Rod, et al., 2018). Although caution was also raised that this took the emphasis away from potential health outcomes (Holt et al., 2017; Scheele et al., 2018).

Other factors challenging intersectoral collaboration include lack of cooperation, or resistance to collaborate across siloed departments (Hendriks et al., 2015; Larsen et al., 2014; Mannheimer, Gulis, et al., 2007; Morrison et al., 2014), the different interests, identities and responsibilities of sectors outside of health (Langeveld et al., 2016; Synnevåg et al., 2019), perceived additional workload by departments outside of health (Corburn et al., 2014), lack of awareness of the shared goals with public health (Synnevåg et al., 2019), the different terminology used for public health (Lawless et al., 2017), lack of ownership (Larsen et al., 2014), as well as the lack of consideration for actions already being undertaken by other sectors that impact on population wellbeing (e.g., cultural strategies) (Synnevåg et al., 2019).

Vertical collaboration between LG staff and political leaders is less reported. In a Danish study, staff were conflicted, whereby they wanted political endorsement of policy, though did not want politicians involved in the planning details (Holt, Rod, et al., 2018). In return, politicians wanted 'vague' actions in the plans that did not require commitment, resulting in poorly articulated actions to address health determinants (Holt, Rod, et al., 2018). Langeveld et al. (2016) reported that support from management and elected officials was something built over time and needed to be prioritised early in the process.

### External collaboration

Collaboration across sectors outside of LG is determined as a positive facilitator for the process of implementing HiAP (Corburn et al., 2014) and healthy planning initiatives (McCosker et al., 2018). Developing external partnerships is reported as existing at a local level (Jansson & Tillgren, 2010; Morrison et al., 2014), although

some perceive intersectoral collaboration as making things more difficult (Morrison et al., 2014) or creating tensions between policy actors (Dhesi, 2014).

Lilly et al. (2020) found that LG staff and elected members perceived a lack of support by other sectors during both policy development and implementation. Hoeijmakers et al. (2007) found that the regional health service in Norway was recognised as working strategically with municipalities, though became far more removed from the process during implementation.

As per factors related to internal collaboration, coordinating with sectors outside of LG had a range of enabling and challenging factors. Enabling factors for collaboration include developing trust (Dhesi, 2014; Mundo et al., 2019), regular contact amongst actors (Mundo et al., 2019; Spiegel et al., 2012), access to decision-makers (Mundo et al., 2019), involving academics (Larsen et al., 2014; Schmidt et al., 2010), shared values of health equity (Dhesi, 2014; Mundo et al., 2019), formal networks to share information (Larsen et al., 2014; Lillefjell et al., 2018), and participation in broader programs (e.g., Healthy Municipalities Network) (Freire et al., 2017). Others have found that collaboration across sectors is stronger for specific issues (e.g. healthy lifestyle programs) (Morrison et al., 2015; Spiegel et al., 2012).

Factors challenging collaboration with external sectors include differing values of environmental and social justice (Corburn et al., 2014), miscommunication between public and private sectors (Morrison et al., 2014), difficulty measuring the cost-benefit of intersectoral policy action (Larsen et al., 2014) and stakeholders not seeing health as important for their own agendas (Hoeijmakers et al., 2007). While it was seen as important for LG to work in an integrated way with higher tiers of government (Bagley et al., 2007), some research suggests this is insufficient (Collins & Hayes, 2013), and difficult given that regional level bodies are unable to cater to each unique LG (Scheele et al., 2018).

#### *3.2.7.5 Organisational structures*

Several sources referred to organisational structures that supported effective cross-sectoral collaboration, such as the development of formal intersectoral committees (Spiegel et al., 2012), having clear goals in strategic planning documents, formal

HIA procedures, and the need for more formal communication structures between departments (Synnevåg et al., 2018a).

Two common structures included a central unit approach and the establishment of intersectoral committees (Holt, Carey, et al., 2018). Both approaches report mixed success. In Denmark, Holt, Carey, et al. (2018) found that municipalities with a central unit report the focus being taken away from public health, making it more difficult for public health staff to engage with other departments. However, a research study in Norway found that the establishment of a strategic development unit built the connections between required stakeholders across departments (Von Heimburg & Hakkebo, 2017).

#### *3.2.7.6 Role of legislation*

Many of the studies included in the review were located in Europe or the United Kingdom where there is already a national legislative mandate for LG to address health determinants, and in the case of Norway, incorporated around the concept of HiAP. Some of the studies in Australia were also located within a state where there is a legislative mandate for municipal public health planning. The included studies agree that legislation by higher tiers of government was an initiator or support for LG health policy (Bagley et al., 2007; Corburn et al., 2014; Exworthy et al., 2002; Jansson & Tillgren, 2010; McCosker et al., 2018; Synnevåg et al., 2019). For some, this was reported as beneficial to gain the legitimacy and visibility of public health (Bagley et al., 2007; Exworthy et al., 2002), though also perceived as higher tiers of government passing on responsibilities (Bagley et al., 2007). Lawless et al. (2017) found that the funding cuts by higher tiers of government contributed to the increased responsibility felt by LG to respond.

Whilst it was agreed that legislation supported action for LG, it is considered most successful when there is a local champion (Jansson & Tillgren, 2010), sufficient resources (including financial) (McCosker et al., 2018), a clear scope, support by senior management, sufficient workforce capacity, and a focus on resourcing for implementation as well as development (Bagley et al., 2007). In Finland, where legislation for municipalities was made more flexible, though without similar resourcing, it resulted in a reduction of health promotion action (Kokkinen, Muntaner, et al., 2019). Contrary to this, Hagen et al. (2017) report that incentives

from higher tiers of government had no impact on the prioritisation of structural determinants of health, referred to as living conditions.

Despite it being seen as an influencing factor, some studies reported that LG do not necessarily follow the legislative mandates (Jansson & Tillgren, 2010; Tallarek née Grimm et al., 2013). The priority still tends to be given to healthcare or behaviour focussed strategies (Fosse et al., 2018; Jansson & Tillgren, 2010), or other local needs (Browne et al., 2019; Jansson & Tillgren, 2010). Kneale et al. (2019) agree that the national public health policies did not always translate well to the local level context. Some authors conclude that given each local area is different, they will need to translate national policy and respond to health inequities in their own unique way (Bekken et al., 2017). McCosker et al. (2018) found that policy for healthy planning and active living in Australian councils experienced similar challenges, regardless of their location within states with or without legislation. This study identifies that respondents of city councils were also more likely to report a supportive legislative environment than rural or remote councils, but there were no differences between the varied legislative jurisdictions (Lilly et al., 2020).

Outside of legislation, leadership from higher tiers of government is also reported as lacking (Lilly et al., 2020; Mundo et al., 2019). However, the broader political environment demonstrates influence on addressing health determinants at a local level. For example, shifts to a more democratic government in Slovakia changed the way health was defined (Mannheimer, Gulis, et al., 2007), and the high level of political support in Cuba is also recognised as contributing to the focus on health-oriented outcomes (Spiegel et al., 2012).

#### *3.2.7.7 Financial and staff capacity*

Staff capacity is recognised as a challenge to progressing local level HWB policy (Lilly et al., 2020; Mundo et al., 2019). A key challenge is the perception by staff that the incorporation of health in planning is an additional task to their existing workload (Corburn et al., 2014; Larsen et al., 2014). Other factors that influenced the success of local HWB policy implementation included having motivated staff to deliver on healthy planning policy (McCosker et al., 2018) and staff having sufficient skills (Bagley et al., 2007), particularly in evidence-informed policymaking or research (Langeveld et al., 2016; Pettman et al., 2013). Other studies did not report

staff capacity as the challenge directly, though reported time constraints as a barrier to being able to integrate health into policies (Langeveld et al., 2016), to undertaking a HIA (Bhatia & Corburn, 2011) and as a barrier to sourcing and utilising evidence (Kneale et al., 2019; Willmott et al., 2016).

Multiple sources identified the lack of funding as a challenging factor (Helgesen et al., 2017; Larsen et al., 2014; Lilly et al., 2020; Morrison et al., 2014; Morrison et al., 2015; Mundo et al., 2019) or access to funding as an enabler (Jansson & Tillgren, 2010). A key challenge is the limited options for revenue raising available at a local level, with LG reluctant to increase property taxes (Collins & Hayes, 2013). This has resulted in plans within LG not specifying activities, as they do not want to commit the budget for them (Holt, Rod, et al., 2018). This is in contrast to the findings by Van Vliet (2018) who reports that planning for social investments addressing health inequities were also incorporated into annual budget plans.

The reliance on funding by higher tiers of government, and the ongoing conflicts with healthcare budgets at a national level are reported as ongoing concerns. The research findings suggest that funding priorities for LG are determined by higher tiers of government (Helgesen et al., 2017), do not always match the needs required by LG (Fosse & Helgesen, 2015), compete with the healthcare budget (Marks et al., 2015), or are focussed on specific health issues, rather than designed to address determinants of health (Mundo et al., 2019). In a study in Norway, municipalities did not see the national grants as a critical source to address social inequities (Tallarek née Grimm et al., 2013). Later, Helgesen et al. (2017) found that Norwegian municipalities that were already doing some public health planning were more successful in accessing the national grants. In their study in the USA, Corburn et al. (2014) describe how external grants have supported initial planning for community health, although also describe how the prioritisation of action within the plan was considered for alignment with broader city planning and budget.

Bekken et al. (2017) conclude that larger municipalities in Norway are more likely to have the resources, competence, and organisational capacity to address health inequities. Bagley et al. (2007) found no clear differences in comprehensive approaches to municipal public health planning based on the wealth of Australian councils. For example, the councils that took a narrow approach were not always the

less financially resourced (Bagley et al., 2007). This study goes on to report that whilst all respondents reported limited funding and staff capacity, regional or rural (non-metro) councils were more likely to report this as true for their council (Lilly et al., 2020).

In a positive trade-off, a few studies identified that the limited funding resulted in LG staff generating more action by working intersectorally (Browne et al., 2019; Jansson & Tillgren, 2010). In addition, two Australian studies found that LG decision-makers consider investment in determinants of health as cost-effective (Browne et al., 2019; Lilly et al., 2020).

#### *3.2.7.8 Use of tools, including Health Impact Assessment*

The use of tools, such as HIA or health equity impact assessments, have been proposed as a formal tool for decision-makers across sectors to use in considering the health impacts of policy (Bhatia & Corburn, 2011; Scheele et al., 2018). The use of HIA training in a USA case study was reported to increase the awareness of SDoH amongst stakeholders, a skill that was acknowledged as contributing to longer-term sustainable change (Bhatia & Corburn, 2011). The approach has also supported health staff to build trust, share information, and engage more effectively in the policy process across a range of sectors, despite concerns that the HIA approach lacked validity (Bhatia & Corburn, 2011). In their study in Slovakia, membership with the World Health Organization Healthy Cities program brought some attention and legitimacy to HIA, which led to strong political commitment to the approach (Mannheimer, Gulis, et al., 2007). Contrary to this, a designated WHO Healthy City in Hungary reported a lack of political support by decision-makers to conduct HIA (de Blasio et al., 2012).

One of the challenges identified for HIA as an approach was the lack of legal obligation (de Blasio et al., 2012). However, Tallarek née Grimm et al. (2013) report that 67% of municipalities had not applied HIA, despite the legal mandate in Norway. Kokkinen, Muntaner, et al. (2019) found that the lack of workforce capacity restricted them fulfilling this requirement. Others also report lack of staff skills and confidence in the HIA process as a barrier to the approach (de Blasio et al., 2012; Mannheimer, Gulis, et al., 2007). Other challenges identified include insufficient resources (including financial) (Bhatia & Corburn, 2011; Mannheimer, Gulis, et al.,

2007), time required to complete the process (Bhatia & Corburn, 2011; de Blasio et al., 2012) and a lack of formal or structured processes (Bhatia & Corburn, 2011; Mannheimer, Gulis, et al., 2007; Synnevåg et al., 2018a). These challenges reinforce the notion that HIA is not only a technical tool to be applied, but also requires a supportive political environment (Bhatia & Corburn, 2011; de Blasio et al., 2012).

#### *3.2.7.9 Evidence for policy decision-making*

##### Types of evidence used

The studies strongly agreed that whilst there were many types of evidence used to inform LG policymaking to address health determinants, local level data (e.g., local knowledge) is considered more powerful and influential than scientific evidence (Kneale et al., 2019; Marks et al., 2015; McGill et al., 2015), particularly where it is compared to other local areas or national indicators (McGill et al., 2015). It is reported that the uniqueness of context was important to LG, rather than adopting best practice from other areas (Phillips & Green, 2015). Without informed data at a local level, it is difficult for LG to know where to invest, or whether to invest at all (Bekken et al., 2017).

Community input was reported as the most common and important type of evidence for informing LG policy decisions (Browne et al., 2017; Corburn et al., 2014; Kneale et al., 2019; Marks et al., 2015; Stoneham & Dodds, 2014). Story-telling, such as citizen stories of disadvantage, was considered an influential and effective type of evidence (Von Heimburg & Hakkebo, 2017; Willmott et al., 2016).

Other types of evidence used in LG included anecdotes (Kneale et al., 2019; McGill et al., 2015), case studies (McGill et al., 2015; Willmott et al., 2016), media (Lawless et al., 2017; Stoneham & Dodds, 2014), government reports (Browne et al., 2017; Lawless et al., 2017; McCosker et al., 2018; Stoneham & Dodds, 2014), and academic research (Lawless et al., 2017; McCosker et al., 2018; McGill et al., 2015; South & Lorenc, 2020; Willmott et al., 2016). Peer communication, informal networking, and advice from population health experts was also considered relevant evidence (Browne et al., 2017; Lawless et al., 2017; Stoneham & Dodds, 2014). Politicians, in particular, prioritised anecdote or strategic reports from higher tiers of government as a key source of evidence (Morrison et al., 2015; South & Lorenc, 2020). Less common types of evidence used by LG include organisational priorities,

directorate priority, hunch, and complaints or enquiries to council (Stoneham & Dodds, 2014). Apart from being used as evidence, media reports are a possible initiator of action on local health policy (Jansson & Tillgren, 2010; Larsen et al., 2014), although decision-makers needed to be aware of media publications to use the research (de Goede et al., 2012).

Academic research was the least cited source of evidence in a review of Australian municipal public health plans (Browne et al., 2017). Phillips and Green (2015) acknowledge that the transition of public health services from national to local level in England has challenged the medical public health specialists in adapting to the broad range of evidence used by LG decision-makers.

### Enabling factors to using evidence

Aligning evidence to both local priorities and plans, along with strategic plans of higher tiers of government was considered important (Corburn et al., 2014; McGill et al., 2015; Willmott et al., 2016). Willmott et al. (2016) found that this meant Directors of Public Health needed to make any evidence locally relevant.

Disaggregated data, that reflect health inequities, are reported to help gain credibility and motivate action to address health inequities (Schmidt et al., 2010). Morrison et al. (2014) agree that data highlighting health inequalities create more action to address them. This was similar to a finding in the UK, whereby the Marmot report (Marmot et al., 2010) was influential in informing priority for action on health equity for LGs in the UK, although many of the priorities ended up being issue-focussed as they gained the most consensus amongst decision-makers (Dhesi, 2014).

Other factors are reported as supporting the use of evidence in LG, including evidence needing to be 'jargon-free' (Kneale et al., 2019), viable (McGill et al., 2015), politically acceptable (Willmott et al., 2016), focussed on values such as doing the 'right thing' (Willmott et al., 2016) and useful where evidence was synthesised (Willmott et al., 2016). However, it is recognised by South and Lorenc (2020) that systematic literature reviews focussed on the determinants of health are limited. Having a cost-effective argument is also important, including evidence of the economic impact of addressing determinants of health that aligns with the role of LG (Kneale et al., 2019; Scheele et al., 2018; Willmott et al., 2016).

### Challenges to using evidence

It is reported that whilst there are LG staff capable and interested in evidence-informed health promotion practice (Pettman et al., 2013), others found that staff outside of health report a lack of information (Morrison et al., 2015), and those responsible for HIAs did not know if data were available or what to do with them (Mannheimer, Gulis, et al., 2007).

Challenges to using evidence include lack of staff time (Browne et al., 2017; South & Lorenc, 2020; Stoneham & Dodds, 2014; Willmott et al., 2016), the availability of evidence (South & Lorenc, 2020; Stoneham & Dodds, 2014), access to locally relevant data (Bekken et al., 2017; Browne et al., 2017; Corburn et al., 2014; McCosker et al., 2018; Stoneham & Dodds, 2014; van der Graaf et al., 2021), dealing with policy actor opinions and interests (de Goede et al., 2012), long timeframes required for academic research, and lack of access to data that was collected across different departments (van der Graaf et al., 2021). This increases the reliance on media as a source of evidence, recognised as risky in terms of validity and reliability (Stoneham & Dodds, 2014).

In addition to lack of access to local health data, access to relevant evidence on what interventions to adopt are noted as largely non-existent (Browne et al., 2017; Scheele et al., 2018). Where evaluations are completed on local interventions, they may lack rigorous scientific approaches to measure impact (Bekken et al., 2017; van der Graaf et al., 2021), and often have to balance community perceptions, accountability, organisational credibility (Phillips & Green, 2015), and political value (Bekken et al., 2017). This raises another challenge proposed whereby LGs are averse to negative evaluations (Phillips & Green, 2015; van der Graaf et al., 2021).

Recognition is given for LG staff to be able to balance the ‘hard’ research data with local knowledge and experience (Phillips & Green, 2015). Priority may be given for quantitative data if staff lack the skills on how to interpret and use qualitative research (van der Graaf et al., 2021). Synnevåg et al. (2018a) agree that there needs to be a balance between quantitative evidence and qualitative discussions. However, Kneale et al. (2019) highlight that whilst qualitative research is helpful, it may be misinterpreted by some decision-makers that the use of anecdote is acceptable.

How evidence is used

Determining the source of evidence used in LG is challenged by the lack of citations in policy documents (Browne et al., 2017; Kneale et al., 2019). Where it is identified, evidence often informs the situation (Browne et al., 2017), or raises awareness of public health (de Goede et al., 2010), rather than informing action (Browne et al., 2017). Involving local officials in the research process is more likely to see the use of evidence to inform action (or lack of action), referred to as instrumental or symbolic use of research (de Goede et al., 2012). However, van der Graaf et al. (2021) raise that collaboration between researchers and LG staff is problematic, given that researchers focus on methodological rigor and lack the awareness of LG policy processes.

In addition, where data exist, they may not be used to inform local health policy. In 2013, Tallarek née Grimm et al. (2013) reported that 29% of Norwegian municipalities had developed a health overview in response to national legislation mandates. These health overviews were developed by the county municipality to highlight local level health data. Recent reports suggest this has risen, with up to 85% of municipalities having completed a health overview (Fosse et al., 2019). Throughout their study, the use of health overviews was positively associated with consideration for living conditions in planning (Hagen et al., 2017) and prioritisation of a social justice perspective (Hagen et al., 2018). However, Fosse et al. (2018) report that health overviews were not often used to guide the municipal policy process with only 12% reporting it informed action planning and 4% reporting it guided a Master Plan (Fosse et al., 2018). On the contrary, municipalities were reported to raise public health in planning documents despite not having a health overview (Fosse & Helgesen, 2015).

#### *3.2.7.10 Leadership support and political commitment*

The role of leadership support and political commitment was apparent across many of the studies (Bagley et al., 2007; Freire et al., 2017; Holt, Waldorff, et al., 2018; Jansson & Tillgren, 2010; Langeveld et al., 2016; Larsen et al., 2014; Lillefjell et al., 2018; Lilly et al., 2020; Mannheimer, Gulis, et al., 2007; Mundo et al., 2019; Schmidt et al., 2010; Steenbakkers et al., 2012; Storm et al., 2016; Storm et al., 2014). This extends to a reported personal and professional obligation amongst LG

decision-makers for HWB (Lilly et al., 2020; Synnevåg et al., 2019), particularly for staff and elected members within city councils (Lilly et al., 2020). In addition, rural councils were least likely to report strong leadership within their council for HWB policy, compared to regional or city councils (Lilly et al., 2020). Support by senior management was reported as a critical factor for local public health planning (Bagley et al., 2007), implementation of planned actions (Jansson & Tillgren, 2010), and for intersectoral collaboration efforts (Steenbakkers et al., 2012; Storm et al., 2016). Leadership that remained stable over time was also a supportive factor (Jansson & Tillgren, 2010).

Commitment by political leaders was also important (Holt, Waldorff, et al., 2018; Lillefjell et al., 2018; Lilly et al., 2020; Schmidt et al., 2010), including to support implementation (Jansson & Tillgren, 2010; Storm et al., 2016; Storm et al., 2014), and to support the use of HIAs (Mannheimer, Gulis, et al., 2007). Some studies reported that political support was apparent to begin with, though decreased during implementation, suggesting it is difficult to maintain the commitment (Bagley et al., 2007; Holt, Rod, et al., 2018; Larsen et al., 2014; McCosker et al., 2018; Scheele et al., 2018). There is appeal in making decisions that are based on popularity or marketability, and ensuring community acceptance, and this requires local champions to make healthy planning happen (McCosker et al., 2018). Mundo et al. (2019) reported a lack of political will or 'buy-in' for HiAP, acknowledging that decision-makers knew what should be done, but lacked the political will to act.

#### *3.2.7.11 Framing*

A number of studies conclude that the term HiAP needs to be reframed to gain political attention and stakeholder input (Hendriks et al., 2015; Holt et al., 2017; Lawless et al., 2017; Mundo et al., 2019; Scheele et al., 2018). Using the term 'health inequities' has gained little political attention and support (Schmidt et al., 2010), and recognised as more of a hindrance than a help in addressing HiAP (Synnevåg et al., 2018b). Terms such as 'social determinants of health' are not used amongst municipalities (Holt et al., 2017). Instead, terms that have been used include living conditions (Holt et al., 2017; Synnevåg et al., 2018b), liveability, or wellbeing (McCosker et al., 2018). The challenge raised is the potential loss of sight of 'health' as the reason for action (Holt et al., 2017; Scheele et al., 2018).

Framing the issue to partially agree with decision-makers, such as agreeing that individuals are responsible for their own health, though highlighting how environmental structures influence behaviours, gained more political traction, as has reframing the issue to existing LG priorities that were already receiving policy attention (Schmidt et al., 2010). This reinforces that each LG will need different advocacy messages (McCosker et al., 2018).

In their study of Norwegian municipalities, putting public health as the priority developed a 'distrust' with other departments (Synnevåg et al., 2018a). Therefore, rather than have a specific public health plan in the municipality, a decision was made to adopt an integrated approach that aligned to already existing work. This avoids the sense of 'health imperialism', whereby public health is perceived as special or more powerful (Synnevåg et al., 2018a). Some respondents felt that the term 'public health' needed to be used initially, though during the planning process could be re-framed to become more relevant to practice, without losing sight of the intention of national mandated legislation (Synnevåg et al., 2018b).

#### *3.2.7.12 Performance measures*

Performance measures were reported as used for monitoring progress over time (Corburn et al., 2014; Lowe et al., 2015), to determine the policy problem (Lowe et al., 2015), and to support cross-department objectives (Lowe et al., 2015). However, some studies reported a lack of performance measures used for measuring health equity or public health action (Exworthy et al., 2002; Jansson & Tillgren, 2010; Larsen et al., 2014). There were several authors that noted the difficulty of measuring health inequities (Dhesi, 2014; Scheele et al., 2018) or the cost-benefit of intersectoral policy outcomes (Larsen et al., 2014; Lowe et al., 2015), with Scheele et al. (2018) suggesting there is a lack of common language to be able to report against. Where performance measures existed, they were reported as vague (Exworthy et al., 2002) and relied on data being publicly available (Corburn et al., 2014). Access to local level, disaggregated data is felt as needed (Lowe et al., 2015). This was made possible in a Norwegian study, although relied on large research studies to obtain the data (Von Heimburg & Hakkebo, 2017). Jansson and Tillgren (2010) found that an absence of measurable goals did not inhibit action. However, as a result of a lack of

indicators, Exworthy et al. (2002) report that health inequities were then not seen as an urgent problem.

#### *3.2.7.13 Role of community*

It is recognised that community expectations, demands, and pressures are powerful influences over local level planning (Bagley et al., 2007; McCosker et al., 2018). Consultation with citizens provides opportunity to gain insight from different community groups (Lillefjell et al., 2018; Morrison et al., 2014) and gain community participation and commitment (Larsen et al., 2014; Lillefjell et al., 2018).

There were several approaches to community consultation outlined in the literature. Corburn et al. (2014) outlined a community development approach to identify health needs, based on a 'cumulative toxic stress model'. The approach raised issues regarding the systemic stresses on the community such as racism, violence, and pollution (Corburn et al., 2014). The approach was found to be incredibly powerful in influencing policy decisions for action on health determinants and increased the priority of health equity on the policy agenda. However, it also required LG to support the approach, establish pilot place-based programs to demonstrate success, and build partnerships that could apply for grants (Corburn et al., 2014). Mundo et al. (2019) also report the effective influence of directly liaising with community and generating personal stories that support the policy idea.

Contrary to this, Morrison et al. (2015) report opposition by the public on local policy strategies as a barrier to the policy process. Browne et al. (2019) found that LG planners were concerned that consultation with community would result in support for behavioural health programs, rather than considering the structural determinants of health. Fisher (2018) adds to this, suggesting that decision-makers at a local level also feel comfortable with behavioural health programs as they are tangible deliveries that they can control. He argues that involving and empowering community members in the policy process may make decision-makers uncomfortable, and require the councils to view their constituents as capable of making decisions, not only consumers of services (Fisher, 2018).

#### *3.2.7.14 Health not the initiator*

In a number of studies, health was not seen as the strategic goal or priority for LG, despite it being addressed (Holt et al., 2017; Jansson & Tillgren, 2010; McCosker et

al., 2018; Phillips & Green, 2015; Steenbakkers et al., 2012; Storm et al., 2016). It seems that health was often utilised to achieve other objectives (e.g., social cohesion) (Holt et al., 2017; Steenbakkers et al., 2012), added to gain external funds or support other goals (Phillips & Green, 2015), or was merely a co-benefit of other actions (McCosker et al., 2018).

#### *3.2.7.15 Scope of LG*

Between 2014 and 2017, Fosse et al. (2019) report that municipalities are increasingly capable of addressing health inequities. Similarly, Lilly et al. (2020) report a strong council commitment to HWB amongst LG staff and elected officials. However, despite LG reporting health inequities as a part of their role (Collins, 2012; Collins & Hayes, 2013; Morrison et al., 2014; Morrison et al., 2015; Synnevåg et al., 2019), many reported that LG have a lack of responsibility, authority, control or power to act (Collins & Hayes, 2013; Dhesi, 2014; Lawless et al., 2017; Morrison et al., 2014; Morrison et al., 2015).

Synnevåg et al. (2019) reported that HiAP, whilst useful as an approach to achieve health outcomes, was less useful to the day-to-day work of the municipality. It was felt that any suggested actions needed to align with the local context, and value the local goals and practices in establishing priorities (Langeveld et al., 2016; Marks et al., 2015). The local autonomy afforded to LGs is beneficial in this regard, as they are able to set their own priorities (Marks et al., 2015).

#### *3.2.7.16 Political ideology*

Political ideologies that aligned with tackling health inequities were associated with commitment by decision-makers (Schmidt et al., 2010). In contrast, where values of social and environmental justice were not shared, or were not favourable for political reputations, there was resistance (Corburn et al., 2014; Kneale et al., 2019). Political ideologies that aligned with interests in economic growth meant that public health got a lower priority (Kokkinen, Muntaner, et al., 2019). Directors of Public Health in England felt that more had to be done to change organisational values to integrate health into policy decisions across LG (Marks et al., 2015), a concept that Synnevåg et al. (2019) doubted that local politicians or administrators fully understood.

### 3.2.8 Application of political science theories

As stated earlier, only 11 of the sources included in this review of literature applied a theory related to the political sciences to help explain the policy process. How the theory was applied varied across the research studies. Of these 11 sources, nine research articles (including an article related to this thesis) use or mention the Multiple Streams Framework (MSF), although the application of the framework is used to various extents across the research. Exworthy et al. (2002), nearly two decades ago, used the MSF to interpret findings regarding health inequities in the United Kingdom. A few studies apply the MSF more explicitly to formulate and interpret their research findings, notably related to HiAP in Slovakia (Mannheimer, Gulis, et al., 2007), child health promotion policy in Sweden (Guldbrandsson & Fossum, 2009), and healthy planning and active living in Australia (McCosker et al., 2018). Others briefly refer to the MSF, though do not explicitly apply this in their study design, results, or interpretation of findings (Jansson & Tillgren, 2010; Scheele et al., 2018; Von Heimburg & Hakkebo, 2017).

In addition to the MSF, a study employed a policy framework by Shiffman and Smith (2007) to analyse and present their results on the policy processes related to health inequities in municipalities in the Netherlands (Schmidt et al., 2010). Hoeijmakers et al. (2007) also utilised network analysis as the primary theory for establishing their research findings, alongside the understanding of policy entrepreneurs informed by the MSF. Fosse et al. (2019) use a framework adapted from the more traditional stages heuristic policy cycle, referred to as the Gradient Evaluation Framework. The authors take a particular aspect of the framework to assess the implementation of policies and to what extent health equity is considered (Fosse et al., 2019). There were three sources (including the related article from this study) that incorporated the use of more than one theory (Hoeijmakers et al., 2007; Jansson & Tillgren, 2010; Lilly et al., 2020).

The application of the MSF allowed McCosker et al. (2018) to provide in-depth discussion on the factors influencing the uptake of healthy planning and active living in Australian LG. Whilst the results were themed under the streams of the MSF, the authors also demonstrated the interrelationships amongst the factors that reinforces the complexity of the policy process, including the role of legislation that provides

impetus for action (policy stream), sometimes challenged by politically-informed decisions locally and hampered by short term political cycles at a state level (politics stream) and yet positively influenced by the possible co-benefits to community wellbeing and non-contentious threat of including 'health' of the community in policy decisions (problem stream).

Exworthy et al. (2002) also discussed the results using the three streams in the MSF, concluding that the streams were not only coupled, though needed to be coupled at both a national and local level, with local policy entrepreneurs critical to sustaining local action. They also proposed that keeping the window of opportunity open would be difficult over the long term whilst the national policy agenda was still competing with "urgent" priorities such as hospital waiting lists.

The network analysis undertaken by Hoeijmakers et al. (2007) provided a conceptualisation of the range and capacity of actors involved, both as a central coordinating role and those that were more peripheral to the policy process. This supported their finding that the medical model of health dominated the policy process, restricting the extent to which other health determinants could be addressed. The additional use of the MSF as a theory also assisted to conclude that the role of a policy entrepreneur was absent.

The application of the MSF streams by Mannheimer, Gulis, et al. (2007) highlighted that health inequities were perceived as a key problem for Slovakia when compared to other countries, and that HIA was seen as a solution to this. However, the politics stream was considered problematic, not sufficiently supporting or funding the process, which authors conclude partially closes the window of opportunity for sustainable action.

Using document analysis and interviews, Guldbrandsson and Fossum (2009) identified the presence of all three streams of the MSF in eight of the nine case studies they considered, along with evidence of a policy entrepreneur in all. The authors demonstrate that the three streams of the MSF can be identified and propose that policymakers who are able to better predict when windows of opportunity will open could generate more timely public health efforts, with the suggestion to have solutions ready for when opportunities arise.

## 3.3 DISCUSSION OF THE LITERATURE

The aim of the scoping review was to establish an understanding of what is currently known about the factors that enable or challenge a HiAP approach in LG, including across different geographical and legislative contexts. In addition, a secondary purpose was to identify the extent to which the literature has utilised theories of the policy process to explain these factors.

The scoping review has highlighted the growing body of literature discussing the policy process in LG adopting a HiAP approach to addressing determinants of health, particularly since 2012. The scoping review identified a broad range of factors that influenced the policy process, updating on previous reviews to include themes such as framing, level of policy priority, the role of evidence, and political ideologies. These factors, however, were not consistent across the studies. Some studies focussed on only one factor of the policy process (e.g., evidence) and others included a wide range of factors. The use of evidence was a prominent theme in the literature, arguably consistent with the dominant linear or stages approach to policy studies in health promotion (Bernier & Clavier, 2011). The role of media, events, policy actor values and beliefs, and political ideologies were less emphasised.

Often using a qualitative, case study narrative, the research identified a wide range of factors, with difficulty at times to determine if they were enabling or challenging the policy process. Baker et al. (2018) agree that factors of the policy process should be referred to as increasing or decreasing the probability of influencing the policy process, rather than being considered enablers or challenges. The authors acknowledge that it is the interaction of the influencing factors that is critical to the complex policy process (Baker et al., 2018). Some studies made explicit interconnections between factors, while others were more implied. Yet, most of the research lacked a theoretical lens to make sense of these interconnections in a meaningful way.

Applying a theory of the policy process did not necessarily relate to studies identifying a wider (or lesser) range of factors in the policy process. The application of theory, however, created a way to interpret the importance of the factors in the policy process, giving meaning to the findings. It is proposed that the use of political science theory could support a clear and shared understanding of the complex policy

process (Cairney, 2015; de Leeuw et al., 2014; Weible & Cairney, 2018). However, there remains a dearth of literature to currently synthesise any findings. For example, the four sources that were identified to explicitly apply the MSF were focussed on four different termed concepts (HiAP, health inequality, HIA, healthy planning) and across three countries. The consistent use of theory to build the evidence-base for a HiAP approach would provide health promotion researchers and practitioners with a better understanding of the policy process, and contribute to a better understanding of the policy process, including across different LG contexts (Baum et al., 2019; Bernier & Clavier, 2011).

This scoping review demonstrates a dearth of policy studies that compare different political and geographical contexts of LG. A large majority of the studies were qualitative in design, retrospective case studies, using a thematic data analysis methodology and written as narratives. Whilst the use of such studies is indicative of policy research (Buse, 2008; Walt et al., 2008), it makes generalisability of the research findings difficult to determine across different LG contexts.

In fact, studies purposely sought different geographical contexts of LG to include in their study, though rarely explored the policy process for contextual differences. The limited research that does exist related to geographical size and remoteness is focussed on intersectoral collaboration, understanding of health determinants and its priority in LG, resources and capacity, and legislation. Baldwin et al. (2021) raise a compelling argument that HiAP may be a solution for rural and remote LGs in Australia to address the existing health inequities that exist between urban and rural populations. However, the empirical research to support this claim is currently inadequate according to these scoping review results.

Many of the studies were conducted in Scandinavian countries, or in contexts where legislation for LG to address determinants of health exists, resulting in a focus on the implementation of HiAP, rather than exploring agenda setting outside a legislative environment. In Australia, LGs have varied responsibilities for addressing health determinants, and many have no mandate at all. Apart from the article related to this thesis, most of the research in Australia was predominantly located in the state of Victoria, which has had some form of municipal public health planning for decades. Further exploration of contextual factors of broader political environments and

agenda setting are needed to understand the generalisability of findings across different governance structures.

Finally, the varying governance structures of LG may misrepresent the interpretation of findings for particular contexts. Where literature refers to 'cross-sector' or 'intersectoral' actions, it is sometimes unclear if this refers to internal collaboration across different LG departments, or collaboration with sectors outside of LG. For example, Hendriks et al. (2015) and Storm et al. (2016) refer to intersectoral collaboration with sectors outside of health, though clearly referring to internal collaboration across municipal departments. Some literature was not as explicitly clear as to whether other sectors were internal of external to LG. Addressing this limitation requires ongoing clarity across international literature for local level policymaking on what is meant when referring to 'cross-sector' or 'intersectoral' collaboration. In agreement, Godziewski (2020) argues that the term 'sectors' or intersectoral collaboration has been misinterpreted over time. For example, in the European Union, this could be interpreted as all sectors of government, whilst others include the views of local stakeholders and private industry.

### 3.3.1 Limitations

There were some limitations to the scoping review. The multidisciplinary databases were chosen for their broad multidisciplinary scope, though there may have been other relevant databases not accessible to the researchers in relevant university libraries. The search only included studies in English language. Given the volume of research in Norway and other Scandinavian countries, it is likely that literature in other languages exists which has not been captured in the scoping review.

Whilst there were a range of measures taken to incorporate the complexities of the concept of HiAP and context of LG by using various search terms, there may be some studies that were inadvertently excluded, either as they were unclear of the concept or context and excluded by reviewers, or used alternative terminology not identified in the database searches. The terminology of HiAP and related concepts proved to be difficult to interpret from articles, as few authors defined the meaning. Some referred to a related concept, though used examples of behavioural approach policies. The interchangeable use of terms and lack of clear definition meant that some studies may have been wrongly excluded, and others that used 'vague' terms

(e.g., health promotion) may have been wrongly included. This may also be the reason that a number of sources were located from reference lists, not initially from search terms in the databases.

All consideration was taken to understand the governance structures of different countries, although where this was unclear, primary authors were contacted directly to enquire. This did result in one article being included that otherwise would have been excluded based on the lack of context communicated in the publication.

Similarly, all consideration was taken to determine if the study was referring to a related factor of the policy process, even if this was not explicitly the aim of the study. Whilst search terms could not feasibly include all of the policy factors for inclusion, regular discussions between reviewers to debate inclusion of articles on this premise hopefully overcame this limitation. In addition, a decision to reduce the high volume of initial sources by changing the search term from 'polic*" to 'policy process" in Proquest may have meant that some relevant sources were inadvertently excluded.

## 3.4 IDENTIFIED RESEARCH GAPS

The scoping review identified a range of factors in the policy process that influence the approach to HiAP, or a related concept. The generalisability of these findings to the Australian context is limited, particularly within LG that is not bound to any legislative mandates for addressing health determinants. In addition, the studies in Australia, whilst growing, have focussed on LG participants within planning and public health roles.

A research gap exists in understanding the policy process from the perspectives of all LG staff, along with elected members and managers. The scoping review also identified the limited research that explores the contextual differences in the factors influencing a HiAP approach across metropolitan and rural LGs. Further research is required to identify if the influencing factors in the policy process are experienced differently across different LG contexts and jurisdictions.

Finally, the review highlighted the lack of applied theory to policy studies in LG regarding HiAP approaches. Further research is required that incorporates a theoretical lens from political science.

These research gaps ultimately inform this study. This study incorporates the perspectives of a wide range of LG policy actors across different LG contexts and jurisdictions. The study also utilises a theoretical lens adopted from political science to understand the policy process.

## 3.5 SUMMARY OF CHAPTER THREE

This chapter has reported the findings from a scoping literature review that explored the understanding of current knowledge regarding factors that influence a HiAP approach in LG, across different legislative and geographical contexts. The review identified research gaps regarding the understanding of different contexts of LG, and the dearth of research applying political science theory to help understand the policy process.

The next chapter provides a descriptive overview of the theories that inform this study, including three frameworks adopted from the field of political science and a policy framework tested in the discipline of health promotion. The chapter provides a descriptive summary of the frameworks and details how they are applied to inform this study.

# 4. OVERVIEW OF THEORETICAL LENS

## 4.1 INTRODUCTION

The previous chapter synthesised the current international literature regarding the factors influencing a HiAP approach in LG and identified the research gaps. One of the identified research gaps was the limited application of theory to better understand the policymaking environment to understand how HiAP is approached in LG. The purpose of this chapter is to describe the theoretical lens applied in this study, utilising multiple frameworks adopted by political science. The chapter provides a rationale for the use of political science theory in health promotion research, an introduction to political science theory, followed by a descriptive summary of four chosen theoretical frameworks that will inform this study, including their similarities and differences. The chapter ends with a summary of how these theoretical frameworks are applied within the research design.

## 4.2 POLITICAL SCIENCE THEORIES

### 4.2.1 Political science in health promotion discourse

As introduced in chapter two, the policy process involves a range of factors that influence whether issues make the policy agenda, or whether policy solutions are implemented, sustained, or monitored over time. Researchers in health promotion policy have identified that whilst healthy public policy research is growing, there is a need to better understand how to engage in the policy process by using theory from the political science discipline (Breton & de Leeuw, 2011; Clavier & de Leeuw, 2013; de Leeuw et al., 2021; Fafard & Cassola, 2020; Greer et al., 2017). The argument is that political science theories are more likely to mimic the reality of the policy process than the policy cycles or stages heuristic frameworks that health promotion have previously relied on (de Leeuw et al., 2014).

The application of theories adopted from political science is relevant to this study given that gaining policy support across different sectors of government has proven difficult for health promotion practitioners and researchers (Clavier & de Leeuw, 2013; Marmot et al., 2008; Raphael, 2008). Incorporating the understanding of the

complexity of the policy process into health promotion discourse may provide additional insight into how the discipline can better action HiAP. The research has produced a number of complex theoretical underpinnings to the policy process, albeit largely theoretical and maintained within the field of political science (Weible & Cairney, 2018). This study aims to contribute to this research gap, by integrating and applying theories of the policy process to inform the research across all stages of the research design.

### 4.2.2 Theories of the policy process

Different theories exist in political science to help explain the complexity of the policy process, including institutional approaches, network theories, socio-economic arguments, rationale choice, and ideas-based theories (John, 1998). Whilst the purpose of this chapter is not to detail these underlying theories, the political science frameworks outlined in this chapter draw on a number of these foundational approaches. This includes 'bounded rationality' (Simon, 1985), suggesting that decision-makers use information and other evidence to inform their decisions, in light of their ability to deal with multiple issues at any one point in time and the resources available for them. In addition, the 'garbage can model of decision-making' (Kingdon, 1995) assumes that policymaking is ambiguous, compounded by time restraints, policy actor perceptions of issues and a 'garbage can' of policy problems, solutions and political environments that are all independent of one another (Herweg et al., 2018). However, theories do not explain the complexity of the process in a more conceptual way. Hence, there is a need to further explore political science frameworks that outline the constructs of policymaking to use in a more empirical sense.

### 4.2.3 Rationale for chosen political science frameworks

Firstly, it is worth noting the different terminology used in policy sciences regarding frameworks and theories. Weible (2018a) gives recognition that the meaning of the term 'theory' is varied within the field of policy science and introduces it as a generic term to describe a range of theories and frameworks. Ostrom (1995) explained this quite explicitly though, identifying that a 'framework' identifies key variables or elements that help explain some causality or outcome, whilst a 'theory' underlies these variables to help explain how and why they came about. Breton and de Leeuw

(2011) interpret that a policy theory helps describe the 'cause and effect' though propose a different terminology for the conditions or phenomena that determine policy theories as 'theories of the policy process'. Whilst the terminology is often used interchangeably, what is agreed on is the purpose of having a theory or framework to support researchers in the field to identify factors that influence the policy process. For the purposes of this study, the term 'framework' is used, since many of the theoretical frameworks applied in the research are titled as such.

It should be acknowledged that being a new researcher in the application of political science, little research is available to determine which frameworks should be utilised and for what circumstances. There are a large number of political science frameworks cited in the literature, with authors seemingly trying to demonstrate that their framework is more superior than others (Cairney, 2013; Howlett et al., 2015b). Highlighted by de Leeuw and Breton (2013) as frameworks useful to the health promotion policy field and according to criteria of Sabatier (2007a), there are three frameworks that have enough clarity in their concepts or variables to be applied, have been rigorously tested in empirical research, and that address the key foundational factors in the policy process, namely the Multiple Streams Framework (MSF) (Kingdon, 1995), Advocacy Coalition Framework (ACF) (Sabatier, 2007), and Punctuated Equilibrium Framework (PEF) (Baumgartner & Jones, 2010). These frameworks are considered three of the seven most established frameworks in the policy sciences, recently assessed against a range of scientific criteria to further verify the criteria set out earlier by Sabatier (2007) (Heikkila & Cairney, 2018; Weible, 2018a). All seven of the frameworks reviewed met the criteria, including having a defined scope and concepts, explicit assumptions, and identified relationships amongst their concepts (Heikkila & Cairney, 2018). Of the other four frameworks, the Policy Framework Theory, Institutional Analysis and Development Framework, and Innovation and Diffusion Models are determined to be less clear on their assumptions and the Narrative Policy Framework has been less rigorously tested to date (Heikkila & Cairney, 2018). However, the authors acknowledge that all of the frameworks are different, and there is no 'best' theory or framework (Heikkila & Cairney, 2018).

One of the fundamental limitations of the three chosen political science frameworks is their emphasis on policy initiation or policy change (Weible et al., 2009). To fill this gap, the Analysis of Determinants of Policy Impact (ADEPT) framework is included in the proposed theoretical lens. The ADEPT framework is not a theory of political science, though adapted from a behaviour change theory within health promotion, originally developed by Von Wright (1976) (Rütten et al., 2013). In keeping with the health promotion discourse, Rütten et al. (2013) refer to the 'determining factors' that contribute to policy outputs or policy outcomes. The flexibility of this approach to many contexts, the previous application of the framework in empirical health promotion policy research, the ease of use, and potential practical application for considering determinants of the policy process lends itself as a feasible option to incorporate alongside political science in policy research (Rütten et al., 2013).

## 4.3 Overview of the political science frameworks

This section provides a descriptive overview of each of the frameworks that form the theoretical lens for the research. A definition of each framework and a comparison of their differences is outlined in Table 5.

### 4.3.1 Multiple Streams Framework

The MSF is a systems-based theory, attempting to address the complex and seemingly unpredictable policy process using three streams: problems, policies, and politics (Zahariadis, 2007). One of the differences between this framework and others is that it is drawn from a 'garbage can model of decision-making', which proposes that problems and solutions available for decision-making are 'dumped' (Cohen et al., 1972). The framework proposes that there are many solutions, often unclear problems and an environment of ambiguity, time constraints, unclear technology, and changes in policy actors influencing the policy environment (Herweg et al., 2018). These conditions help to explain the policy environment in which decisions are made. For example, more information may reduce uncertainty on a policy issue, but may not change ambiguity, depending on whether the issue is viewed as a moral, educational, political, or health issue (Herweg et al., 2018; Zahariadis, 2007). Where departmental or jurisdictional boundaries are unclear,

referred to as unclear technology, frustrations can arise over the unclear roles and responsibilities of different policy actors (Herweg et al., 2018). This is further complicated by constant changes in policy decision-makers, all who have their own policy preferences (Herweg et al., 2018).

Within the MSF, the 'problems' are the issues that need policy attention (Kingdon, 1995). Under the conditions of ambiguity, the actual issue, or policy problem, may be difficult to identify (Zahariadis, 2007). Problems can be raised by a number of sources including through feedback and monitoring of issues, external events (Herweg et al., 2018; M. D. Jones et al., 2016; Zahariadis, 2007) or organisational issues such as budget concerns (Herweg et al., 2018). Sources of 'evidence' can be used to raise the profile of the problem, although it often requires someone, or something, to bring the issue to the attention of decision-makers (Herweg et al., 2018). The raising of a policy problem is usually easier to advocate for if evidence exists of the problem getting worse, or a sense of urgency can be created (Herweg et al., 2018). One of the difficulties is that the number of policy problems being raised at any one time, referred to as 'policy load', can exceed the amount of time and consideration that the relevant decision-makers can give to them (M. D. Jones et al., 2016).

It is also considered important within the MSF that policy problems are framed according to the relevant politics at the time, including the values and beliefs of decision-makers or public discourse (Herweg et al., 2018). For example, attention to a policy problem is more likely where there is strong public opinion (Herweg et al., 2018). This can work both in favour of raising a problem onto the policy agenda, or diverting and reframing problems so that problems remain vague and unclear to policymakers, reducing the likelihood of it getting onto the policy agenda (Herweg et al., 2018).

'Policies' are the proposal for change or solutions offered as the answer to the problem (Kingdon, 1995). Policies may be slow to reach the policy agenda, or they may be rapidly adopted. It may be a new idea, or a minor extension to traditional policies. As there are often many possible policy solutions, the ones most likely to be considered rely on them being perceived by decision-makers as feasible to put into practice, financially and politically viable, and accepted by the public (e.g., voters)

(Herweg et al., 2018; M. D. Jones et al., 2016). How 'integrated' policy subsystems are will influence how feasible the policies are perceived (Herweg et al., 2018). For example, smaller and well-connected policy communities that share common values will be more likely to adopt policy solutions, than larger organisations with a diverse range of actors and values. Policy solutions are more likely to gain attention if they are framed to a decision-maker's values, or the values of their voters, particularly if they are framed to avert a loss to a politician or create a substantial gain (Zahariadis, 2007). For example, if there are unrelated advantages to the solution (e.g., increased votes for politicians, detracting from other problems) then it will be looked on more favourably.

'Politics' is the broader environment where decisions are made (Zahariadis, 2007). This relates to the legislative environment, social norms, and community opinions that influence decision-making (Kingdon, 1995). For example, community opinions, or 'national mood', may be monitored by opinion polls or the sense of support by interest groups (Zahariadis, 2007). Where there are strong advocacy groups putting arguments into the political environment, decision-makers may be more likely to put the problem onto the policy agenda (Zahariadis, 2007). Other factors are also relevant in the policy context, for example the turnover of government staff (Zahariadis, 2007), orientation of political parties and the otherwise overall position, or balance in interests, of individual policy actors or advocacy groups (M. D. Jones et al., 2016). Within the politics stream, consideration is given for a range of different policy actors. These individuals or organisations that are involved in the policy process are referred to as 'policy networks', 'policy communities' or 'policy sub-systems' (Herweg et al., 2018). Some are specific, small networks with clear boundaries, while other are larger with less obvious boundaries (Buse et al., 2012). What is less clear in the MSF is the organisational and institutional context to which policymaking takes place (Heikkila & Cairney, 2018).

The MSF theorises that when the streams of problem, policy, and political environments all align, a window of opportunity opens to influence policy (Kingdon, 1995). As outlined previously, decision-makers are often in a position where they are dealing with a large number of different 'problems', often within time constraints. Therefore the policy idea is more likely to gain traction when problems and solutions

can align with the current political environment (Kingdon, 1995). These windows of opportunity may open spontaneously through predictable circumstances (e.g., budget reviews), or less predictable events (e.g., natural disasters) (Herweg et al., 2018). This requires someone, such as a policy entrepreneur, to bring these alignments to the attention of decision-makers (Zahariadis, 2007). The MSF assumes an individual policy entrepreneur is able to manipulate the coupling of the three streams, knowing which windows of opportunity to pursue (Zahariadis, 2007).

Policy entrepreneurs are most successful when they have access to policymakers, more recently referred to as 'political entrepreneurs' in that they are not trying to couple the streams together, but are in a powerful position to act (Herweg et al., 2018). Policy entrepreneurs are also more successful if they have similar ideologies to decision-makers, have time and financial resources available to them (Zahariadis, 2007), and if they are able to frame policy problems to their preferred policy solution (Herweg et al., 2018). It is also argued that policy entrepreneurs are not necessarily more rational than policymakers, and that sometimes it is the policy decision-maker that is acting as the policy entrepreneur, potentially pushing their own pet project (Herweg et al., 2018).

Whether the three streams are inter-dependent or independent has been debated in the literature (Herweg et al., 2018). As pointed out by Herwig et al. (2018), policy solutions can be made based on all sorts of reasons and not necessarily responding to a clear problem, problems can come and go in the political environment whether they are solved or not, and therefore argues that each stream may well be independent of each other. Others disagree, with examples that increasing problems will influence the likelihood of solutions being given attention, or the failure of policy solutions influencing political opportunities and changeovers (Mucciaroni, 2012), suggesting that the streams are inter-dependent.

The MSF has largely been used to explain policy initiation in research to date. Considering this, Howlett et al. (2015a) proposed a five-stream adaptation of the model that includes a policy formulation stage. It also accounts for where policy process may end abruptly or not continue for various reasons such as other issues emerging and overtaking. A policy entrepreneur is still considered to be influencing

and driving the policy process, much the same as the original framework (Howlett et al., 2015a).

The MSF is increasingly being applied in political research (Herweg et al., 2018). A meta-review found 217 applied cases of MSF between the years 2000 to 2013, applied in 65 countries, across five levels of government (mostly national) and 22 different policy areas (M. D. Jones et al., 2016). As found in the scoping review for this thesis (chapter three), there were nine LG sources that applied the MSF to concepts of HiAP, health inequality, HIA, and healthy planning. In addition, Kickbusch et al. (2014) and Baum et al. (2015) analysed the policy decision-making process to retrospectively describe how HiAP came about in the state of South Australia, using the MSF as a theoretical lens. Application of the MSF highlighted some of the enablers to success, including the interplay between the policy problem, the politics at the time, the generation of a solution and the role of an influential and effective policy entrepreneur. Other empirical studies have also explored HiAP through the lens of MSF in national tiers of government in Iran (Khayatzadeh-Mahani et al., 2016) and Kenya (Mauti et al., 2019). In addition, Rudolph et al. (2013), refer implicitly to the MSF in their guide to HiAP in state and local governments, suggesting that implementing action requires exploring for 'windows of opportunity', recruiting political champions and communicating policy problems and solutions in a way that resonates with effective public health messages.

### 4.3.2 Advocacy Coalition Framework

Similar to the MSF, the Advocacy Coalition Framework (ACF) has been one of the most utilised and applied frameworks in policy research (Jenkins-Smith et al., 2018). Pierce et al. (2017) report the application of ACF as increasing in popularity and breadth, across 54 countries and within a range of disciplines. The framework is mostly applied within national levels of government, across Europe and North America and in the field of environment and energy, followed by public health as a discipline, where the framework has previously been applied across 15 sources (Pierce et al., 2017).

Positioned to purposely move away from the stages heuristic, the ACF comprises four main theoretical constructs, namely policy subsystems, advocacy coalitions, belief systems and policy-oriented learning (Pierce et al., 2017; Weible et al., 2009).

The framework suggests that it is the wide range of policy actors within government, media, and research that interact to influence the policy process (Sabatier & Weible, 2007). The framework is based on the idea that these experts, specialists, and individuals have the most influence on the policy process, but also that they are bounded by political structures and socio-economic conditions (Sabatier & Weible, 2007). The framework interprets the policy process within a 'subsystem', defined either geographically or by topic (Jenkins-Smith et al., 2018). The focus of the ACF is its ability to conceptualise all of the policy actors in the subsystem and determine how they collaborate, based on similar beliefs or values, to lobby together to take policy action (Buse et al., 2012; Heikkila & Cairney, 2018).

It is theorised that policy actors that share understandings and beliefs about a policy problem or policy solution will form 'advocacy coalitions', given that their power together is greater than as individuals (Birkland, 2016). The ACF draws on theories that individuals are 'boundedly rational', in that they are not capable of processing large amounts of information, and instead motivated by their own belief systems (Jenkins-Smith et al., 2018). The values and beliefs of policy actors are described at three different levels (Sabatier & Weible, 2007). The 'deep core beliefs' held by policymakers are proposed as very difficult to change. Deep core beliefs are more personal beliefs based on upbringing and childhood, including perspectives on equality or welfare policy. 'Policy core beliefs' are also difficult to change, though are less personal, aligning to the role and rules of government. 'Secondary beliefs' are proposed as narrower in scope, have less policy actors involved and often easier to change (Sabatier & Weible, 2007).

The framework proposes that advocacy coalitions develop strategies to influence policy, in competition with other coalitions that share different views or beliefs (Sabatier & Weible, 2007). Coalitions may form for different reasons including their own or public interests or economic incentives (Birkland, 2016). The coalitions that form because they hold an ideological position, referred to as 'purposive groups', are more likely to be better coordinated than coalitions that form based on individual economic gain (material groups) (Weible, 2005). In Australia's democratic government structure, interest groups can form and mobilise at their own will, and can 'venue-shop' to find decision-makers with authority who share their common

values and will be more likely to listen to their proposal (Birkland, 2016). Therefore, in democratic societies, coalitions are usually only limited by the resources available to them, not limited by political determinants (Birkland, 2016; Watson, 2014).

The ACF proposes that advocacy coalitions can either work together for a common goal, informally alongside one another, or compete for policy attention or influence (Buse et al., 2012). Some coalitions may only form for short term policy goals and then disband as they have no other commonalities. Coalitions will be stronger and have more influence if they include policy actors with some strategic or legal authority, have strong public support, have information available to them on the severity or cost-benefit of a solution, engage in political activist events, have financial resources available and leaders who are skilled as policy entrepreneurs (Sabatier & Weible, 2007). In democratic political environments, such as Australia, coalitions have an incentive to work together and pool allies and resources to create a bigger impact (Sabatier & Weible, 2007).

Policy-oriented learning plays a crucial role in the ACF, suggesting that individuals and coalitions are able to shift their perceptions of a policy, based on learning across coalitions, changes in policy actors, new scientific or technical information, or exchange of ideas in professional or government forums (Pierce et al., 2017). A foundation of the framework's development is the role of scientific research and technical information in the policy decision-making process (Jenkins-Smith et al., 2018).

Given humans tend to screen out information we do not believe in and take in information that confirms our position, actors within a coalition will have core values they hold and share, which confirms their policy position (Sabatier & Jenkins-Smith, 1999). Contrary to this, competing coalitions view information differently, often develop a lack of trust in one another, and can make negotiations in the policy process very challenging (Sabatier & Jenkins-Smith, 1999). It is proposed that an 'intermediate' level of conflict between policy coalitions generates opportunity for policy learning (Jenkins-Smith et al., 2018). Other factors that impact on policy learning include the level of contribution and type of information provided, the participation by diverse groups and community in decision-making processes, and the attributes of actors, such as their beliefs and network contacts (Jenkins-Smith et

al., 2018; Sabatier & Weible, 2007). Policy learning that impacts on secondary beliefs is likely to create small incremental changes to policy over a long period of time, with major policy change the result of changes in policy core beliefs (Jenkins-Smith et al., 2018; Pierce et al., 2017).

One of the assumptions of the ACF is that actors and coalitions purposely coordinate to act on their beliefs (Sabatier & Weible, 2007; Weible, 2005). This assumption is debated by other authors who argue that just because networks exist does not mean they will take action or be able to influence change (Birkland, 2016; Schlager, 1995). How coalitions form and take action might depend on the networks capacity and their level of influence (Sabatier & Weible, 2007), or it might be the case that coalitions form as they see the benefit of additional resources or influence that others can bring (Weible, 2005).

Coalitions that work cooperatively together within a subsystem, or have dominance over other groups, can maintain the policy monopoly, meaning other challenging groups are less likely to upset the status quo (Jenkins-Smith et al., 2018). This can mean that change to policy is slow, with only incremental changes. Other stable internal factors, such as government structures, also limit policy change (Sabatier & Weible, 2007). Rapid and significant policy change is most likely where there are internal shocks to the subsystem, such as policy failures, or changes in government leadership (Jenkins-Smith et al., 2018; Sabatier & Weible, 2007).

The ACF provides a strong, testable framework on which to explore the sub-systems in the policy process, with more focus on the actors involved and less so on the organisational level context (Heikkila & Cairney, 2018). Whilst primarily focussed on policy initiation, the ACF has been tested across a diverse range of topics and in conjunction with other political science frameworks and shown to be useful (Weible et al., 2009). For example, Breton et al. (2008) used the ACF to examine a case study on Quebec's Tobacco Act. The ACF proved useful to understand the policy subsystem of tobacco, acknowledging the actors involved, their values and the framing of their policy position. Payán et al. (2017) have also used the ACF to identify the actors involved in menu labelling policy in California, USA. The use of the framework assisted the authors to identify two distinct coalitions, in addition to explaining the change in actors involved throughout the policy process and the

adjustments made due to other external impacts (Payán et al., 2017). Johnson et al. (2012) also studied menu labelling policy in Washington, USA, and found similar findings of distinct coalitions with different core beliefs that ended up working together to achieve 'policy learning' and a negotiated outcome.

### 4.3.3 Punctuated Equilibrium Framework

The Punctuated Equilibrium Framework (PEF), developed by Baumgartner and Jones (1993), is interested in the policy change process, particularly how policy can be maintained for a long time and then shift rapidly, referred to as 'punctuated' (Baumgartner & Jones, 2010). The framework considers both the stability of policy and the change in policy as important (Baumgartner et al., 2018; True et al., 2007). Similar to other frameworks, the PEF considers the interaction of different policy actors in the policy process, including organisations, individuals, media, public, and political interests. One of the differences is that the framework looks at how information is processed by individuals, in particular the cognitive attention that decision-makers are able to give to information, rather than the evidence put forward to them or their values and beliefs (True et al., 2007).

The framework equally considers both political institutional structures and bounded rational decision-making as influencing policy change (Baumgartner et al., 2018). The framework suggests that issues will change their definition over time, due to public discourse on what the problem is or how the issue is framed (e.g., economic growth or human rights) (Baumgartner et al., 2018). This change in issue definition may impact policy change if policymakers change their direction of attention, or reinforce current policy positions (Baumgartner et al., 2018; True et al., 2007). The PEF assumes that policy institutions also have limited capacity to deal with lots of information at once (Baumgartner et al., 2018). However, unlike people who can only tend to one problem at a time, the framework is based on the understanding that issues are dealt with amongst policy institutions (or subsystems) in a system that allows for many issues to be addressed at once (Baumgartner et al., 2018). However, it is not until one of the issues reaches the macropolitical level that it is even considered (Baumgartner et al., 2018), or subject to significant change (True et al., 2007).

A stable political environment maintains the current policy position. As referred to in the PEF, 'negative' feedback maintains a policy position, such as organisation structures staying stable and public apathy regarding an issue (Baumgartner et al., 2018; True et al., 2007). Where multiple actors and subsystems within a policy arena support an issue or a problem's definition, often strongly connected to core political values that can be easily communicated to the public, a "policy monopoly" is formed (True et al., 2007). Abrupt policy change, on the other hand, relies on 'positive feedback' into the policy system, such as increased public or media concern or new actors that put pressure on the subsystem to create change in a punctuated way (Baumgartner et al., 2018; True et al., 2007). The use of policy images, the empirical information and emotional appeal used by policy actors, can have a powerful role in influencing policy change (Baumgartner et al., 2018). New policy images that are in disagreement with the current policy monopoly means the policy issue may rise on the policy agenda, bringing new individual and organisational actors into the process (Baumgartner et al., 2018).

Resistance to change can be the result of institutions delaying action on issues, often referred to as adding friction to the process (Baumgartner et al., 2018). Whether through an external input, or friction that creates enough pressure in an institution, some issues are able to overcome the policy stability and rise to the attention of policymakers and attract large scale change as a result (Baumgartner et al., 2018; True et al., 2007). Alternatively, small and incremental changes that impact on the subsystem can all add up until a major change is required (Baumgartner et al., 2018; True et al., 2007). Some of this can be explained by governance systems. For example, less centralised and less rigid governance systems are often able to adapt incrementally to small policy changes, avoiding the friction over time and inevitable large and disruptive policy punctuations (Baumgartner et al., 2018).

The PEF is less utilised in the healthy public policy analysis research, though a study in tobacco control over time has referred to policy processes as a result of phases, which draws on the PEF as its basis (Studlar & Cairney, 2014). Studlar and Cairney (2014) suggest that looking at the minor disruptions and incremental policy change as 'phases' in the policy process offers opportunity to analyse policy retrospectively. Given that policy change regarding health determinants is unlikely to have

'punctuated' policy change, the exploration of policy theory from a phased approach could be useful for exploring HiAP. Whilst it does not predict future policy changes, it can be helpful to conceptualise new policy phases and opportunities.

### 4.3.4 Analysis of Determinants of Policy Impact (ADEPT)

Many of the theoretical frameworks described above focus on the process of policy initiation and policy change, with implementation and evaluation often not considered. The Analysis of Determinants of Policy Impact (ADEPT) framework aims to measure the likelihood of policy outputs and policy outcomes by focussing on the capacities or determinants required to influence the implementation of policy (Rütten et al., 2013). The determining factors were a result of a study that tested if a social action theory, used to determine an individual's intention to act, could be adapted to explain policy level determinants for health promotion policy action (Rütten et al., 2013; Rütten et al., 2003).

The results of the study identified four organisational level determinants that are considered to be required for health promotion policy implementation: goals, obligations, resources and opportunities (Rütten et al., 2011; Rütten et al., 2003). The determining factors in ADEPT for policy implementation state that goals should not only exist, they should also be clear and centred on health, and consider the role of scientific information demanding the action to be taken. Obligations are considered as both the personal and/or professional obligations that decision-makers hold that influence action on an issue, or an obligation to act on behalf of the population that they represent. The resources that determine policy implementation relate to staff and whether they have the sufficient and appropriate skills, along with sufficient financial resources available and a sense of cost effectiveness of the policy action. Finally, political, public, and organisational opportunities form a determinant of policy action. Political opportunity includes the political climate, changes in administration, support from other sectors, cooperation between political levels, and lobbying for action. Public opportunity includes community and media support. Organisational opportunity includes organisational cooperation, or structural changes in the organisation (Rütten et al., 2011).

The framework has been empirically tested at various levels of government, including LG, using both quantitative and qualitative methods, for influencing policy development in negotiation with policymakers and to asses policy or 'organisational readiness' prospectively, mostly regarding the role of physical activity health promotion programs (Rütten et al., 2012; Rütten et al., 2003; Rütten et al., 2009). For example, Rütten et al. (2012) used their quantitative Likert scale tool to survey national decision-makers, from 15 different nations, on their policy goals, obligations, resources, and opportunities regarding policies for promotion of physical activity in older people. This was followed by workshops with decision-makers to share in dialogue around the results. The results were varied and therefore difficult to determine any actual cause and effect in policy development, though the authors acknowledge that the results initiated policy conversations (Rütten et al., 2012). Another study used a qualitative version of the ADEPT tool to assess organisational readiness for policy on physical activity among women in difficult life situations, finding some alignment with the determining factors within the ADEPT framework and engagement in policy (Rütten et al., 2009).

Other studies have applied the ADEPT framework to analyse existing policy implementation, to determine the successes and issues in explaining policy outcomes. For example, Trezona et al. (2018) combined the ADEPT model with another policy analysis framework to assess the extent that public policies in Victoria, Australia, prioritised and operationalised the concept of health literacy. In Botswana, the ADEPT model was used to assess the national disability policy to help explain what factors had hindered or supported the implementation of the policy since 1996 (Omotoye, 2019).

Whilst not intended as a policy theory in the political science perspective, Rütten et al. (2013) point out that the ADEPT framework has some similarities to political science frameworks. For example, the authors highlight that 'organisational opportunities' are similar to the 'policy windows' described in the MSF, and a focus on how actors and groups of actors can influence policy based on their shared values and beliefs, similar to the ACF (Rütten et al., 2013). Given the focus on influencing and analysing policy implementation and impact, the framework does make some

assumptions that policy already exists or at the very least that the policy issue is on the agenda.

## 4.4 ESTABLISHING A THEORETICAL RESEARCH LENS

> *"If anything has endured regarding the study of policy process, it has been an understanding that these phenomena are messy and that theory is necessary to help disentangle them" (Weible, 2018b, p. 364).*

There are some similarities and differences that can be drawn from the descriptive overview of these political science frameworks (Table 5). All four frameworks are a shift away from the stages heuristic cycle, have been well tested and are clear enough to test in different contexts (Heikkila & Cairney, 2018). Each framework considers the role of policy actors involved in the policy process, the values and beliefs of decision-makers, the broader political environment, and the broader public interest and support, including the role of the media, albeit in various ways and considerations. Most (all but ADEPT) clearly articulate the role of policy actors, prioritising problems and agenda raising efforts, and the role of external and major events influencing the policy process.

There are some differences in the focus and/or perspective of each of the frameworks, which gives argument to the usefulness of using more than one framework in the research design. There are many benefits to be gained from each framework. For example, the MSF and ACF are largely about policy initiation and gaining political traction. The PEF also includes this, though can be used across stages of policy to identify times of policy stability and policy changes. The ADEPT focusses, on the other hand, on the level of action once policy is decided on and follows through to see the policy impact that resulted in the policy process. The MSF is the only framework to explicitly refer to a policy entrepreneur. The ACF is focussed on evidence-base, policy learning and the role of advocacy more so than other frameworks. The PEF focusses on external events and although it gives consideration for a range of actors, this is not explicit in an empirical sense. The ADEPT focusses on resources available to implement policy and the role of professional and organisational factors, which is not so explicit in other frameworks.

It seems clear from the literature that not one political science framework is ideal, or better than the other, but instead have their own perspectives and emphasis on elements of the policy process (Buse, 2008; Cairney, 2013). There are two main considerations in the application of policy theory as a research lens to this study:

- How can the frameworks be applied to achieve the pragmatic research aim of this study?
- How can (or should) the combined constructs of the frameworks be used to draw understandings and conclusions of the local policy process?

### 4.4.1 Achieving a pragmatist approach

Political science research is interested in understanding the policy process, whereas public health researchers are interested in how to successfully influence the policy process, yet there has been limited, but arguably long overdue, collaboration between the disciplines (Gagnon et al., 2017). Research in health promotion policy remains largely naïve to the broader understandings of the policy process, which is necessary to have any practical influence on health promotion policy (Bernier & Clavier, 2011). Where policy processes are applied, the research is likely to consider policy retrospectively (Buse, 2008), tends to report on single case studies of specific issues and provides limited guidance as to how research methodology was designed (Walt et al., 2008). This was supported in the scoping literature review findings in chapter three of this thesis. Research in political science has historically been focussed on describing the policy process, using frameworks, as opposed to informing policy decisions or making future recommendations. Whilst both are important to research, there is a need to continue to explore the impacts that understanding the policy process can have, whilst maintaining the continuous improvements to the frameworks themselves (Weible, 2018b). There is a call by political science researchers to make meaning of the frameworks, not to try and minimise the constructs into one reductionist approach, but to demonstrate a better understanding of the policy process that can be communicated to appropriate audiences to be used in a practical, yet theoretically-informed way (Cairney, 2015; Weible & Cairney, 2018).

From their experiences, experts in health promotion research have advocated for policy research in the field to continue to bridge the gap between theory, research, and practice (Baum et al., 2019). Based on a range of research studies, these experts have shared insights into how policy theory can inform health promotion practice, including the use of MSF to explain interactions between the streams of policy problems, solutions, and political will, the use of the ACF regarding the formation of advocacy coalitions to continue advocacy for health promotion policy, and the PEF to emphasise the need for health promotion messages to be framed clearly and consistently (Baum et al., 2019).

Research on single issue case studies, such as physical activity, nutrition, mental health, tobacco control, or food menu labelling, have demonstrated that political science can be used to explain healthy public policy processes (Breton et al., 2008; Cairney & Yamazaki, 2017; Clarke et al., 2016; Craig et al., 2010; Johnson et al., 2012; Milton & Grix, 2015; Payán et al., 2017; Whiteford et al., 2016). It is argued that more complex health issues, such as healthy inequity, may be more difficult to explain using these frameworks given that they involve many layers of politics across different sectors (Breton et al., 2008; Smith & Katikireddi, 2013). In support of this, a systematic review found a dearth of literature that combined the concepts of health inequities and political science frameworks (Embrett & Randall, 2014). A more recent systematic review, based on all tiers of government, demonstrated a growing trend for research on HiAP to discuss at least some concepts related to policy science, although with some argument that they may not always be used appropriately, given that theories can tell us what to consider, but not always what we can do (Cairney et al., 2021).

What is clear from the review of literature in the previous chapter is the lack of application of these policy theories in empirical research at a LG level. Without clear application of the policy theories in the research design, it is difficult to identify all of the factors of the policy process involved or determine if their application is useful to help better understand a HiAP approach in LG, either in research or in practice. The aim of applying the theoretical lens to this study is not to develop a critique of whether the political science frameworks are transferable to address ‘wicked’ health issues at a LG level. The aim is to reduce the naivety of the ‘messy’ policy process

and inform audiences within the health promotion and LG fields how to better understand the policy process. It is intended that practical support in navigating the policy process will better equip these practitioners to influence policy agendas and action.

### 4.4.2 Applying multiple political science frameworks

It seems logical to utilise the combined strengths of these frameworks by increasing the empirical research that aims to apply the frameworks together (Howlett et al., 2015b). However, researchers have raised some caution over the application of multiple frameworks that must be considered. Firstly, it must be taken into account that each of the frameworks are underpinned by different theoretical foundations and therefore have different interpretations of the policy process (Heikkila & Cairney, 2018; Zohlnhöfer et al., 2016). Used appropriately, the combination of frameworks can add different perspectives to the policy process, particularly where the goal is to investigate practical insights to policy processes, rather than advancing the theoretical research agenda (Weible, 2018b). This is confirmed in the review by M. D. Jones et al. (2016) who found that authors that had applied multiple frameworks reported added strengths to their policy analysis. In their review of the literature applying the ACF, Pierce et al. (2017) report that more than half of the applications were undertaken either comparing or integrating multiple theories of the policy process. Researchers within the field of health promotion, whilst collaborating on research applying policy theories to various public health issues, agree that a single framework cannot describe all of the complexities of the policy process and that applying multiple frameworks has been helpful within their research (Baum et al., 2019).

Furthermore, Weible and Carter (2017) note that the research in public policy is so diverse, across so many different issues and disciplines and using theory in so many different ways, that addressing all of the possible factors in a policy process is ‘nearly impossible’ (Weible & Carter, 2017, p. 28). Therefore, there is a risk of trying to include too many factors that may end up providing a superficial understanding (Weible, 2018b). This is exacerbated by the likelihood that researchers outside of the discipline of political science may be applying these frameworks

without a full comprehension of the theoretical underpinnings and nuances of their creation (Heikkila & Cairney, 2018).

Given these cautions by experts within the field of political science, it is not intended to 'synthesise' and combine all of the frameworks in this study, yet to use them appropriately to describe different perspectives and constructs within the policy processes (Cairney, 2013). The frameworks outlined in this chapter will be applied to deconstruct factors of the policy process to guide the data collection methods, analysis, and interpretation of the findings. The balance of exploring the policy process from different perspectives using different frameworks, with potential risk of a superficial analysis, has been weighed up in terms of the goals of this study. The limited use of three political science frameworks and an additional policy framework based on behavioural and organisational health policy is considered a balanced approach to this potential risk. Further to this, the interpretation of the data will be analysed through the application of individual frameworks to understand the intricacy and complexity of the policy process, with the goal to be able to communicate the key aspects of the policy process to other researchers and practitioners in a meaningful, less 'messy' way. How the frameworks are applied in the research design is covered further in chapter five.

**Table 5** *Summary of each of the frameworks informing the research, including a definition and points of difference.*

| | MSF | ACF | PEF | ADEPT |
|---|---|---|---|---|
| Definition of the framework | The framework is based on three 'streams': problem, policy, and politics. It is theorised that when the streams align, a 'window of opportunity' opens. The framework includes the notion of a policy entrepreneur, working to manipulate the three streams to open a window (Zahariadis, 2007). | The framework is based on the level of influence that individuals can have on policy decisions, and that these individuals will form 'advocacy coalitions' with others that share similar values and beliefs. It is theorised that coalitions work alongside or in competition for policy attention (Sabatier & Weible, 2007). | The framework is based on policy change theory, explaining why policy often has long periods of stability or undergoes only small incremental changes, that are then 'punctuated', resulting in major policy change (Baumgartner & Jones, 1993). | The framework, adapted from a social action theory, outlines four determining factors of policy implementation, including goals, obligations, resources, and opportunities (Rütten et al., 2011). |
| Points of difference | The application has focussed on policy agenda setting (Herweg et al., 2018).<br><br>Based on system-level perspective, without clear boundaries (Heikkila & Cairney, 2018).<br><br>Emphasis is on the role of a policy entrepreneur manipulating the three streams to open a policy window (Zahariadis, 2007).<br><br>Not all of the concepts are explicitly clear and therefore may be difficult to measure (e.g., 'national mood') (Heikkila & Cairney, 2018).<br><br>There is no clear emphasis on the role of political institutions (Heikkila & Cairney, 2018). | Focus is on policy initiation and change in policy over time (Sabatier & Weible, 2007).<br><br>Policy change relies on influencing policy actor and coalition values and beliefs (Leach & Sabatier, 2005).<br><br>Point of reference is individuals or networks, and subsystems that have rules and norms (or specific issues), rather than whole systems (Heikkila & Cairney, 2018).<br><br>Best applied where a level of conflict around an issue exists (Heikkila & Cairney, 2018).<br><br>The role of institutions is less clear (Heikkila & Cairney, 2018). | Focus is on policy stability or large scale change (Baumgartner et al., 2018).<br><br>Based on system-level perspective, without clear boundaries (Heikkila & Cairney, 2018).<br><br>Articulates organisational systems influencing the policy process, referred to by Baumgartner et al. (2018) as organisational information processing.<br><br>The framework limits ability to predict when policy punctuations and shifts in attention will happen (Baumgartner et al., 2018).<br><br>Policy change requires a change in cognitive attention of decision-makers to a particular issue and solution (Leach & Sabatier, 2005) | The focus is on policy implementation and outcomes (Rütten et al., 2011).<br><br>Encompasses organisational capacities to explain policy action (Rutten 2011).<br><br>Easy to use (Rütten et al., 2012)<br><br>Directly applicable in practice (Rütten et al., 2012)<br><br>Limited to four main concepts (Rütten et al., 2011).<br><br>Can be used retrospectively and prospectively (Rütten et al., 2011). |

## 4.5 SUMMARY OF CHAPTER FOUR

This chapter has provided an overview and justification for applying theories adopted from political science to understand the policy process within the health promotion field. It has described three political science frameworks and an additional policy framework, adapted from social action, including acknowledgement of the differences they contribute to the policy process. The chapter concluded with an overview of how the theoretical lens is used to inform the research design, both justifying why multiple theories are applied and in alignment with the pragmatist approach of the research. The next chapter provides a comprehensive overview of the research design for both phases of the research.

# 5. RESEARCH DESIGN AND METHODS

## 5.1 INTRODUCTION

The previous chapters have outlined the research problem, as well as introduced the research aim and objectives for this study. This chapter provides a detailed explanation of the research design, including an outline of the research design and methods used in the two phases of the research. The chapter begins with a review of how the two phases of the research answer the research questions. The research design and associated methods are then outlined separately for each phase of the research. This includes clarity on the participants involved at each stage, data collection methods, and data analysis techniques applied.

## 5.2 RESEARCH DESIGN

This study adopts the philosophical research approach of pragmatism, acknowledging the value of theory, though in a 'real world' context that acknowledges that multiple realities may exist (Feilzer, 2010). A philosophy of pragmatism puts emphasis on the usefulness of knowledge in a particular situation or context (Morgan, 2014). A pragmatist approach utilises multiple forms of research methodologies to suit the purpose of the research inquiry, which can include quantitative and qualitative methods (Creswell, 2014; Feilzer, 2010), with a clear reasoning for combining the strengths of these research methodologies (Morgan, 2014).

There are a few reasons that a pragmatist approach has been taken. Policy theory has not been applied rigorously in health promotion research and there is limited understanding of its contribution to the field (Breton & de Leeuw, 2011). A positivist or postpositivist approach might appear otherwise logical and expected in traditional policy science research (McNabb, 2010), although it is considered potentially reductionist in this exploratory phase of research and may inadvertently miss new learnings (Creswell, 2014). Even if it is possible to apply and verify policy theory in this context, from a health promotion perspective, the possibilities for future action by practitioners and policy advocates who work with or within LG are important to this study. Therefore, whilst the research employs a policy science theoretical lens to better understand the policy process, it is not bound to it in an empirical sense. In support of a pragmatist approach, the use of theory will guide data collection and analysis, and be used to guide action to be taken (Creswell, 2014).

The research study used an explanatory, sequential mixed methods design, which is consistent with a pragmatist research philosophy (Creswell, 2014). The mixed method research design consisted of combining and integrating quantitative and qualitative research and data across two phases of the study (Creswell, 2014). The design of mixed methods started in the 1950s when researchers began collecting data using a number of different sources, albeit largely quantitative (Creswell, 2014). Over time, the integration of quantitative and qualitative data together have been recognised as useful to help explain data more comprehensively and meet a better fit for the research question (Creswell, 2014).

The first phase of the research uses largely quantitative data to attempt to better understand the current policy context within LG through a cross-sectional, online survey targeted to relevant decision-makers and operational staff across over 540 LGs in Australia. The cross-sectional survey design is useful to gauge knowledge, beliefs, and attitudes of individuals that are representative of the research population of interest (Schofield & Forrester-Knauss, 2013). Given the large sample available across a wide geographical location, a survey allowed for large numbers of respondents, in a way that is not feasible through interviews (Schofield & Forrester-Knauss, 2013). Collecting survey data first was done intentionally to gain a broad understanding of the scope of factors that influence staff and elected members in Australian LG regarding local HWB policy decisions. The national scope of the survey aimed to gauge the similarities and differences in responses across different legislative and geographical locations of councils.

However, the research design acknowledges that survey data alone is descriptive, and in this instance, does not describe the complexity of interrelationships and different contexts and circumstances where policy is applied. Therefore, discussing the survey findings with people employed or elected in LGs in Australia, in the second phase of the research, allowed a more in-depth understanding of the policymaking environment in which decisions are made. It is acknowledged that case study data are not generalisable to all other contexts, though the purpose was to further explain the inter-relationships between policy factors (Creswell, 2014).

Informing all stages of the research is a theoretical lens (outlined in chapter four), based on political science frameworks that guides the data collection, analysis, interpretation, and presentation of research findings. The use of mixed methods research, along with an overarching theoretical lens provides an opportunity in this study to be able to triangulate data at a 'concept' level between phases one and two. This use of several research methods and testing of frameworks across multiple data sets ensures greater convergent triangulation of the results (Turner et al., 2017). A visual representation of the research design, as provided in chapter one, is outlined in Figure 6. The study was approved by the Curtin University Human Research Ethics committee (SPH-88-201). Any ethical considerations are integrated in the following methods section.

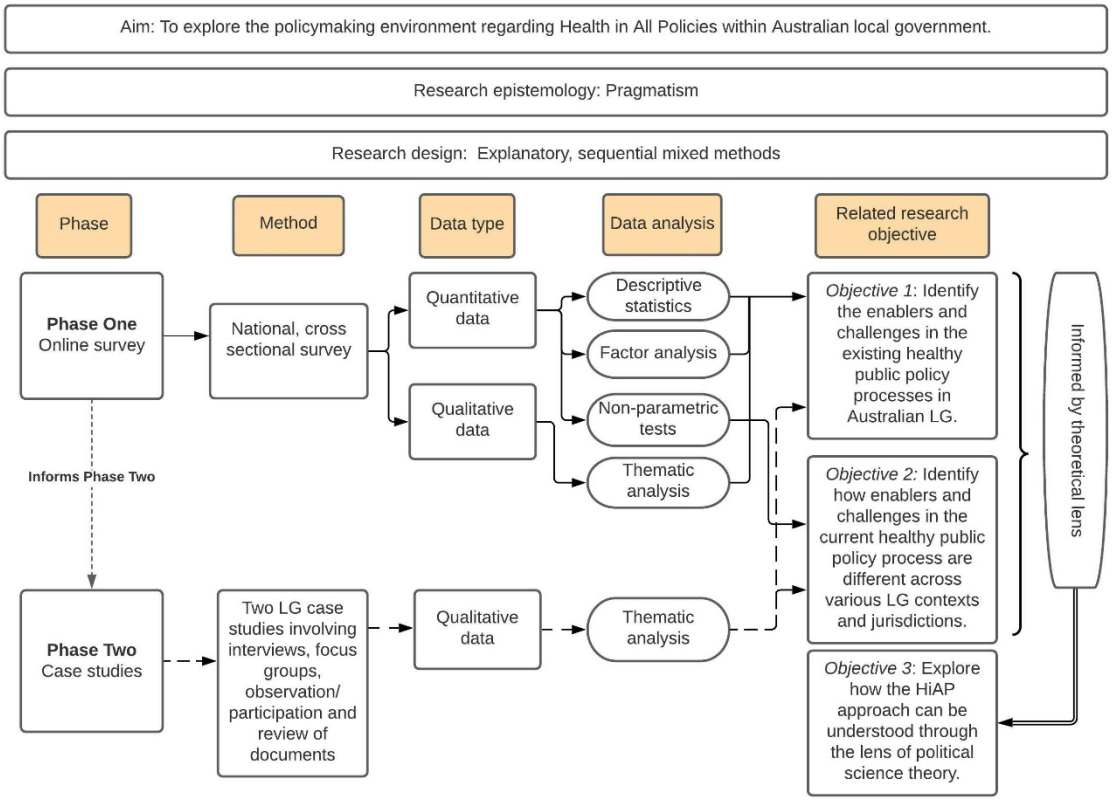


**Figure 6** *Overview of the research design, including how the phases of the mixed method approach align with the research objectives.*

## 5.3 *RESEARCH METHODS*

Having provided an overview of the research design, the following section provides a detailed description of the research methods for each phase of the research.

### 5.3.1 Phase one: National survey

Phase one of the research responds to research objectives one and two. The phase employed a cross sectional survey, administered across Australian LG as an online questionnaire. The survey was designed to establish the existing factors of the policymaking environment that is influencing policy decisions, from the perspective of elected members and staff. The methods and results for phase one are also presented in a publication in Health Promotion International (Appendix A).

#### *5.3.1.1 Participants*

The online questionnaire was distributed to policymakers within a LG context, including CEOs/Executive Managers (herein CEO), elected members and senior management staff (e.g., department directors). The survey was distributed via a personally addressed email where public information was available[4]. Alternatively, a generic council email address was used. A generic email was mostly used for contacting CEOs (57%), and less so for elected members (10%) and other staff (20%). During the process of collecting contact details, some local council areas were amalgamated, resulting in 461 CEOs, 440 mayors, 3532 elected councillors and 1636 managers across a possible 545 councils[5] receiving both initial and follow up emails. A Research Information Sheet (RIS) (Appendix D) outlining the involvement in the study was attached to the email and a link embedded in the commencement page of the online survey. Consent to participate was implied by the completion of the survey.

#### *5.3.1.2 Questionnaire design*

The questionnaire was divided into sections to distinguish between policy initiation, development, implementation, and evaluation. Each of the sections included factors related to the combined constructs of political science frameworks including Multiple Streams

[4] The process for compiling contact details was mostly completed manually, with only SA and WA contact details available for purchase, and in print only.

[5] At the time of data collection (Department of Infrastructure and Regional Development. (2017a). *Local Government:* http://regional.gov.au/local/)

(Kingdon, 1995), Advocacy Coalition (Sabatier & Jenkins-Smith, 1999), Punctuated Equilibrium (Baumgartner & Jones, 1993), and ADEPT (Rütten et al., 2011). As outlined in chapter four, these frameworks were chosen as they cover the main factors of the policy process, have been previously applied in research, and proposed as useful to health promotion policy research (Breton & de Leeuw, 2011; de Leeuw & Breton, 2013; Sabatier, 2007). An overview of how the political science frameworks informed the questionnaire are outlined in Table 6.

Previously used and/or validated research objectives were used where applicable, including domains of goals, resources and opportunities tested in the ADEPT framework (Rütten et al., 2011), and a question regarding the extent to which policymakers prioritised HWB (Robbins et al., 2013). All other factors to be investigated in the policy process were developed into closed or open-ended questions, or where feasible listed as statements on a Likert scale.

**Table 6** *A description of how the four theoretical frameworks inform the questionnaire to understand the policy process.*

| MSF | ACF | PEF | ADEPT |
|---|---|---|---|
| • Definition of HWB<br>• Understanding of health influences across policy<br>• Priority given to HWB<br>• Current HWB policy actions<br>• Influence and support of senior levels of government, including legislation<br>• Involvement of other policy actors (including media) and public opinion<br>• Presence and role of policy entrepreneurs | • Values and beliefs of policy actors in LG<br>• Support and involvement of policy actors (including media)<br>• Level of formal arrangements for different policy actors involved<br>• Level of agreement or conflict between policy actors<br>• Community involvement in decision-making<br>• Role of scientific evidence to inform policy<br>• Internal and external advocacy for HWB | • Problem 'load' and macro-level priority for HWB policy<br>• Extent of policy monitoring and feedback<br>• Existence of policy monopolies or shared interests amongst policy actors<br>• Influence of media and public interests | • Existence of goals for HWB action<br>• Personal, professional, and organisational obligations of LG decision-makers<br>• Existence of performance indicators for measuring HWB outputs<br>• Financial and staff capacity and resources |

The questionnaire tool was drafted and piloted with several LG staff within Australia, identified through personal networks. The pilot enabled a test for appropriateness of language, logical flow of questions, and time taken to administer. Some minor changes were made to the framing of language as a result of the pilot testing and relevant survey instructions were adapted for greater clarity (e.g., bolding and underlining of the stage of the policy development or implementation).

The final questionnaire included 13 overarching questions regarding LG healthy public policy processes and five demographic questions. The survey comprised 41 variables on a five-point Likert scale that sought to identify how true a range of policy constructs are perceived in councils, with others comprising of tick boxes and areas for free text. A full copy of the online questionnaire is provided in Appendix E.

#### *5.3.1.3 Data collection*

The online questionnaire, using Qualtrics[6] online software, was distributed to participants by email either in June 2015 (QLD) or May 2016 (all other states/territories). The Australian Capital Territory was not included in the study as LG services are incorporated into the territory government responsibilities. Participants were given four weeks to complete the survey, with a reminder email sent to recipients after one and three weeks. Recipients were encouraged to forward the link to the survey to other relevant LG staff, particularly those in decision-making roles. The online questionnaire was also promoted via newsletters and social media of three consenting LG associations, as the representative bodies of local governments in each state and territory.

#### *5.3.1.4 Data analysis*

The survey required both quantitative and qualitative data analysis. The quantitative survey data were analysed using three techniques. Data were firstly described using frequency and descriptive analysis, followed by further investigation of differences according to demographics of councils and participants, utilising non-parametric testing. A factor analysis was employed to reduce the number of variables that explained most of the variance in the dataset. The qualitative responses from open ended survey responses were analysed using

[6] Version 2015/2016 of Qualtrics. Copyright ©2021 Qualtrics. Qualtrics and all other Qualtrics product or service names are registered trademarks or trademarks of Qualtrics, Provo, UT, USA. https://www.qualtrics.com.

deductive and/or inductive thematic analysis depending on their intent. Each of these data analysis techniques is explained separately.

### Descriptive and non-parametric analysis

The quantitative data responses to the questionnaire were initially analysed using descriptive analysis. This included frequency data for close-ended questions, and cross tabulations based on demographic data such as geographical size of the council, location within Australian states and territories and by role of the respondent in their council. The data were then analysed for significant differences using the Kruskal Wallis *H* Test (referred to as KWt herein). The non-parametric analysis was used appropriately given there were more than two independent samples being compared, and the Likert scale data were treated as ordinal data (Corder & Foreman, 2014). The distributions of the datasets were assessed as similar across all independent samples. The results are presented using the KWt with a *H* value and *p* value set at 0.05. For all variables the hypothesis:

$H_0$= there is no variation or significant difference between groups

$H_1$= there is a significant variation between at least two of the groups

Post-hoc tests were carried out for paired comparisons, with adjusted significance according to the number of dependent variables in the groups (e.g., size of council 0.05/3).

### Factor analysis

An exploratory factor analysis (EFA) was undertaken to reduce the large number of variables into a smaller number of factors that explain and help interpret most of the data variances related to the policy process (Williams et al., 2010). An EFA, as the name suggests, is appropriate when the research is exploratory and the nature of the variables are unknown (Williams et al., 2010). Prior to conducting the factor analysis, data were subjected to a Kaiser-Meyer-Olkein (KMO) Measure of Sampling Adequacy (Kaiser, 1970) and Bartlett's Test of Sphericity (Bartlett, 1950) to determine if a factor analysis was suitable for the dataset (Howard, 2016; Williams et al., 2010). An ideal sample size for factor analysis is still debatable in research methodology design (Fabrigar, 2012; Williams et al., 2010), with participant-to-variable ratios proposed anywhere from 5:1 to 10:1 as appropriate, or samples up to at least 400 (Fabrigar, 2012). Ultimately, the sample size needs to be as large (and as relevant) as possible. For the purposes of this analysis, there were a total of 1825 available

responses to the survey. Amongst other questions, the survey questionnaire included 41 variables related to the policy process. Respondents were asked, on a five-point Likert scale, how 'true' each of these variables were to the healthy public policy process within their council. These 41 variables were included in the factor analysis. Whilst missing data across variables were not included for the purposes of the factor analysis, the sample size is considered sufficient for the purposes of analysis, with a participant-to-variable ratio of 46:1.

Principal components analysis (PCA) and principle axis factoring (PAF) are the two most commonly used factor extraction methods (Reio Jr & Shuck, 2015; Williams et al., 2010). PCA was chosen for this analysis to retain as much of the original data (the principal components) as possible, as opposed to conducting a PAF, which interpret information based on the latent structure underlying the variables (Fabrigar, 2012). Factors were extracted based on the eigenvalue being greater than one (Kaiser, 1960). However, using eigenvalue alone is not considered to be the most accurate decision-making process to decide on how many factors to retain (Fabrigar, 2012). Understanding and judgement regarding the theory underlying the research and the scree plot can also be used (Fabrigar, 2012; Reio Jr & Shuck, 2015). This was replicated as appropriate in reference to the scree plot and the researcher's judgement based on understanding of the underlying theories used for survey development. There are two major factor rotation methods, orthogonal and oblique (Reio Jr & Shuck, 2015). This analysis used oblique rotation method, promax, which allows for the variables to be correlated or uncorrelated (Fabrigar, 2012). Factor coefficients with a value less than 0.3 were excluded from the analysis as they are considered as weak in explaining the variance (Williams et al., 2010). Where coefficients extended across more than one factor, these variables were removed and the factor analysis re-run. Factors were required to have at least three variables to be retained (Reio Jr & Shuck, 2015), with coefficients stronger than 0.5, which is beyond the 0.4 factor load cut-off proposed in recent literature (Howard, 2016).

### Thematic analysis of qualitative survey data

There were two open-ended questions in the survey, with variations on how they were analysed, based on their intent. A reflexive, inductive method of thematic analysis (Braun & Clarke, 2006; Braun et al., 2019) was used for the qualitative comments in the final open-ended question (*Question 30: Is there anything related to health and wellbeing policy in local government that you would like to have the opportunity to add?).* This approach was

considered appropriate given that respondents were free to provide their commentary, opinions, and experiences on the topic, but were not bound to any particular question, and results were not bound to any particular theory (Braun & Clarke, 2006). Following the key steps in thematic analysis proposed by Braun and Clarke (2006), the qualitative responses for this question were read to become familiar with the data, making note of potential codes as the data were reviewed. Using NVivo software[7], the responses were coded, then continually reviewed to form related themes. Themes were continually revised on re-reading the data analysis, prior to writing up key findings.

Where participants were asked to list policy areas (*Question 17: What policy areas of local government do you believe have the potential for improving health and wellbeing of your community? List as many as applicable.*), the responses were deductively coded into distinct policy areas. This process resembles the coding-reliability process outlined by Braun et al. (2019), whereby data are categorised into prior themes. In keeping with this approach, the data on identified policy areas were represented as frequency counts and then later collapsed into broader policy areas, based on the experience of the researcher. In the process of deductively coding, it became apparent that participants were also reporting on a range of underpinning values and beliefs that they felt should be considered when referring to HWB policy. Therefore, in addition to the deductive process already outlined, the data were reviewed through a reflexive, inductive process allowing for alternative themes to be captured in the analysis and reporting.

### 5.3.2 Phase two: Case study

Phase two employed a case study design to further inform research objectives one and two. The aim of phase two was to further explore the interpretation of the survey findings from phase one, with greater depth and understanding to the context of LG, a recognised strength of triangulating with qualitative data (Jick, 1979). This supports holistic triangulation, which refers to the use of different data sources, where one of these provides additional insight into the other (Turner et al., 2017). Using a case study methodology allowed the research to be conducted within a single policy context to help explain the policy process and the interconnections between the variables in a '*real world context*' (Yin, 2018, p. 15). For this

[7] QSR International Pty Ltd. NVivo Versions 11 (2015) and 12 (released 2018). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

reason, case studies are an appropriate method to explore the 'how' and 'why' component of the research objectives (Yin, 2018). This is supported by the theoretical lens employed for this study, understanding the interconnection between policy actors, organisations, internal and external politics, geographical context, and fiscal resources of a LG are all likely to influencing a 'policy subsystem'. Exploring policy processes in-depth, given the complexity of their nature, requires this insight into how and why (or why not) policy decisions are made.

#### *5.3.2.1 Case study design*

The design is based on a case study within a survey (Yin, 2018). To represent more than one single context, a multiple case study design was undertaken (n=2). Although one case study site would allow for further exploration of the concepts raised in the survey, multiple case sites strengthen the theoretical and empirical findings (Tsang, 2013) and allows for the exploration of the similarities and variations in the different contexts, as raised by the initial online survey data collected in phase one (Yin, 2018). The two case study sites were both located within the same state/territory to minimise the impact of the broader political and legislative environment.

#### *5.3.2.2 Case study recruitment*

The intention of including multiple case studies was to provide viewpoints from LGs of different size, both geographically and population size. The criteria for involvement as a case study site included their previous and current interest in HWB, a willingness to be involved, along with accessibility to the researcher (Yin, 2018). The initial site was recruited through a known contact to the researcher and commenced through an invitation to be a stakeholder in a reference group for the development of a new community wellbeing policy led by the council. The site was representative of a small regional council, with a reputation of responding to social and environmental issues, along with a strong level of community engagement. Due to their interest and the convenience to the researcher, the site was formally asked through a written letter to the CEO to be involved in the research as a case study site. The site agreed to participate.

The second case study site was far more difficult to recruit. Direct email and phone contact was made with CEOs, LG staff and elected members known through extended networks in academia and by referrals from the first case study site. As a result of discussions with these networks, two of the councils were deemed unsuitable due to recent organisational instability.

Two large city councils were approached separately. A written proposal was tabled at a council meeting for one of the city councils, following discussions with management staff. This site declined to be involved. No reason was provided nor sought, given the ethical instructions that participation was voluntary. The second city council site was approached directly through a referral to the CEO. An invitation was sent to the CEO by email, requesting a discussion of their potential involvement in the research. The CEO declined the invitation, again with no reason provided nor sought. A third council was approached via professional contacts between academic colleagues and an elected member. This site was a larger regional council than the first case study site, located a short distance from the researcher, but remaining accessible. After a brief phone meeting with the site contact, a written letter was constructed for the CEO to seek approval to be a case study site. The site agreed to participate.

For anonymity and brevity, the case study sites have been given pseudonym names within the presentation of study findings. The first case study site is herein referred to as Finchville and the second case study site as Roseford.

#### *5.3.2.3 Case study data collection and analysis*

Case study research requires the use of multiple sources of data, including documents and other physical artefacts, interviews, and observations (Yin, 2018). The multiple sources of evidence provide a more in-depth analysis of the context and inferences drawn from the research process, allowing triangulation of data to provide a convincing conclusion of findings. Using multiple sources of data is a combined strength of both case study and mixed method research (Creswell, 2014; Yin, 2018). This case study research includes analysis of relevant existing policies and meeting minutes of ordinary council meetings, interviews with elected members and senior staff and focus groups with operational staff. Data collection at Finchville also included active participation within a reference group to develop a new policy, allowing for direct observation of policy decision-making processes within the LG context. An overview of the data collection methods for each of these sources of data are outlined below.

## Document analysis

### *Data collection: Document analysis*

The use of documentation as a data source in the case studies was to prepare for discussions in the interviews and focus groups, through the use of examples, as well as to retrospectively corroborate evidence raised during the collection of data from other sources (Yin, 2018). Policy documents (including plans and other strategic documents) were included in the document analysis for each case study site if they were publicly available on the website or provided voluntarily to the researcher during the interview process. Policy documents included policy, planning, and strategic documents that were current at the time of the case study research. Policies included community HWB plans, strategic plans for specific priority groups (e.g., ageing), transport, housing, social services, and sustainability. Policies not relevant to the research, including policies related to staffing and human resources, complaints and grievances, finance and accounting, privacy policy, etc., were excluded from the study.

Publicly available meeting minutes for general council meetings were also included in the document analysis. These were considered the most relevant meetings as this is where decisions were made on behalf of the case study site. The use of meeting minutes for the purposes of the research were twofold: 1. to corroborate the decision-making process around the development of the new policy in Finchville and 2. to inform if HWB was raised during decision-making on any issue. Meeting minutes were included for the time of involvement in the case study site for all data collection, which was held over six months (Finchville) and two months (Roseford), numbered chronologically over the course of the case study site research period for the purposes of analysis and reporting. Whilst it is recognised that not all of the written policy documents represent all policy perspectives or decisions, nor are all policy documents and meeting minutes written down, they were used and treated as an additional source of data in the triangulation of the findings across each case study site analysis (Harrison et al., 2017).

### *Data analysis: Document analysis*

Relevant policy documents were read and imported to NVivo. The content of the policies were analysed for both latent and manifest content (Leung & Chung, 2017). Manifest content analysis included the frequency of terms, such has ‘health’, ‘wellbeing’, and ‘health

determinants'. This was completed to gauge the extent to which these themes were explicitly referred to in each of the policy documents. Other latent themes were informed by previous research that had considered a coding framework to assess existing health policy for use of evidence and inclusion of action to address SDoH and health equity, also based on policy theory as outlined in the MSF (Fisher et al., 2015; Fisher et al., 2016). The themes chosen as relevant to this study, based on the coding framework developed by Fisher (2015), were then considered in light of the constructs of the political science frameworks to determine their alignment for data analysis and triangulation. The document analysis themes identified as useful for this study related to use of evidence, cross sector involvement, community engagement, and workforce resourcing (Fisher et al., 2015). In addition to this, a theme was adapted from Fisher (2015) to give recognition where determinants of health were raised in written policies (as opposed to SDoH and health equity specifically), as well as an adapted theme on the measure of HWB and the use of performance indicators, as opposed to recognition of SDoH within goals and objectives. The resultant themes used for analysis, including their relationship to the constructs of political science theory used for this research design, are outlined in Table 7. These latent themes were further triangulated and integrated into the interpretation of data within the case study site analysis.

**Table 7** *Themes that informed document analysis, including the relationship with theories of the policy process relevant to this research design.*

| Action within document analysis | Relationship with political science constructs |
|---|---|
| Number of times in documents that refers to 'health' or 'wellbeing' or 'health determinants' | Definition of health as a policy problem (MSF) |
| Inclusion of health determinant statements in goals/visions and objectives | Clear goals related to health (ADEPT)<br>Approach is clear (ADEPT) |
| Recognition/inclusion of determinants of health within strategies | Policy solutions and outputs (MSF) |
| Performance indicators that refer to health outcomes | Use of performance indicators (MSF, PEF, ADEPT)<br>Cost-benefit (ADEPT)<br>Policy monitoring and review (MSF, PEF, ADEPT) |
| Types of evidence used to inform action | Scientific evidence used (MSF, ACF, ADEPT) |
| Evidence of community consultation/engagement | Community is engaged (ACF) |
| Evidence of cross-sector involvement | Cross-sector involvement (MSF, ACF, PEF, ADEPT) |
| Workforce and organisational support | Leadership/commitment (ADEPT)<br>Staff capacity (ADEPT)<br>Financial capacity (ADEPT) |

### Reference group involvement (Finchville)

The opportunity to participate in a reference group for the development of a new community HWB plan allowed for additional contextual understanding of the policy development process in Finchville. The findings generate an insight into the policy development stage, as well as provide reference points and examples that support (or refute) data gathered through interviews and focus groups. According to Yin (2018) this role of 'Participation-Observation' provides an otherwise inaccessible exposure to rich data, though notes the difficulties that are inherent in playing this role as a researcher. The key challenge is potential researcher bias, along with the need for balance between being an active participant and a dedicated observer of events and perspectives going on through the process (Yin, 2018).

The purpose of the reference group was to assist the case study site to develop a new community HWB plan by providing advice and support to the plan. The membership for the reference group comprised a range of stakeholders within the broader health sector, including state and federal government and community organisation representation. The reference group met formally on three occasions over the period of four months. There was written, email communication between meetings. Once the written policy document was in its final draft format and proposed to the council, the reference group was disbanded. The reference group were advised several months later that the draft policy was being circulated for community consultation. My role on the reference group was an active participant, with expertise as a previous health promotion practitioner and current academic in health promotion. My role as a 'participant observer' was to gain insight into an example of the policy process within the council and be able to draw on this knowledge to inform the research of the case study site.

#### *Data collection: Reference group participation*

The primary sources of data collected for the purpose of the participant-observation phase of the study included meeting minutes of the reference group, observations and field notes from involvement in the reference group meetings, supporting documentation from the meeting convenors, along with the ongoing iterations of the draft policy documents. The role of participant-observer was largely that of participant, and unstructured, in that there were no pre-determined behaviours or themes to guide data collection (Mulhall, 2003).

#### *Data analysis: Reference group participation*

The theoretical constructs of the policy process were used as a guide for field notes and analysis of the data using a deductive approach. In particular, the analysis drew on the same policy factors that informed the survey around policy development. In addition, the personal perspectives and thoughts as a participant in the process provided additional inductive analysis, both informed when writing field notes and when interpreting the data post-involvement (Marvasti, 2014). The data are presented in a narrative form to explain the process of policy development from the perspective of the researcher. The data were further triangulated with the case study site analysis.

### Interviews and focus groups

Interviews are considered a key data collection source for case study sites, allowing the researcher insight into the research topic from the viewpoint of research participants (Yin, 2018). Semi-structured interviews were designed to focus specifically on the role of determinants of health in the local decision-making policy processes, through the perspectives of decision-makers in LG. Given that the determinants of health are not always well understood outside of the public health discipline, being able to discuss the topic with decision-makers was the most effective way to guide and focus this discussion meaningfully. Focus groups were arranged for non-decision-makers to be involved in sharing their opinions of how determinants of health are discussed within the policy process in council from their perspective.

#### *Participants (interviews and focus groups)*

CEOs, elected members, and strategic managers were invited to participate in an interview through a personalised email, with information regarding the importance of the study and a RIS attached for their reference (Appendix F). Non-responders were followed up with a reminder email after approximately two weeks. Participants who agreed to participate were provided an email confirmation of their interview time a week prior, with the RIS re-attached. Demographic details and agreement/consent to be involved were confirmed prior to the commencement of the interview.

Operational managers and staff employed by council in non-decision-making positions were invited to attend a focus group. Participants were invited via contacts within the case study sites. A RIS (Appendix F) was circulated with the invitation email. Participants could

respond to the invitation directly to the researcher to maintain anonymity. All participants were also asked to nominate other staff in a snowball recruitment process until a) no new names arose, b) data were considered saturated, or c) participants had previously declined participation in the study.

### *Interview schedule design*

The purpose of the interview was to further explore and interpret the factors that influence the initiation, development, and evaluation of local policies, with a particular focus on addressing determinants of health. An interview schedule and questions were developed to guide the interviewee through a process of understanding of determinants of health, along with a qualitative explanation to provide insight into the interconnectedness of different factors within the complex policy process. The questions focussed on exploring factors in the policy process where the survey data were not clear (e.g., majority of responses were '*sometimes true'*). These prompts were revised from the original interview schedule to further explore factors such as the presence of a key champion, the cooperation amongst policy actors, the role of community and lobbying efforts, the role of media, the use of evidence, the use of measurable performance indicators, and the influence of legislation (Table 8). A full copy of the interview schedule is included in Appendix G.

**Table 8** *Interview questions asked of decision-makers in the case study sites.*

1. What do you see as council's role in considering determinants of health in policy decisions?
2. To what extent are determinants of health brought up in discussions at this council?
    a. *[prompts] Who/when/why?*
    b. *Key champion*
    c. *Community demand*
    d. *Scientific evidence*
    e. *Lobbying*
    f. *Stakeholder input*
    g. *Role of media*
3. In your experience, to what extent would you say the determinants of health get integrated into different policies and plans of council?
4. What processes are in place for review of council's policies and plans?
    a. *[prompts] What do the performance indicators or reviews measure? Are they measured?*
    b. *How is the review process used to feed back into future policy changes?*
5. What impact does a change in elected members/council have on the approach or commitment to healthy public policy planning?
6. What are your views on legislating health and wellbeing as a LG role?

### *Focus group schedule design*

A focus group schedule was developed to explore the perspectives of staff on the enablers and challenges that influence LG policy to address determinants of health. Whilst staff are not involved in decisions at a council level, they are most often the driver of policy development and action. The focus group questions, for this reason, focussed on identifying their perspective of how decisions are made of what to include or not include in policy, the key enablers for determinants of health being integrated into policy and planning, as well as their views on the monitoring of policy outcomes and the potential future role of LG in actioning determinants of health. A copy of the focus group questions is outlined in Table 9. A full copy of the focus group schedule is included in Appendix H.

**Table 9** *Interview questions asked of operational staff in the case study sites*

| |
|---|
| 1. From your experience, what influences the council's policy decisions around health and wellbeing?<br>a. *[prompts] Community demand, scientific evidence, lobbying, stakeholders, media etc*<br>2. What would you say are the factors that enable council to incorporate determinants of health in local policy and planning?<br>3. What would you say are the key challenges?<br>4. In your opinion, how do you see council investing in determinants of health in the future?<br>a. *[Prompts]Why? What is the motivation for this?*<br>b. *Resources*<br>c. *Political influences* |

### *Data collection: Interviews and focus groups*

Interviews and focus groups were organised on-site at the case study sites at a convenient time. Where this was not possible, a phone interview was scheduled instead. Participants were provided with a RIS on arrival. Consent to be involved, along with documenting of demographic details, was sought in writing where possible and recorded at the commencement of each interview or focus group. The interviews took between 30 and 45 minutes each. The focus groups took approximately one hour. Once interviews or focus groups were transcribed, participants were emailed a copy of the transcript and offered the opportunity to check for accuracy and make any amendments by responding to the researcher. This process of checking was considered important, not only for verification of the information provided, but also an ethical responsibility to provide the opportunity for participants to reflect and add information they felt to be useful, or remove information they would prefer not to be included in analysis (Hagens et al., 2009).

*Data analysis: Interviews and focus groups*

Interviews and focus group data from each case study site were analysed using the thematic analysis approach of Template Analysis (King et al., 2018). Thematic analysis is based on '*identifying, organising and interpreting themes in detailed qualitative (textual) data to highlight and convey key messages'* (King et al., 2018, p. 180). Template Analysis is suitable for this study as it allows flexibility for both inductive and deductive reasoning, multiple levels of codes, and provides a guiding framework (King et al., 2018). King et al. (2018) outline the steps involved in Template Analysis as 1) familiarisation with the data, 2) preliminary coding, 3) clustering, 4) developing the initial template, 5) modifying the template, 6) defining the 'final' template, 7) using the template to interpret the data, and 8) writing up.

A within case analysis was completed for each case study site, with the data collection and analysis for Finchville being completed in full prior to beginning Roseford. All interviews and focus group audio for Finchville were manually transcribed to become familiar with the data. This supports the first step in the Template Analysis process (King et al., 2018). The transcripts were emailed to interviewees to check and feedback any amendment requests. There were no suggested changes from participants in Finchville. Each transcript was then de-identified and replaced with the role of the participant and chronologically numbered accordingly (e.g., elected member #1, elected member #2). To maintain anonymity, as per ethical considerations, the CEO interviewed is referred to as a strategic manager and mayors as elected members. Using a hard copy of the transcriptions, comments and notes were made on all documents to capture key concepts, which later became initial codes. This inductive process identified data-driven codes, developed by identifying themes across all interview transcripts at the 'level of meaning', as opposed to coding line by line (DeCuir-Gunby et al., 2011). Coding the data inductively was completed first to try and minimise any bias and ensure all data were considered in the analysis. These codes were entered into an Excel spreadsheet. It is acknowledged that prior knowledge of factors in the policy process may have influenced the decision of codes to focus on, and what to name them, though is recognised as permissible in the Template Analysis procedures (Brooks et al., 2015).

The initial coding template was then developed from a process of merging and comparing the preliminary inductive codes identified by the researcher with a list of policy theory-driven

deductive codes, identified through the political science frameworks (DeCuir-Gunby et al., 2011). There were similarities between inductive and deductive codes. This was to be expected given that the interview questions were based on political science frameworks. There was one theme retained from the inductive process, 'role of local government'. There were three codes from the inductive process integrated into other existing themes: 'events trigger policy', 'organisational stability', and 'media informs decision-makers'. All other themes and codes were consistent from both the deductive and inductive analysis of data. There were no deductive codes that were not matched by inductive codes.

The third step in the Template Analysis process is the 'clustering' stage, which involved clustering codes that were similar to a common theme to understand the possible relationship between them. The resultant themes developed from joint deductive and inductive clusters which were then cross referenced with the policy science factors identified in the theoretical lens. All codes were consistent with the theoretical lens. Initial theme names were developed, considering the inductive, deductive, and theoretical lens meanings. From this, the initial template of themes and codes were developed, the fourth stage of the process. The templates were translated from lists in Excel and documented as 'mind maps' (Appendix I). One of the advantages of using a mind map is that it is easier to identify 'lateral themes' or 'integrative themes' as the templates evolve (King et al., 2018). The integrative themes are constructs that are threaded across a number of themes (King et al., 2018).

In preparation for stage five, the initial coding template was entered into NVivo for data sorting and further analysis of all data. As interpretations and conclusions were drawn from the data, the names of the themes were updated to better reflect their overall meaning. This is consistent with stage five of the template analysis methodology to modify the template and further define and name themes (King et al., 2018). At this point, the mind maps were colour coded to reflect where enablers to the policy process were identified, red for the challenges reported, and amber where the comments conveyed mixed perceptions. This process assisted to identify broader themes and propositions during the data analysis phase, supporting an emerging conclusion as data were continually analysed (Yin, 2018). There were five versions of the template after analysing all data for Finchville. The final template resulted in nine overall themes with 29 codes. Details of the variations made to the templates are in Appendix I.

The process was repeated for the case study site of Roseford, varying only that the interviews from Roseford were all professionally transcribed, and one participant requested certain data be removed from analysis. The analysis for the second case study site commenced with the final coding template developed in Finchville. Where new data did not readily 'fit' the template themes and codes, further adjustments were made, resulting in a sixth template. This included the re-naming of a theme, removal of one code and addition of a new code (Appendix I). Six of the codes established in Finchville were not used in Roseford as there were no data that related to these.

### *Within case analysis*

The final stage in the Template Analysis is 'writing up' (King et al., 2018). The analytic technique of explanation building was used to synthesise the data for each individual case study site (Yin, 2018). This technique uses the results from the combined synthesis of data sources in the case study site, to build an explanation of the policy process using the study's theoretical lens (Yin, 2018). This process builds on the intention to use a deductive process in the form of a prior theoretical lens, though within an inductive perspective that draws on the context and understanding of each case study site (Yin, 2018). There are no strict rules to the technique of explanation building, although it is proposed that the final narrative is formed through the iterative process of making explanatory propositions, followed by cross referencing back to the case study data and comparisons of other details from the case or other case study site narratives. Yin (2018) refers to this as "*the process of refining a set of ideas*" (p. 181). To ensure the highest quality of analysis as possible, considerable attention was given to revising the data to make certain that all of the evidence had been included in the explanation building, that the analysis investigated any possible rival interpretations, and that it focussed on the theoretical lens to keep consistent with the initial research objectives (Yin, 2018).

### *Cross case analysis*

Following the analysis of data for each case study site, a cross-case analysis was undertaken (Creswell, 2012). The cross-case analysis continued the explanation building technique to compare the narratives from the analysis of each site to make inferences on what was similar across the case study sites and what was different (Yin, 2018). Through the process of explanation building in the cross-case study analysis process, several of the codes were

continually collapsed into main themes. This was due to the increasing understanding of the relationship between the codes. Given that Template Analysis has a focus on cross-case analysis, it was expected that the comparisons across case study sites would further refine the themes, acknowledging that this potentially suppresses the specificity and intricacies of each individual case study site (Brooks et al., 2015). The nine themes, including 29 codes, as represented in the final template analysis, were revised to 13 key concept themes for reporting the cross-case analysis.

### 5.3.3 Triangulation of findings

Triangulation of the different methodologies utilised in the research design requires a convergence of findings across the two phases of research. This was achieved through alignment with the aim of the research (identification of factors in the policymaking process) and informed by the theoretical lens (Figure 7).

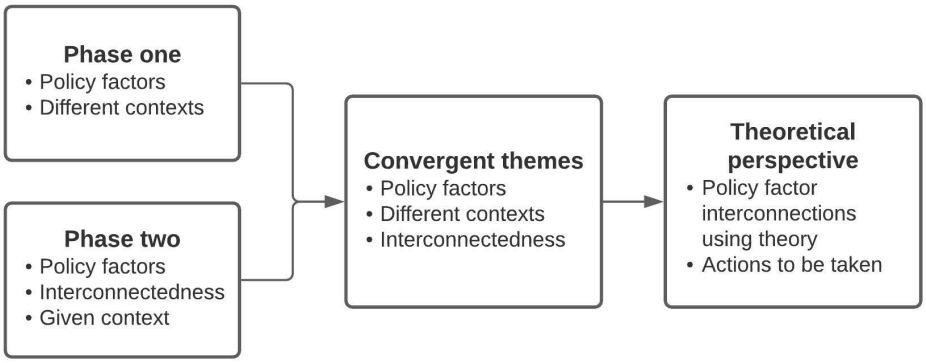


**Figure 7** *Method for triangulation of mixed methods in the research design using research aim and theory.*

## 5.4 SUMMARY OF CHAPTER FIVE

This chapter has provided a detailed overview of the explanatory, sequential mixed methods research design adopted for this study, including the research design and methods for the two phases of the research. Phase one involved an online survey administered to LG decision-makers across Australia, which included both quantitative and qualitative data for analysis. Phase two of the research involved two case study sites, collecting data from document analysis, participation and observation of a reference group, along with interviews and focus group discussions with LG staff, managers and elected members. The next chapter outlines the results for the first phase of the research, the national survey.

# 6. PHASE 1 NATIONAL SURVEY RESULTS

## 6.1 INTRODUCTION

The previous chapter provided an overview of the explanatory, sequential mixed methods research design adopted for this study. It detailed the research design and methods for the two phases of the research, including the online survey administered to LG decision-makers across Australia in phase one and the involvement of two case study sites in phase two.

This chapter presents the results of phase one of the research, a national online survey of decision-makers and staff within Australian LGs. At the time of completion of the data analysis, the survey results were summarised in an infographic and circulated to all CEOs of Australian LG (Appendix J). The preliminary survey findings for the state of Queensland were presented at a national health promotion conference in 2016, and findings from the perspective of CEOs was presented at an international health promotion conference in 2019 (conference abstracts in Appendix K). In addition, a peer review article communicating a majority of the results was published in the Health Promotion International journal in 2020 (Appendix A).

This chapter provides a more comprehensive overview of the results from the survey that inform research objectives one and two. The survey results are presented for all respondents across Australia, followed by an assessment of results comparing data across different state and territory locations, and by size (geographical remoteness) of the council. The chapter concludes with a summary of the key findings from phase one of the research outlining the enabling and challenging factors of the healthy public policy process in Australian LG.

## 6.2 NATIONAL SURVEY RESULTS

### 6.2.1 Survey respondents

There were 2008 responses to the survey. Respondents that did not start the survey or completed only the demographic questions were removed. A total of 1825 responses to the survey remained, including 243 CEOs, representing 45% of Australian councils. The respondents also included elected members, strategic and operational managers, and staff,

representing all states and territories in Australia (except ACT) and across rural, city, and regional councils (Table 10). The small number of respondents by Indigenous councils meant that these results were merged with respondents of rural councils.

**Table 10** *Demographics of respondents to national, online questionnaire.*

| **Role in local government** | |
|---|---|
| Elected member | 60.1% (*n* = 1096) |
| CEO | 13.3% (*n* = 243) |
| Strategic manager | 7.5% (*n* = 135) |
| Operational manager | 8.8% (*n* = 160) |
| Other staff | 10.5% (*n* = 191) |
| **Location by state/territory** | |
| Western Australia | 31.9% (*n* = 583) |
| New South Wales | 19.8% (*n* = 362) |
| South Australia | 15.2% (*n* = 278) |
| Victoria | 14.7% (*n* = 268) |
| Queensland | 10.6% (*n* = 194) |
| Tasmania | 6.2% (*n* = 114) |
| Northern Territory | 1.4% (*n* = 26) |
| **Geographical remoteness of LG** | |
| Rural/shire* | 41.8% (*n* = 761) |
| City | 30.6% (*n* = 556) |
| Regional | 27.6% (*n* = 502) |

*Includes five Indigenous councils

## 6.3 SURVEY FINDINGS

### 6.3.1 HWB as a priority and policy problem for LG

This section reports how respondents perceive LG currently prioritises investments in HWB and to what extent HWB is a consideration across different policy areas. This section also reports how respondents perceive their LG and community defines HWB, and how they personally define HWB.

#### *6.3.1.1 Investments in HWB in LG*

Respondents were asked to nominate, on a four-point scale from '*no priority'* to '*high priority'*, the priority their council currently gives to four policy areas relevant to LG. An example was provided for each of the policy areas to help clarify their meaning. Most

respondents reported a '*high priority'* to policy areas of urban planning (48.6%, *n* = 775), individual lifestyle programs (25.8%, *n* = 416), mental and social wellbeing (21.7%, *n* = 349), and factors outside of traditional health areas (20.4%, *n* = 327). 'Factors outside traditional health areas' were given '*no priority'* or '*very little priority'* by 32% (*n* = 511) of respondents. Respondents reported a lower level of priority for mental health and social wellbeing programs (25.7%, *n* = 312), behavioural and lifestyle programs (18.2%, *n* = 294), and urban planning and design (8.5%, *n* = 135).

The level of priority for these investments was reported as unlikely to change in the future. Respondents were asked where they predicted the priority for HWB would be over the next five years. The areas of *'high priority'* were reported as urban planning (46.3%, *n* = 629) and lifestyle programs (27.8%, *n* = 381), followed closely by mental health and social wellbeing (25.8%, *n* = 353), and factors outside traditional 'health' areas (25.1%, *n* = 343).

#### *6.3.1.2 Health as a consideration in other policy areas*

Respondents were asked to what extent HWB was considered in seven relevant policy areas (e.g., housing), on a five-point scale from '*never*' to '*always*'. Policies related to sport and recreation, healthcare, and urban planning were more likely to have HWB considered (Table 11). Nearly 5% (*n* = 74) reported '*always'* considering HWB across all seven listed policy areas that were applicable, and approximately one-fifth (19%, *n* = 342) indicated either *'always'* or *'most of the time'* considering HWB across all policy areas listed. Respondents were more likely to report HWB '*always*' or '*most of the time'* considered in sport and recreation policies (81%, *n* = 1194), followed by healthcare (65%, *n* = 889), urban planning (63%, *n* = 892), economic development (53%, *n* = 770), housing (51%, *n* = 706), energy and sustainability (50%, *n* = 707), and transport (50%, *n* = 690). Approximately 90% (*n* = 1329) of respondents reported that HWB was *'always'* or *'most of the time'* considered in the development of at least one of the listed policy areas. No respondents indicated *'rarely'* or *'never'* considering HWB across all policy areas.

##### Differences by state or territory

There was little difference in responses from across Australia, although respondents from NT and QLD were less likely to report that their council *'always'* or *'most of the time'* considered

health across all the listed policy areas, including housing, transport, economic development, energy and sustainability, sport and recreation, urban planning, and healthcare.

### Differences by rurality

Respondents within city councils (28.6%, *n* = 122) were most likely to report that their council *'always'* or *'most of the time'* considered health within all of the listed policy areas, including housing, transport, economic development, energy and sustainability, sport and recreation, urban planning, and healthcare. This was followed by respondents of rural (24%, *n* = 145) and regional areas (18.8%, *n* = 73).

#### *6.3.1.3 HWB as a priority for councils*

Respondents were asked to indicate where addressing HWB fell amongst all other council priorities, on a ten-point scale from *'not a priority'* to *'high priority'*. Of all respondents, 65.8% (*n* = 1149) indicated a seven or above, including 68.3% of CEOs (*n* = 160). When prompted for where respondents personally felt that HWB should fall as a priority, 82.6% (*n* = 1437) reported a seven or above (Figure 8).

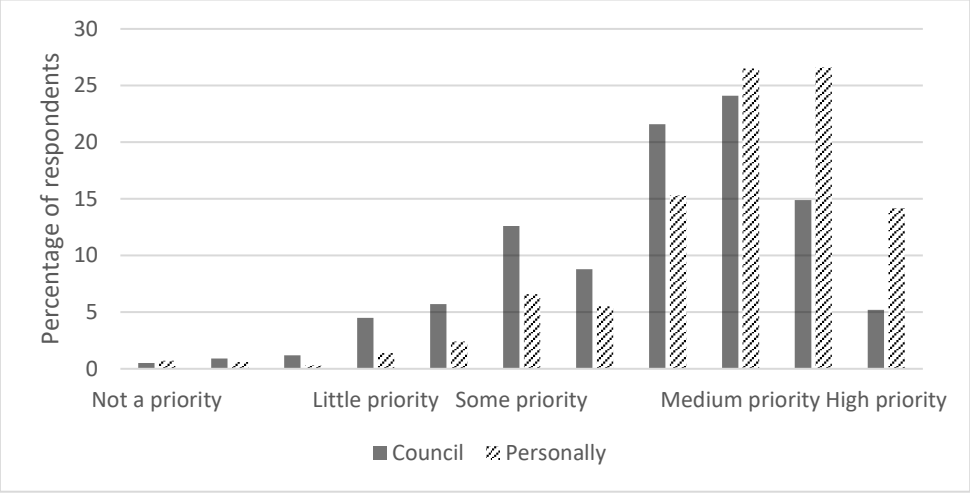


**Figure 8** *Priority of HWB as perceived by survey respondents for their council (n = 1748) and where they feel it should personally be a priority (n = 1741).*

### Differences by state or territory

Respondents from Victoria reported a higher priority of HWB for their council compared to other state/territories. There was a significant difference between states and territories (*H* = 38.345, *p* = 0.00). Post-hoc tests demonstrate a significant difference between Victoria and QLD (*p* = 0.000), SA (*p* = 0.001) and NSW (*p* = 0.001). WA was also more likely to report

HWB as a higher priority compared to QLD respondents ($p = 0.001$). Data from CEOs ($n = 234$) suggest no difference in reported level of priority across different states and territories ($H = 11.696$, $p = 0.069$).

#### Differences by rurality

Respondents of rural and city councils reported a higher priority for HWB by their council compared to respondents of regional councils ($H = 9.332$, $p = 0.009$). Post hoc tests show a significant difference between city and regional councils ($p = 0.031$) and rural and regional councils ($p = 0.015$).

#### *6.3.1.4 Definition of the policy problem*

Respondents were asked to choose from a list of four definitions of HWB, to indicate how they perceived their council defined HWB, how they personally defined HWB, and how their community defined HWB. The four definitions ranged from managing disease by individuals taking responsibility of their lifestyles, through to a broader socio-ecological definition of HWB to include social and economic influences (Table 11).

**Table 11** *List of definitions of' health and wellbeing' within the survey.*

| |
|---|
| Health is about being free from or managing a disease. It is up to individuals to take responsibility for their lifestyle choices. |
| Health is about being free from or managing a disease. It is up to individuals to take responsibility for their lifestyle choices. The built and social environment also plays a role. |
| Health is being not only free from disease, though a complete state of physical, mental and social wellbeing. |
| Health is being not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environments, family, individual circumstances and socioeconomic position. |

Of all respondents, 58.1% ($n = 984$), reported that their council adopted the broadest definition of HWB , and only 6.4% ($n = 109$) reported that their council defined HWB as being up to individuals to take responsibility for their own health. When offered to include an *'other'* definition, several respondents ($n = 58$) took the opportunity to further document their opinion or justification of their response, samples of which are below.

> *"I don't think council really defines HWB at all from a community perspective. I believe local government sees health as a State and Federal Govt responsibility."*
>
> [QLD, Regional, Elected member]

*"Why would a local council have a definition of health and wellbeing?"*

[WA, City, Elected member]

*"I am sorry since when does a council look after anyone's health. (Name of council) is very active in developing parks and sporting grounds for the physical health of our residents. Definitely NOT looking after their health that a doctor would normally do"*

[NSW, Regional, Elected member]

*"Council definition does not include disease but does include fitness, a healthy lifestyle through diet, physical exercise and social activities. Built environment and outdoor natural settings play a large role to how health is viewed in this Shire. Disease and mental health as well as root issues of poor lifestyle choices are often ignored."*

[WA, Regional, Other staff (Environmental health)]

When respondents were asked how they personally defined HWB, a larger majority (72.3%, $n$ = 1215) indicated it was of the broadest definition stated in the survey. Few respondents reported it was up to individuals to take responsibility for their health (6.1%, $n$ = 103).

*"My definition aligns with the last dot point, however does include the individual's responsibility for lifestyle choices. There needs to be appropriate education to allow informed choices in better lifestyle options, and perhaps it needs some form of recognition, reward, or indeed penalty, for those lifestyle choices. There is a significant amount of information currently available, yet so many take no notice."*

[QLD, Regional, Elected member]

*"Health is involved in everything that a council does, because it affects the physical and emotional health and well-being of all its residents, ratepayers and visitors to the city or region."*

[SA, City, Elected member]

There were mixed responses for how respondents reported their community defined HWB. The majority (39.2%, *n* = 654) reported that the community define HWB as the broadest definition. Comments by respondents (*n* = 63) suggest that the definition of HWB by the community is unknown.

> *"I couldn't possibly know what 71000 people define as health and wellbeing"*
>
> [WA, City, Elected member]

> *"Our community consultation feedback reflects individual wants and needs"*
>
> [SA, Regional, Elected member]

> *"Varies within the community"*
>
> [NSW, Rural, CEO]

#### Differences by state or territory

Most respondents reported that their council define HWB as the broadest definition, regardless of their state/territory. There was a significant difference reported across states/territories regarding how councils define HWB ($H = 25.950$, $p = 0.000$) and how respondents personally define HWB ($H = 27.556$, $p = 0.000$). Victorian respondents were more likely to report that their council define HWB more broadly than respondents in QLD ($p = 0.000$), NSW ($p = 0.009$) and WA ($p = 0.014$) and were more likely to personally define HWB more broadly than respondents in WA ($p = 0.000$), QLD ($p = 0.010$), SA ($p = 0.006$) and NSW ($p = 0.009$).

#### Differences by rurality

Regardless of the size of council, a majority of respondents reported that their council adopted the broadest definition of HWB, including 65.3% of city respondents (*n* = 331), 55.8% of rural respondents (*n* = 401) and 53.1% of regional respondents (*n* = 246). When respondents were asked how they personally defined HWB, a large majority indicated it was of the broadest definition stated in the survey, including respondents from city (76.5%, *n* = 384), regional (72.3%, *n* = 331), and rural areas (69.4%, *n* = 496).

### *6.3.1.5 Understanding of HiAP*

When asked an open-ended question on what local government policy areas impact on HWB, respondents most commonly reported the built environment (40%, *n* = 473) and community

development (34%, *n* = 406). Of all responses, 6.5% (*n* = 75) indicated that *'all policies impact'*.

> *"Our whole reason for existence is improving the HWB of our communities. So simply – EVERYTHING"*
>
> [NT, Rural, CEO]

> *"In all areas of policy making there should be an element of health and wellbeing taken into consideration"*
>
> [Victoria, City, Elected member]

An outline of the codes related to these and other policy areas are summarised in Table 12.

**Table 12** *Policy areas reported as having the potential for improving HWB of the community, reported by proportion and number of respondents coded to each area (n = 1178).*

| Policy area | Inclusions in policy area | % (n) |
|---|---|---|
| Built environment | Includes facilities; urban planning; town planning; infrastructure; asset management; facility maintenance | 40% (473) |
| Community development | Community development; community social plans and events; community cohesiveness; working with or supporting other community organisations; safety; volunteering | 34% (406) |
| Sport and recreation | Sporting and recreation facilities; programs | 34% (400) |
| Individual HWB | HWB plans; specific strategies and/or health issues to address e.g., drugs, domestic violence, mental health | 25% (302) |
| Natural environment | Includes nature reserves; bushland management; parks, gardens, and open space planning | 24% (286) |
| Lifestage planning | Includes specific plans for population groups along the lifespan, including children, youth strategies, age friendly communities, aged care facilities | 18% (212) |
| Transport | Includes active transport where specified as this; roads; traffic management | 16% (190) |
| Medical health services | Includes health services and infrastructure; immunisation | 15% (181) |
| Arts and culture | Includes cultural diversity; reconciliation plans; libraries and arts and cultural events | 14% (168) |
| Public / environmental health | Includes waste management; animal management; disaster management; air; water; risk management | 12.5% (148) |
| Economic development | Includes employment; creating economic opportunities for the community | 12% (141) |
| Governance | Includes overarching plans, e.g., community plan, strategic plan; financial governance | 11% (133) |
| Housing | Includes housing infrastructure, affordability, and social housing | 9.5% (113) |
| Sustainability and environment | Sustainability; recycling; climate change | 8.5% (100) |
| All policies | Reference to ‘all policies’ as a response | 6.5% (75) |
| Education | Investment in education, schools, and school retention | 4% (47) |
| Communication and information technology | Includes internet access and speed, information sources and community information services | 2.5% (32) |
| Disability, access, or social inclusion | Policies of disability, access and/or social inclusion | 2% (25) |
| Tourism | Tourism | 1% (15) |

In addition to these policy areas, there were other themes that related to the understanding of HWB from a socio-ecological perspective. These themes were unexpected, although very relevant to the understanding of HWB from an equity and social justice perspective, and therefore were analysed separately. Of the respondents, 11% ($n$ = 129) made statements related to inclusiveness, equity, or supporting marginalised and vulnerable groups. Others drew on strengths, highlighting the need for respect of diverse population groups and ensuring an equal opportunity for all.

*"Councils need to support the most disadvantaged by leading by example on diversity, racism, violence against women, disability and other programs"*

[Victoria, Regional, Elected member]

The role of community engagement or community consultation was also reported by 7.5% (*n* = 88) respondents. Most of the statements included the single terms of 'engagement' or 'consultation', though a few elaborated further to demonstrate the importance within a health policy context.

*"Policy in this area should always involve the community/rate payers."*

[WA, Rural, Staff]

*"Examining different ways of getting the local Indigenous population involved in council decisions & policy"*

[WA, Rural, Elected member]

There were 4% (*n* = 47) of respondents that used the opportunity of this question to highlight their beliefs that health should be the responsibility of other levels of government. Of these respondents, a third reported that health could be a responsibility of LG, though is not adequately resourced to do so.

*"Health is not a local government issue and should not be considered as such"*

[NSW, Regional, Elected member]

*"Health is a state government responsibility and failure to provide adequate resources to regional and rural area leaves the local council out of pocket to provide services that they shouldn't need to. E.g medical centres, Dr's housing etc."*

[NSW, Rural, CEO]

Improved coordination amongst government and non-government organisations that can deliver services and programs was also a common theme raised by 3% (*n* = 37) of respondents.

*"Ensuring all levels of government work together without blockers to manage a localised problem"*

[SA, Regional, Strategic manager]

*"Often poor socio-economic issues and Indigenous health issues are beyond the resources of council to target and so needs to be an active partner with other bodies and organisations."*

[NSW, Regional, CEO]

### 6.3.2 Factor analysis

This section reports the results of a factor analysis undertaken including all Likert scale responses within the survey. There were a large number of possible variables in the policy process responded to within the survey. The factor analysis was undertaken to identify variables that were similarly responded to, that might explain most of the variation in the dataset. This further exploration of the data informs research objective one, exploring the influencing factors in the policy process.

Respondents were asked to identify how 'true' a range of factors were in their council, related to the consideration of HWB in the policy process. There were 41 variables included, to identify the factors that explained most of the variances within the data. The Kaiser-Meyer-Olkein of 0.960 and Bartlett's Test of Sphericity significance at 0.000 indicates that the dataset was suitable for a factor analysis (Howard, 2016). The factor analysis resulted in four key factors over 30 variables. An additional variable, the presence of a key champion, was removed during the factor analysis process, though later reinstated within the policy subsystem factor as it was considered an essential component of one of the frameworks informing the research. The four key factors were assigned titles that best represented their collective factor and checked with supervisors for consensus. The factors included *policy subsystem* (16 variables), *partnerships and actors* (7 variables), *resources and capacity* (4 variables), and *policy initiators* (4 variables) (Table 13).

There were ten variables removed during the process of the factor analysis, mostly as they spanned several factors, rather than weighting high on any single factor. Most of these variables related to the role of community, which overlapped with weighting against the

policy subsystem, including *'The community is involved in decision-making'*, *'The community supports the councils approach to health and wellbeing'*, *'The community is engaged effectively in implementing action*', *'Community demand the action',* and *'Community supports action'.* Other variables were also overlapping across more than one factor, including *'Staff provided with knowledge and skills necessary for implementation',* '*Formal collaborative partnerships are established for health and wellbeing',* and *'The local political climate supports health and wellbeing of the community'*. Variables related to the media were exclusive, though with only two variables were not considered sufficient to create another factor. These included variables *'Media supports the action'* and *'The media supports the council's approach to health and wellbeing'.* All variables excluded from the factor analysis are considered in the results separately.

#### *6.3.2.1 Factor 1: Policy subsystem*

The variables within this factor were related to internal leadership, cooperation, and systems that support the initiation, implementation, and monitoring of HWB policy in councils. This is allocated the factor title of 'policy subsystem'. Many responses within each of the 16 variables in this factor reported statements as *'definitely true'* or *'mostly true'* (Table 13). This included that their council have a clear commitment to HWB (60%, $n$ = 824), strong support and leadership within council (56%, $n$ = 773), sufficient evidence available to support council decisions (55.8%, $n$ = 779), and that considering the costs, the benefits made it worthwhile (60%, $n$ = 816). This was supported by respondents reporting it *'definitely true'* or *'mostly true'* that there is sufficient cooperation within council when both developing (54%, $n$ = 764) and implementing HWB policy (56%, $n$ = 762) and that the staff agree on action to be taken (55.1%, $n$ = 822). Elected members were significantly more likely to report that there was sufficient internal cooperation than other roles ($p$ = 0.000), except CEOs.

A majority of respondents also reported it *'definitely true'* or *'mostly true'* that various HWB strategies and/or activities are implemented (59.1%, $n$ = 810), that the approach to HWB is clear in the policy (53.3%, $n$ = 745), and that the actions centre on improving the HWB of the community (58.8%, $n$ = 822). CEOs and elected members were significantly more likely to report action as centred on improving HWB of the community than strategic managers ($H$ = 12.676, $p$ = 0.013). In addition, respondents reported it *'definitely true'* or *'mostly true'* that there is ongoing monitoring and review of policy in council (58.7%, $n$ = 800), and that policy

reviews consider HWB impacts (51.2%, $n = 696$), though less likely to report that the goals for HWB are concrete enough (47.3%, $n = 661$) or that the council uses performance indicators to measure HWB impacts (41%, $n = 562$). Respondents were also less likely to report that it was *'definitely true'* or *'mostly true'* that there was a key champion for HWB in the council (46%, $n = 692$) or that current lobby action exists for HWB within the council (30.4%, $n = 424$) (Table 13).

### Differences by state or territory

Respondents from Victoria were more likely to report the legislative environment as supportive ($H = 18.211$, $p = 0.006$), though only significantly more than NSW and QLD respondents. The respondents from locations where mandated public health plans exist or were being introduced (e.g., Victoria, SA, and WA) were more likely to report leadership from higher levels of government ($H = 31.928$, $p = 0.00$), though only more than respondents of QLD. There were differences in reports of leadership by other tiers of government ($H = 13.464$, $p = 0.036$), although the only post hoc adjusted significance was Victoria reporting leadership as more true than NSW respondents. This result was consistent with results for CEOs. When only analysing the responses from CEOs ($n = 205$) regarding views of a favourable legislative environment, no significant difference exists between states/territories ($H = 3.896$, $p = 0.691$). Regardless of legislative environment, CEOs report a clear council commitment to action on HWB policy ($H = 3.765$, $p = 0.708$) (Table 14).

### Differences by rurality

Across the variables related to this factor, respondents of city councils were more likely to report factors as true than both rural and regional respondents. Data from CEOs of city councils were consistent, with CEOs more likely to report sufficient cooperation within their council during development of HWB policy ($H = 10.354$, $p = 0.000$), compared to both regional ($p = 0.008$) and rural ($p = 0.02$) council CEO respondents. CEOs of city councils were more likely to report cooperation within their council during implementation of policy ($H = 7.523$, $p = 0.023$), though only compared to regional respondents ($p = 0.024$). CEOs of city councils reported it true that HWB strategies are implemented ($H = 14.017$, $p = 0.001$), significantly more than regional ($p = 0.001$) and rural CEOs ($p = 0.02$) (Table 15).

#### *6.3.2.2 Factor 2: Partnerships and actors*

The variables within this factor were related to the external cooperation with, and support from other sectors and higher tiers of government. These were collectively named as 'partnerships and actors'. Across the seven variables, less than half of respondents reported the statements as *'definitely true'* or *'mostly true'* (Table 13). This included the existence of strong leadership from other levels of government in initiating HWB policy (29%, $n = 434$) and a favourable legislative environment for HWB action (33%, $n = 444$). Respondents reported a low level of cooperation and support amongst stakeholders, particularly with other tiers of government. Less than half of respondents reported it was *'definitely true'* or *'mostly true'* that there was support from other sectors when either developing (41%, $n = 574$) or implementing HWB policy (40%, $n = 546$), cooperation between public and private organisations (34.2%, $n = 478$), cooperation between different political levels involved during HWB policy development (29.7%, $n = 415$), or during HWB policy implementation (28.9%, $n = 393$) (Table 13).

##### Differences by state or territory

Across all seven variables, respondents from Victoria were more likely to report factors as true, at least more than one of the other states/territories. The only exception was WA respondents who were more likely to report cooperation between different political levels involved during policy implementation, though only moreso than SA respondents ($p = 0.047$) (Table 14).

##### Differences by rurality

There was little to no differences in responses between city, rural, and regional respondents related to leadership or cooperation from other levels of government and other sectors when developing policy, or cooperation between public and private organisations. There were some differences in other sector support during implementation of actions, with city respondents considering this more true than regional respondents ($p = 0.002$). However, fewer respondents in Victorian city councils, compared to their regional counterparts, reported that it was true that there was cooperation between political levels ($p = 0.032$) and cooperation between public and private organisations ($p = 0.031$). Although this was not the case for city councils in SA, where legislation also exists and cities were significantly more likely to

report cooperation between different political levels, than rural counterparts ($p = 0.001$) (Table 15).

#### *6.3.2.3 Factor 3: Resources and capacity*

The four variables in the survey related to staff and financial capacity to develop and implement policy are included in this factor, titled 'resources and capacity'. Across all four variables, less than half of respondents reported that it was *'definitely true'* or *'mostly true'* that staff or financial capacity exists in their council to develop and implement HWB policy, including staff capacity to develop HWB policy (38%, $n = 527$), staff time and capacity to implement actions (36.7%, $n = 501$), the financial resources to develop HWB policy (22%, $n = 303$), or financial resources to implement policy actions (22%, $n = 312$) (Table 13). Elected members were more likely to report that there was staff capacity to develop ($H = 58.237$, $p = 0.000$) and implement policy ($H = 27.886$, $p = 0.000$) than all other roles ($p < 0.05$). Elected members were also more likely to report there was financial capacity for development of HWB policy ($H = 24.177$, $p = 0.000$), significantly more than CEOs and strategic managers ($p = 0.002$, $p = 0.003$ respectively), and more than CEOs when considering the implementation of HWB policy ($p = 0.05$) (Table 13).

##### Differences by state or territory

There were mixed responses regarding financial capacity. Most respondents from all states and territories rated the two variables on financial capacity for both development and implementation of policy as *'sometimes true'* or *'rarely true'*. There was a significant difference in financial resources being sufficient for development of policy ($H = 26.177$, $p = 0.000$), with respondents of Victoria, WA, and TAS more likely to report they have the financial resources than QLD. When considering the financial resources available when implementing policy, there was no difference when comparing pairwise post-hoc testing between states and territories (Table 14).

##### Differences by rurality

Across all four variables, respondents from city councils were more likely to report staff and financial capacity to develop and implement HWB actions. This is consistent with data from CEOs across Australia. CEOs from cities were more likely to report it true that staff capacity exists for HWB development, compared to their rural and regional counterparts ($p = 0.000$, $p = 0.000$ respectively). CEOs representing city councils also are more likely than regional and

rural council CEOs to report financial resources to develop ($p = 0.000$, $p = 0.000$ respectively) and implement HWB policy ($p = 0.000$, $p = 0.000$ respectively). This remained the case within the legislative environments of Victoria and SA. Compared to rural councils in Victoria, respondents from city councils reported it more true that there was staff ($p = 0.006$) and financial capacity ($p = 0.001$) to develop HWB policy and staff and financial capacity for implementation ($p = 0.000$, $p = 0.001$ respectively). Respondents from city councils in SA also reported it more true than rural councils that there was staff capacity to develop policy ($p = 0.005$), and more true than both rural and regional councils that there was staff capacity to implement policy ($p = 0.000$, $p = 0.000$ respectively). City council respondents in SA reported it more true than both rural and regional counterparts that there is financial capacity to develop policy ($p = 0.001$, $p = 0.002$ respectively), and implement policy ($p = 0.000$, $p = 0.000$ respectively) (Table 15).

#### *6.3.2.4 Factor 4: Policy initiation*

This factor includes variables related to personal, professional, and organisational obligation to do something about HWB. It also includes the demand from scientific evidence to initiate HWB policy. Most respondents reported these variables as *'definitely true'* or *'mostly true'*, including that the council is obliged to the community to act (70%, $n = 1043$), that they felt a personal obligation to do something in the field (68%, $n = 1020$), that the action is part of professional duties (66%, $n = 981$), and that scientific results demand the action (53.2%, $n = 788$) (Table 13). There were no significant differences when comparing responses across roles in council for variables related to organisational obligation ($H = 6.177$, $p = 0.186$), part of professional duties ($H = 4.531$, $p = 0.339$), or demand from scientific evidence ($H = 2.320$, $p = 0.677$). Elected members were more likely to report a higher personal obligation ($H = 14.291$, $p = 0.006$), though only significant in comparison to other non-management staff ($p = 0.035$) (Table 13).

##### Differences by state or territory

There was no significant difference between states/territories in post-hoc testing for the variable of personal obligation to do something in the field. Across the other three variables, respondents from Victoria were more likely to report factors as true, at least more than one of the other states/territories (Table 14).

#### Differences by rurality

Across all four variables, respondents from city councils were more likely to report variables as true than their rural and/or regional counterparts (Table 15).

#### *6.3.2.5 Other variables*

This section reports the results of variables that were excluded from the four main factors. There were mixed responses regarding the role of the community. A majority of respondents reported it was *'definitely true'* or *'mostly true'* that the community supports the approach to HWB (54.4%, $n = 759$), that the community supports the action (55.2%, $n = 751$), and that community demands the action (52.8%, $n = 788$). There were less respondents who felt that it was *'definitely true'* or *'mostly true' that* the community was involved in decision-making (42.4%, $n = 592$) and that the community were engaged effectively in implementing action (40.7%, $n = 555$). Elected members were more likely to report that community are involved in decision-making compared to all other roles ($H = 9.897$, $p = 0.042$), significantly different to strategic managers ($p = 0.017$). Less than half of the respondents reported that it was *'definitely true'* or *'mostly true'* that media support the action (38.2%, $n = 518$) or support the council's approach to HWB (37.6%, $n = 521$). Less than half of the respondents also reported that it was *'definitely true'* or *'mostly true'* that staff are provided with the necessary skills and knowledge to implement HWB in policy (49.6%, $n = 674$), that formal partnerships were established (44.5%, $n = 606$), and that the local political climate supports HWB of the community (48.5%, $n = 679$) (Table 13).

#### Differences by state or territory

Analysis of variables related to media showed no differences in responses between states and territories for *'media supports the action'* ($H = 8.162$, $p = 0.226$) or '*media supports the council's approach to HWB*' ($H = 9.883$, $p = 0.130$). For the variables related to the role of the community, there were no differences in '*community demands the action'* ($H = 4.331$, $p = 0.632$) or *'the community supports the council's approach'* ($H = 12.785$, $p = 0.047$). Analysis of all other variables related to community indicated a few differences in responses between states/territories, including community being involved in decision-making ($H = 17.630$, $p = 0.007$), community engaged in implementing action ($H = 17.655$, $p = 0.007$), and community supporting the approach ($H$=13.180, $p = 0.040$). Post hoc pairwise testing shows that respondents from WA were more likely to indicate the variables as true, though only

significantly different when compared to the respondents of QLD ($p = 0.008$, $p = 0.002$, $p = 0.020$ respectively). Respondents from Victoria were more likely to report having formal partnerships established ($H = 34.042$, $p = 0.000$), significantly different when compared to respondents from WA ($p = 0.000$), NSW ($p = 0.000$), QLD ($p = 0.000$) and SA ($p = 0.001$). Victorian respondents were also more likely to report that it is true that staff are provided with skills and knowledge ($H = 14.375$, $p = 0.026$), though only significantly different when compared to respondents of QLD ($p = 0.005$) (Table 14).

### Differences by rurality

There were no differences in responses between different geographical location of councils for 'media supports the action' ($H = 3.567$, $p = 0.168$) or 'media supports the council's approach to health and wellbeing' ($H = 0.345$, $p = 0.842$). For the variables related to the role of the community, there were no reported differences in community demand for HWB ($H = 1.215$, $p = 0.545$). Respondents of city and rural councils were more likely to report it as true that community are involved in decisions around HWB ($H = 20.272$, $p = 0.000$), that the community is engaged in implementation of action ($H = 14.607$, $p = 0.001$), community supports the action ($H = 14.901$, $p = 0.001$), and approach to HWB ($H = 19.123$, $p = 0.000$) than regional counterparts ($p < 0.05$). Respondents of city councils were more likely than regional and rural council respondents to report that staff are provided with skills and knowledge ($p = 0.000$), and that formal collaborative partnerships are established ($p = 0.000$). Cities were also more likely than regional counterparts to report the local political climate as supportive for community wellbeing than regional respondents ($p = 0.012$) (Table 15).

**Table 13** *Responses to each of the 31 variables that explained most of the variance in the data, explained across four factors.*

| | Definitely true | Mostly true | Sometimes true | Rarely true | Not true at all |
|---|---|---|---|---|---|
| *Factor 1: Policy subsystem* | | | | | |
| Staff agree on what action needs to be taken to address HWB *(n = 1492)* | 12.5% | 42.6% | 34.1% | 7.9% | 2.9% |
| The approach to HWB is clear in the policy *(n = 1399)* | 17.0% | 36.3% | 32.2% | 10.6% | 3.9% |
| The goals for HWB are concrete enough *(n = 1398)* | 10.1% | 37.2% | 32.8% | 15.6% | 4.4% |
| The actions centre on improving the HWB of the community *(n = 1398)* | 19.5% | 39.3% | 28.8% | 9.9% | 2.4% |
| There is sufficient cooperation within the council during development of policy *(n = 1403)* | 14.1% | 40.4% | 30.6% | 10.9% | 3.9% |
| There is current lobby for action on HWB within council *(n = 1398)* | 8.4% | 22.0% | 33.5% | 25.0% | 11.1% |
| There is sufficient evidence available to support council decisions *(n = 1397)* | 15.1% | 40.7% | 30.1% | 11.0% | 3.1% |
| There is strong support and leadership from within council *(n = 1367)* | 20.3% | 36.3% | 27.4% | 11.0% | 5.1% |
| Various HWB strategies and/or activities are implemented *(n = 1370)* | 19.9% | 39.2% | 31.2% | 7.5% | 2.2% |
| There is clear council commitment *(n = 1368)* | 23.9% | 36.4% | 27.3% | 8.8% | 3.5% |
| There is sufficient cooperation within my council during implementation of policy *(n = 1367)* | 14.8% | 41.0% | 29.0% | 10.8% | 4.5% |
| There is ongoing monitoring and review of policy in council *(n = 1362)* | 22.0% | 36.7% | 25.0% | 12.2% | 4.1% |
| Policy reviews consider HWB impacts *(n = 1360)* | 17.7% | 33.5% | 29.7% | 13.8% | 5.2% |
| Council uses performance indicators to measure HWB impacts *(n = 1362)* | 15.3% | 26.0% | 27.5% | 20.6% | 10.6% |
| Considering cost-benefits, action to address HWB is worthwhile *(n = 1364)* | 24.0% | 35.9% | 25.2% | 10.0% | 4.9% |
| There is a key leader/champion in HWB in our council *(n = 1494)* | 18.1% | 28.2% | 29.2% | 15.9% | 8.6% |
| Factor 2: Partnerships and actors | | | | | |
| There is strong leadership from other levels of government to act *(n = 1491)* | 7.4% | 21.8% | 38.2% | 24.3% | 8.2% |
| There is support from other sectors when developing policy *(n = 1400)* | 6.7% | 34.4% | 41.4% | 14.6% | 2.9% |
| There is cooperation between different political levels involved during policy development *(n = 1398)* | 4.1% | 25.6% | 42.2% | 21.8% | 6.2% |
| There is cooperation between public and private organisations *(n = 1398)* | 4.7% | 29.5% | 43.3% | 18.7% | 3.8% |
| There is support from other sectors when implementing actions *(n = 1361)* | 6.4% | 33.8% | 42.0% | 14.2% | 3.6% |

| | Definitely true | Mostly true | Sometimes true | Rarely true | Not true at all |
|---|---|---|---|---|---|
| There is cooperation between different political levels involved (during policy implementation) *(n = 1359)* | 4.2% | 24.7% | 41.9% | 22.7% | 6.6% |
| The legislative environment is favourable for HWB action *(n = 1361)* | 5.7% | 27.0% | 40.5% | 20.7% | 6.1% |
| *Factor 3: Resources and capacity* | | | | | |
| The council has the necessary staff capacity to develop HWB policy *(n = 1401)* | 8.9% | 28.8% | 30.0% | 21.6% | 10.7% |
| There are sufficient financial resources to develop HWB policy *(n = 1403)* | 5.1% | 17.2% | 30.3% | 31.8% | 15.6% |
| The council has the staff time and capacity to implement actions *(n = 1365)* | 8.6% | 28.1% | 36.0% | 19.4% | 8.0% |
| There are sufficient financial resources to implement actions *(n = 1366)* | 4.7% | 17.6% | 29.4% | 32.0% | 16.3% |
| *Factor 4: Policy initiation* | | | | | |
| Personally I feel obliged to do something in the field *(n = 1492)* | 32.1% | 36.3% | 23.1% | 5.8% | 2.7% |
| The action is part of my professional duties *(n = 1490)* | 33.8% | 32.1% | 21.7% | 6.9% | 5.6% |
| Scientific results demand the action *(n = 1482)* | 21.7% | 31.5% | 34.0% | 8.7% | 4.0% |
| The council is obliged to the community to act in this area *(n = 1497)* | 31.3% | 38.3% | 23.2% | 5.1% | 1.9% |

**Table 14** *Results of Kruskal-Wallis non-parametric testing (H value), including pairwise post hoc testing between all states and territories (p = < 0.05).*

| | Kruskal Wallis *H* | *p value* | Post-hoc test ($p < 0.05$) |
|---|---|---|---|
| *Factor 1: Policy subsystem* | | | |
| Staff agree on what action needs to be taken to address HWB *(n = 1492)* | $H = 12.162$ | $p = 0.058$ | - |
| The approach to HWB is clear in the policy *(n = 1399)* | $H = 47.377$ | $p = 0.000$ | VIC more than WA, NSW, and QLD<br>SA more than QLD |
| The goals for HWB are concrete enough *(n = 1398)* | $H = 56.818$ | $p = 0.000$ | VIC more than WA, SA, NSW, and QLD<br>WA and SA more than QLD |
| The actions centre on improving the HWB of the community *(n = 1398)* | $H = 43.491$ | $p = 0.000$ | VIC more than NSW, QLD, WA, and SA<br>WA more than QLD |
| There is sufficient cooperation within the council during development of policy *(n = 1403)* | $H = 41.681$ | $p = 0.000$ | WA, SA, VIC, NSW, and TAS more than QLD |
| There is current lobby for action on HWB within council *(n = 1398)* | $H = 20.830$ | $p = 0.002$ | VIC more than QLD, NSW, and WA |
| There is sufficient evidence available to support council decisions *(n = 1397)* | $H = 19.432$ | $p = 0.003$ | VIC more than QLD |
| There is strong support and leadership from within council *(n = 1367)* | $H = 21.667$ | $p = 0.001$ | VIC, WA, and SA more than QLD |
| Various HWB strategies and/or activities are implemented *(n = 1370)* | $H = 33.323$ | $p = 0.000$ | VIC more than QLD, NSW, and WA |
| There is clear council commitment *(n = 1368)* | $H = 29.521$ | $p = 0.000$ | VIC more than QLD and NSW<br>WA and SA more than QLD |
| There is sufficient cooperation within my council during implementation of policy *(n = 1367)* | $H = 21.017$ | $p = 0.002$ | WA, SA, VIC, NSW, and TAS more than QLD |
| There is ongoing monitoring and review of policy in council *(n = 1362)* | $H = 27.793$ | $p = 0.000$ | VIC more than QLD and NSW<br>SA and WA more than QLD |
| Policy reviews consider HWB impacts *(n = 1360)* | $H = 28.280$ | $p = 0.000$ | VIC more than QLD and NSW<br>SA and WA more than QLD |
| Council uses performance indicators to measure HWB impacts *(n = 1362)* | $H = 52.602$ | $p = 0.000$ | VIC more likely than WA, NSW, QLD, SA, and TAS |
| Considering cost-benefits, action to address HWB is worthwhile *(n = 1364)* | $H = 9.212$ | $p = 0.162$ | - |
| There is a key leader/champion in HWB in our council *(n = 1494)* | $H = 31.066$ | $p = 0.000$ | VIC more than WA, SA, NSW, and QLD |

| | Kruskal Wallis *H* | *p value* | Post-hoc test ($p < 0.05$) |
|---|---|---|---|
| *Factor 2: Partnerships and actors* | | | |
| There is strong leadership from other levels of government to act *(n = 1491)* | $H = 31.928$ | $p = 0.00$ | VIC, WA, and SA more than QLD |
| There is support from other sectors when developing policy *(n = 1400)* | $H = 19.229$ | $p = 0.004$ | VIC more than QLD, NSW, and SA |
| There is cooperation between different political levels involved during policy development *(n = 1398)* | $H = 27.248$ | $p = 0.000$ | VIC and NT more than QLD and SA |
| There is cooperation between public and private organisations *(n = 1398)* | $H = 14.686$ | $p = 0.023$ | - |
| There is support from other sectors when implementing actions *(n = 1361)* | $H = 19.229$ | $p = 0.004$ | VIC more than QLD, NSW, and SA |
| There is cooperation between different political levels involved (during policy implementation) *(n = 1359)* | $H = 21.010$ | $p = 0.002$ | WA more likely than SA |
| The legislative environment is favourable for HWB action *(n = 1361)* | $H = 18.211$ | $p = 0.006$ | VIC more than NSW and QLD |
| *Factor 3: Resources and capacity* | | | |
| The council has the necessary staff capacity to develop HWB policy *(n = 1401)* | $H = 22.879$ | $p = 0.001$ | VIC and WA more than QLD |
| There are sufficient financial resources to develop HWB policy *(n = 1403)* | $H = 26.177$ | $p = 0.000$ | VIC, WA, and TAS more than QLD |
| The council has the staff time and capacity to implement actions *(n = 1365)* | $H = 18.307$ | $p = 0.006$ | Vic and WA more than QLD |
| There are sufficient financial resources to implement actions *(n = 1366)* | $H = 19.153$ | $p = 0.004$ | - |
| *Factor 4: Policy initiation* | | | |
| Personally I feel obliged to do something in the field *(n = 1492)* | $H = 15.053$ | $p = 0.02$ | - |
| The action is part of my professional duties *(n = 1490)* | $H = 31.410$ | $p = 0.00$ | VIC more than WA and SA |
| Scientific results demand the action *(n = 1482)* | $H = 34.966$ | $p = 0.00$ | VIC more than WA, QLD, and SA |
| The council is obliged to the community to act in this area *(n = 1497)* | $H = 28.161$ | $p = 0.000$ | VIC more than WA, QLD, SA, and NSW |

**Table 15** *Results of Kruskal-Wallis non-parametric testing (H value), including pairwise post hoc testing between different remoteness of council (p = < 0.05).*

| | Kruskal-Wallis *H* | *p value* | Post-hoc test ($p < 0.05$) |
|---|---|---|---|
| *Factor 1: Policy subsystem* | | | |
| Staff agree on what action needs to be taken to address HWB *(n = 1492)* | $H = 14.133$ | $p = 0.001$ | City more than rural and regional |
| The approach to HWB is clear in the policy *(n = 1399)* | $H = 11.596$ | $p = 0.003$ | City more than rural and regional |
| The goals for HWB are concrete enough *(n = 1398)* | $H = 15.032$ | $p = 0.001$ | City more than regional |
| The actions centre on improving the HWB of the community *(n = 1398)* | $H = 9.957$ | $p = 0.007$ | City more than regional |
| There is sufficient cooperation within the council during development of policy *(n = 1403)* | $H = 14.359$ | $p = 0.001$ | City and rural more than regional |
| There is current lobby for action on HWB within council *(n = 1398)* | $H = 2.024$ | $p = 0.363$ | - |
| There is sufficient evidence available to support council decisions *(n = 1397)* | $H = 10.087$ | $p = 0.006$ | City more than regional |
| There is strong support and leadership from within council *(n = 1367)* | $H = 10.858$ | $p = 0.004$ | City and rural more than regional |
| Various HWB strategies and/or activities are implemented *(n = 1370)* | $H = 56.986$ | $p = 0.000$ | City more than rural and regional |
| There is clear council commitment *(n = 1368)* | $H = 17.751$ | $p = 0.000$ | City more than rural and regional |
| There is sufficient cooperation within my council during implementation of policy *(n = 1367)* | $H = 16.735$ | $p = 0.000$ | City more than regional |
| There is ongoing monitoring and review of policy in council *(n = 1362)* | $H = 15.032$ | $p = 0.001$ | City more than regional |
| Policy reviews consider HWB impacts *(n = 1360)* | $H = 14.703$ | $p = 0.001$ | City more than rural and regional |
| Council uses performance indicators to measure HWB impacts *(n = 1362)* | $H = 37.031$ | $p = 0.000$ | City more than rural and regional |
| Considering cost-benefits, action to address HWB is worthwhile *(n = 1364)* | $H = 30.381$ | $p = 0.000$ | City more than rural and regional<br>Rural more than regional |
| There is a key leader/champion in HWB in our council *(n = 1494)* | $H = 17.710$ | $p = 0.000$ | City more than rural and regional |
| *Factor 2: Partnership and actors* | | | |
| There is strong leadership from other levels of government to act *(n = 1491)* | $H = 5.455$ | $p = 0.065$ | - |
| There is support from other sectors when developing policy *(n = 1400)* | $H = 4.912$ | $p = 0.086$ | - |
| There is cooperation between different political levels involved during policy development *(n = 1398)* | $H = 5.681$ | $p = 0.058$ | - |
| There is cooperation between public and private organisations *(n = 1398)* | $H = 0.329$ | $p = 0.849$ | - |

| | Kruskal-Wallis *H* | *p value* | Post-hoc test ($p < 0.05$) |
|---|---|---|---|
| There is support from other sectors when implementing actions *(n = 1361)* | $H = 11.866$ | $p = 0.003$ | City more than regional |
| There is cooperation between different political levels involved (during policy implementation) *(n = 1359)* | $H = 5.681$ | $p = 0.058$ | - |
| The legislative environment is favourable for HWB action *(n = 1361)* | $H = 14.367$ | $p = 0.001$ | City more than rural and regional |
| *Factor 3: Resources and capacity* | | | |
| The council has the necessary staff capacity to develop HWB policy *(n = 1401)* | $H = 39.925$ | $p = 0.000$ | City more than rural and regional |
| There are sufficient financial resources to develop HWB policy *(n = 1403)* | $H = 71.931$ | $p = 0.000$ | City more than rural and regional |
| The council has the staff time and capacity to implement actions *(n = 1365)* | $H = 81.197$ | $p = 0.000$ | City more than rural and regional |
| There are sufficient financial resources to implement actions *(n = 1366)* | $H = 111.491$ | $p = 0.000$ | City more than rural and regional |
| *Factor 4: Policy initiation* | | | |
| Personally I feel obliged to do something in the field *(n = 1492)* | $H = 9.827$ | $p = 0.007$ | City more than rural |
| The action is part of my professional duties *(n = 1490)* | $H = 26.420$ | $p = 0.000$ | City more than rural and regional |
| Scientific results demand the action *(n = 1482)* | $H = 63.022$ | $p = 0.000$ | City more than rural and regional<br>Regional more than rural |
| The council is obliged to the community to act in this area *(n = 1497)* | $H = 8.474$ | $p = 0.014$ | City more than regional |

### 6.3.3 Qualitative responses

This section reports on the responses to the final open-ended question in the survey. At the end of the questionnaire respondents were asked "*Is there anything related to health and wellbeing policy in local government that you would like to have the opportunity to add?*"**.** Of the 414 comments, a majority were from WA respondents (*n* = 117), followed by NSW (*n* = 76), SA (*n* = 66), VIC (*n* = 66), QLD (*n* = 43), TAS (*n* = 30) and NT (*n* = 8). The respondents represented councils from rural (*n* = 170), regional (*n* = 112) and city (*n* = 124) areas. The data were themed inductively, with two key themes identified: 1) lack of broader political support and 2) financial limitations. These two themes are further elaborated on below. Additional themes are summarised in Appendix L.

#### *6.3.3.1 Lack of broader political support*

Respondents (*n* = 80) wrote of a lack of cooperation with other tiers of government, a sense that other tiers of government were more responsible for HWB, the impact by decisions made of other tiers of government and the tension that LG are left to 'pick up the pieces'. One of the subthemes was the lack of cooperation with higher tiers of government. Many of these respondents were from SA, WA and VIC. It is noted that these are amongst the respondents most likely to respond to the survey, though also the states where there was existing legislation for municipal public health planning (SA, VIC) or being introduced (WA) at the time of the survey. There were a range of comments related to the need for greater role clarity and cooperation between tiers of government and departments to be able to achieve greater efficiency in delivery of HWB outcomes.

> *"Areas of responsibility between Federal, State and local Government are often blurred and sometimes crossover results in inefficient duplication"*
>
> [WA, Regional, Elected member]

> *"We need to work with all three levels of Government to set our goals on public health and then make sure each level is aware of its role and is properly funded to do so ….."*
>
> [SA, City, Elected member]

Another sub theme was related to the sentiment that HWB is the responsibility of higher tiers of government. This was at times referred to as the delivery of healthcare services, particularly amongst respondents from rural and remote areas, though also from a holistic HWB point of view.

> *"….there is tension in the community as to why local government has to be involved in these areas when state government should be taking the prime responsibility."*
>
> [WA, City, CEO]

#### *6.3.3.2 Lack of financial and staff capacity*

Related to the theme above, respondents ($n$ = 92) noted the importance of a range of HWB roles that LG can have, either voluntarily or because they are bound by legislation. The comments suggest considerable tension that the commitment is not met with the financial resources required at a local level. The comments demonstrated the limited funding revenue that LGs have, met with high infrastructure and maintenance costs for mandated responsibilities of these councils, particularly in rural areas and large geographical councils where the costs of roads, bridges, footpaths, and other necessary built infrastructure are high. In addition, respondents spoke of the reliance on short term grants from higher tiers of government, which often leaves them to take on the long-term costs to sustain community action. Many of the respondents also included the lack of staff capacity and expertise to be able to deliver action on HWB.

> *"Small rural shires have very limited resources and capacity whilst being in ideal positions with their communities to implement health and wellbeing plans."*
>
> [WA, Rural, CEO]

> *"Many health and wellbeing initiatives are established through seed funding from the Australian and NT Governments. However this funding is very rarely for long-term programs and the programs generally fall over unless local government takes on the fall funding."*
>
> [NT, City, CEO]

## 6.4 KEY FINDINGS

The factors influencing policy on health and wellbeing in local government are summarised below as enabling and challenging factors. The factors related to community engagement and support were considered as neither enabling or challenging. A summary of how these factors align to the four theoretical frameworks used in this study are outlined in Appendix M.

**Key research findings from phase one**

***Enabling factors:***

- Respondents reported a **strong policy subsystem** within council and possible initiators of local policy such as **organisational, professional and personal obligation to act**.
- **HWB was defined broadly**, recognising a wide range of policy areas that could influence HWB.
- HWB was identified as a **priority** for councils. Many personally believed it should be a higher priority.
- Respondents reported a **professional duty to act** for community HWB.
- Respondents reported **strong local leadership**.
- Respondents reported **council commitment** for HWB
- There was **sufficient internal cooperation** for the development and implementation of HWB policy. This is consistent with results for **staff agree on action to be taken**.
- Respondents reported that **HWB goals are concrete enough**.
- Respondents reported that **actions centre on HWB of the community**.
- It was considered that there was **sufficient evidence** to support decision-making.
- A majority of respondents reported that **scientific results demand action**.
- There is **ongoing monitoring and review of policies** that **consider HWB impacts**.
- The approach is considered **cost-effective**.
- **City council respondents were more likely to report all enabling factors as true** for their council, except the broad definition of HWB, which was consistent across all council types. Respondents from **rural councils were also more likely than regional councils** to report HWB as a priority, strong local leadership and community supporting the approach.
- There were **few significant differences between respondents of different states or territories**. Respondents from VIC were more likely to report a professional obligation to act, sufficient evidence and that evidence demands the action, though not moreso than all other states/territories. The states where legislation for HWB exists, including WA, SA, and VIC, were more likely to report strong leadership and council commitment, though only moreso than QLD.

***Challenging factors:***

- Results indicate a **lack of partnerships and collaboration across sectors**, as well as **limited resources and capacity** for action.
- The **legislative environment** was not perceived as supportive.
- Health was reported as a **responsibility of higher tiers of government**, including in regional and rural areas that are responding to gaps in healthcare service provision.
- A majority reported a **lack of leadership from higher tiers of government**.
- Many reported a **lack of external cooperation with higher tiers of government** during policy development and implementation.
- There was a **lack of cooperation with other sectors**.

- A **key champion for HWB was absent** according to most respondents.
- Less than half of the respondents reported that **formal partnerships** were established.
- There is **limited lobby action** for HWB within council.
- A majority reported a **lack of media support** for councils' approach and action to HWB.
- **Use of performance indicators** was lacking.
- **Staff and financial resources** were reported as limited.
- Less than half of the respondents reported that **staff are provided with the necessary skills and knowledge** to implement HWB in policy.
- Respondents of **city councils were more likely to report factors as true**, including staff having the necessary skills and knowledge, community involved, having a key champion, using performance indicators, having staff and financial resources, a supportive legislative environment, and cooperation with other sectors. **Rural councils** were also more likely to report community involvement than regional counterparts.
- Respondents from the **state of Victoria** were more likely to report a supportive legislative environment, key champion, formal partnerships, the use of performance indicators, lobby action, and cooperation with other sectors.
- The **states with existing legislation** for HWB, including Victoria, WA, and SA, reported a stronger level of leadership from higher tiers of government, though only moreso than QLD.
- Victoria and WA reported more staff resources than other states/territories, and Victoria, WA, and TAS more financial resources. The level of resourcing remained a challenge for all states/territories and no difference for policy implementation.

***Factors less clear as enablers or challenges:***

- A majority reported that the **community support the approach** and action taken for HWB and approximately half felt that **community demand the action**. Many reported a **lack of community involvement** in decision-making and implementation of action.

## 6.5 SUMMARY OF CHAPTER SIX

This chapter provided an overview of the results of the national online survey that represents phase one of the research. Results demonstrate that most LG staff and elected members have a holistic understanding of HWB and indicate it is a medium to high priority for their council. The factor analysis highlights four main factors that explain much of the HWB policy process in LG. Factors likely enabling the policy process include the *strong policy subsystem* that comprises variables related to organisational systems and policy monitoring, and the *policy initiators* such as personal and organisational obligations. Factors likely challenging the HWB policy process include the limited cooperation with *partnerships and policy actors* such as cooperation between different political levels and other sectors, as well as the *insufficient resources and capacity* required such as staff and financial resources.

There were few variances in the responses between councils located across different states and territories. However, city councils were more likely to report variables as favourable than their regional and rural counterparts. The next chapter elaborates further on these themes within two case study site contexts, which represents phase two of the research.

# 7. PHASE 2 CASE STUDY SITE RESULTS

## 7.1 INTRODUCTION

The previous chapter outlined the results of a national survey, with respondents from across all states/territories (except ACT). The survey results found that most LG staff and elected members have a broad understanding of HWB and perceive it as a medium to high priority for their council. The factor analysis highlighted four main factors that explain much of the HWB policy process in LG. Factors likely enabling the policy process include the *strong policy subsystem* that comprises variables related to organisational systems and policy monitoring, and the *policy initiators* such as personal and organisational obligations. Factors likely challenging the HWB policy process include the limited cooperation with *partnerships and policy actors* such as cooperation between different political levels and other sectors, as well as the *insufficient resources and capacity* required such as staff and financial resources. There were few variances in the responses between councils located across different states and territories. However, city councils were more likely to report variables as favourable than their regional and rural counterparts.

This chapter presents the results for phase two of the research design, including two case study sites. The case studies further explore the findings of the survey and investigate the inter-relatedness of factors in the policy process in a given context, responding to research objectives one and two. The chapter begins with an introduction to both case study site contexts. An in-depth analysis of the results is then presented for the case study sites. This includes the analysis of documents, involvement in the reference group for the first case study site, and the interviews and focus group data for both sites. A full summary of the separate results for each case study site were presented back to each council CEO (Appendix N).

## 7.2 CONTEXT

The two case study sites were councils located within the one state/territory where legislation for HWB does not exist beyond the traditional health protection measures (e.g., food safety). Finchville is a small, regional council with wide geographical

diversity, from coastal suburbs to hinterland townships. It is located within 150 km of a major city. It consists of a population of approximately 50,000 people, with slow population growth, and an ageing population. The population has a lower level of Aboriginal and Torres Strait Islander people, or people born overseas, compared to the national average. The region has a similar rate of unemployment compared to Australia. Employment is based on tourism, retail, and healthcare. The median income is substantially lower than the national average and continues to be a cause of concern for the area, particularly with the increasing costs of living and lack of affordable housing in the region. The population is highly engaged in volunteer and social activity, demonstrating higher volunteer rates than the national average. The region has long held core values regarding environmental protection, and this continues to be a shared vision for the local community and council alike.

Roseford is a large regional council with a wide range of different townships, from coastal suburbs to rural towns, located sparsely over a large geographical area. It has a population of approximately 100,000 people, with population growth similar to the national average. The population consists of a higher-than-average representation of Aboriginal and Torres Strait Islander persons, a lower-than-average population born overseas, and a higher-than-average population over the age of 65 years. The region has a high unemployment rate and a high level of disadvantage. Employment is based on education, retail, and hospitality services. The median household income is considerably less than the national average. The population has a slightly lower level of volunteerism compared to the national average.

## 7.3 Document analysis

### 7.3.1 *Inclusion of policy documents*

In Finchville, there were four policy documents publicly available and reviewed prior to the interviews. This included the corporate plan, along with social, transport and economic strategic plans. During the interviews, another written policy of interest was raised and later included in the policy review, resulting in five total documents included in the analysis. In Roseford, there were seven policy documents publicly available and reviewed prior to the interviews. This included the corporate

plan, along with economic, technology, culture, youth, and sustainability strategic or operational plans.

### 7.3.2 *Manifest themes*

The documents were analysed for both manifest and latent data. The manifest data included how many times terms such as 'health', 'wellbeing', and 'health determinants' were explicitly incorporated into the plan. The manifest data are outlined for both sites in Table 16.

**Table 16** *The number of times terms are reported in written policies for each case study.*

| | 'health' | 'wellbeing' | 'health determinants' |
|---|---|---|---|
| **Finchville** | | | |
| Corporate plan | 3 | 1 | 0 |
| Social strategy | 20 | 11 | 0 |
| Transport strategy | 1 | 0 | 0 |
| Economic strategy | 17 | 3 | 0 |
| Social justice strategy | 1 | 1 | 0 |
| **Roseford** | | | |
| Corporate plan | 1 | 0 | 0 |
| Economic strategy | 15 | 0 | 0 |
| Sustainability plan | 4 | 6 | 0 |
| Culture strategy | 2 | 5 | 0 |
| Youth strategy | 3 | 6 | 0 |
| Smart Communities plan | 2 | 1 | 0 |

In Finchville, most references to health were within the social and economic strategies. The references to health in the social strategy mostly referred to health services, mental health, or other health related risk factors. There were some instances where the term was framed from a positive 'health and wellbeing' perspective. The references to health in the economic plan were predominantly related to the priority of the health and wellness sector to create employment. There is no reference to employment being a determinant of health. Reference to the term 'wellbeing' was mostly found in the social strategy, referring to both individual and community wellbeing perspectives.

In Roseford, most references to the term 'health' were in the economic strategy. These were mostly in relation to the growing healthcare services required in the future, given the ageing population in the region. Similarly, in the youth strategy, the

term ‘health’ referred to mental health services. The term ‘health’ in the sustainability plan was broadly referring to the health of the local economy, environment, and workplaces. The culture strategy had references to the health benefits of arts and culture, particularly focussed on aged care, disability facilities, and mental health programs. The term ‘wellbeing’ was mostly referred to in the youth and sustainability strategies. The youth strategy was referring to a range of programs, particularly to promote healthy lifestyle choices to enhance wellbeing. The sustainability strategy referred to the wellbeing of the environment, as well as the people, with reference to social wellbeing and social equity, though indicated through strategies related to healthy lifestyle choices. The cultural strategy referred to fostering and improving community wellbeing through investment in the arts.

### 7.3.3 *Latent themes*

Latent themes were identified in policy documents, with the purpose to inform discussions with case study participants and to triangulate the interpretation of data within the case study site analysis. The themes were determined by an adapted framework used in a previous study, as outlined in chapter five. An additional theme was added, with regard to reference of the legislative environment, as this had become increasingly important through the survey findings. The themes identified as relevant to this study and the results of each case study site are outlined below in Table 17.

**Table 17** *Latent themes and examples from analysis of policy documents within the two case study sites.*

| Finchville | Roseford |
|---|---|
| **Inclusion of health determinant statements in goals/visions and objectives** | |
| • Some statements refer to ‘safe’, ‘happy’, or ‘healthy’ communities<br>• Terms related to achieving community wellbeing through wellness<br>• Social strategy recognised that living circumstances impacted individual and community wellbeing | • Youth strategy included reference to wellbeing of young people, with a focus on crime and drug education |
| **Recognition/inclusion of determinants of health within strategies** | |
| • Referred to in social and transport plans<br>• Examples include reduce social isolation, affordable housing, design of built environment, accessible play spaces, increasing social capital, response to domestic violence, addressing unemployment, and access to active and sustainable transport | • Referred to in all plans except culture strategy<br>• Examples included planning for job growth, accessible transport, employment, accessibility to services, social equity, cultural awareness/safety and security and quality natural environments |

| | |
|---|---|
| **Performance indicators that refer to health outcomes** | |
| • No performance indicators<br>• Some broad visionary statements that reflect long term goals<br>• Three of five policies refer to monitoring and evaluation<br>• Refer to annual reviews and adaptation of strategies over time<br>• Reference to monitoring data sources (e.g., Australian Bureau of Statistics) over time<br>• No specific monitoring for population health | • Performance indicators in corporate, economic, and Smart Communities plans<br>• No performance measures explicitly related to health benefits<br>• Five of the seven policies refer to policy reviews<br>• Reference to general review processes, measures of achievement based on short- and long-term trends in data<br>• No specific monitoring for population health |
| **Types of evidence used to inform action** | |
| • Population demographic data<br>• Health related data on disease and risk factors<br>• Reviews/feedback from previous council strategic plans | • Population demographic data<br>• Community consultation |
| **Evidence of community consultation/engagement** | |
| • Community input explicit in two of five plans<br>• Social strategy reports a highly engaged community, with willingness to formalise in a multi-sector partnership<br>• Plans referred to organised public workshops and online forums<br>• Community input included contact with elected members | • Community input explicit in six of seven plans<br>• Stakeholder feedback explicitly in youth strategy<br>• Consultations in the form of ambassadors, workshops, surveys, and advisory groups with community and stakeholders |
| **Evidence of cross sector involvement** | |
| • Recognition of need to partners with range of stakeholders including business, commercial industry, government, and not-for-profit sector<br>• Advocacy efforts acknowledged with state government (e.g., transport)<br>• Explicit acknowledgement of the obligation to community wellbeing, regardless of decisions by higher tiers of government | • Recognition of need to partner with a range of stakeholders including business, commercial industry, government and not-for-profit sector |
| **Workforce and organisational support** | |
| • Two of the five policies briefly refer to resources and capacity<br>• Recognition of the need to provide financial resources<br>• Recognised need for expertise by other stakeholders to achieve outcomes | • Refer explicitly to resources and capacity<br>• Recognition of activities being implemented within an operational budget, along with those requiring capital project funding<br>• Refers to implementation of plans within existing resources, including both human and fiscal resources available |
| **Reference to legislative requirements** | |
| • Did not refer to any legislative requirements | • Acknowledged requirement to adopt a corporate plan |

### 7.3.4 *Meeting minutes*

The decision-making council of both sites, comprising of elected members and departmental strategic managers, met monthly to address raised agenda items.

Documented discussions mostly focussed on local, legislative decisions or enquiries raised by internal committees and strategic managers. In most instances, decisions were carried unanimously. There was no reference to 'health', 'community wellbeing', or 'liveability'. There was some reference to social outcomes for community in Finchville (e.g., role of partnerships, advocacy for gambling restrictions). Further detail outlining examples of addressing determinants of health in the council meeting minutes is provided in Appendix O.

## 7.4 Reference group participation (Finchville)

A local HWB plan was initiated as a commitment of Finchville council's social strategy. The intended goal of developing a specific HWB plan was to create an informed and coordinated approach to improve the wellbeing and quality of life of residents in the region. A reference group was established by the council prior to the development stage of the policy document, with the aim to inform and guide council on current issues and actions required to improve community wellbeing. Prior to the site being established as a case study site, I was invited to participate in the reference group, as a public health academic and stakeholder with health promotion expertise. The main themes informing the narrative below are structured by the constructs of political science, namely those that are related to the development of policies, given that the policy had already been initiated and the aim decided on by the council. These constructs are consistent with those used to inform the questionnaire in phase one of this study around policy development, which focussed on the involvement of policy actors and their level of agreement of the policy problems and solutions, along with how evidence was used to inform policy action, and the use of goals and performance indicators for policy monitoring.

### 7.4.1 Involvement of other sectors

The reference group was chaired by an elected member of the case study site, along with invited members from state government (e.g., Public Health Services, Child and Youth Health), Primary Health Network, Aboriginal Medical Services, university academics, hospitality industry representatives, and two internal managers within the community development and environmental health departments of the council. The

manager of environmental health services was responsible for the writing and development of the plan.

### 7.4.2 Use of evidence

The evidence used to inform the development of the plan included international, national, and local plans. Examples included World Health Organization targets, national chronic disease strategies, state/territory health plans and local demographic data, along with the results of a local wellbeing survey conducted by a third party. Additional data were supplied by the local Public Health Unit on notifiable conditions. A review was also undertaken of other internal council documents to ensure alignment. It was also the intention that, once completed, the local HWB plan would inform other policies over time.

### 7.4.3 Approach is clear

A summary of the evidence resulted in a list of 'potential topics' for inclusion in the plan. These included individual behavioural factors (e.g., physical activity, sun protection), protective health factors (e.g., food safety), health service accessibility, community initiatives (e.g., social inclusion), built infrastructure (e.g., housing), and economic initiatives (e.g., employment). When defining the initial scope of the HWB plan, it was noted that the determinants of health played a role, along with the need for a partnership approach.

Reference group members were given the opportunity to give feedback on the proposed topics. As a participant in the reference group, it was observed that there was considerable reliance on the expertise and prioritisation of health issues that came from organisational or personal opinions of individual stakeholders, rather than from scientific data or academic literature. Whilst secondary health data were presented to stakeholders in the first instance, the priority health issues to be addressed were decided after a 'brainstorm' amongst the stakeholders in the room at one particular meeting. However, there was agreement between the stakeholders that a holistic approach to HWB was needed and resulted in a range of behavioural, environmental, and social factors being discussed and agreed on.

### 7.4.4 Clear goals and actions centred on HWB

Actions included strategies already being implemented in the community, identifying where the council could have a role. Strategies already being implemented in other council plans that related to community HWB were also included. In early drafts, these were written based on what council's role could be, which largely related to regulatory activity, provision of information, or advocacy to support action on HWB issues that shared responsibility with other tiers of government. These initial drafts of the plan also included broad actions that aligned to national goals, though with no specific actions at a local level (e.g., working with community to address 'Close the Gap' initiative and National Disability Insurance Scheme (NDIS)).

As a participant in the group, I suggested the application of an ecological model of health to address HWB from an individual, family, community, and environmental perspective. The group agreed, and this led to the plan being structured around themes including healthy individuals, healthy communities, HWB (largely health determinants), healthy environments, and healthy partnerships. Whilst this approach was adopted, many of the actions remained the same. Over time, there was refinement and reduction of the number of strategies in the plan and a removal of the final 'healthy partnerships' section, instead integrating this way of working throughout the plan. However, this was not the case for the theme on 'health and wellbeing', which retained a number of strategies related to either facilitation of partnerships or collaboration with other partners. This was in recognition that LG does not have the resources or expertise to action HWB alone. Some example roles outlined in the strategy included advocating for more social housing programs, partnering with other agencies to strengthen the action on family violence, and continuing to implement economic strategies to enhance community wellbeing.

Outside of the meetings, feedback from other stakeholders was not transparently shared, so it is unknown what impact other stakeholder input had on the content of the plan, or how the various versions were informed. However, based on personal experience, suggestions made, such as changing the language to be more strength focussed, was adopted by the coordinator of the plan. Other new strategies were also included in the final draft, related to staff wellbeing policies and programs, which

were not discussed within the reference group. Where there were regulatory actions (e.g., environmental health), these strategies remained consistent over all drafts of the planning cycle, along with the focus on improving individual and community HWB.

### 7.4.5 Use of performance indicators

Initially, state government health targets were considered for informing local level performance indicators. The performance indicators were not included in draft copies of the plan, nor discussed in the reference group meetings. However, at the stage of the final draft the council chose to purposely omit performance indicators and report only on activities. The rationale was that performance indicators were more appropriate for an operational plan.

### 7.4.6 Community consultation and finalisation

The plan was sent out for public consultation. The reference group was dissolved by this stage and therefore not privy to the feedback provided by the community, nor involved in the finalisation of the plan after this point. Minutes from a council meeting, nearly 18 months later, documented the approval of the final plan, with a minor amendment to acknowledge the impact of global climate change on public health outcomes. This was feedback incorporated by a new manager of environmental health that had taken over responsibility for the plan. The plan was then approved unanimously amongst the council, noting that it is subject to resourcing requirements in the following financial year budget.

### 7.4.7 Resources and leadership

The manager overseeing the planning process of the local HWB plan left the organisation whilst the draft plan was distributed for community consultation. The role was not replaced for nearly eight months and caused delays in the final adoption of the plan. The chairperson and LG managers on the reference group often raised that there were likely limited financial and staff resources to implement the plan. However, decisions for inclusion in the plan were not based around resource constraints, and instead intended to form the basis for ongoing discussions of what could be prioritised, as resources became available. However, there was a sense that council were reasoning that the focus on partnership development and their role in advocacy was because of limitations to take any other form of action.

### 7.4.8 Summary of learnings from reference group participation

Participation in the reference group was insightful in a number of ways. A key learning was the observed value that council took to a collaborative stakeholder approach, both internally and externally. For example, actions included in the newly developed HWB plan were aligned with existing internal planning documents and designed to be implemented alongside local stakeholders. However, there was no sense of commitment sought by all of the stated policy actors involved. In contrast, the stakeholders that were invited to participant and actively involved in the development of the HWB plan had a very significant level of input into the priorities chosen and actions to be implemented, seemingly far more influential than any other forms of evidence. A majority of the stakeholders invited and who participated were from healthcare-related fields. Evidence in the form of international, national and locally available sources was used initially to guide the purpose of the HWB plan and present broad topics of interest to the reference group.

In light of this, the developed plan comprised of both specific actions that were already being implemented within Council (e.g., environmental health regulatory activities) and vague actions (e.g., addressing the 'Closing the Gap' initiative). It was observed that the actions were included regardless of the feasibility to implement them, in terms of stakeholder commitments or financial and staff resourcing. This reinforced that written (strategic) policies may not always reflect the reality of what is actioned in practice.

## 7.5 Interviews and focus groups (Finchville and Roseford)

### 7.5.1 Participants

The participant sample in Finchville represented 57% of elected members and 50% of the senior managers of the council. A staff focus group comprised five staff employed within the community development department. The sample in Roseford represented 55% of elected members and 80% of the senior managers of the council. The participant demographics for each case study sites are outlined in Table 18.

**Table 18** *Participant demographics for the case study sites.*

| | Finchville | Roseford |
|---|---|---|

| Total number of participants | 13 | 12 |
|---|---|---|
| Role represented in council | | |
| Mayor | 1 | 1 |
| Elected members | 3 | 5 |
| CEO | 1 | 0 |
| Strategic manager | 2 | 5 |
| Operational manager | 1 | 1 |
| Other staff | 5 | 0 |
| Number of years working in LG | | |
| >10 years | 7 | 6 |
| 6-10 years | 3 | 3 |
| 0-5 years | 3 | 2 |
| Unknown/Not answered | 0 | 1 |

### 7.5.2 Themes

A full report of the results for each case study site was presented back to the respective council CEOs (Appendix N). Through the process of explanation building in the cross-case study analysis process, several of the codes were collapsed into main themes (Yin, 2018). Many of these collapsed themes were a result of the codes becoming increasingly inter-related to one another. The summary of the cross-case results is presented using the collapsed themes that represent the factors influencing the local policymaking process.

#### *7.5.2.1 Strong organisational obligation*

The strong commitment and obligation of LG to respond to local community needs was a commonly reported theme from participants across both case study sites. It became clear by participants at both sites that community is at the centre of what LGs do and the rationale for every decision that they make. Interview participants commented that the focus on responding to community needs was ultimately the role of LG.

> *"So I think that this is a council that very much takes to heart its responsibilities to our community in terms of social wellbeing."*
>
> [Elected member #4, Finchville]

> *"It does create work and demand on local government, but at the end of the day, that's what governments are there for, to support the people."*
>
> [Operational manager #1, Roseford]

Both sites indicated this obligation was due, in part, to a lack of support by other tiers of government to respond to community wellbeing, and that LGs were then obligated to the community to do something. It was reported by both sites that LG 'pick up the pieces' where other tiers of government do not invest, and that this role will likely continue in the future.

> *"And I think over time we are going to migrate more and more down that hierarchy where we end up doing more for our communities, because no one else will."*
>
> [Strategic manager #3, Finchville]

Their commitment to the community also aligned to their personal values and beliefs. Participants in both case study sites provided commentary or examples where policy decisions were influenced by personalities, life experience, personal values, and opinions. This was favourable where personal values, interests, and beliefs were in favour of addressing determinants of health. In Finchville, even where participants felt that LG should not be expected to respond to HWB, they still often referred to the desire to contribute to a happy and vibrant community. An elected member of Roseford commented that decisions were more likely be made based on their personal values and understanding, moreso than reference to existing policy.

> *"But, our councillors really make decisions, you know, with their head and their heart, they don't – I'd be just as likely to vote against something that was consistent with policy than for it…..I would vote on whether it's a good idea or bad, not whether it met an existing policy."*
>
> [Elected member #6, Roseford]

Both sites highlighted the role that their council takes in responding to this obligation to the community, both as an enabler and an advocate. Weaved into examples were comments referring to being able to influence HWB across so many different decisions they make. Across both sites, there were examples of current action taken, including the provision of built and natural environment infrastructure such as new sport complexes, all ability playgrounds, and creation of safe and attractive green spaces. There were also examples of social and economic strategies such as child reading programs, community connection opportunities, youth employment initiatives, provision of social housing, business creation initiatives, and support for tourism attractions, including further creation of sport tourism.

Finchville referred to the fact that their social strategy is not a requirement of LG in the state/territory, though captured the essence of their obligation to meet the social, cultural, and wellbeing needs of their constituents. In Finchville, it was noted that the holistic approach to health has been a longstanding commitment to the community.

> *"So if you start to take a holistic approach to the community then health, social determinants of health are part of that data set that you'll look at and try and respond to. So I think at that level of holistic planning that's been a longstanding sort of approach from [case study site]."*
>
> [Strategic manager #1, Finchville]

#### *7.5.2.2 Internal leadership and multiple champions*

The strong leadership by CEOs and mayors was reported as particularly important to set the direction of the council decisions and focus on community HWB. This was reported by some participants at both sites as a commitment by the CEO and mayor as leaders in ensuring community wellbeing was a core function of LG. However, it was far more likely to come up in interviews from participants in Finchville, strongly related to their long-term standing and organisational stability of leadership roles.

> *"In terms of the council here there's a…I think there's an understanding of the importance of wellbeing that rests with the mayor. The mayor is interested in this concept of wellbeing. He believes that wellbeing is a lot of wellbeing rests on your sense of belonging I suppose, of the social capital in the community. But is it his number one priority? No."*
>
> [Strategic manager #1, Finchville]

This commitment was equally met across both sites with a level of championing for HWB by elected members and strategic managers, who saw that addressing the determinants of health contributed to community liveability and the happiness of constituents within their LG region. However, there was consensus amongst both sites that there was not anyone in particular working as a policy entrepreneur to manipulate and look for opportunities to address determinants of health. It was seen that there were multiple champions, and this was a shared role that was accepted as part of their decisions, in everything that they do.

> *"But I don't really have a handle on politically who is going to fly the flag on that front"*
>
> [Operational manager #1, Finchville]

*"Not sure that it specifically within council, any councillor who goes in to bat for that kind of perspective whenever it arises. I think that's sort of probably spread across a number of councillors."*

[Elected member #5, Roseford]

When prompted with conversation around how the social plan came about in council, staff in Finchville commented that there was no real champion driving the policy.

*"There wasn't a passionate champion for it. I mean it was just something that had to be done I think."*

[Staff member #2, Finchville]

Within Finchville, participants reported similar values, although some reported that they do have debates over their differing views. There was a consensus that most decisions are agreed on by the decision-makers, particularly why they are taking action, but less on decisions of what type of action.

*"..one of the reasons I like working at this council is that all of our elected representatives have a very similar philosophy or belief about what's important for [case study site]. In fact, it probably aligns with 80 or 90 percent of the community as well. Any arguments they have is about the how not the why."*

[Strategic manager #3, Finchville]

#### *7.5.2.3 Scope of LG role*

The context of each unique local region was commented on by participants at both sites, though was made clearer in Roseford. Many participants made insights into the close proximity of LG to the community, and that this informed much of their policy response. Elected members, particularly, reported being responsible to represent and provide a voice for everyone in the community. Participants of Finchville often spoke of their community as having a 'sense of place', 'sense of belonging', or 'sense of believing' in their locality. This was considered as a reflection of the culture and values of the local community, both as unique to each council and one of the greatest strengths of LG.

The scope of LG responsibility, and how much was invested in community wellbeing, was closely aligned with the organisational obligation, where participants commented that they invest in action on health determinants to support their community, not because they are required to.

> *"I suppose any, without going into specifics, I think local government, the scale and its integration is its key strength compared to other levels of government and understanding local need."*
>
> [Elected member #1, Finchville]

Participants differentiated between the role of 'health' and 'wellbeing'. One elected member commented that whilst 'health' and 'healthcare' should remain the responsibility of the state/territory, the role of 'wellbeing' was seen as something that LGs were doing anyway. Another elected member agreed, suggesting the term 'wellbeing' should replace the word 'health', as it was more aligned to LG.

> Interviewer: *"It's called health in all policies"*
>
> Elected member #1, Roseford: *"yeah, not wellbeing"*
>
> Interviewer: *"Not wellbeing, yes"*
>
> Elected member #1, Roseford: *"Even though wellbeing is what they want to achieve."*

There were a range of broad statements based on what role LG could (or should) have in addressing determinants of health. The main terms used by participants included 'enabling' and 'advocating' for community wellbeing. Examples of enabling action related to the development of built infrastructure and opportunities through urban planning to support community safety, physical activity, access to services, supporting social inclusion, or an aesthetically pleasant environment. Other enabling action was support for business establishment, program delivery to different population groups and responding to identified needs of individual townships. These were examples provided where the case study sites reported they had a direct responsibility to support community HWB. Alternatively, council would act as an advocate. Examples were advocating for facilities, programs, and support of higher tiers of government or local organisations. Unlike enable and advocate, the third key role identified by participants was to 'mediate'. The role of LG was reported clearly as a facilitator of bringing different stakeholders together to build the capacity locally in addressing specific community needs. Examples were supporting the changes to the NDIS and addressing homelessness.

Participants from both sites reported that addressing health determinants in LG would continue as a priority into the future. There were comments that future investment will be determined by both community demand and the role of higher tiers of government.

> *"I still think that councils are often driven by the figures and the deliverables, and the political pressure, rather than the health and wellbeing of people, unfortunately."*
>
> [Operational manager #1, Roseford]

> *"I think over time local governments tend to grow their services and focus on matters as a result of meeting growing expectations in the community, so I think those expectations are raising."*
>
> [Strategic manager #4, Roseford]

#### *7.5.2.4 Mixed response regarding legislation*

The case study sites were located in a state/territory where LG responsibility for public health centres around health protection measures (e.g., water, waste, food safety), with no current mandated legislation for public health planning beyond these roles. Participants from both sites had mixed feelings regarding whether legislation to further address determinants of health would be favourable or not. There was agreement amongst the case study sites that LGs did not need to be mandated to address HWB, or specifically health determinants. From those interviewed, responding to health determinants was reported as already being actioned, regardless of any legislation, albeit informally. However, there were some who expressed that legislation could be beneficial as it could place a higher priority on community HWB for councils. Finchville had already made more formal arrangements within their written policy planning to document their approach to addressing social issues in their community, though noted this was their own decision to do this. Finchville expressed that they were responding to their community's needs and that this may not necessarily match with the priorities of higher tiers of government. For this reason, a universal approach did not exist for addressing health determinants, as each LG context is different. There were some concerns that legislation could create a top-down compliance approach, rather than a community focussed approach.

Nearly all interviewees reported an increased expectation in responsibilities of LG, perceived as agenda and cost shifting from higher tiers of government. This shift in responsibility is reported historically as not met with the additional financial and staff capacity to respond accordingly.

> *"Look I would have no problem with the state legislating with the proviso that they weren't devolving more of their responsibility down to local government and that's an ongoing history unfortunately that states have a tendency to offload costs and effort on to local government rather than deal with it themselves when it's really fundamentally their responsibility."*
>
> [Elected member #4, Finchville]

Outside of state/territory legislation, there was one strategic manager that raised the potential for international agendas to impact on local policy, such as *Sustainable Development Goals* and the *Man and Biosphere* program. It was considered that LG does not leverage off these global policy documents enough, potentially due to lack of awareness and understanding.

> *"… it would help that prioritisation between roads, rates and rubbish, versus your health, social issues, wellbeing and all that. It gives you more weighting in terms of that space."*
>
> [Strategic manager #2, Roseford]

#### *7.5.2.5 Difficulty defining HWB*

There were factors raised through the process that are likely challenging progress on addressing determinants of health in LG. There was shared agreement amongst participants that the definition of HWB was very broad, which included addressing determinants of health across a range of policy areas. It was noted that all participants had a good understanding of the broader role of economic, social, physical, built, and natural determinants of health. In Roseford, links were also made to poor community health as a result of the vulnerable populations within the region with low income, low education, and high levels of disability.

> *"So I think the challenge with community health and wellbeing is that it is such a broad topic and the social determinants of health, that's everything really isn't it?"*
>
> [Strategic manager #1, Finchville]

However, interview discussions also often reverted to healthcare-oriented services or traditional behavioural responses to disease prevention. Given the broad definition of health determinants, it was hard to get participants to navigate how the problem was defined or if it was a priority amongst the LG. It was identified that it was not something that came up explicitly and that it was certainly not a policy problem on its own. It was more often reported as part of the solution, to many other issues that the LG was responding to. It was described that it is not the reason that council make their decisions, but a 'by-product' of what the council do.

> *"Well, they come up all the time, but probably not really addressing those things. They are the outcomes of other things that we are doing."*
>
> [Elected member #2, Roseford]

> *"Health and wellbeing is in every decision we make isn't it? It's all about the greater goodwill of the community."*
>
> [Elected member #2, Finchville]

There was also understanding that LG are in a position whereby they can influence many of these determinants.

> *"You can see wellbeing in many different avenues, but it's, how do we define it. That's why I mean I think it's unconscious. Because it's hard for them to define it, yet if you looked at some of the things that were happening across the local government spectrum, there would be a lot that is happening in that space."*
>
> [Operational manager #1, Roseford]

It was reported that the term 'health', however, was never used. In fact, it often raised a level of defensiveness and argument that 'health' was the responsibility of state/territory government. Instead, the terms 'liveability', 'community vibrancy', 'happiness', and 'community cohesion' were all used largely interchangeably to mean determinants of health or wellbeing of the community. Regardless of how it was framed, the conversations kept returning to community wellbeing as the result of the decisions made, not the problem being addressed. The solution of addressing health determinants included responding to policy issues of social inclusion and equity, homelessness, safety, economic viability, environmental protection, and community connectivity. The terms 'health', 'health and wellbeing', or 'health

determinants' were reported as never being raised as an agenda item or policy issue to make decisions about.

> *"The term health and wellbeing is probably never heard, but I have heard things like build better communities, excellent place to live, excellent place to invest. These are all the kinds of things being used and I think one stream within that is always a healthy community."*
>
> [Strategic manager #3, Roseford]

Some strategic managers referred to the priority of basic infrastructure such as water and waste, explicitly linked to community wellbeing, but the higher priority of LG as it is regulated and seen as part of their core role.

> *"We've got to make sure we've got all those in the right place because I think some of these higher-order health and well-being things won't go so well if people haven't got basic good access to their roads and clean water and efficient sewer systems and waste taken away regularly. That remains a priority focus in my view."*
>
> [Strategic manager #4, Roseford]

#### *7.5.2.6 Evidence tends to be anecdotal*

Participants of both case study sites reported the evidence used for decision-making as very broad. Examples of evidence used to inform policy included census data, academic sources, and secondary health data. Seeking information from frontline services was reported as useful to source information that is otherwise difficult to gain access to (e.g., crime statistics), along with a strong reliance on community input and complaints (or lack of complaints).

> *"So getting the data is a challenge. And so then of course you end up relying, which is always challenging, you rely on anecdote…we probably rely too much on anecdote, too much on a complaint or a letter that says why aren't you doing something about this."*
>
> [Strategic manager #1, Finchville]

Seeing evidence first-hand, rather than use of secondary data, was reported as the preference. For example, seeing people using facilities or high attendance at events was reported as an indication that things were going well. Observing evacuation centres after a disaster was reported as a visible way of seeing the vulnerabilities within the community.

> *"Local governments get involved in things like that but it tends to be just someone had a good idea or someone heard something out in the community or sometimes it's just when you've got really strong advocates in the community sector who can convince local government politicians or bureaucrats that there's a need and that we should play in a space. Often it's not overly strategic in how we approach some of these issues."*
>
> [Strategic manager #1, Roseford]

Participants were quite unanimous that LG are not investing in measurable indicators for community HWB. There were a number of issues raised amongst the case study sites around why this was the case. Both case study sites raised that wellbeing is difficult to measure, given it is such a broad issue. For Finchville, the concerns were over cost-benefit, with monitoring and evaluation seen as a possible waste of resources, given that they could use these resources to invest in possible solutions. Finchville also reported a lower priority to measure things that were not seen as an issue. In this instance, addressing determinants of health was not being raised by community or external advocates and therefore not considered to be a priority that needed to be addressed. Instead, the evidence reported by both case study sites tended to be reliant on far less rigorous use of data, such as gauging the level of complaints from community members, community input, and feedback from frontline community services staff. One participant in Roseford commented that it is difficult to keep up with all the issues being raised in such a large community.

> *"But just to give you a picture on that I feel people don't have an issue in coming to us to say if they were concerned about something. I think the fact that they're not bringing those concerns to us I think is a good thing that people are happy."*
>
> [Elected member #1, Roseford]

There was very little scientific evidence used to make decisions, and no scientific evidence driving the initiation of health determinants as a local problem onto the policy agenda. Where scientific evidence was used, it was usually by operational staff who were providing a rationale for strategy formulation or to raise issues. This evidence largely consisted of demographic data, disease rates, and international, national, and state/territory government strategies. Gaining council support to utilise more rigorous research was identified by one elected member as challenging.

*"I struggle constantly to get people to agree to do research, rather than just speak in terms of their community."*

[Elected member #3, Finchville]

It was noted by interviewees that performance indicators are not always included and that where they do exist, they are not usually consistent over time. Participants questioned if measures for HWB were even feasible, given the difficulty to ascertain the impact that LG had on some of the issues, and the reliance on collaborative action across different tiers of government and stakeholders to address determinants of health.

*"whilst we can do a bunch of stuff supporting the health and influencing those determinants of health, there's a bunch of other players that are in that space as well so are things we're doing making a difference, or are the things another group is doing making the difference?"*

[Strategic manager #4, Roseford]

In Finchville there was sentiment that without measuring HWB impacts, there are no triggers for issues to be raised in policy discussions. This was based on logic that data that tends to trigger policy review are those indicators that demonstrate poor results. It was reported by interviewees that it is difficult to measure the role that LG contribute to HWB, as it is difficult to get information at a local level, difficult to measure determinants of health, and it is costly for council to collect their own data.

*"Some of which are easier to measure than others. That's the other side of the equation is that once you start getting into these areas I suppose of social issues, community determinants of health etc the challenge is measuring, the challenge is say particularly for local government to measure what it's contribution is and how it's made a difference because the stats are often at a much higher level and many of the levers are also at that higher level."*

[Strategic manager #1, Finchville]

*"I'm not even sure how we would measure it. What quantitative measure you could do… I guess it's a small enough community that we can take it anecdotally and, you know, get a sense from people around us, their sense of well-being."*

[Elected member #6, Roseford]

#### *7.5.2.7 Lack of external advocates*

There was little demand outside of LG reported by the case study sites for addressing health determinants, or HWB in general. There were no reported local advocacy groups or individuals with a focus on lobbying for more action on community wellbeing. There was no demand coming from local stakeholders for the case study sites to put a stronger emphasis on community wellbeing. On occasion, the sites reported being approached by private or community sectors with requests related to physical infrastructure or programs, though these were isolated cases. Interviewees in Roseford reported that the community were not keen for any investments by council to be made that may require increases to their property rates, as they could not afford this financially.

> *"they're not the loudest people, they're not the most persistent people and that's unfortunately the moment, sort of the mood of the loudest people is saying don't spend money."*
>
> [Elected member #6, Roseford]

The local media were considered apathetic, with limited capacity to drive any social campaigns, and certainly not likely to have a focus on health determinants. There were mixed views regarding the media response to council's actions on HWB. Both sites made comments that the media report what council request them to. Several interviewees reported that media take whatever view they want to make issues controversial. Either way, it was not seen that the media were intentionally supporting, or not supporting, action on health determinants and not reporting them with that particular angle.

> *"So they have a tendency to take a media release and publish it, so in that sense the council gets their media release published."*
>
> [Elected member #3, Finchville]

> *"I don't think that media raises expectations too much around health issues and local government. They don't make that link."*
>
> [Elected member #1, Finchville]

> *"There aren't traditional media advocates as you might see in bigger cities or you might have seen in regional cities in previous times."*
>
> [Strategic Manager #1, Roseford]

#### *7.5.2.8 Limited financial and staff capacity*

The shared sentiment amongst both case study sites was the constant shifting of agendas onto LG by higher tiers of government, without the additional resources being made available. In addition, the case study sites saw that they were left to continue to service their communities where other tiers of government were disinvesting or unable to continue funding services. Both sites acknowledged the continued financial constraints across all tiers of government, and that they anticipated that demand would continue for LG to fill this void as a result.

> *"So we're under pressure not to put rates up but the other levels of government are getting a lot of money that no one even notices."*
>
> [Strategic manager #3, Finchville]

> *"We haven't got the luxury of other bigger councils with more money and things like that."*
>
> [Staff member #2, Finchville]

The reliance on project or financial support from higher tiers of government was reported by both sites, though mostly raised as an issue for Roseford. As a region that is experiencing large population growth, it was made clear that council were experiencing high costs associated with developing and maintaining essential infrastructure such as roads. The financial support of higher tiers of government that provided funding for this allowed LG to focus on other community priorities. However, short term program funding for specific projects was reported as problematic in terms of sustainable action. Running programs for a short time raised community expectations of continuation, of which LG reported not being able to afford. Participants acknowledged that additional funding was unlikely to come from increases in property rates, as this was a known financial burden on their constituents. Both sites noted the difficulty in increasing property rates as this would raise complaints and dissatisfaction amongst the majority of residents, along with the recognition, particularly in the more disadvantaged populations of Roseford, that this itself represented a determinant of health and was not seen as solving any problems for community wellbeing. One solution proposed by a strategic manager was to increase employment in the region, not to address health outcomes, though to

alleviate the financial stress for their constituents, as they had experienced in more wealthier council areas.

> *"You tend to find, at least in my experience, in the big regional councils in [state/territory] that so much of your money just goes on the roads, the core, traditional core, local government infrastructure and there's often not a lot left over."*
>
> [Strategic manager #1, Roseford]

> *"So when state government puts more services on us, we have to fund it from somewhere and our primary source is rates and that's always a contentious point you know?"*
>
> [Strategic manager #3, Roseford]

Participants reported that actions for addressing health determinants may be added to written policies, but not implemented. Interviewees reported that policy actions within different plans compete for financial and human resources from year to year. It was reported that decision-making often comes down to cost-benefit.

> *"I mean it takes a while, you can do a plan and then to implement is another matter and they are not always resourced."*
>
> [Elected member #3, Finchville]

> ***"****Well, I suppose I am more business oriented and more financial oriented. I want to see the cost benefit of it."*
>
> [Elected member #2, Roseford]

Staff capacity was also reported as limited, with staff capacity stretched over many demands from the community. A participant noted that there may be more staff with the appropriate expertise to deal with determinants of health employed within higher tiers of government.

> *"The changing demographics of our region, and our ability to meet the demand, and the change is what's going to be difficult with the - especially with the level of staffing."*
>
> [Operational manager #1, Roseford]

> *"I would have thought that in other upper level, the states are going to have far more expertise in doing that."*
>
> [Elected member #5, Roseford]

Yet, existing staff commented on working with other experts and stakeholders to gain the appropriate knowledge and capacity, though that staff changes in other organisations could challenge the level of action taken. In Finchville, there was comment that staff are not only recruited to work in a council based on their level of expertise in a certain area, though whether they fit the same 'values' of the council. Staff report that they work in LG as a genuine commitment to the community.

#### *7.5.2.9 Organisational stability*

One of the key differences between the case study sites included the stability of the organisation and administration. Finchville reported consistent re-election of mayors for long periods of time, a longstanding CEO and stability of staff employed within the council. These staff and elected members were also mostly longstanding residents of the area and felt very connected to the region. It was felt by participants that the community were not likely to elect anyone to LG who held a different vision.

> *"It won't disrupt it in a massive way because I doubt that the community is going to elect a majority of councillors who want to change the direction of the community…therefore they're pretty conscientious about electing people who reflect those same values."*
>
> [Elected member #4, Finchville]

In contrast, Roseford reported recent leadership changes and significant staff turnovers, leading to a level of organisational instability, along with reports of a change in vision of the council under the new leadership. These experiences of organisational instability within Roseford were connected with less internal cooperation, and weaker sense of collaboration with the community. Participants in Roseford were less confident whether upcoming elections might see a shift in elected members and mayor. Yet, organisational stability was described as critical, particularly for planning of long-term strategies for public health.

> *"Because if you've got a council that doesn't see it, doesn't see public health planning as a priority and just absolutely goes no, thank you, we're not interested, well every four years you can get an opportunity to get a council that is interested and does want to know about it. But question back to you is does four years' worth of public health planning help?"*
>
> [Strategic manager #3, Roseford]

The organisational stability of Finchville was seen as an enabler for informal cooperation within the council, both vertically and horizontally across sectors and roles, as well as integration between written policy documents. This is likely also due to the smaller size of the council, recognising that there are fewer elected members and staff and a smaller geographical area to consider. Vertical cooperation between elected members and staff was also reported in Finchville, with strategic and operational responsibilities often the same people in small councils.

> *"So there's no clear breakdown between operation and policy and it would be very rare to see that breakdown in a small council like this"*
>
> [Strategic manager #1, Finchville]

> *"So we have a very open relationship I suppose from the councillors, to managers to the lower staff members. So I think that is good in terms of outputs for the community but also in terms of the culture within the council."*
>
> [Staff member #3, Finchville]

Participants in Roseford reported that new changes and a sense of organisational instability meant that those in decision-making roles were not necessarily involved in approving the policies and could not recall them when voting on matters put to the council. However, they also reported that new organisational structures were being put in place to support cross-department discussion, such as staff roundtable meetings.

> *"we need like a check list for every single thing that goes through, that crosses council's desk to go, have we checked if there's any way we can make it smart technology. Is there anything we can do to make it sun smart….I don't think that's happening but in my opinion it should."*
>
> [Elected member #1, Roseford]

> *"We're a big organisation. We're not without silos. We've got some strategies around trying to improve the collaboration, so that we work better as an entity."*
>
> [Strategic manager #5, Roseford]

#### *7.5.2.10 Cooperation with higher tiers of government*

A key difference between the sites was the level of perceived support of higher tiers of government. Roseford were more critical of the support and strategic direction given by both state/territory and federal levels of government on matters related to

HWB. Finchville participants reported that there was local collaboration, with recognition of the financial pressures impacting all levels of government decision-making. Whilst participants reported that they did seek out state/territory funding (e.g., for cycleways), working with other tiers of government was not something raised as a contentious issue.

> *"State governments are pretty good at getting to the table and they are pretty good at being cooperative. Probably a little less enthusiastic about putting their hands in their pockets and put money forward because they are under financial constraints as well, but they are generally good partners in terms of sharing experiences and talking about things and so on, but perhaps less so than on bringing forward funding."*
>
> [Strategic manager #3, Finchville]

Roseford relied more heavily on access to program and infrastructure grants to meet the growing needs of their communities. With this reliance came frustration of the changing directions in priorities and the lack of sustainable funding for programs.

> *"It's about actually making the states and funding bodies understand it's not worthwhile having all these little separate programs if you're covering it all together for a - well what other real community outcomes you want to deliver and putting that money towards those outcomes."*
>
> [Strategic manager #2, Roseford]

In one example provided, LG were responding to a funding proposal to address the determinants of health, established through federal government funding. It was alleged that a stakeholder from a healthcare service had more influence over the funding decision-makers and resulted in funding for a healthcare facility. The participants claim that the decision was made without consideration of LG and community feedback. This resulted in a service that LG would not have otherwise prioritised or committed to.

> *".....we drew up a list of priorities and we voted on them and we sent them in and then no one even had ever heard of a proposal to put a hospice up."*
>
> [Elected member #5, Roseford]

Roseford participants also noted the lack of clarity in the responsibilities for each tier of government regarding community HWB in general. Participants in Roseford provided examples where cooperation between other tiers of government was

lacking. For example, a youth project addressing the collective outcomes of health, employment, and crime was funded by a higher tier of government. The program was reported to have ceased once the initial funding ended. This is despite demonstrated positive outcomes that the program had achieved for a range of government agencies. However, it could not be determined who would take responsibility for the ongoing coordination of such a cross-sector program.

There were sentiments across both sites regarding the disruption of amalgamations to LG. Given reports that LGs respond to their unique communities, using a bottom-up approach to address local issues, the shifting of boundaries was reported as either disrupting the continuity of policy positions or adding to the complexity of responding to larger and more diverse populations.

#### *7.5.2.11 Support from other sectors*

The participants in Finchville were more inclined to discuss the support and interaction with other sectors and stakeholders to achieve community HWB outcomes. The staff of Finchville reported strong connections with other sectors outside of council, with relationships built over time and shared values of the community bringing together a range of stakeholders in formal collaborations, where council facilitated this. Finchville expressed that other sectors played a critical role in providing council with anecdotal evidence and feedback on community needs. Participants in Finchville regularly raised an example of a formal collaborative partnership that they initiated as a result of a local social issue. The collaborative group comprised government, community, and charitable organisations, chaired by the LG. The group were initially set up to focus on affordable housing and homelessness issues, though continue to collaborate on a range of community issues.

> *"I'm impressed by what goes on in our community development area which is one of the areas that [strategic manager Community Development] has been responsible for, in coordinating agencies getting together to look at how they overlap and underlap around things like providing services to homeless people or to people in need, so that kind of initiative is ongoing here and I think that is already done well here."*
>
> [Elected member #3, Finchville]

Interviewees recognised that collaboration with other sectors is critical to getting things done. Participants in Roseford also mentioned their role of bringing sectors together, though the primary focus for participants was on internal cooperation being improved, rather than the priority being on working outside of the council. There were only a few interviewees that gave examples of where council were working with other sectors. In many ways it was probably implied, rather than discussed explicitly. It is also worth noting that Roseford were still establishing a new direction under changed leadership, with a focus on community engagement and internal system improvements. However, at an operational level creating partnerships was seen as critically important for quality, sustainable action.

> *"So instead of them competing for their funding, we want them to work together on these collective issues that are actually working towards some good, rather than everybody trying to do the same thing and probably getting half the way there."*
>
> [Operational manager #1, Roseford]

#### *7.5.2.12 Role of community in decision-making*

The role of community was very strongly highlighted by both case study sites. However, the way the community voice was involved in decision-making was reported as different across the two sites. In Finchville, whilst seeking community feedback through engagement strategies, there were also reports that the community and council together held a strong policy monopoly, with shared values and ideas. This was often referred to as the strong community 'sense of place' amongst residents, that ultimately support council decisions.

> *"many people come to (case study site) because they identify with the (case study site) brand, with the values that (case study site) espouses and therefore they're pretty conscientious about electing people who reflect those same values."*
>
> [Elected member #4, Finchville]

This reflects the perspective that the community are already highly engaged and have a high level of volunteerism in the community. This level of sentiment was reinforced by most participants. However, participants at operational and strategic level acknowledged that the council was not always engaging across diverse population groups, particularly the most vulnerable groups within the region.

> *"[suburb] are a low socioeconomic community with major health and wellbeing issues but we don't deal with them on a daily basis"*
>
> [Staff member #1, Finchville]

Roseford reported a more deliberative and considered engagement of community, with a focus on seeking the views of different community members in decision-making. Whilst LG are required to seek community input and feedback on policy decisions, there is no mandated method or consensus on how this should be done at a local level. Finchville reported they already knew (to a large extent) what the community needs were; Roseford was investing more time and resourcing across council to further formalise the way they interacted with community on decisions. The site was prioritising the building of trust in their community, through a process of deliberative dialogue around community issues as they arose, with the goal to reach a diverse range of constituents' viewpoints.

> *"..we spend too much time worrying about the squeaky wheel, where we should just be getting on with it. The silent majority are the ones who I try and engage with, because someone who is all over social media bagging us all the time, that's one opinion, but in my case, I try and engage with as many people as I can."*
>
> [Elected member #4, Roseford]

#### *7.5.2.13 External events as a trigger for policy*

In addition to the shocks of amalgamations and elections that impact on organisational stability, there were a few 'external events' raised by Finchville that placed pressure on the council to respond to determinants of health. Finchville had a circumstance where homelessness and displacement issues were brought to the agenda, as a result of other planning decisions that had to be made. Rather than ignore the issue, the council facilitated broader sector involvement to address the issue of homelessness in a collaborative response. Council's response to the circumstances were noted as aligned to their core values and personal obligation that they felt were 'the right thing to do'.

Interviewees in both sites reported not being reactive to local media stories, though some acknowledged that broader media influences policy discussion in the council. Both case sites reported instances where they responded to issues that were gaining broader media attention. Some of the examples included national media discourse

around marriage equality, the NDIS, and water security. These media debates meant that issues of social justice and equality were brought to the agenda forefront and discussed in terms of council's responsibility to respond. Not all participants agreed the LG should get involved in national or media priorities, though it was agreed that media does influence policy discussions at a local level.

> *"When I look broader, I do think things like radio national, good news sources do influence people in here. People get something, this is interesting, and they'll share it between the councillors to try and educate ourselves about the issues and experiences of others."*
>
> [Elected member #1, Finchville]

An example was provided where the national 'media noise' around the national marriage equality debate influenced the council in Finchville to develop a charter that outlined their social justice values. One elected member recalls championing the cause, albeit indirectly to get council support. Through discussions with strategic managers, the proposal put forward was to reinforce the social justice values of the council as transparently as possible to the community, to support a whole range of issues rather than just marriage equality. When prompted, it was revealed that there was no objection by council to this decision.

> *"Politically you know. I mean you couldn't…"*
>
> [Elected member #3, Finchville]

## 7.6 KEY FINDINGS

The results presented throughout Phase 2 comprise the document analysis, interviews, and focus groups, along with the opportunity to be a participant-observer in a reference group as Finchville developed a new community health and wellbeing policy. The qualitative data throughout the interviews and focus groups highlighted the interconnections between factors in the policy process, acknowledging the nuances and different circumstances that are raised. For this reason, it becomes more difficult to categorise the themes raised as either enablers or challenges. They become more 'influencing factors', sometimes positively and other times negatively. The factors outlined below are therefore reported as enablers, challenges, and other

influences. A summary of how these factors align to the four theoretical frameworks used in this study are outlined in Appendix M.

**Key research findings from phase two**

***Enabling factors:***

- There was a unanimous perception that the council has an **organisational obligation** to the community.
- Organisational obligation was aligned with **personal values and beliefs** of decision-makers.
- **Leadership by mayors and CEOs** was particularly important.
- **Internal leadership** was a seen as important to set the council priorities, along with a **range of champions** amongst elected members and management staff.
- Whilst both case study sites were not experiencing **organisational stability**, both were clear that it was a necessary condition to allow for cooperation between staff and elected members and for planning and recalling longer term commitments.
- Understanding the views of the **local community** was seen as centre to the role of LG in every decision that they make, each recognising some of the difficulties in gaining the voices of the diversity in the community and the need to build trust.
- **Working with other sectors** was seen as a way to get things done, with resources being so tight.
- Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues.
- The concept of 'health determinants' was more accepted when **framed** in other language, such as 'liveability'.

***Challenging factors:***

- Participants had difficulty **defining health and wellbeing** and exactly what health determinants meant. The use of the term **'health'** created tension over whether this was LG responsibility. 'Health' was seen as **a responsibility of higher tiers of government**.
- Addressing community wellbeing was considered a high council priority, although it is **never explicitly raised** on the agenda or discussed. It was felt that HWB becomes the 'by-product' of other decisions make. Roseford reported that being a growing region resulted in a lot of **competing priorities**.
- Participants reported **limited advocacy efforts** or pressures from any policy actors to address health determinants, including community, media and other external sectors.
- The perceived **cost-shifting** from higher tiers of government and **reliance on grants**, and **reluctance to increase property rates** results in **limited financial and staff capacity** for meeting all demands that council would like to meet.
- **Difficulty in measuring health**, due to its influence from a range of determinants, but also difficult to establish the influence that LG has. Investments for measuring health were not considered 'cost-effective'.
- **Stakeholder input** is determined by the council, with the reference group in Finchville an example of inviting mostly representatives of 'health services' to inform the policy.
- There is **no strong lobbying action** from external stakeholders, community, or media.
- There were **no specific drivers or policy entrepreneurs** to navigate the policy process.
- There were many **sources of evidence** used to inform policy, with acknowledgement of the reliance on **anecdote, community complaints** (or lack of) and use of other less credible

| Key research findings from phase two |
| --- |
| sources of evidence. There was **limited, if any, scientific evidence** informing LG decision-makers. Evidence that could be 'seen' (attendance at events) or 'heard' (community complaints) was reported as the preferable way to gauge the effectiveness of LG actions.<br>• LG respondents report not always aligning to the **strategic direction** of higher tiers of government. |
| ***Other influencing factors (neither enabling nor challenging):***<br>• Some LG decision-makers felt that **legislation** could be beneficial to bring attention to addressing health determinants, though only if it came with sufficient resourcing.<br>• Participants reported on the important role of LG to facilitate partnerships, with one site drawing on current **support from other sectors** in a formal collaboration to address health determinants, though not for the benefit of 'health'. Participants reported the **critical role of community services and organisations** to provide feedback to LG on community needs.<br>• Respondents expressed that the **responsibility of LG** was on community wellbeing, not necessarily related to 'health'.<br>• There were different experiences of successfully **working across sectors** internally.<br>• The **community were involved** in decision-making, although reported differently across the case study sites.<br>• **Changes in leadership and LG amalgamations** created opportunity for change, though also organisational instability. |

## 7.7 SUMMARY OF CHAPTER SEVEN

This chapter has presented the findings for the two case study sites, including their similarities and differences. There were a range of identified themes that represented the key factors that enable or challenge the policy processes to address determinants of health in each council. Whilst the case study sites were similar in some ways, including being within the same state jurisdiction and located in regional areas, they also showed some differences in their enablers and challenges in the policy process to address determinants of health in their community. Similar enabling factors included a strong organisational obligation to their community and internal leadership. Challenges were raised around the difficulty of defining what health determinants meant, the scope and responsibility of LG to respond, the lack of external advocacy, and limited financial and staff capacity. Each of the case study sites differed in their current views on cooperation with higher tiers of government and gave different accounts of current organisational stability, engagement of community, and response to local and national events. The written policy documentation did not explicitly address determinants of health as the purpose of any

action, though strategies raised in documents, along with examples provided in interviews, suggest that the case study sites are in fact taking some action. The next chapter presents a triangulation of enablers and challenges from both phases one and two of the research, comparing this to international literature.

# 8. Discussion Part I: Influencing factors in the LG policy process to achieve HiAP

## 8.1 Introduction

Chapters six and seven outlined the findings for the two phases of the research, responsive to research objectives one and two. Results from phase one highlighted a number of enabling and challenging factors contributing to the LG HWB policy process. Enabling factors included a strong, supportive policy subsystem within LG and a personal and professional obligation to take action. Challenging factors included the difficulty of collaborating with external partnerships and lack of coordination with higher tiers of government, along with limited staff and financial capacity. The insights from the regional case study sites in phase two supported some findings such as the strong personal and professional obligations to act and limited staff and financial capacity. The insights from case study sites also added further commentary on the role of media, community, policy actor values and beliefs and political structures that influence decision-making at a local level.

This chapter is the first of two discussions in relation to the research findings. This chapter responds to research objectives one and two by presenting a triangulation of the key themes, compared and contrasted to relevant international literature related to HiAP in the LG context. In response to research objectives one and two, the chapter provides a discussion on the policy factors that influence a HiAP approach in LG, including their interconnectedness, along with a critique of the differences between the varying legislative environments and geographical remoteness of councils. The second discussion (chapter nine) will answer research objective three, providing an insightful critique of the findings using the theoretical lens of political science.

## 8.2 Influencing factors in the policy process

This chapter discusses the influencing factors in the policy process, as a triangulation of findings across both phases of the research. This chapter responds to the first two research objectives:

1. Identify the enablers and challenges in the existing healthy public policy processes in Australian LG.
2. Identify how enablers and challenges in the current healthy public policy process are different across various LG contexts and jurisdictions.

Before being able to answer the research objectives above, some of the terminology used in the original research objectives needs to be addressed, particularly the terms 'enablers' and 'challenges'. As raised in chapter three, Baker et al. (2018) report that factors should be considered as either increasing or decreasing the probability of health inequities reaching the policy agenda. Likewise, research findings in this study, particularly the qualitative data, became difficult to categorise as either enabling or challenging. Therefore, the chapter refers mostly to 'influencing factors' in the policy process.

The findings from both phases of the research are presented as factors of the policy process that have been identified as converged themes throughout the study. Each subheading reflects a factor that is considered as influencing the policy process, cross-referenced to one another to demonstrate where they interact.

### 8.2.1 Understanding the policy problem

Overall, the understanding of health as being influenced by many determinants seems well understood as a holistic concept, congruent with other research in Australia and internationally (Browne et al., 2019; Collins & Hayes, 2013; Hendriks et al., 2015; Lawless et al., 2017). This is an important influence in the policy process, given Polley (2019) identified that a low health literacy in public health challenged municipal public health planning as it was being introduced in Western Australia.

As demonstrated in the findings, HWB is seen from a social justice perspective, as well as the responsibility of individuals. Survey respondents were able to identify a wide range of policy areas that impacted on health, although few recognised that 'all policies' impact health. City councils were more likely to incorporate health across a range of policies, although the definition given to HWB is similarly broad across all types of councils, including an understanding of the determinants of health. This is in

contrast to previous literature that metropolitan councils are more familiar with the determinants of health, though agrees that metropolitan councils are more likely to act on them (Collins & Hayes, 2013; Lawless et al., 2017).

Despite the broad understanding of health determinants, participants often reverted to discussion on individual lifestyle behaviours or health services (e.g., obesity, physical activity, aged care), in what is commonly referred to as 'lifestyle drift'. This term refers to the good intentions of policymakers to address determinants of health, but end up focussing on individual lifestyle behaviours instead (Popay et al., 2010).

One of the observations in the study was that the term 'health' often triggered a defensive response from participants that LG was not, or should not, be responsible for health "*that a doctor would normally do*". Similarly, where written policy documentation included the term 'health' it usually referred to healthcare. Where the term 'wellbeing' was used, it did not reflect a broad and holistic health paradigm. For example, the Roseford youth strategy had a goal to improve wellbeing, though focussed predominantly on drug education. In agreement with previous literature, the understanding of health determinants as a complex concept seems to also contribute to its ambiguity as a policy issue to address or agree on (Hoeijmakers et al., 2007; Synnevåg et al., 2018b) (*see 8.2.2 Framing*). Regardless, previous research has found that a shared understanding of health as a policy problem is not necessarily an indicator for generating any policy action (Collins, 2012; Didem et al., 2012).

Whether the issue is posed as 'HWB' or 'health determinants', the problem was complicated because it could be viewed as a health issue, or alternatively as an individual, social, political, environmental, or economic issue. This is supported by the analysis of policy documents that rarely referred to HWB or health determinants. However, actions outlined within the council plans could be identified as addressing determinants of health, albeit not responding to 'health' as the policy problem. This is consistent with other Australian and international literature that report health determinants being addressed, despite 'health' not being a priority for LG (Holt et al., 2017; Jansson & Tillgren, 2010; McCosker et al., 2018; Phillips & Green, 2015; Steenbakkers et al., 2012; Storm et al., 2016) (*see 8.2.3 Policy priority & 8.2.4 Policy actions*).

### 8.2.2 Framing

According to case study participants, addressing community 'liveability' is always on the agenda. Therefore, the framing of the term 'determinants of health', and the term 'health in all policies' is very important if it is going to gain any policy traction in Australian LG, similar to findings elsewhere (Hendriks et al., 2015; Holt et al., 2017; Lawless et al., 2017; Mundo et al., 2019; Scheele et al., 2018; Schmidt et al., 2010; Synnevåg et al., 2018b) (*see 8.2.1 Understanding the policy problem & 8.2.3 Policy priority)*. In spite of this, concerns are raised in literature that taking the focus away from health results in a lack of explicit discussion of the negative and positive impacts of actions on population health and health inequities (Holt et al., 2017; Scheele et al., 2018). The debate on whether health should be reframed to engage decision-makers in policy initiation, or reframed as policy is developed, is as much a debate for policy advocates in Australia as in Norway (Synnevåg et al., 2018a; Synnevåg et al., 2018b).

### 8.2.3 Policy priority

Study participants agree that HWB and health determinants are priorities in LG, but not the highest priority amongst other issues. Previous research has found similar findings, with most reporting that health inequities or SDoH is a priority, though not for all LGs (Browne et al., 2019; Collins & Hayes, 2013; Fosse & Helgesen, 2015; Lawless et al., 2017; Morrison et al., 2015). Interestingly, the level of priority given to HWB was not notably different across different legislative jurisdictions, including from the views of CEOs. Whilst survey respondents in the state of Victoria were more likely to report HWB as a priority, this was only moreso than two other states. However, survey respondents in city or rural councils were more likely to report HWB as a higher priority than their regional counterparts.

Participants in Roseford, a large regional council, reported that the fast-growing region brought a lot of competing priorities. In addition, respondents of rural councils reported tension of the competing priority for healthcare service delivery that were not provided sufficiently by the state/territory government. Other research has identified that health inequities not only competes with other policy priorities, but also the high volume of policy issues being dealt with at any one time (Bagley et al., 2007; Collins, 2012; Exworthy et al., 2002; Fosse et al., 2019; Holt, Rod, et al.,

2018; Phillips & Green, 2015; Van Vliet, 2018). In contrast, participants in Finchville indicated that addressing health determinants remained a long-term consideration within their council and was unlikely to change as the local community would be unlikely to elect councillors that disagreed with their views. The strong 'sense of place' that is reported by interviewees, and the shared values reflected in decision-making, indicate that a strong policy monopoly exists (*see 8.2.11 Policy actor values and beliefs*). This is complemented in Finchville with a stable administration, low staff turnover and long term elected members and mayors (*see 8.2.5 LG ideology*).

Exworthy et al. (2002) proposed that the lower priority given to addressing health inequities was due to the perceived lack of urgency for action. This study agrees, finding a lack of lobbying action from other sectors or community putting any pressure on LG for change, and a lack of performance indicators used for policy feedback (*see 8.2.10 Performance measures & 8.2.14 Lobbying action*). In addition, for most Australian councils, 'health' was not considered the policy problem that needed to be dealt with, with many seeing this as the responsibility of higher tiers of government (*see 8.2.1 Understanding the policy problem & 8.2.2 Framing & 8.2.13 Role of higher tiers of government*). However, current public health planning in Australian LG responds to the state government priorities of a behavioural approach to health, which seems incongruent with the priorities of LG, whereby behavioural and preventive healthcare initiatives are given lower priority than SDoH (Browne et al., 2019).

### 8.2.4 Policy actions

Across the research, there were multiple examples of action taken to address health determinants. However, these were rarely connected explicitly as being a determinant of health or framed to achieve any health outcomes. The case study meeting minutes confirm this, with any HWB terminology rarely raised. Research confirms that health is often an 'add on' or 'co-benefit' to other LG goals (Holt et al., 2017; McCosker et al., 2018; Phillips & Green, 2015; Steenbakkers et al., 2012) (*see 8.2.1 Understanding the policy problem)*.

In Finchville, the main policy solution to the problem of HWB was to create a new and separate strategy, under the premise of 'community health and wellbeing'. Within the plan, there were explicit alignments to other council policies, such as economic plans, environmental health, and urban planning schemes. However, many of the strategies related to addressing health determinants referred to establishing partnerships or taking on an advocacy role. This indicates that LG identified their role in addressing determinants of health as an advocate and recognised that action could not be successful without the collaboration of other policy actors within and external to the council. This incorporation of different sectors and LG policies throughout the community health and wellbeing plan is considered as progress towards taking a HiAP approach. The willingness to take this approach stems largely from the leadership and strong organisational values within Finchville, along with a presence of stakeholders that were able to influence the plan (*see 8.2.8 Local leadership support & 8.2.7 External collaboration*).

However, discussions about addressing health determinants sometimes reverted to examples about individual lifestyles or behavioural programs. This was also reflected in the survey respondents' identification of priority areas of action. Whilst urban planning was reported as the highest of the four key priorities, this was followed by individual lifestyle programs. The results imply that Australian LG policy does not appear to be immune to the concept of lifestyle drift, with individual behaviour programs gaining priority as a policy solution over other health determinants, something that is described elsewhere (Collins, 2012; Dhesi, 2014; Fosse et al., 2019; Tallarek née Grimm et al., 2013) (see *8.2.1 Understanding the policy problem*).

Based on previous literature, LG value the local commitment to addressing health determinants, yet still compete with individual lifestyle programs that are perceived as more 'politically attractive', or priorities set by higher tiers of government that do not align to local priorities (Browne et al., 2019) (*see 8.2.13 Role of higher tiers of government*). This is also raised in previous research whereby LGs perceive health inequities as part of their role, though lack the responsibility, control, or authority to

take action (Collins & Hayes, 2013; Dhesi, 2014; Morrison et al., 2014; Morrison et al., 2015) (*see 8.2.5 LG ideology*).

### 8.2.5 LG ideology

The role of LG and its commitment to community wellbeing was a consistent theme raised in the study. For example, most survey respondents across Australia reported a clear council commitment for HWB. Case study participants reported that whilst no regulation exists regarding what LGs must respond to, plans and policies to address HWB remain fluid and at the discretion of each individual LG. In this instance, it is likely that current actions towards addressing health determinants are informally considered in everything that the council does at a local policy level, regardless of the broader policy environment. In addition, participants reported that LGs have a strong organisational obligation to respond to community wellbeing and determinants of health, because '*no one else will'*. This sentiment was explicitly written into the Finchville social plan that reports the council will commit to the plan, regardless of decisions made of higher tiers of government. Participants in Victoria, as well as city councils across Australia, reported a stronger organisational obligation than their rural and regional counterparts. Although, the obligation remained strong across all geographical locations, despite reports that higher tiers of government may have more expertise and responsibility in this area; the tensions with lack of consistency in policy targets set by higher tiers of government, lack of resourcing, and limited legislation that compels LG to do anything (*see 8.2.12 Role of legislation & 8.2.13 Role of higher tiers of government & 8.2.18 Staff and financial capacity*).

In contrast, under half of the survey respondents reported that the local political climate supports HWB of the community, particularly for rural and regional councils. Given the strong organisational obligation and council commitment to HWB, the perception of an unsupportive political climate is perplexing. The question in the survey was in response to the political opportunities and responsibilities of levels of government as outlined in ADEPT (Rütten et al., 2011). How respondents interpreted this is unknown and not defined in the survey. However, it does suggest that LG decision-makers, as an organisational subsystem, agree that addressing health

determinants is important, though are challenged by the responsibilities of LG and the broader political climate (*see 8.2.13 Role of higher tiers of government*).

### 8.2.6 Internal collaboration and cooperation

Cross sector collaboration is a recognised element for success of a HiAP approach (World Health Organization, 2014; World Health Organization and the Government of South Australia, 2010). These study findings suggest that Australian LGs find working across sectors within LG largely cooperative and that most staff agree on actions to be taken. The survey findings reported stronger cooperation within city councils, although the regional case study sites also reported internal collaboration as largely cooperative. Previous literature reports internal collaboration as more difficult in larger LGs addressing health promotion policy (Pettman et al., 2013). This raises debate if the level of cooperation is based on geographical remoteness alone, or size of council. The smaller site of Finchville reported a more cooperative, albeit informal, political decision-making environment within the council, both across departments and between staff and elected members. Part of the reason provided was that they are a small council, with fewer elected members and staff, many who overlap strategic and operational roles simultaneously. This is a trait also identified by other studies, with suggestions that small councils have closer social ties and trust amongst staff, co-located staff, managers that span more than one policy area, collaboration necessary to achieve goals when resource-constrained, lower number of issues to address, and less bureaucratic organisational structures (Hendriks et al., 2015; Hendriks et al., 2013).

The findings are also congruent with previous research that argues LG is more likely to utilise informal collaboration, regardless of structures put in place (Larsen et al., 2014; Mannheimer, Lehto, et al., 2007; Rantala et al., 2014). Although, the informality of this collaboration has been identified as a challenge for LG to undertake municipal public health planning (Polley, 2019). In Roseford, as a larger regional council, participants acknowledged there were silos within their governance structure and reported less cooperation horizontally and vertically within the council in recent times. However, there were shifts to this level of organisational structure, with more formalised opportunities being put in place to address cooperation across

departments. On the other hand, the level of cooperation within council was reported as largely informal, with 'head and heart' decisions being decided on by individuals, depending on the circumstance and personal opinion, rather than any formalised response (*see 8.2.11 Policy actor values and beliefs*). The formalised roundtables were a result of changes in leadership within the council, suggesting that management support also has some level of influence on internal cooperation between departments (Steenbakkers et al., 2012) (*see 8.2.7 External collaboration*). Other LG research supports the establishment of formal collaborations to enable intersectoral collaborations within LG (Spiegel et al., 2012; Synnevåg et al., 2018a), albeit recognised as difficult to achieve (Holt et al., 2017).

Some participants in Roseford felt that more formal, systematic processes could be useful to incorporate health perspectives into local decision-making. The use of such tools, such as HIA, have been found to support decision-makers across sectors to consider health impacts (Bhatia & Corburn, 2011; Scheele et al., 2018). However, there are associated challenges with having time, staff and financial resources to complete them (Bhatia & Corburn, 2011; de Blasio et al., 2012; Kokkinen, Muntaner, et al., 2019; Mannheimer, Gulis, et al., 2007), and requires a political commitment to integrate the process (Bhatia & Corburn, 2011; de Blasio et al., 2012). Based on this, Australian LGs demonstrate the willingness, although already acknowledge the limited resources available, making any further expectation of use of tools such as HIA unlikely to be feasible in the current policy environment (*see 8.2.18 Staff and financial capacity*).

### 8.2.7 External collaboration

Participants were clear that achieving community HWB required the role of LG working collaboratively with other sectors, such as higher tiers of government, local community organisations and commercial businesses in the region. This level of collaboration with external stakeholders is frequently cited as a requirement for successful action on HiAP or healthy planning (Corburn et al., 2014; de Leeuw et al., 2015; McCosker et al., 2018). Survey findings in this study indicate that a lack of formal collaborative partnerships for HWB, and the difficulties in getting support from other sectors in the development and implementation of HWB policy. There

were few variations in reports of collaboration with other sectors from respondents in city, rural and regional councils, with a level of cross-sector cooperation likely challenging all size and location of LGs. It appears that LGs demonstrate working across a range of sectors, though also recognise the challenges that this poses.

There were several examples in the case study sites that explained the difficulties of working collaboratively. In Roseford, a cross government collaboration to address a range of health determinants in the region ceased once funding was no longer available. Whilst there were benefits of involvement recognised by all stakeholder departments, the responsibility for coordinating action on health determinants was not seen as any single agency responsibility. This perception of health determinants not being their responsibility, or seen as additional work by other sectors outside of health, is noted in research as a challenging factor to external collaboration (Corburn et al., 2014; Larsen et al., 2014; Rantala et al., 2014). However, the perception of additional work is proposed as a result of 'health imperialism', and that framing the goals less on health outcomes improves policy traction (Exworthy et al., 2002; Hagen et al., 2017; Hoeijmakers et al., 2007; Holt et al., 2017; Holt, Rod, et al., 2018; Scheele et al., 2018; Synnevåg et al., 2019) (*see 8.2.2 Framing*). The project in Roseford is an example where health was not the reason for departments coming together, though established on co-benefits. Yet neither LG, nor other sectors, were able to take the responsibility or resource the coordination of the collective project and so the initiative ceased (*see 8.2.18 Staff and financial capacity*).

In addition, a reference group was established for the development of a HWB plan in Finchville. In the development of the community HWB policy, it was always clear that council were developing a cross-sector plan that they intended to deliver alongside stakeholders. This approach of cross-sector delivery is evident across many of the written policies within the case study sites. However, the experience of the reference group suggested there is no clear strategy of how implementation of the plan would be achieved. Similar to Karlsson et al. (2017), stakeholders were more involved during policy development. In Finchville, this was demonstrated in the level of power and decision-making being handed to those at the 'coalface', and represented on the committee (*see 8.2.9 Evidence*). This is consistent with research

that proposes that engagement with stakeholders saves decision-makers from having to do the research themselves (Karlsson et al., 2017). In this instance, the group comprised mostly healthcare-oriented stakeholders. These policy actors were then in a powerful position to influence the decision-making agenda. This is in contrast to the restricted process preferred by policymakers in the Danish case study (Karlsson et al., 2017). The preference experienced in the Danish study was for a closed and quick consultation with external stakeholders, as a result of limited financial resources and time (Karlsson et al., 2017).

Another partnership group addressing homelessness within Finchville was often raised as a successful cross-sector collaboration. The example suggests that formal partnerships, with varying sectors involved, may be established to address more 'wicked' social issues, not framed around health. It may also have established around a specific issue, something suggested by Morrison et al. (2015) as an enabler to cross-sector collaboration *(see 8.2.2 Framing)*. Spiegel et al. (2012) agreed, finding cross-sector partnerships were more successful for healthy lifestyle programs, rather than for programs addressing structural determinants of health.

A scoping review by Chircop et al. (2015) demonstrates that LGs are not likely unique in experiencing the complexities of implementing an intersectoral approach to address health determinants. Whilst an abundance of literature on intersectoral collaboration exists, it is often not clear what tier of government they refer to. Outside of the scoping review completed for this thesis, there is a seemingly sparse amount of literature on the practice of intersectoral collaboration in LG, particularly in reference to addressing more 'upstream' determinants of health (Rantala et al., 2014). Additionally, most of the studies identified in LG addressing HiAP involve only the perceptions of decision-makers within LG, disregarding the views of external stakeholders.

In studies that included sectors outside of LG, there was little information on how the external stakeholders understood health impacts of their work, apart from engaging for their own agendas (Hoeijmakers et al., 2007). A survey of staff and volunteers of community-based organisations in two Canadian municipalities identified that they would most likely support action on clean air and water and healthy lifestyles, and

least to actions on income (Collins et al., 2007). In addition, findings by Collins et al. (2007) report that staff and volunteers of community-based organisations were not aware of the social determinants of health, or the level of influence that determinants have on health outcomes, particularly structural determinants of health. The responses were consistent with the local municipality respondents, markedly the least priority given to determinants of health (Collins, 2012).The limited research on stakeholder support for HiAP suggests that more evidence is required identifying the views of other stakeholders, particularly regarding the benefits of a HiAP approach from their perspective. Similar to research on viewpoints of stakeholders in the state-wide HiAP initiative of South Australia (Baum et al., 2017), exploring perspectives from local community organisations and stakeholders would help support advocates to establish 'win-win' scenarios for a HiAP approach in LG (Kokkinen, Freiler, et al., 2019; Rudolph et al., 2013).

### 8.2.8 Local leadership and support

Participants reported strong support and leadership within council for addressing HWB, particularly the leadership of CEOs and mayors, who had strong values, or personal interests in supporting community wellbeing (*see 8.2.11 Policy actor values and beliefs*). The support of management and political leaders is widely agreed as an important factor for policy action on HWB in LG (Bagley et al., 2007; Holt, Waldorff, et al., 2018; Jansson & Tillgren, 2010; Lillefjell et al., 2018; Lilly et al., 2020; Schmidt et al., 2010; Steenbakkers et al., 2012; Storm et al., 2016; Storm et al., 2014).

In Roseford, recent changes in the leadership of the mayor and CEO caused some disruption to policy. In this instance it was an opportunity for renewal and refocus of the priority on community engagement and wellbeing. However, leadership support did not necessarily equate to the support of existing policy. The new Mayor of Roseford, for example, was not aware of the content in existing policies and was more likely to make day-to-day decisions based on personal beliefs. In fact, policy changes were more likely to happen because a decision-maker does not like the policy, rather than policy driving decisions (*see 8.2.11 Policy actor values and beliefs*).

Other studies raise that whilst political support exists for the idea of health determinants, the commitment becomes difficult to maintain during implementation (Larsen et al., 2014; Scheele et al., 2018). This study also raised concerns by interviewees in Finchville that whilst a community HWB plan had been developed, implementing the plan was another challenge. Although, in this instance, it appeared related to potential lack of resources, rather than lack of leadership and support (*see 8.2.18 Staff and financial capacity*).

### 8.2.9 Evidence

This study agrees with previous research that LGs use a wide range of evidence to inform decisions, including anecdotal evidence (Kneale et al., 2019; McGill et al., 2015), media (Lawless et al., 2017; Stoneham & Dodds, 2014), government reports (Browne et al., 2017; Lawless et al., 2017; McCosker et al., 2018; Stoneham & Dodds, 2014), academic research (Lawless et al., 2017; McCosker et al., 2018; McGill et al., 2015; South & Lorenc, 2020; Willmott et al., 2016), and information from networks and other stakeholders (Browne et al., 2017; Lawless et al., 2017; Stoneham & Dodds, 2014).

The findings support that demographic data, health statistics, and community consultation informed what the policy issues were, and that policy solutions were informed by local stakeholders (Armstrong et al., 2014). This was experienced in the participation of the reference group in Finchville, with the prioritisation of issues partly driven by available demographic and health data, though the emphasis and final decision-making for policy solutions reliant on the input and local expertise of stakeholder organisations working at the 'coalface' (*see 8.2.7 External collaboration*).

In addition, case study participants in both Finchville and Roseford reported that decision-making is largely driven by anecdotal evidence and community complaints (or lack of). The emphasis on this study was on 'visible' evidence, judged by community utilisation of facilities and attendance at events. This is congruent with research that has found community input as the most important and influential evidence to guide LG decision-making (Armstrong et al., 2014; Browne et al., 2017; Corburn et al., 2014; Kneale et al., 2019; Stoneham & Dodds, 2014) (*see 8.2.15 Role*

*of community*). In contrast, Stoneham and Dodds (2014) found that level of complaints or enquiries to council were the least used type of evidence in municipal public health planning in Western Australia.

Whilst the range of evidence used is vast, most survey respondents reported that there was sufficient evidence to support council decisions on HWB and that scientific evidence demanded action on HWB policy. However, in case study sites, use of scientific evidence was not raised as the reason for initiating health determinants onto the policy agenda or informing policy solutions. Generally, there was a lack of scientific or rigorous research informing LG health policy. A review of municipal public health plans in Victoria, Australia, found that academic research is the least cited source of evidence in documents (Browne et al., 2017), with others finding academics have the least influence on policy decisions, and academic literature being the least useful to LG decision-makers (Armstrong et al., 2014). In Roseford, the mayor highlighted that decision-making is more likely to be made based on values, rather than what is informed by other evidence (*see 8.2.7 External collaboration & 8.2.11 Policy actor values and beliefs*). This is consistent with Armstrong et al. (2014) who report that mayors and CEOs, public health managers, and community have the most influence in policy decision-making (*see 8.2.7 External collaboration*).

It is apparent in the studies from the United Kingdom that LGs put emphasis on local evidence and feasibility of policy decisions, rather than the hierarchy of evidence model previously applied at a national level (Marks et al., 2015; Phillips & Green, 2015; Willmott et al., 2016). There is acknowledgement that LGs have always been responding to determinants of health as a result of responding to community needs, though the merging of other public health responsibilities has created tensions over competing priorities with healthcare and concerns of funding for public health being absorbed into the many competing policy agendas at a local level (Phillips & Green, 2015).

Local data were reported as difficult to obtain, especially for small councils, a commonly reported challenge in LG in Australia and internationally (Bekken et al., 2017; Browne et al., 2017; Corburn et al., 2014; McCosker et al., 2018; Stoneham &

Dodds, 2014; van der Graaf et al., 2021). A written policy in Finchville explicitly noted a need for more local data. However, it was reported by interviewees that collecting their own data is too expensive, and therefore creates ongoing conflict in decision-making of whether to spend the already stretched resources on gathering data, or to put the resources into actionable strategies (*see 8.2.18 Staff and financial capacity*). Previous research has highlighted the lack of staff capacity and time as one of the challenges to using evidence (Armstrong et al., 2014; Browne et al., 2017; South & Lorenc, 2020; Stoneham & Dodds, 2014; Willmott et al., 2016), despite them likely being highly skilled in sourcing and compiling research (Armstrong et al., 2014).

Further to this, other studies have highlighted the need for disaggregated data to inform health equity (Morrison et al., 2014; Schmidt et al., 2010). This was not something raised by LG decision-makers in the study, although some participants referred to certain population groups not being heard within the community, suggesting they were aware of inequities within the population. Qualitative comments in the national survey also resulted in a theme related to inclusiveness and equity, though there were no reports that LG decision-makers were seeking out any evidence of how this influences policy decisions.

### 8.2.10 Performance measures

The findings conclude that LGs do not likely use performance indicators or invest in measures for HWB. Survey respondents reported that while council reviews policy and considers HWB impacts, there are a lack of performance indicators used in measurement of this. Case study participants confirmed this. There were very few performance indicators within any of the written policy documents, including the newly developed community HWB plan in Finchville. Previous research has also found a limited use of performance measures for monitoring public health action (Exworthy et al., 2002; Jansson & Tillgren, 2010; Larsen et al., 2014), noting this as a challenging factor in local public health planning action (Polley, 2019).

Case study participants reported that measuring action on health determinants is complicated, with difficulty in knowing what to measure, difficulty collecting data over time, having the resources available to collect data, and the lack of access to

local data. This was reported as particularly difficult in small councils (*see 8.2.18 Staff and financial capacity*). Much of the literature notes the difficulty of measuring public health or health equity success, including a lack of argument regarding cost-effectiveness (Dhesi, 2014; Larsen et al., 2014; Lowe et al., 2015; Scheele et al., 2018). This is not a new concept, with academics within public health themselves finding health determinants difficult to measure (Bauman et al., 2014). Paradoxically, participants of Finchville commented that they only measure things they believe could be an issue. Addressing health determinants was not seen as an issue, therefore, investing in measuring health outcomes was not considered 'cost-effective' for the council.

Previous research has shown some success in incorporating performance measures for increasing understanding of the policy problem (Lowe et al., 2015) and measuring performance over time (Corburn et al., 2014; Lowe et al., 2015). An example is the City of Richmond in California (Corburn et al., 2014). After agreeing to adopt a HiAP approach, Richmond developed performance indicators to align to priority areas of strategic plans. The performance indicators for each of these were based on relevant, and existing, indicators, and portraying them in a spider chart to demonstrate their interconnectedness (Corburn et al., 2014). The performance indicators also served to set concrete goals for various departments to strive for, helping to embed the practice of HiAP amongst the different municipality departments (Corburn et al., 2014).

Other studies report using tools to measure health and act on equity, such as the Urban HEART (Health Equity Assessment and Response Tool) in Spain (Novoa et al., 2018). Similar to the use of HIA to inform policy, utilising tools to measure health equity gaps and responses still requires political will (Novoa et al., 2018). This need for political will is recognised as a key first step in the World Health Organization manual for the application of Urban HEART (World Health Organization, 2010b). However, the term 'political will' is recognised as ambiguous, acknowledging this means more than the political intent of individual decision-makers (Post et al., 2010; Zalmanovitch & Cohen, 2015). Political will encapsulates stakeholder support, capacity, and commitment over the long term (Post et al., 2010).

Given the challenges proposed by participants of this study, such as a lack of staff and financial resources, the use of such tools is unlikely in Australian LG. Overall, the findings from both phases of the study report that LGs are not measuring HWB outcomes, either intentionally or because they are difficult to measure, especially given the level of influence that LGs have.

#### 8.2.11 Policy actor values and beliefs

The beliefs of achieving a 'happy' and 'liveable' community are important to LG decision-makers, demonstrated through reports of a personal and organisational obligation to the community, and sense that personally, HWB should be a higher priority for councils. The beliefs of LG staff and elected members became a strong enabler for local policy decisions in favour of HWB. Interestingly, the strong personal obligation was similarly reported across all respondents, regardless of legislative environment or geographical remoteness.

Within case study sites, there were reports of multiple champions for the cause of community wellbeing outcomes. Finchville demonstrated these shared values in their initiation and development of a social justice statement. The debate on marriage equality for Lesbian Gay Bisexual Transexual and Intersex populations was framed by an elected member as an issue the council should respond to, from a social justice perspective, though also aligned to the core of many individual values and beliefs within council decision-makers (*see 8.2.16 Role of media*). Even where it was not well aligned to personal beliefs, the way it was framed may have made it politically difficult to disagree with.

The shared beliefs within the LG subsystem may also be reinforced through recruitment strategies, whereby staff are employed not only for their expertise and skills, but also based on their shared philosophy and values. At the same time, whilst agreement exists that addressing community wellbeing is the role of LG, the ambiguity of the policy problem means that addressing health determinants becomes the role for everyone, but at the same time for no one (*see 8.2.1 Understanding the policy problem*).

Other research has found that commitment to addressing health inequities aligned with decision-maker political ideologies (Kokkinen, Muntaner, et al., 2019; Novoa et

al., 2018; Schmidt et al., 2010). However, Simonsen-Rehn et al. (2012) found that length of time as a politician in LG explained more of the differences in perceptions of 'health promotion' impact, than did political party ideology. Many of the case study participants were long-standing managers, CEOs or elected members in Australian LG, which may also explain the high level of commitment demonstrated.

The literature refers to politicised decision-making as a potential challenge to gaining traction on health policy (Kokkinen, Freiler, et al., 2019; Marks et al., 2015; McCosker et al., 2018). An example is the long timeframes required to see population health impacts, which makes addressing health determinants less politically attractive (Ollila, 2011). One case study participant also raised this as a challenge, given the short election cycles (*see 8.2.17 Events*). Otherwise, any argument that election cycles influenced policy were related to the leadership commitment required (*see 8.2.8 Local leadership and support*) and organisational stability at a local level, or reliance on the strategic direction or funding from higher tiers of government (*see 8.2.13 Role of higher tiers of government*).

### 8.2.12 Role of legislation

Most respondents to the survey perceived the legislative environment as unsupportive. Regardless, case study site participants reported that policy decisions on health determinants were made in the absence of any mandates, regulations, or external political environment. Similarly, previous LG research has identified that whilst legislation can be supportive of action on health determinants, LGs still prioritise action based on local needs and structures (Browne et al., 2019; Jansson & Tillgren, 2010; Kneale et al., 2019). This is also consistent with studies in Healthy Cities in Europe, where initiation of policy was driven from mostly internal municipal structures (de Leeuw et al., 2015). This may explain why the survey findings from this study showed little to no difference in perceptions of a supportive legislative environment between the different states and territories, despite the varying legislative mandates. Participants in this study reinforced that 'health' was a responsibility for state or territory government. This suggests that existing 'clear mandates', as a key element for HiAP (World Health Organization, 2014; World

Health Organization and the Government of South Australia, 2010), are not necessarily relevant for LG.

There remains continued debate in the literature that national level mandates for HiAP have a positive impact on the ability to address health equity amongst populations (Tonelli et al., 2020). The experiences from the state government HiAP initiative in South Australia has argued over time that strong leadership and mandates from politicians in power was supportive of action (Baum et al., 2015; Baum et al., 2010), along with helping to integrate HiAP into governance systems to encourage policy learning across departments (Baum et al., 2015). In addition, the inclusion of LG in addressing health determinants was said to be strengthened by the introduction of a new Public Health Act in 2015 (Baum et al., 2017). Interestingly, and despite this, respondents from LG in South Australia in this study did not report the broader political environment as any more supportive than other states and territories. Given the survey data were collected only a year after the new public health act was implemented in South Australia, it would be of interest to determine if this perception has changed over time. In a study across several national and state case studies in multiple countries, Molnar et al. (2016) cautions that legislative mandates can be counterproductive for the implementation of HiAP, creating tension and delays if the responsibilities remain unclear.

Based on the broader research and findings from this study, it is recommended that health promotion practitioners advocate to higher tiers of government for greater cross-government support in addressing health determinants that clearly outlines roles and responsibilities of all tiers of government, whether this is legislated or not. Where legislation does exist for LG, an emphasised focus on addressing determinants of health would better match LG responsibilities and ideologies. However, this needs to be matched with sufficient and equitable resourcing. In agreement with this, authors that have explored public health planning in the state of Victoria, Australia, where municipal public health planning has been legislated for decades, suggest that future planning for HWB should be done in collaboration between LG and higher tiers of government, in an attempt to reconcile their different priorities (Bagley et al., 2007; Browne et al., 2019).

Whilst the case study site participants were not currently bound by any mandatory requirements to address health determinants, most expressed support for future legislative action, as long as it was sufficiently resourced. Participants across both phases of the research raised concerns that the state/territory government may devolve further responsibilities to LG for addressing HWB without additional funding resources, as they report has previously occurred (Browne et al., 2019; Polley, 2019). Browne et al. (2019) found that while LG attempts to respond to the state legislation for public health planning, the grants available were not always sufficient, leaving the LG to either contribute resources or not respond to certain priorities (Browne et al., 2019). Previous research also cautions that effective legislation requires adequate staff and financial resourcing for policy implementation, not only for policy development (Bagley et al., 2007; McCosker et al., 2018) (*see 8.2.13 Role of higher tiers of government & 8.2.18 Staff and financial capacity*).

### 8.2.13 Role of higher tiers of government

Survey findings report a lack of cooperation with, and leadership from higher tiers of government, consistent across city, regional, and rural council contexts, and mostly consistent across different states and territories. Case study participants agreed. On one hand there is appreciation of funding received by higher tiers of government for various programs and capital investment projects. Alternatively, there were examples that this funding restricts sustainable community action, such as short-term or diminishing funding made available for specific projects, and regular changes in strategic direction and priorities. One of the key frustrations portrayed by LG interviewees was the lack of consistency and sustainability of policy issues over the long term by higher tiers of government (*see 8.2.12 Role of legislation & 8.2.18 Staff and financial capacity*). As a highly influential and important stakeholder supporting action on SDoH (Baum et al., 2013), the lack of cooperation between tiers of government appears to be a significant barrier to further action on HiAP.

Findings by Lawless et al. (2017) are congruent with the case study findings in Finchville, where participants reported that action on addressing health determinants will continue at a LG level, despite, or even as a result of, the disinvestment by other

tiers of government. However, as others have reported, higher tiers of government are restricted in their own capacity to address determinants of health, as they experience competing issues of 'urgent', short-term healthcare priorities (Baum et al., 2015; Embrett & Randall, 2014; Pinto et al., 2015).

### 8.2.14 Lobbying action

Despite many policy actors involved, the study found a lack of either internal or external lobbying efforts putting pressure on LG to take action to address health determinants. This is likely challenging the policy process, given that Polley (2019) found internal advocacy supported municipal public health planning in Western Australian councils. The survey questions did not ask participants whether there was any demand for action from external stakeholders. This was a study limitation identified early, with prompts for answers to this question included within the case study sites. When asked, case study participants could not recall any local advocacy groups, campaigns, or external stakeholders that were putting pressure on LG to address any determinants of health.

With LG the closest tier of government to the community, and their stated responsiveness to community needs, the role of community demand was considered particularly relevant to the study. There were mixed views on the level of demand from the community for action on HWB. For instance, most survey respondents reported that there was demand from community for action on HWB, although this was not echoed in comments from case study participants. Whilst it was stated that LG responds to local community demands (which is possibly how this question was interpreted in the survey), there is little evidence of community demanding action on addressing health determinants from LG. However, survey respondents also reported a reluctance to indicate how their community define HWB as a policy problem or commented that they '*couldn't possibly know'*. This suggests that for some councils and decision-makers, communities are not particularly engaged in the process (*see 8.2.15 Role of community*).

Whilst this is the case, there are no conflicting community viewpoints of what should be done to address HWB. Amongst the study findings, concerns of rising property rates were the only community feedback being received that supports LG taking no

action at all. Overall, the findings suggest it is unlikely that public opinion and lobbying efforts from community are influencing LG decisions to address determinants of health. This is consistent with a study of Healthy Cities in Europe, where initiation of policy was driven from community action in only 5% of cases (de Leeuw et al., 2015).

#### 8.2.15 Role of community

Whilst there was a lot of rhetoric around obligations of LGs to respond to community wellbeing 'in every decision' that they make, there appears to be mixed evidence from the research findings of the extent to which communities themselves are involved. Most survey respondents in this study reported that the community supported the approach to HWB by LG, but that the local community were not necessarily involved in the decision-making or implementing action. Survey findings indicate that respondents from city and rural councils were more likely to report that there was community engagement and support. However, this study did not measure the extent or quality of this community engagement. It was noted by a few of the case study participants that there were some population groups within the community that do not have a voice, are not creating 'noise', and hence may not be influencing decisions being made by council as much as they could be.

Previous research highlights that community consultation and interest from the community was a key driver for local policy action on public health planning (Bagley et al., 2007; McCosker et al., 2018; Polley, 2019), or were challenging the council on prioritising health inequalities (Morrison et al., 2015). The regional case study sites each took different approaches to community voices in decision-making, with Finchville feeling more confident that the community agreed with their values and philosophies already (*see 8.2.11 Policy actor values and beliefs*), and Roseford reporting less confidence that the community were engaged. For this reason, Roseford made significant efforts to increase community engagement through formal dialogue processes.

There was also acknowledgement within written policies that community input had been sought, with more consistent evidence of this in Roseford. Finchville, on the other hand, tended to utilise community consultation once a plan had been nearly

fully developed. This involvement of community at the end of the policy process has been reported elsewhere, leaving community little opportunity for influencing the strategic direction of a policy (Karlsson et al., 2017).

Case study findings suggest that the community are quite removed as policy actors in the policy process, despite being seen as having a lot of power in LG decisions (*see 8.2.9 Evidence*). Browne et al. (2019) found that health planners in LG perceived community consultation would reinforce the need for behavioural programs. In agreement within the broader literature, it is suggested that the public's dominant health discourse focussed on 'illness' could restrict the community support for health promotion efforts (Barry, 2021). The hesitations of including community may explain the lack of closely networked community groups and organisations in policy decisions reported by Hoeijmakers et al. (2007).

Others have called for a shift in power, generating more community-led engagement processes (Fisher, 2018). Corburn et al. (2014), using a single case study, demonstrated how community input, facilitated by the LG, influenced the policy agenda for health equity. The study demonstrates an encouraging indication of how engaging community around health determinants could be utilised as a powerful policy tool for those advocating for change in LG. Other research in Germany has reported that community members, including members of local government, focus HWB on topics such as supportive natural and built environments, a sense of community and social cohesion, and access to services (Hilger-Kolb et al., 2019). This helps to reinforce that community members consider their wellbeing as determined by structural determinants of health, rather than focussed on individual lifestyle determinants.

Whilst it is the remit of Australian LG to engage with their communities, the level of engagement and extent of this may vary, based on this evidence. In addition, key local evidence was reported as the level of complaints being received by the community. There were several participants that indicated that if there were no complaints by the community, then this reinforced the perception that the community were happy (see 8.2.9 *Evidence*).

As reported previously, neither survey data nor case study participants report a strong lobbying effort by the community on HWB actions. Whether the public are apathetic about HWB, or whether the public is part of the policy monopoly, is difficult to devise from this data, given there is no input from the community themselves. The reliance then is on the community groups who service these populations to create political pressure (see 8.2.7 *External collaboration*).

### 8.2.16 Role of media

Study participants agreed that local media were neither a challenge, nor an enabler to the health policy process. Survey findings suggest that the media do not support the action or the council's approach to HWB, consistent across all geographical locations, including different states/territories and remoteness of councils. In case study sites, the media involvement was reported as apathetic. The local media were seen as an ally, reporting what the council would like them to, and otherwise not engaging in broader debate regarding addressing determinants of health. Therefore, respondents felt that local media were unlikely to have any influence on local policy decisions.

If any, LG policy on HWB was influenced by broader national media discourse (*see 8.2.9 Evidence*). In an example, the broader media debate around marriage equality for Lesbian Gay Bisexual Transexual and Intersex populations resulted in the rapid escalation of social justice onto the policy agenda of Finchville. In this instance, values of social justice were able to rise above the policy noise and reach the policy agenda (*see 8.2.11 Policy actor values and beliefs*). Similarly, some examples were provided in Roseford around water security and drought, the NDIS, and youth unemployment. In these instances, media outside the local region were influencing local decision-makers and the policy agenda. There remains little research of the role of media influencing LG policy processes regarding action on health determinants, apart from being used as a form of evidence.

### 8.2.17 Events

The study findings suggest that the role of events, including organisational changes such as amalgamations and government elections, impact either positively or negatively on local policy decisions. An example provided, such as community

displacement in Finchville, was an event which raised homelessness onto the policy agenda of the council. In addition, participants from both case study sites mentioned experiences of LG amalgamation or changes in leadership, that disrupted the policy process. This was seen as either a potential positive opportunity to renew policies where the values or beliefs of new decision-makers aligned to values of health equity, or alternatively a negative impact where new leadership and decision-makers did not agree with previous policies (*see 8.2.7 External collaboration*). Little research is known to exist regarding the role of events in HWB policy processes in LG in which to compare the study findings to, either in Australia or internationally.

### 8.2.18 Staff and financial capacity

Few respondents to the national survey reported the necessary level of financial and staff capacity available throughout the policy process. One third of respondents felt that there was staff capacity and less than a quarter who reported the financial capacity for development and implementation of local HWB policies. Funding for addressing HWB in LG is consistently reported as a challenge across international studies (Helgesen et al., 2017; Larsen et al., 2014; Morrison et al., 2014; Morrison et al., 2015; Mundo et al., 2019).

Respondents in city councils, whilst few still reporting it as true, were more likely to report sufficient financial and staff resources than regional or rural counterparts. The regional case study sites confirmed that it is difficult to resource everything they prioritise. Previous studies have agreed that larger municipalities have more resources available to them (Bekken et al., 2017), although Bagley et al. (2007) found that the wealthiest Australian councils did not necessarily reflect level of investment in public health planning and that other factors were more influential, such as strategic and formal planning processes and community involvement.

In this study there was recognition by participants that increasing property rates was not a solution to generate more funding, as it was also detrimental to population HWB, especially for those on low incomes. This limited ability to increase revenue has been noted elsewhere (Collins & Hayes, 2013). Allender et al. (2009) further add to this debate, highlighting that councils with higher socio-economic populations can charge higher rates than those in lower socio-economic areas, which impacts on how

much funding is available. This was noted as a reason for LG to focus on employment in Roseford, not to address employment as a health determinant, though to aid the capacity of constituents to be able to pay higher rates.

In the current policy environment, reports exist of conflict regarding the cost effectiveness of increasing property rates to gain other potential community outcomes. This is despite survey respondents reporting that investment in HWB was a cost-effective strategy. As a result, decision-making relies on debating the cost-effectiveness of policy actions, weighing up fiscal costs with the potential positive or negative impacts this might have on community wellbeing. Decision-makers want to know that money spent will have a good community outcome, yet money is not spent measuring the outcomes to inform decision-makers (*see 8.2.10 Performance measures*).

As a large regional council, Roseford reported being more reliant on funding support from higher tiers of government, creating a level of conflict not reported in Finchville, but reported amongst other studies (Collins & Hayes, 2013; Marks et al., 2015). The friction reported by participants was the often short-term grants and lack of consistency and sustainability of funding to keep delivering outcomes for the community (*see 8.2.13 Role of higher tiers of government*). A study in Norway also found that funding from higher tiers of government does not always match the needs required by LG (Fosse & Helgesen, 2015), creating debate regarding the scope of legislation for LG in addressing health determinants (*see 8.2.12 Role of legislation*). One of the beneficial insights of utilising the stages heuristic in the survey design was the recognition of funding challenges for policy implementation, moreso than policy development. This may be aligned to the reported waning of 'political will' after policy has been developed (Larsen et al., 2014; Scheele et al., 2018).

The experience with Finchville suggests that staff capacity is also a challenge, with a comment by a participant that whilst the new community HWB plan was well developed, there is an inadequate level of staff to be able to deliver on it. Amongst other written policy documents there were caveats integrated into the written plans with recognition that action would occur within staff capacity expertise and financial resources. Staff capacity is also raised as a challenge in other literature, with

recognition that staff require the skills, motivation, and time to deliver on effective policy at a local level (Bagley et al., 2007; Bhatia & Corburn, 2011; Kneale et al., 2019; Langeveld et al., 2016; McCosker et al., 2018; Mundo et al., 2019; Polley, 2019; Willmott et al., 2016).

#### 8.2.19 Policy entrepreneur

Less than half of the survey respondents indicated that there was a key champion in their council for HWB. Participants in the case study sites also reported there was no specific champion, though likely multiple champions for addressing community wellbeing. Whilst these local champions were reported to have a focus on community wellbeing, there was no reported evidence of a focus on health equity or addressing broader determinants of health. The data suggests that it is unlikely anyone is manipulating windows of opportunities for action to address health determinants across local policy agendas, at least within LG. To date, there has been limited research in LG of the presence of a policy entrepreneur navigating the policy process. Hoeijmakers et al. (2007) mapped a range of stakeholders involved in a local health policy process in the Netherlands and did not find evidence of a policy entrepreneur. However, McCosker et al. (2018) found that healthy planning and active living advocates acted as policy entrepreneurs, both in and outside of LG.

## 8.3 Summary of influencing factors in LG policy process for HiAP

The key elements stated to make HiAP a successful approach include a clear mandate, co-benefits for all stakeholders, intersectoral support, stakeholder engagement processes, formal and informal structures, and clear roles and responsibilities (Rudolph et al., 2013; World Health Organization, 2014; World Health Organization and the Government of South Australia, 2010). The study findings presented here indicate that Australian LG demonstrates some challenges to achieving these key elements. For example, many respondents, including CEOs and decision-makers, reported a lack of support by higher tiers of government, including an unsupportive legislative environment, tension over responsibilities of councils to address HWB as a policy problem, and difficulties collaborating and gaining support of external sectors. Despite this, evidence exists of factors that facilitate opportunities for LG to act on health determinants.

The first research objective posed was to identify the enablers and challenges in existing healthy public policy processes in Australian LG. The study findings have identified a range of factors influencing the policy process, that largely support the existing literature (Table 19). The values and beliefs of policy actors, the lack of lobbying action and focus on the role of events were themes raised in this study, not previously stated in other literature related to HiAP within LG.

The factors likely positively influencing the policy process in LG include strong personal beliefs and obligations from individuals that addressing HWB is a high priority agenda, albeit not likely framed to respond to population health issues. Similarly, this contributes to a strong commitment by LG to respond to policy that address health determinants within the community, something identified as consistent across all LG in Australia, regardless of legislative environment. This action is informed by all types of evidence, based on local data that is available, and through the voices of community, whether through community engagement, or through the response to community complaints. There is otherwise a lack of pressure on LG for action, either from higher tiers of government, media, community, external advocates or internal champions. The lack of measures for health equity or health determinants, and the lack of lobbying action does little to raise health equity as a policy problem for LG. Where it is recognised, there is often a limited amount of resourcing available. In addition, the influencing factors are well demonstrated in this study as interconnecting in a 'messy' process. However, the listing of factors in this way does little to reduce the ambiguity of the complex policy process. The next chapter will further explore the findings through the theoretical lens of multiple political science frameworks to gain insight on how they are able to better understand the policy process.

**Table 19** *Comparison between research findings (themes) from this study as compared to international literature, either supporting, refuting or new.*

| Research findings | Comparative literature: Support/refute/new |
|---|---|
| Understanding the policy problem | Support |
| Framing | Support |
| Policy priority | Support |
| Policy solutions | Support |
| Local ideology | Support |
| Internal local cooperation | Support |
| External cross-sector relationships | Support |
| Local leadership support | Support |
| Evidence | Support |
| Performance measures | Support |
| Policy actor values and beliefs | New |
| Role of legislation | Support |
| Roles of higher tiers of government | Support |
| Lobbying action | New |
| Role of community | Support |
| Role of media | Support/New |
| Events | New |
| Staff and financial capacity | Support |
| Policy entrepreneurs | Support |

## 8.4 DIFFERENCES IN POLICY PROCESS FACTORS ACROSS AUSTRALIAN LG CONTEXTS AND JURISDICTIONS

The second research objective of this study was to determine how the enabling and challenging policy factors to current healthy public policy processes are different across various LG contexts and jurisdictions. Overall, research is lacking regarding a HiAP approach in LG, and particularly limited in relation to different LG contexts. Exworthy (2008) stated that the "*Understanding of the policy process in particular contexts has been missing*" (p.321). This appears to still be the case over a decade later, complicated by the focus on single case studies, lack of theory and the consequent lack of generalisability.

The national, online survey in phase one of the research provided an opportunity to gain the perspectives of a large range of LG contexts. The research findings identified that the factors influencing HWB policy were no different across different states and territories. Regardless of legislative environment, the priority and

commitment for HWB, along with personal and organisational obligations, are high, and the investment was seen as worthwhile. Limited resources were reported across all legislative environments, particularly in regional and rural councils. The legislative environment did not impact on the level of local commitment to addressing health determinants, with a perception that LG had little support and cooperation with higher tiers of government to provide sufficient support and guidance. In this study, legislative environment may be somewhat influencing policy, as seen with Victorian respondents reporting many of the variables as more true, though not universally different to all other states and territories. CEO data confirms that the high priority and clear council commitment for HWB is the same across all states/territories, as well as the perceived unfavourable legislative environment.

There is very limited research in Australia comparing different legislative environments to addressing determinants of health. However, McCosker et al. (2018) also concluded that healthy planning policy in LG had similar barriers across different legislative environments. Previous research in the World Health Organization's Healthy Cities project suggests that the length of time cities were involved in the healthy cities program determined their level of engagement in policymaking (de Leeuw et al., 2015). This may explain the more positive political environment reported by LG respondents in Victoria, given their long-term participation in municipal public health planning.

The findings suggest that legislation, as a public health response to approaching HiAP in LG, is not a key factor to be pursued independently of other considerations. In particular, the findings propose that appropriate resourcing is needed to accompany the legislation, particularly for regional and rural councils. Otherwise, state or territory-wide legislation may facilitate LG in cities to be more successful than others in more regional areas, potentially contributing to further health inequities between rural and metropolitan populations.

It should be noted that the number of studies in Australia are limited in comparison to studies in countries where there are existing national level mandates for LG to address determinants of health (e.g., United Kingdom) and specifically taking a HiAP approach (e.g., Norway). What makes Australia unique from other countries is

the varied legislative environments across the country, where the majority of LG are not bound to any legislative action and LG do not have any responsibility for healthcare or social services. However, this study has concluded that the factors influencing the policy process to adopt a HiAP approach in LG were much the same as other countries, and similar across states and territories in Australia. This further contributes to the argument that the legislative environment does not play a key role in policy action to address health determinants in LGs. In contrast, respondents of city councils reported that the legislative environment was more favourable than rural and regional counterparts. There is no known research on the size or geographical remoteness of LGs and impact of legislations to compare these findings.

Whilst financial and staff capacity was a factor that challenged all councils, regardless of legislative environment, the survey findings highlight that this was particularly the case for regional and rural councils. In addition, Roseford demonstrated a greater level of resourcing challenges. Roseford is possibly hampered by challenges to resourcing known within large regional councils, such as low population density, a growing population, and high proportion of Aboriginal and Torres Strait Islander people (Tran & Dollery, 2019). This presents an ongoing challenge for Australia, with the amalgamation of councils that has seen regions amalgamate into one large LG, reported as inefficient where population size alone is the premise for this change, rather than looking at other considerations such as geographical topography (Dollery et al., 2008).

These findings contribute to the limited research on different LG contexts. Bekken et al. (2017) have previously reported that larger municipalities (often metropolitan) were better resourced, of which this study agrees that metropolitan councils had a more favourable policy environment. Although, Bagley et al. (2007) report that the wealth of councils did not always determine how effectively Australian LG approached municipal public health planning. This reinforces that resources alone are not the only influencing factor in the policy process and that other factors within city councils contribute to explaining the successes of addressing HWB of populations.

Case study participants added to this discourse, confirming that the size of council is a contextual factor. Differences between the case study sites included their level of organisational stability, informal and formal ways of working together, reliance on higher tiers of government, and interaction with communities, all ultimately informing their approach to addressing health determinants. However, there were also some similar factors such as strong leadership, personal obligations to community, and a commitment to providing a liveable community for their constituents. Qualitative responses in the national survey also provided insight into the difficulty of rural councils focussing on addressing determinants of health, as they still compete with the expectation of delivery of medical care which other tiers of government do not resource.

It should be noted that most of the research findings are informed by self-reported survey data. Whilst this has been highly beneficial to explore contextual and legislative differences across Australian LG, it may not reflect all councils. In addition, the two case study sites only represented regional councils, albeit with varying contexts. Whilst this offered additional insight, more qualitative research is required to test the generalisability of these findings with LGs of differing legislative and geographical contexts.

## 8.5 SUMMARY OF CHAPTER EIGHT

This chapter presented a convergence of the study findings to answer research objectives one and two, with comparisons made to existing literature. The research findings concluded that there are a wide range of factors influencing LG health policy. Many of the influencing factors of the policy process identified in this Australian study confirm results presented internationally. The legislative environment was found to have little impact on the factors that influence the policy process, although size and rurality of LG did have an impact, with city councils reporting a more favourable policy environment.

The next chapter provides a further analysis and critique of the research findings, exploring the influencing factors of the policy process regarding a HiAP approach in

Australian LG through the lens of political science frameworks. The final chapter will conclude with recommendations for future policy, practice and research.

# 9. Discussion Part II: Understanding the policy process through the lens of political science theory

## 9.1 Introduction

The previous chapter outlined the research findings in response to research objectives one and two. The identification of influencing factors, and their interrelatedness helped to understand the policy process, but not necessarily how they are theoretically related. This chapter will analyse and critique the research findings in relation to the third research objective, explaining how the HiAP approach in a LG context can be understood through the theoretical lens of political science. The chapter commences with a narrative for how each of the frameworks inform the understanding of the research findings, followed by a critique of how the application of political science frameworks have contributed to the exploration of the policymaking environment in regard to HiAP in LG.

## 9.2 How can the HiAP approach be understood through the theoretical lens of political science?

As recent as 2021, Cairney et al. (2021) report that few research studies on HiAP use policy theories to understand the dynamics of the policy process, reinforcing that theory should be used to inform how policy processes work, including for HiAP. As established in the scoping literature review in chapter three, there has been a dearth of literature on the policy process related to LG adopting a HiAP approach.

This study employed multiple frameworks to help explain the policy process in LG, identifying a wide range of influencing factors and their interconnectedness. These factors were outlined in chapter eight. However, with so many factors and interconnections, these also became difficult to interpret and understand the policy process in any meaningful way. This section interprets the key findings of the research through the lens of each of the theoretical frameworks. As will be demonstrated, each framework brought its own perspective and emphasis to the research findings. These are summarised as a narrative on each framework in Table 20.

The proposed learnings and recommendations from this perspective are incorporated in the narratives. The recommendations for practice arising from this study apply to a range of policy actors attempting to influence a HiAP approach in LG. This is highly applicable for health promotion practitioners and LG staff or elected members that are working at a local level to influence policy initiation or change in addressing determinants of health. However, it could also extend to those in roles within state or national LG professional associations or state and national government employees and advocates outside of LG (e.g., researchers). These policy actors are herein referred to collectively as practitioners and policy advocates.

### 9.2.1 Multiple Stream Framework

The MSF reminds practitioners and policy advocates that three policy streams need to align to open a window of opportunity, which facilitates policy issues reaching the agenda (Zahariadis, 2007). There are insights from this study on ways to assist the alignment of these streams. Given that the MSF theorises that to gain policy traction, a problem must be agreed on (Herweg et al., 2018), the broad and often ambiguous definition of health potentially becomes one of the difficulties in being able to define the actual policy problem. According to the MSF, this ambiguity is likely challenging its inclusion in the policy agenda (Herweg et al., 2018). The framing of HWB became quite vague, sometimes as 'liveability' or 'quality of life', and other times as an individual lifestyle issue. Reframing the issue is a factor in the policy process raised by this study and others. Regardless, caution should be raised in what alternative terms are used. Arguably, the term 'liveability' itself is open to interpretation. For example, various documents exist for LG as a guide to achieving 'liveability', with the term used as a definition for healthy eating and physical activity (Active Living NSW, 2020), attracting and retaining regional populations (Houghton, 2021), and as a guide for future infrastructure planning (Infrastructure Australia, 2018). Based on the results of this study, it is agreed that reframing the policy issue away from 'health' is necessary, though should not be replaced with another equally ambiguous term. According to the MSF, a policy problem will gain more attention if it seems relevant to decision-makers (Herweg et al., 2018). Therefore, advocating for HiAP should align to LG ideologies, including organisational and personal values and beliefs.

Baum et al. (2020) conclude, from case studies in state government, that framing of health inequities needs to shift towards the political benefits to be gained (e.g., moral position or social justice), and away from a biomedical or behavioural discourse. From a public health advocacy perspective, this concurs with good practice in advocacy messaging (Dorfman et al., 2005). Given the ideological values of social justice and commitment to community demonstrated by LG decision-makers, this could be an important recommendation on framing for future advocates in the LG context. However, the suggested action contrasts with the MSF, that theorises problems that are communicated as 'getting worse' gain the most political attention. With this perspective in mind, there is an opportunity to demonstrate social inequities, by sourcing and compiling local level evidence.

One of the difficulties is the lack of evidence for both policy problems and solutions, which is mostly local and anecdotal evidence. The MSF proposes that decision-makers can only deal with a limited number of problems at any one time, yet suggests that indicators, feedback or specific events are needed to raise the issue onto the policy agenda (Herweg et al., 2018; M. D. Jones et al., 2016; Zahariadis, 2007). This study identified some events, both broader national debate and local events, that raise health determinants onto the policy agenda, albeit very opportunistically.

Contrary to this, evidence demonstrating that health inequities are getting worse is unlikely to be informing LG policy. It is acknowledged that obtaining and using local data has challenged LG policy processes to-date (Bekken et al., 2017; Browne et al., 2017; Corburn et al., 2014; McCosker et al., 2018; Stoneham & Dodds, 2014; van der Graaf et al., 2021). In this study, participants also shared that collecting their own local data was perceived as difficult and lacked a sense of cost-effectiveness, despite local level data recognised as influential in local policy decision-making. Yet, poor health outcomes and health inequities have gained attention of policy problems in other studies that have applied MSF, in both local level government (Exworthy et al., 2002; Mannheimer, Gulis, et al., 2007; Mannheimer, Lehto, et al., 2007), and higher tiers of government (Khayatzadeh-Mahani et al., 2016).

From the perspectives of former national health ministers in Australia, scientific evidence was seen as important to showcase an argument for SDoH (Baum et al.,

2013). There was recognition that evidence needed to highlight the problem and possible solutions, whilst also appealing to political ideologies (Baum et al., 2013). One recommendation is that practitioners and policy advocates clearly articulate a policy problem to influence the local policy process. There is a role for practitioners and policy advocates to incorporate a range of evidence to present to LG decision-makers, including disaggregated health and social data at a LG level where it exists, and community stories and news to draw attention to health inequities, making it a 'local' problem. This is consistent with literature that supports a policy problem needs to be framed to align with local priorities (Hendriks et al., 2015; Holt et al., 2017; Kickbusch et al., 2014; Lawless et al., 2017; McCosker et al., 2018; Mundo et al., 2019; Scheele et al., 2018). However, Fosse et al. (2018) report that data in the form of health overviews do not necessarily inform action. This reinforces the theory of the MSF that the problem stream needs to be coupled to the policy and politics streams (Zahariadis, 2007).

The 'policy' stream of the MSF proposes that a range of policy solutions are available to implement, though waiting on a policy problem to be coupled with (Zahariadis, 2007). This study suggests that any policy solutions should be framed to LG ideology, which will often not be in the interests of benefits to health. This is based on findings that LG currently considers health determinants, but never framed as such, and rarely in response to health equity as a policy problem. There appears to be many policy problems at a LG level that addressing health determinants can help to solve, something that the MSF refers to as a policy 'primeval soup' of problems and solutions (Kingdon, 1995). In addition, this study found that behavioural level interventions, as policy solutions, still compete with a more 'upstream' approach, which reinforces the need to reframe the policy problem away from a focus on individuals, and more towards social justice to couple with a more 'upstream' policy solution.

Those attempting to influence the policy process should be aware that complex solutions are barriers to action (Baker et al., 2018). Resources have been developed to support LG actions. For example, the Victorian Government have provided LG with a guide to support municipal public health planning (Victorian Government,

2013). The guide provides a process for planners to follow, along with links to resources that support LG to learn how to incorporate evidence in decision-making, and tools to engage successfully in partnership. Although the tool does less to advise on what LG could do as policy solutions. As acknowledged in chapter one of this thesis, there are other guiding documents for LG regarding action on SDoH or a HiAP approach (Ritsatakis, 2012; Rudolph et al., 2013; Stone, 2015; World Health Organization, 2012, 2014). These guides provide some level of action-oriented advice for LG, though all focus on health, and assume that there is already vested interest in addressing health equity with some level of leadership and staff capacity to do so. It is recommended that possible policy solutions be advocated to LG, in a way that creates a benefit for local communities, and are feasible to action, including demonstrating cost effectiveness (Exworthy et al., 2002; McCosker et al., 2018). It is recommended that practitioners and policy advocates have ideas and policy solutions prepared to help solve a range of LG policy problems (Cairney, 2018).

The politics of aligning local problems with feasible solutions relies on a supportive political environment. While it has been established that LG make decisions in the best interests of their community, they are influenced by broader media discourse, or what MSF refers to as the 'national mood' (Herweg et al., 2018; Zahariadis, 2007). However, there is a lack of public lobbying to address health determinants. This lack of strong public opinion does not energise LG to initiate a new, or different, policy discourse or action (Herweg et al., 2018). Further to this, councils appear to be challenged by the broader political environment, with a perceived unsupportive legislative environment, and a lack of support and leadership by higher tiers of government.

Where a legislative environment exists for municipal public health planning in Australia, LGs are expected to align to state public health priorities. This likely reinforces a lifestyle and behavioural approach to policy solutions. This results in conflicting political ideologies and perceived responsibilities (unclear technology) between local and higher tiers of government, a consideration in the policy stream as a factor influencing policy decisions (Zahariadis, 2007). However, there was no indication amongst this study that political ideologies were a particular influencing

factor at a local level. An opportunity exists for future research to further explore the influence of political ideologies at a local level, as this remains an under-researched topic. Further research on the perceptions of state/territory government decision-makers regarding their expectations of LG would also help to clarify the level of tensions that exist between the tiers of government, given previous studies have largely focussed only on the individual perceptions from local, state, or national government.

The MSF proposes that a policy entrepreneur, or someone manipulating the policy streams, increases the probability that policy will reach the agenda of decision-makers and be acted on (Zahariadis, 2007). Policy entrepreneurs were largely absent in the local policymaking environment. Recognising and engaging with any key champions within council, and the community, would gain more political traction in support for HiAP. This study proposes that there are many windows of opportunity that open to address health determinants opportunistically, though are often as solutions to address policy problems outside of the scope of health. Opportunity exists to couple the streams of policy problem, policy solution and local politics to drive a more sustainable and institutionalised approach to adopt HiAP. The ability to couple problems and feasible policy solutions at a local level will continue to be challenged by the influence of higher tiers of government in the politics stream. This requires a policy entrepreneur to utilise local opportunities to draw attention to windows of opportunity for further action. This requires practitioners and policy advocates to build skills as a successful policy entrepreneur to manipulate the policy agenda setting for HiAP in Australian LG.

### 9.2.2 Advocacy Coalition Framework

The ACF comprises domains related to policy subsystems, advocacy coalitions, beliefs of policy actors, and policy-oriented learning (Pierce et al., 2017; Weible et al., 2009). Councils are recognised in this study as a policy subsystem establishing the ‘rules’ in which policy actors interact and participate in policymaking (Heikkila & Cairney, 2018).

Across the study, the consistent reference to the strong organisational and personal obligations to act for community wellbeing outcomes indicate they are ‘deep core’

beliefs, which according to the ACF are difficult to change (Sabatier & Weible, 2007). The 'deep core beliefs' of LG decision-makers to act on HWB of their community are congruent with keeping HWB on the policy agenda, whether this is to deliver on 'liveability', or 'happiness', or 'employment'. This is likely the result of the type of people elected or recruited to working in LG, hence the 'range of champions' on behalf of community wellbeing. These core values were seen to be shared with the community in Finchville, maintaining a strong policy monopoly. The alignment of policy issues to values and beliefs of different policy actors is identified in the ACF as a key factor in positively influencing the policy agenda (Jenkins-Smith et al., 2018).

One of the key concepts within the ACF is focussed on the pressure that policy actors put on decision-makers by lobbying together (Buse et al., 2012; Heikkila & Cairney, 2018). This study found a lack of either internal or external policy actors advocating for LG to address HiAP, including community, media, external organisations, or higher tiers of government. The findings from this study contribute to the understanding of the powerful role that stakeholders, community, and media can have to influence decision-makers in LG, given their reliance on their input for setting policy priorities. The extent to which the council engage with the community determines the level of input the community have in voicing their values and ideas, particularly the engagement across a diverse population group (Jenkins-Smith et al., 2018; Sabatier & Weible, 2007). Where the community agree with addressing 'upstream' determinants of health, this could be beneficial. Although where a behavioural approach is prioritised by community could be detrimental. This is a debate echoed in the literature (Browne et al., 2019; Fisher, 2018). In this study, Finchville reported being clear what their community value in terms of investments in HWB, although the survey respondents were not confident of how their local community define HWB. Corburn et al. (2014), in engagement with the local community, took the discourse from 'health' to 'toxic stressors' experienced by community members, an approach that may have more value in achieving HiAP outcomes.

The limited number of studies in the scoping literature review (chapter three) that addressed stakeholder lobbying, or the role of media or events, is indicative of the lessons that practitioners and policy advocates still need to engage with to ensure a more comprehensive shift in understanding the policymaking environment. It is recommended that policy actors wishing to achieve health equity at a local level should create opportunities for national media attention, focus on goals of social justice, such as achieving health equity, and create more opportunities for advocacy at a local level (avoiding health imperialism as this could be counter-productive). This may be more likely to gain the attention of LG, not by decision-makers receiving more information, though by aligning to their values and beliefs (Jenkins-Smith et al., 2018).

The role of policy-oriented learning is recognised as a mostly unclear and elusive concept in political science literature (Weible & Cairney, 2018). Jenkins-Smith et al. (2018), in outlining the ACF, hypothesise that collaborative forums can contribute to policy learning across different policy actors, particularly where there is some medium level of conflict. In this study, participants acknowledged a wide range of policy actors that were involved in local decision-making. There was evidence of policy learning between LG, community, and other external actors through both formal and informal collaborative approaches. The informal nature of collaborations between LG and external stakeholders may be challenging, though the stronger policy monopoly demonstrated by Finchville likely sustains action and the focus on health from a social justice perspective, by formation of informal coalitions of shared values and beliefs. These partnerships across sectors have also helped to sustain action in the South Australian example of HiAP, even where leadership changes threatened the future of the approach (Baum et al., 2017). These findings support the role of practitioners and policy advocates to facilitate both informal and formal coalitions of like-minded organisations and policy actors in the community that can together put pressure on LG to address health determinants. This provides an opportunity for policy-oriented learning, deriving benefit from the reliance by LG on anecdotal evidence for policy action at a local level.

However, the ACF also refers to scientific evidence as a form of policy learning (Pierce et al., 2017). How LG policy actors receive their information becomes important to policy learning opportunities, given perceptions (particularly secondary beliefs) are able to change based on new information (Pierce et al., 2017). In this instance, the use of scientific evidence is mixed. The survey results report that scientific evidence demands action on HWB policy and that it is used to support council decisions, though the case study sites suggested that this was not the case. Participation in the reference group in Finchville reinforced that credible evidence sources were used initially to scope policy priorities (e.g. World Health Organization documents), though LGs were more likely to rely on media and community sources for policy learning opportunities, which may be restricting an evidence-informed policy approach to addressing health determinants. In this regard, Jenkins-Smith et al. (2018) propose that data that are more qualitative, subjective, or lacking in conclusive evidence are more problematic in challenging beliefs of decision-makers, although there is inconclusive research in the area. Based on this study and other international literature, use of qualitative and subjective evidence is the preferred evidence in LG.

Media have often been claimed as a source of evidence, though not as an opportunity for advocacy on HiAP. Participants in the study raised that broader, usually national or international, media stories can be a useful tool to initiate policy onto the agenda or help provide feasible solutions to existing problems. Yet, the advocacy for HiAP remains largely absent at a local level. This presents an opportunity for practitioners and policy advocates wishing to influence the local policy process to create opportunities for evidence-informed local advocacy action on HiAP through media and community sources. Media or community events at a local level may be more likely to bring about policy change, if they influence or align to the values and beliefs of decision-makers (Leach & Sabatier, 2005).

### 9.2.3 Punctuated Equilibrium Framework

The PEF refers to the role of external events, policy feedback loops, policy images, and policy load as concepts in the theory of the policy process (Baumgartner et al., 2018; True et al., 2007). In this study, LG have demonstrated that organisational

stability also provides stability to address longer term actions, such as action on health determinants. According to the PEF, organisational stability and a stable political environment creates a 'negative feedback' loop, as it reinforces the stability of a policy issue (Baumgartner et al., 2018; True et al., 2007). However, LGs also experience the shocks of elections and leadership changes. Where smaller, engaged communities existed, such as Finchville, the policy monopoly likely withstands some of these shocks. In the instance of Roseford, leadership changes provided a more punctuated change in policy discourse, with a renewed focus on community engagement and wellbeing. Engagement of community such as this may help to sustain a local 'policy monopoly' over the long term, that helps stabilise the ongoing role of LG in addressing health determinants and minimising the impact of election cycles. As highlighted by Fisher (2018), this takes a level of confidence by LG decision-makers to truly value community as a capable resource.

However, according to the PEF, there is limited 'positive feedback' in the existing policymaking environment to change the policy discourse on HiAP (Baumgartner et al., 2018; True et al., 2007). For example, there are no performance indicators or measures for HWB available for policy review feedback. The most common policy feedback loop is reported as the level of complaints from the community. A lack of complaints was interpreted as acceptance by the community of supporting action. According to the PEF, this 'negative feedback' loop maintains the current policy position (Baumgartner et al., 2018; True et al., 2007).

Given the lack of performance measures, HiAP as a policy priority is unlikely to rise to the macro political level, restricting any new policy ideas. There is also little evidence of positive feedback loops as a result of public concern, media coverage, or new perceptions and framing of the issue of addressing health determinants. The PEF proposes framing policy discourse to be easier to communicate, and creating a new policy image, makes it more likely to change policy direction or generate policy focus (Baumgartner et al., 2018; True et al., 2007). This study highlighted the need to reframe the terminology used, given the terms 'health' and 'health determinants' are never raised in discussion. The PEF proposes that generating cognitive attention through changing the discourse of a policy problem is effective for policy change

(True et al., 2007). In addition, the level of competing priorities, as experienced in the growing regional council of Roseford, is likely challenging the cognitive attention that decision-makers can give to the range of policy issues at any point in time (True et al., 2007). The creation of a new 'policy image' away from 'health' to one that highlights the benefits of addressing health inequities within the community is recommended as an alternative, particularly if able to utilise media advocacy and local community stories to raise the policy image.

### 9.2.4 Analysis of Determinants of Policy Impact

The ADEPT outlines factors influencing implementation of policy. According to the framework the organisational and personal obligation to act on health determinants is a strong enabler to gaining policy traction (Rütten et al., 2011). Making decisions based on the wellbeing of communities was perceived as the responsibility of an effective LG, led by the strong organisational obligation and personal commitment by LG staff and elected members, along with strong leadership by mayors and CEOs. However, the obligation to address health determinants was never raised as such when making decisions. There was little attention given explicitly to health determinants as a discussion in LG, at least where there is no current legislation. However, this raises that a traditional approach to knowledge translation to convince LG staff and elected members of the importance of addressing health determinants is not likely going to gain any more commitment, as it already exists amongst a majority of decision-makers in Australian LGs.

However, the ADEPT framework did focus on practical factors required for implementation of policy action. In this regard, there were a number of enabling and challenging factors identified in the local policy process. One of the key challenging factors included the lack of staff capacity and financial resources, not only for policy development, though moreso for policy implementation. There was also argument for further information on the cost-effectiveness of addressing health determinants, something the ADEPT framework suggests is required to gain support for policy implementation (Rütten et al., 2011). Further evidence is needed on the cost-effectiveness of addressing health determinants in LG decisions.

Other challenges to the implementation of HiAP, according to ADEPT, include the lack of clear goals and performance indicators focussed on health, the lack of community involvement, and apathetic media (Rütten et al., 2011). Enabling factors in the policy process included the organisational opportunities needed for implementation of HiAP, including cooperation within organisations (Rütten et al., 2011). The research findings suggest that the cooperation within LG remains strong, although mostly reliant on informal collaborations.

**Table 20** *Summary of how each framework can interpret the study findings, and an example of implications for practice, policy or research.*

| Framework | Key findings | Implications for practice |
|---|---|---|
| Multiple Stream Framework | There are many windows of opportunity that open to address determinants of health within LG, though this is restricted by the lack of coupling between the 'problem', 'policy', and 'politics' streams. There are policy problems that a HiAP approach could potentially address, although unlikely in response to 'health' as the policy problem. The political commitment and personal values of local decision-makers supports a HiAP approach, though is challenged by a lack of support by other tiers of government, an unsupportive legislative environment, apathetic media, and a lack of new information entering the political subsystem to generate action. LGs also lack policy entrepreneurs to recognise windows of opportunity to act for health equity. | Create a clear policy problem that can be understood by LG decision-makers, framed to appeal to their values and beliefs. For example, presenting data on health and social inequities at a LG level where it exists, and incorporate community stories and news to draw attention to health inequities, making it a 'local' problem. This would be more effective if the inequities were seen to be worsening over time.<br><br>Given health is unlikely the policy problem, advocacy of policy solutions to address health inequities across different policy sectors needs to align to existing LG priorities.<br><br>Approaching HiAP in LG requires the skills of a successful policy entrepreneur, coupling action on health determinants to other LG policy problems. |

| Framework | Key findings | Implications for practice |
|---|---|---|
| Advocacy Coalition Framework | The ACF brings attention to the 'deep core beliefs' of LG decision-makers for addressing HWB within their community. LG recognises the broad range of policy actors that are required to sustain action across policy sectors, though are challenged in their capacity to facilitate an intersectoral approach. There is unlikely to be any pressure on LG to respond to HWB due to lobbying action. There is no evidence of lobbying action internal to LG, or by external stakeholders, higher tiers of government, community, or media. Opportunities for policy learning exist, though are not always formalised or based on credible sources of evidence. | It is recommended that policy actors wishing to achieve health equity at a local level should create opportunities for national media attention, focus on social justice goal of achieving health equity, and create more lobbying action (avoiding health imperialism as this could be counter-productive). This may be more likely to gain the attention of LGs through the alignment to their values and beliefs.<br><br>Organise and facilitate informal or formal advocacy coalitions comprising of like-minded organisations to put pressure on LG for action (e.g., engagement with community-based organisations). |
| Punctuated Equilibrium Framework | Addressing health determinants is not likely being heard over the range of policy issues currently being considered in LG, despite it being considered a priority overall. Broader national debates in the media provide the most likely 'positive' feedback loops to generate action. However, there are no performance measures (particularly demonstrating health outcomes getting worse) nor any events, media attention or new information putting pressure on LG to abruptly change policy approaches to community wellbeing. Policy punctuations are more likely where LGs experience leadership changes, in the absence of strong community support and engagement. | Generate community engagement on addressing local 'toxic stressors' to raise attention to the issue and maintain longer-term policy stability, regardless of leadership changes.<br><br>The creation of a new 'policy image' that communicates benefits to the community is recommended as an alternative policy discourse. |
| Analysis of Determinants of Policy Framework | The strong organisational, professional, and personal obligations of LG decision-makers and staff provide a foundation for action to address determinants of health. LGs are clear on their goals, though are challenged by a lack of performance indicators to measure impact or change. The limited staff and financial resources contribute to many of these challenges. | Given the limited staff and financial capacity, support further evidence on the cost-effectiveness and integration of actions to address health determinants in LG policy-making decisions. |

## 9.3 How has the application of political science theory contributed to the exploration of the policymaking environment in regard to HiAP in LG?

### 9.3.1 Contribution to research findings

The overall aim of this study was to explore the policymaking environment in relation to HiAP in Australian LG. The application of frameworks from political science provided a foundation for building a shared knowledge on how to navigate an otherwise 'messy' policy process. This was particularly useful as this study was not describing a retrospective policy process but using the theory to explore the policymaking environment of LG in adopting a HiAP approach. The use of theory brought attention to lesser-known research on the role of values and beliefs, media, events, and lobbying efforts. The application of the MSF helped understand the need for clear policy problems, coupling of HiAP to other policy problems and focus on local ideologies, rather than rely on unsupportive legislative environments of higher tiers of government. The application of the ACF helped to focus on the need for stronger lobbying efforts by stakeholders, community, and the media, and the role of practitioners and policy advocates to help facilitate this. The PEF reminds practitioners and policy advocates that strength-based policy images may gain the cognitive attention required of LG decision-makers, using positive feedback loops, whilst supporting the stability of the policymaking environment to withstand external shocks such as elections. Finally, the ADEPT provides focus on a range of implementation issues such as the lack of resources and evidence on cost-effectiveness of policy decision for addressing health determinants.

However, these study findings did not refer to formal organisational structures or use of HIA tools for action on health determinants, despite this being raised previously in the literature. This may result from the use of political science theories as a deductive lens, given debate on the limited extent to which organisational or institutional systems are made explicit in policy frameworks (Heikkila & Cairney, 2018). However, the inductive nature of the research was employed to overcome these limitations, and yet LG did not raise any formal structures and systems in place to address health determinants, suggesting they are currently absent in the policymaking environment. This supports the evaluation of the Healthy Communities Initiative in

Queensland, that found HIA uptake minimal, despite endorsement of such an approach (Local Government Association of Queensland, 2013).

It also raises the question of whether the theories combined in this study encapsulate all of the possible factors in the policy process. There are examples of studies that are trialling the combination of multiple political science frameworks in state and national tiers of government. For example, the Real-Dato's framework, a synthesis of ACF, PEF, MSF and Institutional Analysis and Development Framework (IAD) is currently being adapted into a conceptual framework for a study on global health (C. M. Jones et al., 2017). P. Harris et al. (2017) also use the ACF, MSF, and PEF to analyse how health ended up on the urban and regional land-use planning agenda in New South Wales, Australia. Further studies such as this will ultimately provide valuable insights and understanding for practitioners and policy advocates to pursue policy action and to build collective evidence in research that can be replicated, tested, and compared. Given the dearth of literature that currently exists in explaining the policy process in LG to adopt HiAP, it is recommended that more research is conducted utilising theories of the policy process. Rather than remaining naïve to the policy process, health promotion should look to fill these research gaps, with a goal of becoming more political (Sparks, 2009).

### 9.3.2 Application of multiple frameworks

There are no known studies in Australia that have applied political science frameworks to research a HiAP approach in LG. The most similar research was conducted by McCosker et al. (2018), looking at healthy planning and active living policy in Australian LG through the perspective of the MSF, gaining information from a range of relevant policy advocates in various tiers of government (including LG) and private industry. The MSF has also been the most common theory of the policy process adopted by other LG studies identified in the literature review. In contrast, this study has applied multiple frameworks to identify a wide range of influencing factors and how they are useful to understand the policy process.

The use of multiple theories is reported as useful to explain the comprehensiveness of all intricacies of policy process (Baum et al., 2019). In this instance, the use of theory helped to identify a broad range of factors associated in the policy process, but

more importantly to help explain how they are theoretically related and interconnected. It shifted the thinking away from 'toolkits' for practitioners and policy advocates to implement HiAP, and instead reinforced that practitioners and policy advocates are better placed to understand the foundation of policy processes, with the skills and knowledge to apply these in different contexts. Exworthy (2008) agrees, acknowledging that an understanding of the policy processes can help to explain patterns and practices across different contexts. However, the limited use of theory in research makes it difficult to support or refute the findings of this study in comparison with other research. It is also acknowledged that whilst applying multiple theories of the policy process assisted with the comprehensives of the study findings, it raised difficulty in presenting the findings in any great depth for each of the frameworks. This has run the risk of applying theory superficially (Weible, 2018b). The challenging aspect of applying political science theory without the expertise supports the call for future collaboration between the disciplines of health promotion and political science to find a shared contribution to both fields (Baum et al., 2019; Fafard & Cassola, 2020).

### 9.3.3 Application of theory in the research design

This study is one of the few related to HiAP that explicitly describes the application of theories of the policy process in LG and the first to my knowledge in Australia. The key factors of the policy process were researched and used to inform all data collection tools, including the online questionnaire and interview and focus group questions. The key factors supported the naming of themes in the factor analysis and were used as part of the inductive and deductive theming process of qualitative data, along with the convergent themes discussed in chapter eight. This gave a theoretical basis to collect data around a range of themes and converge them in a triangulation process across different data collection phases. As identified in the scoping literature review, this explicit application of theory is largely absent in the related literature.

### 9.3.4 Generalisability of the research findings

The mixed method study design demonstrated the value of a pragmatist approach to the research. The survey data allowed for a comparison of responses to relevant factors in the policy process across a wide range of LG contexts. However, a survey

is unable to determine the interconnectedness of the factors, something that relied predominantly on the qualitative data collected in the case studies. The case study sites, however, only represented regional councils, and only within one legislative context. This cannot be considered as transferable findings to other LG contexts. It is recommended that further research be conducted with relevant audiences. Firstly, further discussions and consultation with LG managers and decision-makers is needed to test the generalisability of information on the policy factors in different LG contexts. In addition, testing the applicability and usefulness of research findings in practice is needed, through the views of other policy advocates, particularly health promotion and LG practitioners working at a local level that are interested in pursuing a HiAP approach in LG. The sharing of findings with these practitioners may help to create more confidence in navigating the policy process, rather than remaining bound to the stages heuristic (Cairney, 2015).

Furthermore, this study supports the notion that practitioners and policy advocates of HiAP should adopt a more reflexive approach to the policy process (Cairney, 2015) and design policy approaches that are appropriate to the given context (Weible & Cairney, 2018). Given the uniqueness of each LG, and the difficulty in tailoring advice on policy processes (Cairney et al., 2021; Greer et al., 2017), understanding the theory of the policy process will be a far more valuable skill to practitioners and policy advocates than referring to a toolkit or checklist to understand how to navigate HiAP and apply this to different LG contexts.

It is recommended that professional competencies for health promotion incorporate the knowledge requirements to navigate the complex policy process to reflect more contemporary practice, similar to the more recently updated Foundation Competencies for Public Health Graduates in Australia that include ‘political processes’, requiring an underpinning knowledge of political theory (Council of Academic Public Health Institutions Australia, 2016). In contrast, the current global and national competencies for health promotion do not sufficiently address the knowledge or skills required to successfully influence the policy process (de Leeuw et al., 2014; Dempsey et al., 2011). Within the Australian Health Promotion Competencies, the term ‘policy’ is referred to as a strategy (e.g., policy development)

(Australian Health Promotion Association, 2009). Likewise, the International Union for Health Promotion and Education Core Competency Framework (Dempsey et al., 2011) highlights advocacy as a skill, however, this does not assist in knowing how, when, and with whom to influence to achieve intended policy outcomes. Whilst it is recognised that there are limited resources and capacity for competencies to be updated either nationally or internationally (Battel-Kirk et al., 2009), professional competencies are increasingly being utilised as an accreditation system for health promotion individuals and university degrees to add legitimacy to health promotion as a discipline (Battel-Kirk et al., 2021). For this reason, it is recommended that future updates of the competencies include knowledge requirements regarding theories of the policy process. This process represents a 'double-edged sword', given that competency updates are usually done based on consultation with existing health promotion practitioners to determine if they meet current practice demands (Battel-Kirk et al., 2009). This presents a more urgent call to gauge the understanding of the complex policy process amongst existing health promotion practitioners and determine the usefulness of this knowledge in their practice. Further research on the extent to which policymaking processes are incorporated into training of future health promotion students is also warranted, given a similar, previous call to include a more focussed curriculum on politics for public health students (Greer et al., 2017).

## 9.4 SUMMARY OF CHAPTER NINE

This chapter has outlined the research findings in response to research objective three. The chapter began with a narrative account of the research findings, explained by each of the frameworks employed by the theoretical research lens. The insights from each of these frameworks demonstrated how the factors are theoretically connected, helping to explain how some factors are positively influencing opportunities for initiation and action of policy to address health determinants, and how other factors are less influential. The chapter culminated in a discussion on the usefulness of political science frameworks, and how they have been applied in this study, to assist in understanding the policymaking environment for adopting HiAP in Australian LG.

The conclusion of the thesis is presented in the next chapter. The conclusion will summarise the key findings from the research in relation to the research aim and objectives. It will outline the strengths and limitations of the research design, followed by recommendations for future policy, practice, and research.

# 10. CONCLUSION

## 10.1 INTRODUCTION

The previous two chapters have provided an in-depth discussion related to research objective one and two (chapter eight) and research objective three (chapter nine). The discussion highlights the increased scope of identified factors influencing the policy process, as well as the contextual differences between city, regional, and remote councils that impact on their likelihood of being able to successfully address health determinants. The use of political science theory was justified to help understand the theoretical underpinning of the policy factors in a more meaningful way.

This final chapter presents a summary of the study, including the research aim and methodological design, and highlights the significant and original contribution that the study has presented. This is followed with a discussion of the strengths and limitations of the study. A brief summary of the research findings, as they respond to each of the three research objectives is provided. The chapter concludes with a range of recommendations for future policy, practice, and research.

## 10.2 SUMMARY OF THE STUDY AIM AND RESEARCH DESIGN

This study responds to the health inequities amongst populations across the globe, including in Australia, that are unfairly created through structural determinants of health (Marmot et al., 2008). This study explored the local policymaking environment in relation to the adoption of HiAP as an approach to address structural determinants of health to achieve health equity within LG (Bacigalupe et al., 2010; Ollila et al., 2013).

As highlighted in chapter one, there remains little empirical research on HiAP and a lack of research in understanding the factors that influence the policymaking decisions to address health determinants. The scoping review, outlined in chapter three, highlighted the research gaps regarding the understanding of the factors in the policy process in relation to HiAP in LG. The literature review particularly emphasised the lack of research exploring factors of the policy process in different LG contexts and jurisdictions and evidenced the dearth of literature that employs

political science frameworks to describe and interpret the local policymaking environment.

As detailed in chapter five, the research employed a pragmatist approach, with a view to determine the practical possibilities for pursuing action of a HiAP approach in Australian LG settings. This was achieved using an explanatory, sequential mixed method research design across two phases. The study was informed by a theoretical lens using political science frameworks, each of which were described in chapter four.

Each of the phases of the mixed method research responded to the three research objectives, including to identify the enablers and challenges in the existing healthy public policy processes in Australian LG, to identify how these policy factors are different across various LG contexts and jurisdictions and to explore how the HiAP approach can be understood through the theoretical lens of political science. Chapter six outlined the results of phase one, the national online questionnaire. The results of phase one contributed to the understanding of factors that enable or challenge the local policymaking environment for HWB, as well as contributing to the understanding of how these factors vary across different LG contexts and jurisdictions. Chapter seven outlined the results of phase two. The results of the two regional case studies provided further insights to the factors influencing the local policymaking environment for addressing health determinants. The case study methodology also contributed to the insights of how the factors of the policy process were interconnected. Chapter eight converged the findings across the two phases of the research, and compared this to international literature, prior to an explanation in Chapter nine of the findings as described by the theoretical lens of political science frameworks embedded in the research design.

## 10.3 THE SIGNIFICANT AND ORIGINAL CONTRIBUTIONS OF THE STUDY

This study was the first to explore the local policymaking environment regarding a HiAP approach in Australian LG. This study has contributed to the existing international research on the scope of factors influencing policy decisions on addressing determinants of health in LG. The study contributes to the dearth of

literature identifying how the factors of the policy process regarding HWB vary across LG contexts, including legislative mandates and geographical remoteness. It was the first study to explicitly embed political science frameworks in the research design to explore, interpret, and present research findings regarding a HiAP approach in LG.

## 10.4 Strengths and limitations of the research study

### Phase one: National online survey

- The online survey allowed for a large sample, to compare findings across different legislative and geographically diverse environments. However, random sampling was not undertaken for the survey, likely contributing to a selection bias. Participants that responded to the survey or agreed to be interviewed in the case study sites were more likely interested in health and wellbeing than non-responders. Measures such as email reminders were implemented to mitigate these challenges (Wright, 2019). In addition, the snowballing method for the distribution of the survey, whilst helpful to broaden the participation, meant that a total response rate could not be determined (Fowler, 2009).

- There was a high response rate by LG CEOs in the survey, representing nearly half of all Australian councils. However, it is unknown how many councils were included in the total responses, apart from the 243 councils that the CEOs represented.

- The survey did not ask about the use of HIAs, or the role of events in the policy process. However, the role of events was further explored in the case study sites.

### Phase two: Case study sites

- Case study participants had the opportunity to check interview transcripts, increasing the validity of the case study methodology (Creswell, 2014).

- The case study sites were both located within the same state/territory. This had strengths of limiting the broader political impacts but did not allow

comparisons within different legislative systems. The two case study sites did not differ in context as much as intended, due to the difficulties of recruiting large city councils to the study.

- Referring to documents during interviews was difficult as many participants were not aware of them. In addition, the policy documents are static and only include information that did make it into policy. They do not represent the policy process of what was considered and omitted prior to finalisation (Yin, 2018).

- Involvement in the reference group in Finchville was the most difficult part, as a researcher, to manage. The role of participating and influencing the policy process was prioritised, which made balancing the role of observer of the policy process challenging (Marvasti, 2014; Yin, 2018). Being absent from some reference group meetings, whilst unavoidable, meant opportunities for note taking and observation were also limited. Whilst the experience allowed insight into the policy processes adopted by LG, in hindsight my field notes were minimal and informal. This was pertinent as I reflected on new learnings across the long period of the study, which then relied on memory of the experience in the reference group, with inherent recall bias possible (Mulhall, 2003).

### Mixed method research design and triangulation of findings

- The study is the first known empirical research in Australia to include the views of LG staff, management, and elected members regarding HWB policy, not only those responsible for public health planning.

- The process of triangulating findings from multiple sources of data contributed to the validity of the mixed method approach to the study (Creswell, 2014).

- The application of political science frameworks was made explicit in the research design, results, and interpretation of findings. However, not having a background or expertise in political science, the application and interpretation of political science frameworks may have been misinterpreted.

- The attempt to collect data on so many variables within the policy process, around a complex concept of health equity, resulted in a lot of data to interpret. Some important information may have been unintentionally excluded.
- The term HiAP is used synonymously with so many other terms (e.g., health equity, intersectoral policy). This study has also been limited by the lack of clarity and definition of the concept as introduced earlier in the thesis. The survey referred to 'health and wellbeing' and gauged the understanding of this amongst LG staff and decision-makers. The interviews gave an opportunity to address this further, with many having a good understanding of health determinants, though participants sometimes reverted to an individual or behavioural perspective of health.
- The results are based on voluntary participation in the study. Whilst all action was taken to include as many people as possible in the study, the findings may not include all of the views of LG staff and elected members.
- The research has focussed on the views of elected members and staff in LG, who do not represent all of the policy actors involved in decision-making. This study has not included the perceptions of external policy actors, including stakeholders, community or media.

## 10.5 Concluding findings

*Research objective one: Identify the enablers and challenges in the existing healthy public policy processes in Australian LG.*

Research findings in response to research objective one highlighted a wide range of influencing factors of the policy process within the existing policymaking environment of Australian LG. Many of the influencing factors of the policy process identified in this Australian study confirm results presented in other countries.

The factors likely positively influencing the policy process in LG include strong personal beliefs and obligations from individuals that addressing HWB is a high priority agenda, albeit not likely framed to respond to population health issues.

Similarly, this contributes to a strong commitment by LG to respond to policy that address health determinants within the community, something identified as consistent across all LG in Australia, regardless of legislative environment. This action is informed by all types of evidence, based on local data that is available, and through the voices of, or level of complaints, from community.

There is otherwise a lack of pressure on LG for action, from higher tiers of government, media, community, external advocates, or internal champions. The lack of measures for health equity or health determinants, and the lack of lobbying action does little to raise health equity as a policy problem, or HiAP as a policy solution, for LG. Where it is recognised, there is often a limited amount of resourcing available.

This study added to the relevant empirical literature on the limited role of lobbying action, the need to appeal to LG ideology, the role of media as an influencer, the lack of immunity to local and national events as influences on decisions, and the influence of policy actor values and beliefs. However, the listing of factors in this way does little to reduce the ambiguity of the complex policy process.

*Research objective 2: Identify how enablers and challenges in the current healthy public policy process are different across various LG contexts and jurisdictions.*

The research findings concluded that the legislative environment of LG across different states and territories had little impact on factors that positively influence the policy process. Regardless of legislative environment, the priority and council commitment for HWB, along with personal and organisational obligations are high and the investment was seen as worthwhile. Limited resources were reported across all legislative environments, particularly in regional and rural councils. The legislative environment had little impact on the level of local commitment to addressing health determinants, with a perception that LG had little support and cooperation with higher tiers of government to provide sufficient support and guidance. In this study, legislative environment may be somewhat influencing policy, as seen with Victorian respondents reporting many of the variables as more true, though not universally different to all other states and territories. CEO data confirm

that the high priority and clear council commitment for HWB is the same across all states/territories, as well as the perceived unfavourable legislative environment.

In contrast, the differences between city, regional, and rural councils was more consistently reported. City councils reported generally more favourable conditions for HWB policy than regional and rural counterparts. Respondents of city councils reported that the legislative environment was more favourable than rural and regional counterparts. Whilst financial and staff capacity was a factor that challenged all councils, regardless of legislative environment, the findings highlight that this was particularly the case for regional and rural councils.

*Research objective 3: Explore how the HiAP approach can be understood through the theoretical lens of political science.*

The application of political science frameworks shifted the focus away from a stages heuristic approach to policymaking. The use of theories of the policy process brought attention to the dearth of research on the role of values and beliefs, media, events, and lobbying efforts in local policymaking environments. In particular, the application of the MSF helped understand the need for clear policy problems, coupling of HiAP to other policy problems and a focus on local ideologies, rather than relying on unsupportive legislative environments of higher tiers of government. The application of the ACF helped to focus on the need for stronger lobbying efforts by stakeholders, community, and the media, and the role of practitioners and policy advocates to help facilitate this. The PEF reminds practitioners and policy advocates that other policy images may gain the cognitive attention required of LG decision-makers, using positive feedback loops, whilst supporting the stability of the policymaking environment to withstand external shocks such as elections. Finally, the ADEPT provides focus on a range of implementation issues such as the lack of resources and evidence on cost-effectiveness of policy decision-making for addressing health determinants.

## 10.6 Recommendations

The findings from the study resulted in a range of recommendations for future policy, practice, and research.

### Policy

- Advocates for HiAP need to call for greater emphasis on addressing health determinants within existing legislation, or alternatively advocate for greater cross-government support that clearly outlines roles and responsibilities of HiAP for all tiers of government, regardless of legislation.

- Adequate and equitable resourcing of councils needs to be embedded within legislative requirements to minimise harm of further contributing to health inequities between metropolitan and rural populations.

- The competencies for health promotion should be reviewed and updated for health promotion practitioners internationally to sufficiently address the knowledge and skills required to influence the policy process.

### Practice

- Practitioners and policy advocates should incorporate a range of evidence to present to LG decision-makers, including disaggregated health and social data at a LG level where it exists, making it a clear and 'local' problem. Data that suggest the health inequities are getting worse could gain the most policy attention. The creation of a new 'policy image' that communicates benefits to the community is recommended as an alternative discourse.

- Practitioners and policy advocates need to become more successful policy entrepreneurs, coupling policy solutions to address health determinants to other LG policy problems. Rather than focus on a reframing of 'health' to align to LG values, the policy solutions such as HiAP could be aligned to other LG priorities.

- Policy actors wishing to achieve health equity through involvement of LG would be more effective in creating opportunities for lobbying action by media, community, and external stakeholders than advocating for HiAP directly to LG decision-makers. The lobbying messages should focus on a social justice perspective and frame advocacy to align to the goal of achieving health equity. This may be more likely to gain the attention of LG

through their preferred sources of evidence and in alignment with their values and beliefs.

- Policy actors should engage with community to identify their experience of health determinants and local 'toxic stressors'. Local community input and engagement in policy decisions may help to sustain a local 'policy monopoly' over the long term, that helps stabilise the ongoing role of LG in addressing health determinants and minimising the impact of election cycles and other external events.

- Practitioners and policy advocates should organise and facilitate informal or formal advocacy coalitions comprising like-minded organisations to influence LG action on health determinants (e.g., engagement with community-based organisations).

### Research

- Research is required to test the generalisability of these findings across a wider range of local government contexts, particularly where legislation for health determinants exists (e.g., Victoria, South Australia) and more in depth, qualitative research in rural contexts.

- Research investigating the views on being involved in addressing health determinants of policy actors outside of LG would assist in identifying opportunities for co-benefits and collaborative partnerships. Policy actors may include decision-makers within state/territory and federal government departments, media, community members, and community-based organisations.

- Research is required to gauge the extent that frameworks of the policy process are understood by, and resonate in practice, with health promotion practitioners, LG managers and policy advocates involved in LG policymaking.

- Further research that advances evidence regarding cost-effectiveness and integration of actions to address health determinants in LG policy-making decisions needs priority to support local advocacy.
- Further research on HiAP in LG should explicitly apply theories of the policy process, including a range of different political science frameworks and the benefits of their combined use. The consistent application of theory will enhance future practice-based learnings to influence a HiAP approach in LG.
- The influence of political ideologies at a local level is under-researched. This is an opportunity for future research in explaining the influence of the politics stream in influencing LG decisions regarding HiAP.

## 10.7 SUMMARY OF CHAPTER TEN

This final chapter of the thesis has presented a summary of the study, including the research aim and methodological design, and highlighted the significant and original contribution that the study has presented. This was followed with a discussion of the strengths and limitations of the study, before summarising the key findings in relation to each of the research objectives. The chapter concluded with a range of recommendations for future policy, practice, and research.

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# APPENDICES

# APPENDIX A: ACCEPTED MANUSCRIPT

*This is a pre-copyedited, author-produced version of an article accepted for publication in Health Promotion International following peer review. The version of record* Lilly, K., Hallett, J., Robinson, S., & Selvey, L. A. (2020). Insights into local health and wellbeing policy process in Australia. *Health Promotion International, 35*(5), 925-934 *is available online at:*
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# Insights into local health and wellbeing policy process in Australia

**Abstract**

To investigate factors that enable or challenge the initiation and actioning of health and wellbeing policy in Australian local governments using political science frameworks. An online survey was distributed to staff and elected members of Australian local governments. The survey sought responses to a range of variables as informed by political science frameworks. Data were analysed using descriptive statistics and results were compared between local governments of different geographical sizes and locations using Kruskal Wallis non-parametric testing. There were 1825 survey responses, including 243 CEOs, representing 45% of Australian local governments. Enablers for local government policy initiation and action included the high priority given to health and wellbeing (44%), local leadership (56%) and an organisational (70%) and personal obligation (68%) to the community to act. Less true is a favourable legislative environment (33%), leadership from higher levels of government (29%) and sufficient financial capacity (22%). Cities are better positioned to initiate and action health policy, regardless of the broader legislative environment. Health and wellbeing is a high priority for Australian local governments, despite lack of funding and limited lobbying and support from other sectors and higher levels of government. The insights from political science frameworks assist to understand the policy process, including the interrelatedness of enablers and challenges to initiating and actioning health and wellbeing policy. Further understanding the policy drivers would support practitioners and researchers advocating to influence local health and wellbeing policy.

*(Abstract 238 words)*

## Introduction

In Australia, the responsibility for health is largely the role of national and state tiers of government, both dominated by a biomedical model of healthcare (Keleher, 2016). Strong evidence suggests that to achieve major population health gains, the underlying determinants of health must be addressed (Marmot and Friel et al, 2008). In essence, addressing population health and wellbeing relies on cross-sector collaboration and most often outside of the healthcare system, including investments in education, employment, early years development, housing and transport (Marmot and Allen et al, 2010). In practice, and despite the evidence, the required coordination to integrate health and wellbeing (HWB) across different policy areas has proven challenging to facilitate across any tier of government (Clavier and de Leeuw, 2013). An integrated approach to HWB competes with the attention given to a biomedical approach to health (Baum and Laris et al., 2013)

and raises difficulties in working collaboratively across government sectors (Exworthy and Hunter, 2011). With local government being the closest tier of government to the community (Rantala and Bortz et al., 2014) and focussed on a more social model of health (World Health Organisation, 2012), researchers have long proposed that local government may be the most feasible level of government to take action for underlying health determinants (Harris and Wills, 1997; de Leeuw and Clavier, 2011; Collins and Hayes, 2013). Whilst somewhat autonomous, Australian local governments are legislated by the senior State or Territory tier of Government. Therefore, the role of HWB in local governments vary, depending on their binding Local Government Act (Dollery, 2009). However, given that local governments have responsibility for a range of social, environmental and economic decisions, the question of where, or if, the determinants of health fit into these responsibilities continues to remain unanswered.

Whilst evidence is growing at national and senior levels of government, recent reviews of the literature conclude there is a dearth of research at the local government level investigating the policy process addressing health determinants and health inequities (Guglielmin and Muntaner et al., 2017; Van Vliet-Brown and Shahram et al., 2017; Baker and Friel et al., 2018). Within the limited research at a local level, the identified enablers to addressing health determinants include: having political will, involvement of media and community (Larsen and Rantala et al., 2014; Rantala and Bortz et al., 2014), commitment by local policy makers (Jansson and Fosse et al., 2011), the capability to work across sectors (Larsen and Rantala et al., 2014) and support from higher levels of government (Rantala and Bortz et al., 2014). The challenges include: lack of funding (Collins and Hayes, 2013; Larsen and Rantala et al., 2014); absence of a policy entrepreneur (Hoeijmakers and de Leeuw et al., 2007); siloed departments (Larsen and Rantala et al., 2014; Rantala and Bortz et al., 2014); perception of extra work; lack of measurable objectives and a lack of ownership by any one department (Larsen and Rantala et al., 2014).

Understanding the enablers and challenges that influence the likelihood of local government addressing determinants of health requires investigation into the complex policy process. In the absence of frameworks to navigate the complex policy process, health promotion has largely relied on rational frameworks such as the 'stages heuristic' that looks at policy identification, formulation, implementation and evaluation (Breton and de Leeuw, 2011; Buse and Mays et al., 2012), or influencing policy through awareness of research evidence and traditional knowledge translation strategies (Raphael, 2008; de Leeuw and Clavier et al., 2014). Health promotion practitioners and researchers are largely aware of more complex policy influences, though are not exposed to policy frameworks (Breton and de Leeuw, 2011). The frameworks within political science shift the thinking of policy beyond a rational linear process to analyse the inter-relatedness of how and why policy issues are understood, the range and influence of policy actors involved, the broader politics around priorities and solutions and how external pressures influence the policy environment over time. There are few known studies using political science frameworks to investigate how and why health determinants end up in health policy or not (Embrett and Randall, 2014) and none in the local government setting. Notably, Hoeijmakers and de Leeuw et al. (2007), who used stakeholder and network analysis as a framework to explore local health

policy in the Netherlands, made a call to apply political science with more rigour in health promotion research more than a decade ago. This research aims to address these two research gaps by further investigating the factors that enable or challenge the current HWB policy process in local government, along with applying a theoretical lens from political science to further understand the complex policy process.

**Methods**

Survey design

An online questionnaire was designed using the combined constructs of four political science frameworks including Multiple Streams Framework (MSF) (Kingdon, 1995), Advocacy Coalition Framework (ACF) (Sabatier, 2007a), Punctuated Equilibrium (Baumgartner and Jones, 1993) and Analysis of Determinants of Policy Impact (ADEPT) (Rütten and Gelius et al., 2011). These frameworks were chosen as they are comprehensible, tested in a research environment and proposed as useful to health promotion policy research (Sabatier, 2007b; Breton and de Leeuw, 2011; Clavier and de Leeuw, 2013). Each of the frameworks look at the policy process from different theoretical viewpoints, with their own strengths and limitations. In more recent literature, there is a move by researchers to apply multiple frameworks in recognition of their individual strengths to explain the policy process (Baker and Friel et al., 2018; Harris et al, 2017). A broad overview of the political science frameworks applied and how they informed the questionnaire are outlined in Table 1. The questionnaire included 13 overarching questions regarding local government healthy public policy processes and five demographic questions, including geographical region, size of local government and role of respondent. The questionnaire comprised 42 variables on a five-point Likert scale that sought to identify how true a range of policy constructs are perceived, in addition to tick boxes and areas for free text including self-reported inclusion of HWB across several policy areas. The study was approved by the XX Human Research Ethics Committee (*insert ethics confirmation*), Australia. The full questionnaire tool is available on request from the corresponding author.

[Insert Table 1: How and why the four frameworks of MSF, ACF, PEF and ADEPT inform the questionnaire to understand the policy process of local government.]

Data collection

The online questionnaire, using Qualtrics online software, was distributed to Chief Executive Officers (CEO), elected members, management and other staff in Australian local governments (individually referred to as a 'council') between June 2015 and May 2016. The Australian Capital Territory (ACT) was not included in the study given their different governance structure for the delivery of local government services. The survey was distributed via a personally addressed email and followed up with a reminder after one and three weeks. Where the email addresses were not publicly available a generic council email address was used, resulting in

461 CEOs, 440 mayors, 3532 elected councillors and 1636 managers across a possible 545 councils receiving both initial and follow up emails. To encourage responses, the questionnaire was promoted through newsletters and social media by three consenting local government associations. All of the emailed participants were encouraged to forward the survey to other council staff, particularly those in decision making roles.

Data analysis

Descriptive analysis was conducted for variables related to the understanding and definition of HWB and the priority given to HWB by the council. In addition, the 42 variables that influence policy decisions were included in an exploratory factor analysis to narrow down the number of variables measured by Likert scale that explained most of the data variances within the dataset. Prior to conducting a factor analysis, the data were subjected to a Kaiser-Meyer-Olkein (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity to determine if a factor analysis was suitable for the dataset (Williams and Onsman et al., 2010). Both scores, including KMO of 0.960 and Bartlett's Test of Sphericity significance at 0.000, indicated that the dataset was suitable. Factors were extracted using a principal component analysis method, with factors kept where the eigenvalue was greater than 1 (Kaiser, 1960). This procedure was replicated to eliminate variables represented across more than one factor. Variables were analysed using descriptive statistics and non-parametric tests including Kruskall Wallis post hoc testing for pairwise comparison between councils of varying size and location. The results were analysed using SPSS Version 22 (IBM Corp, 2016).

**Results**

Of the 1825 responses to the survey, 243 CEOs responded, representing 45% of Australian councils. The respondents also included elected members, strategic and operational managers and other staff, representing all States and Territories in Australia (except ACT) and across rural, city and regional councils (Table 2).

[Insert Table 2: Demographics of respondents to online questionnaire (N=1825)]

*Integrating HWB in policy areas*

When asked to what extent HWB outcomes were considered in developing policies, 90% (n=1329) of respondents reported that HWB was 'always' or 'most of the time' considered in the development of at least one of the listed policy areas of transport, urban planning, housing, energy and sustainability, sport and recreation, health care and economic development. Of these policy areas, respondents were most likely to report that HWB was integrated 'always' or 'most of the time' in sport and recreation (80%), urban planning (60%) and healthcare (60%). There were 295 respondents (16%) who reported HWB was considered across all listed policy areas 'always' or 'most of the time'. There were no respondents that only reported HWB as 'rarely' or 'never' considered across all the policy areas listed.

*Understanding the policy problem*

From a list of varying definitions, a majority of respondents (58%, n=984) reported that their council defined HWB as "*Health is being not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environments, family, individual circumstances and socioeconomic position*". Of the four listed, this definition was the most comprehensive, ecological approach to HWB. The responses were similarly distributed across all sizes of councils.

Respondents were asked what policy areas they believe have the potential for improving their community's HWB. A total of 62% (n=1178) of all survey respondents answered the open-ended question. The most common policy areas reported included the built environment (n=473), community development (n=406), sport and recreation (n=400), health behaviours and issues (n=302) and the natural environment (n=286). Of all responses, 6.5% (n=75) indicated that 'all policies impact'.

*Priority able to give to HWB as an issue*

When asked on a scale of 1-10 '*Where does addressing HWB in your region fall among all of the other priorities your council have to consider?*', 44% (n=421) of respondents reported an eight or above, including 43% of CEO's. There was a significant difference by location of council (H= 9.332, p=0.009), with respondents from rural and city councils reporting HWB as a higher priority than regional councils.

*Factor analysis*

A factor analysis resulted in four key factors over 30 variables. The four key factors were named *policy subsystem (16 variables)*, *resources and capacity (4 variables)*, *partnerships and actors* (7 variables) and *policy initiators* (4 variables) (Table 3). Variables related to the role of media and community, staff knowledge and skills, formal collaborative partnerships and the presence of a key champion did not group into any of the four factors. The responses related to the presence of a key champion were retained within the *policy subsystem* factor as this was considered critical to at least one of the political science frameworks that informed the research.

*Policy subsystem*

More than half of respondents reported that it was 'definitely' or 'mostly true' that their council have a clear commitment to HWB (60%, n=824), strong support and leadership within council (56%, n= 773), sufficient cooperation within council when developing policy (54%, n=764) and implementing policy (56%, n=762) and that considering the costs, the benefits made it worthwhile (60%, n=816). Respondents were less likely to

report that it was 'definitely' or 'mostly true' that there was a key champion for HWB in the council (46%, n=692), that the council uses performance indicators to measure HWB impacts (41%, n=562) and that there is current lobby action for HWB within the council (30.4%, n=424). Respondents from city and rural councils were more likely than their regional counterparts to report strong leadership and support from within council (H=10.858, p=0.004) and sufficient cooperation within council during development (H=14.359, p=0.001).

*Policy initiation*

Variables relating to initiators of policy were reported as 'definitely' or 'mostly true' by a majority of respondents, including an obligation by council to act (70%, n=1043), a personal obligation to do something (68%, n=1020) and that the action is part of their professional duties (66%, n=981). Respondents from city councils were more likely than their rural counterparts to report a personal obligation to act (H=9.827, p=0.007), more likely than regional counterparts to report an organisational obligation to the community (H=8.474, p = 0.014) and more likely than both regional and rural council respondents to report that the action is part of their professional duties (H=26.420, p<0.001).

*Partnerships and actors*

Less than half of respondents reported that it was 'definitely' or 'mostly true' that council have support from other sectors when either developing (41%, n=574) or implementing policy (40%, n=546), there is strong leadership from other levels of government in initiating HWB policy (29%, n=434) and a favourable legislative environment for HWB action (33%, n=444). Respondents from city councils were more likely than their regional and rural counterparts to report support from other sectors when implementing action (H=11.866, p=0.003) and that there is a favourable legislative environment (H=14.367, p=0.001). Across States and Territories, pairwise post hoc testing shows that respondents from the State of Victoria were more likely to report a favourable legislative environment compared to respondents from the States of New South Wales (p=0.008) and Queensland (p=0.014).

*Resources and capacity*

Less than half of respondents reported that it was 'definitely' or 'mostly true' that there is staff capacity (38%, n=527), financial resources to develop HWB policy (22%, n=303) and financial resources to implement policy actions (22%, n=312). Respondents from city councils were more likely than their regional and rural counterparts to report sufficient financial capacity (H=111.491, p<0.001) and staff capacity (H=81.197, p<0.001).

[Insert Table 3: Overall responses to how 'true' a range of variables in the policy process are, with demonstrated statistical significance by size of council.]

**Discussion**

The findings from this research in Australian local governments identify a range of enablers and challenges to addressing HWB in a local government context. Some factors confirm previous research, particularly having a strong commitment to HWB (Jansson and Fosse et al., 2011), strong political will to act (Larsen and Rantala et al., 2014; Rantala and Bortz et al., 2014) and a lack of funding resources (Collins and Hayes, 2013). However, the intent of this research is not only to identify the enablers and challenges in the policy process, but also to demonstrate the policy constructs through the lens of political science to deconstruct an otherwise seemingly illogical policy process. When researching the literature on policy initiation and actioning of health inequity amongst all levels of government, Baker and Friel et al. (2018) referred to this as not just interpreting enablers and challenges as stand-alone entities, but considering their inter-relatedness as increasing or decreasing the 'probability' of issues reaching the policy agenda.

*Policy problem*

The MSF by Kingdon (1995) suggests that the three streams of policy problem, solution and broader politics need to align for policy to be initiated. According to the results of this study, the problem of HWB is clear to those in local government and defined from a socio-ecological perspective. Lawless and Lane et al. (2016) have previously surveyed local government staff in two Australian States and found similar findings, albeit with local government staff who already had public health responsibilities. In their study, the staff reported a reasonable understanding of health promotion theory and a self-reported personal obligation to improve HWB through policy work. The results of this survey support this level of understanding, focussing on decision makers across a range of local government responsibilities, including CEOs and elected members, and has found similar findings across all size councils in Australia.

*Policy solution*

In addition to a clear policy 'problem', a clearly agreed solution is needed to progress beyond a policy idea (Kingdon, 1995). The results from this survey indicate that local governments are integrating HWB across some known determinants, with some integrating HWB amongst a diverse range of policy areas, although the quality and extent to which this is done in local policy has not been explored as part of this research.

Respondents agreed that there was sufficient cooperation during policy development and implementation, suggesting that internally there is at least some collaboration across departments. Whether decision makers within a single council collectively understand and define the problem of HWB similarly and agree on the solution is not known from these survey results. This is likely an enabler to local HWB policy given that the nature of addressing health determinants requires cooperation across a broad range of sectors (Marmot and Friel et al., 2008), with cross sector communication considered a key enabler to adopting local health policy (Larsen and Rantala et al., 2014; Hendriks and Jansen et al., 2015). The ACF adds value to the understanding of this policy process by focussing on the role of different individuals and groups involved in influencing policy action (Sabatier, 2007a; Clavier and de Leeuw, 2013). However, the collaborative support of other

sectors in actioning HWB was not always considered true by survey respondents. Given the experience by Corburn and Curl et al. (2014) whereby the not for profit sector triggered the initiation of local policy addressing health equity, the lack of other sector support reported by Australian local governments may be limiting health determinants reaching a higher priority on the local policy agenda.

*Politics*

The broader political environment is the third inter-related stream in the MSF (Kingdon, 1995). Previous research would agree that support from higher levels of government is an important enabler to local health policy initiation (Rantala and Bortz et al., 2014). The results from the survey indicate this is not currently the case in Australia for a large majority of local governments, regardless of size and location. Whilst all Australian local governments have some responsibility and autonomy for how they respond to HWB, legislation for addressing health determinants only exists in two of the eight States/Territories. Respondents from city councils were most likely to report that a favourable legislative environment, yet there was little difference in response across different States or Territories of Australia. While there has been a legislative requirement for health plans in the State of Victoria for several decades and respondents of Victoria reported a more supportive legislative environment for HWB, these were only significantly different to two of the other five States and Territories included in the research. Our research findings suggest that local government are already actively considering HWB beyond their required legislation.

Previous research has found local government policies, whilst somewhat responsive to broader political agendas, tend to give priority to local community needs (Jansson and Fosse et al., 2011; Browne and Davern et al., 2018). For example, local policies in Swedish municipalities addressed determinants of health, though not to the extent of addressing health inequities as the national policy intended (Jansson and Fosse et al., 2011). Research in Victoria, Australia, found that planners gave more emphasis on an upstream approach to creating wellbeing for their communities than the State legislation intended (Browne and Davern et al., 2018). The reported commitment to HWB by respondents, regardless of legislative responsibilities and measurable performance indicators, suggests that local government may not be driven by health outcomes. Previous literature has also observed that local government staff and elected members perceive that they have limited responsibility for reducing health inequities (Collins and Hayes, 2013) and tend to focus on health policy for their own interests, such as quality of life or social connection, rather than for health outcomes (Hoeijmakers and de Leeuw et al., 2007; Steenbakkers and Jansen et al., 2012). The results of this survey, combined with findings of previous research, queries whether involvement or incentive by higher tiers of government are required to initiate or action local HWB policy, or whether the strong leadership and commitment within the local subsystem of local government withstands any broader political pressures.

*Policy entrepreneur*

The MSF considers policy entrepreneurs as a critical element to being able to influence the policy process, by recognising and acting on a 'window of opportunity' (Kingdon, 1995). Over half of the respondents to the survey indicated that the presence of a key champion was sometimes, rarely or not true. This is consistent with research by Hoeijmakers et al (2007) who found no key champion for health policy in the four local governments of the Netherlands that they followed over several years. Political science frameworks, particularly the ACF, would suggest that combined with the lack of lobbying efforts within councils, as reported by respondents in this study, this could potentially challenge the attention given to HWB when competing with other priorities (Sabatier, 2007a).

*Policy priority*

Despite the impacts of addressing health determinants being long term and difficult to measure (Bauman and King et al., 2014; Larsen and Rantala et al., 2014) and amongst all other priorities that local governments are responsible for, HWB is still reported as a high priority by Australian councils across all sizes and locations, something not previously documented in research to date. As local governments deal with many competing community and senior government demands, one of the enablers to keeping HWB a priority is likely the shared obligation amongst decision makers. This is a key enabler to the initiation and stability of the policy environment raised within policy frameworks, including the MSF, ACF, PEF and ADEPT (Kingdon, 1995; Rütten and Lüschen et al., 2003; Sabatier, 2007a). Whether this strong obligation to address HWB is indicative of the type of staff and representatives elected into or employed in local government, whether the drive is to address other issues beyond health outcomes, whether the results are driven by respondent selection bias, or whether this is something that is part of organisational and professional duties (or all of these) is not able to be derived from the results of this survey.

*Funding*

The ADEPT framework is slightly different to other policy frameworks in that it considers the implementation, action and evaluation of health policy once it is initiated (Rütten and Gelius et al., 2011). In the initial testing of the framework, having sufficient resources was found to be a key factor in generating policy outcomes (Rütten and Gelius et al., 2011). Consistent with literature, funding is reported by respondents as one of the biggest challenges in the policy process (Collins and Hayes, 2013; Larsen and Rantala et al., 2014). This was reported across councils of all sizes, though particularly rural councils. Local government have such limited opportunities to raise funding, apart from accessing grants or raising rates paid by property owners (Collins and Hayes, 2013). Smaller local governments find revenue raising more difficult, given the low property numbers and higher infrastructure costs associated with remote locations (Tan and Artist, 2013). However, despite insufficient financial capacity, a majority of respondents agreed that the investment in HWB was cost-effective. This suggests that local governments may be considering the benefits of HWB policy beyond addressing health outcomes.

## Applying the theories

Applying political science theories to these findings, local government demonstrate an understanding of the problem and policy solution of determinants of health, and to some extent at least, these are actioned in policy. According to the MSF, the broader political environment would need to be supportive, which is also the case within the subsystem environment of local government. However, the central role of the policy entrepreneur to manipulate the three streams is mostly absent in many local government settings. As theorised by the ACF, and PEF, the strong values and obligations to act on HWB of communities are likely causing a stable policy monopoly by a group of local government policy actors. This maintains the attention and priority that can be given to HWB. These policy decisions are actioned within the resources and capacity available to the different sized local governments, with larger, city councils in a better financial position to enable this.

### *Limitations*

The reliance on voluntary, self-reported responses may create a bias in the results as those most interested or active in the field of HWB were more likely to respond. However, there were a high response of CEO's and a wide range of respondents across different States, Territories and geographical sizes of local government in Australia. HWB is a broad topic area and whilst respondents defined HWB as a socio-ecological perspective, it is unknown what context some of their responses were considering. In addition, for many of the responses, there were reports of the variables being 'somewhat true'. The use of a factor analysis to reduce the number of variables demonstrating the key variances in the dataset have meant that the role of the community and media in the policy process have not been included in this analysis. As part of the growing literature in addressing health determinants, supported by political science theory, more investigation is required through qualitative research to further demonstrate the inter-relatedness of the policy constructs.

## Conclusion

The results of the study add to the argument that local government can address the determinants of health and certainly have local political will to do so, particularly in larger city councils. The personal obligation, commitment by council, and local leadership are likely to increase the initiation and action of local HWB policy. Local governments report incorporating HWB across a range of policy areas, despite limited funding, absence of broad political support and at times without a policy entrepreneur or other sector support and lobbying efforts. Further research should investigate what HWB outcomes local governments are interested in, as this has practical implications for the framing of future health promotion advocacy efforts, legislative requirements and policy monitoring measures. Using political science frameworks assists to conceptualise the varying constructs in an otherwise complex policy process, which is a useful tool for health promotion practitioners to better navigate the healthy public policy process.

*(Body 4359 words)*

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*(References 1040 words)*

Table 1: How and why the four frameworks of MSF, ACF, PEF and ADEPT inform the questionnaire to understand the policy process of local government.

| | MSF | ACF | PEF | ADEPT |
|---|---|---|---|---|
| Definition of the framework | Theorises that when three 'streams' of problem, policy and politics align, a 'window of opportunity' arises. The framework proposes that policy initiation is more likely where a policy entrepreneur manipulates the three streams (Sabatier, 2007a). | Theorises that it is largely individuals within a policy sub-system that influence policymaking. The framework proposes that individuals with similar values and beliefs form 'advocacy coalitions' that then compete for policy attention (Sabatier, 2007a). | Theorises that policy often has long periods of stability, that are then 'punctuated' by policy activists, events or heightened public awareness (Baugmater and Jones, 1993) | This model is adapted from a behavioural change theory. It identifies four organisational capacities that are considered to be required for policy implementation, including goals, obligations, resources and opportunities (Rutten et al., 2011) |
| How the framework informed the questionnaire | -Defining the problem of health and wellbeing for local government;<br>- Problem 'load' and priority given to health and wellbeing;<br>-Current solutions for health and wellbeing across local government policy areas;<br>-Role of senior levels of government, including legislation;<br>-Role of individual policy entrepreneurs. | -Values and beliefs of elected and non-elected decision makers in local government;<br>-Range of policy actors involved;<br>-Competing and similar interests across policy actors;<br>- Role of community in decision making;<br>-Use of 'evidence' to inform decisions;<br>-Level of advocacy efforts by different policy actors. | - Problem 'load' and priority given to health and wellbeing;<br>- Role of policy monitoring feedback;<br>-Shared interests of policy actors and policy monopolies;<br>- Role of external events;<br>-Role of media and public concern. | -Clarity of goals for health and wellbeing action;<br>-Personal obligations of elected and non-elected members;<br>-Organisational obligation by local government;<br>-Use of performance indicators for measuring health and wellbeing;<br>-Financial and staff resources. |
| Strengths and limitations of the framework | *Strength*<br>Recognises the inter-relatedness of a complex policy process.<br>*Limitation*<br>Focus is on policy initiation. It strongly implies the role of a policy entrepreneur to navigate and manipulate the three streams (Sabatier, 2007a). | *Strength*<br>Bases decision making on the underpinning individual or organisation beliefs and values (Sabatier , 2007a).<br>*Limitation*<br>Focus is on policy initiation. Assumes that actors or coalitions will actively coordinate their behaviour or act on their beliefs. | *Strength*<br>Focus on policy change and external influences to subsystem policy environments.<br>*Limitations*<br>Given the focus on uncertainty, the framework limits ability to predict policy priorities (Sabatier, 2007a). | *Strength*<br>Focus is beyond policy initiation and includes organisational capacities to action policy solutions.<br>*Limitations*<br>Limits to four concepts, adapted from a behavioural model of health (Rutten et al., 2011). |

Table 2: Demographics of respondents to online questionnaire

| Role in local government % (n) | | Location by State / Territory % (n) | | Size of local government % (n) | |
|---|---|---|---|---|---|
| Elected member | 60.1% *(n=1096)* | Western Australia | 31.9% *(n=583)* | Rural/shire | 41.8% *(n=761)* |
| CEO | 13.3% *(n=243)* | New South Wales | 19.8% *(n=362)* | City | 30.6% (*n=556)* |
| Strategic manager | 7.5% *(n=135)* | South Australia | 15.2% *(n=278)* | Regional | 27.6% (*n=502)* |
| Operational manager | 8.8% *(n=160)* | Victoria | 14.7% *(n=268)* | | |
| Other staff | 10.5% *(n=191)* | Queensland | 10.6% *(n=194)* | | |
| | | Tasmania | 6.2% *(n=114)* | | |
| | | Northern Territory | 1.4% *(n=26)* | | |

Table 3: Overall responses to how 'true' a range of variables in the policy process are, with demonstrated statistical significance by size of council.

| | Definitely true | Mostly true | Sometimes true | Rarely true | Not true at all | ** |
|---|---|---|---|---|---|---|
| **Policy Subsystem** | | | | | | |
| Staff agree on what action needs to be taken to address HWB *(n=1492)* | 12.5% | 42.6% | 34.1% | 7.9% | 2.9% | City |
| The approach to HWB is clear in the policy *(n=1399)* | 17.0% | 36.3% | 32.2% | 10.6% | 3.9% | City |
| The goals for HWB are concrete enough *(n=1398)* | 10.1% | 37.2% | 32.8% | 15.6% | 4.4% | City |
| The actions centre on improving the HWB of the community *(n=1398)* | 19.5% | 39.3% | 28.8% | 9.9% | 2.4% | City |
| There is sufficient cooperation within the Council during development of policy *(n=1403)* | 14.1% | 40.4% | 30.6% | 10.9% | 3.9% | City Rural |
| There is current lobby for action on HWB within Council *(n= 1398)* | 8.4% | 22.0% | 33.5% | 25.0% | 11.1% | - |
| There is sufficient evidence available to support Council decisions *(n=1397)* | 15.1% | 40.7% | 30.1% | 11.0% | 3.1% | City |
| There is strong support and leadership from within Council *(n =1367)* | 20.3% | 36.3% | 27.4% | 11.0% | 5.1% | City Rural |
| Various HWB strategies and/or activities are implemented *(n=1370)* | 19.9% | 39.2% | 31.2% | 7.5% | 2.2% | City |
| There is clear Council commitment *(n=1368)* | 23.9% | 36.4% | 27.3% | 8.8% | 3.5% | City |
| There is sufficient cooperation within my Council during implementation of policy *(n=1367)* | 14.8% | 41.0% | 29.0% | 10.8% | 4.5% | City |
| There is ongoing monitoring and review of policy in Council *(n=1362)* | 22.0% | 36.7% | 25.0% | 12.2% | 4.1% | City |
| Policy reviews consider HWB impacts *(n=1360)* | 17.7% | 33.5% | 29.7% | 13.8% | 5.2% | City |
| Council uses performance indicators to measure HWB impacts *(n=1362)* | 15.3% | 26.0% | 27.5% | 20.6% | 10.6% | City |
| Considering cost-benefits, action to address HWB is worthwhile *(n=1364)* | 24.0% | 35.9% | 25.2% | 10.0% | 4.9% | City Rural |
| There is a key leader/champion in HWB in our Council *(n = 1494)* | 18.1% | 28.2% | 29.2% | 15.9% | 8.6% | City |
| **Partnerships and actors** | | | | | | |
| There is strong leadership from other levels of government to act *(n=1491)* | 7.4% | 21.8% | 38.2% | 24.3% | 8.2% | - |
| There is support from other sectors when developing policy *(n=1400)* | 6.7% | 34.4% | 41.4% | 14.6% | 2.9% | - |
| There is cooperation between different political levels involved during policy development *(n = 1398)* | 4.1% | 25.6% | 42.2% | 21.8% | 6.2% | - |

| | | | | | | |
|---|---|---|---|---|---|---|
| There is cooperation between public and private organisations *(n = 1398)* | 4.7% | 29.5% | 43.3% | 18.7% | 3.8% | - |
| There is support from other sectors when implementing actions *(n=1361)* | 6.4% | 33.8% | 42.0% | 14.2% | 3.6% | City |
| There is cooperation between different political levels involved (during policy implementation) *(n=1359)* | 4.2% | 24.7% | 41.9% | 22.7% | 6.6% | - |
| The legislative environment is favourable for HWB action *(n=1361)* | 5.7% | 27.0% | 40.5% | 20.7% | 6.1% | City |
| **Resources and capacity** | | | | | | |
| The council has the necessary staff capacity *(n=1401)* | 8.9% | 28.8% | 30.0% | 21.6% | 10.7% | City |
| There are sufficient financial resources *(n=1403)* | 5.1% | 17.2% | 30.3% | 31.8% | 15.6% | City |
| The Council has the staff time and capacity to implement actions *(n=1365)* | 8.6% | 28.1% | 36.0% | 19.4% | 8.0% | City |
| There are sufficient financial resources *(n=1366)* | 4.7% | 17.6% | 29.4% | 32.0% | 16.3% | City |
| **Policy initiators** | | | | | | |
| Personally I feel obliged to do something in the field *(n=1492)* | 32.1% | 36.3% | 23.1% | 5.8% | 2.7% | City |
| The action is part of my professional duties *(n=1490)* | 33.8% | 32.1% | 21.7% | 6.9% | 5.6% | City |
| Scientific results demand the action *(n=1482)* | 21.7% | 31.5% | 34.0% | 8.7% | 4.0% | City Regional |
| The Council is obliged to the community to act in this area *(n=1497)* | 31.3% | 38.3% | 23.2% | 5.1% | 1.9% | City |

***Statistically significant p=<0.05*

Total word count: 6757 (including title, abstract, body, references, tables)

# APPENDIX B: SCOPING REVIEW PROTOCOL

This scoping review protocol is available in green open access:

Lilly, K., Kean, B., Robinson, S., Hallett, J., & Selvey, L. A. (2021). Factors of the policy process that influence local government to progress a Health in All Policies approach: scoping review protocol. https://doi.org/10.6084/m9.figshare.14691414.v1

# The policy process factors influencing HiAP in LG: A scoping review protocol.

## Authors

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## Abstract

***Objective:*** This scoping review aims to identify what factors of the policy processes enable and/or challenge Health in All Policies to gain political traction as an approach within local government. The review will consider different contexts of local government, and the application of theories of the policy process.

***Introduction:*** Health in all policies is an approach to population health that requires sectors outside of health to consider their potential impacts on health outcomes. Local government has been proposed as a feasible tier of government to establish this approach, though the research on how and why is lacking. Describing this policy process could best be done through the lens of political science theories of the policy process, an underutilised approach in health promotion.

***Inclusion criteria:*** The scoping review will include studies published in academic peer-review journal articles and thesis dissertations, along with grey literature such as government reports. Sources will be included if they refer to Health in All Policies (or a related concept), describe any aspect of the policy process and focussed within the local government setting.

***Methods:*** Searches will be conducted in Scopus, Proquest and EBSCO for sources between 2001-2020 and in English. Two reviewers will independently review all sources for inclusion, initially based on title and abstract, followed by full text review and a manual scan of reference lists. Data extraction will be piloted by two reviewers and completed in full by one researcher. Data will be presented diagrammatically, along with a narrative summary.

## Introduction

The health and wellbeing of populations is influenced by a range of social, environmental, political, economic and physical factors (Marmot et al., 2008). Addressing these influences requires the cooperation of sectors outside of the traditional healthcare model to achieve greater population health outcomes (WHO and the Government of South Australia, 2010). There have been several

attempts to frame this cross-sectoral approach to population health, more recently referred to as the 'Health in All Policies' (HiAP) approach. HiAP is defined as "*an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity*"(World Health Organization, 2014, p. i20).

Achieving a HiAP approach in practice has been challenging, as it requires a systematic approach to overcome siloed governance structures, political will and leadership (Ollila et al., 2013) and to manage the resistance from sectors outside of health to take responsibility for population health outcomes (Koivusalo, 2010). Most research to date has focussed on the national and state/provincial levels of government (Shankardass et al., 2012). It has been argued the third tier of government, termed local government (LG) or municipality, is better positioned as a more feasible tier of government to address the range of determinants of health (Burris et al., 2007; Collins & Hayes, 2013; Harris & Wills, 1997). This notion of feasibility is based on, though not limited to, the opportunity of LG to design urban neighbourhoods, influence transport and employment conditions, contribute to social capital and provide access to local facilities, whilst also being in a position to bring different sectors together to address local community needs (World Health Organization, 2012).

However, the research on how or why HiAP would be adopted by decision makers, within any tier of government is very limited (Shankardass et al., 2014). Understanding the policy process of how or why could be better described through the use of political science theory, of which researchers in health promotion conclude there has been little adoption (Breton & De Leeuw, 2011). Furthermore, in instances where political science is described, it tends to be superficial (Shankardass et al., 2012).

Therefore, this scoping review will explore what factors of the policy processes enable and/or challenge HiAP to gain political traction within the local government (LG) policy subsystem. The review will consider different LG contexts (e.g., legislative environment, geographical size and location), and the use of theories of the policy process applied to the research methodology and findings. The purpose of the scoping review is to determine to what extent these concepts have been applied together in the international body of research. As acknowledged by Peters et al. (2015), scoping reviews are appropriate for addressing research questions that go beyond a specific intervention or specific questions, which is the case in this research.

Two scoping reviews with some similarities to this topic were identified in an initial search of the databases SCOPUS and PROQUEST. Guglielmin et al. (2017) aimed to identify the barriers and enablers to HiAP at a local level. The focus of the scoping review was to identify factors that impacted the implementation of HiAP or in response to a mandated action to act on HiAP. For this reason, the review included articles within LG that had already applied or implemented HiAP, or a similar concept that aims to achieve health and wellbeing or address health inequities. Articles were excluded if they were based at a state or national tier of government, though included if LG was involved. The review also excluded articles on health impact assessment tools, unless directly linked to the HiAP process. The review included only articles written in English between the years 2002 to 2016. The authors identified 23 peer review articles and four government documents to be included.

Van Vliet-Brown et al. (2017) aimed to identify how HiAP is utilized in municipalities and identify research gaps. The scoping review reported on both recommendations for successful implementation of HiAP, though also the common themes that arose in the literature related to the

barriers and enablers for adoption of the approach in LG. Articles were included from both peer review sources and grey literature between 2006 to 2015, using 'HiAP' specifically as a term, focussed on the local or municipal tier of government. Related concepts and other similar terms, such as health equity, were not included in the search. Articles were excluded if they referred to other tiers of government or in a language other than English. Other inclusion and exclusion criteria were not provided. The authors identified 27 sources, including peer review research, commentaries, policy documents, government information sources and conference abstracts, posters and presentations.

The proposed scoping review in this protocol has some similarities and differences to the two reviews outlined above. The interpretation of HiAP is used similarly to Guglielmin et al. (2017), in that it uses the term 'health in all policies' both explicitly and implicitly alongside terms such as 'health equity'. This extension of the definition and understanding of the term is adopted to include it's underlying purpose of addressing a range of health determinants across different policy areas that impact populations to address health inequities (Ollila et al., 2013). This is also a key difference to the review by Van Vliet-Brown et al. (2017) which limited search terms to those relevant to the explicit use of 'health in all policies'. The role of LG, alongside other tiers of government, will also be used as per Guglielmin et al. (2017), with the addition of sources where LG has a clear role amongst other tiers of government. This is something that was also excluded in the review by (Van Vliet-Brown et al., 2017). The proposed review will also similarly exclude articles related to health impact assessment tools as per Guglielmin et al. (2017), though will consider them if they are clearly a factor in the policy process. As per both scoping reviews, sources will be in only the English language.

Overall, the proposed scoping review takes a broader perspective of the policy process. The aforementioned scoping reviews focussed only on implementation of HiAP. This scoping review will explicitly focus on the full policy process from agenda setting through to monitoring and evaluation. To guide decision-making, a deconstruction of variables related to factors in the policy process (according to various political science frameworks) has been provided to all reviewers (Appendix IV). Additionally, Guglielmin et al. (2017) focussed on studies where HiAP was already mandated, whereas the proposed scoping review will not limit to only those cases where HiAP is already legislated. It was not clear if Van Vliet-Brown et al. (2017) excluded any studies based on context. This scoping review will distinguish the research findings based on LG contexts of various geographical location and size, of which neither of the existing scoping reviews has included. In addition, the proposed scoping review will consider the application of political science theory to inform the research of the policy process, of which neither of the existing scoping reviews has applied.

In summary, the proposed scoping review provides a more in-depth and nuanced focus on the HiAP approach, locating this within the LG context, though not excluding their relationship with higher tiers of government. The scoping review will include the most recently available research (up to year 2020) and captures a broad scope to include underlying concepts of HiAP, including determinants of health and health inequities. The review includes all factors related to the policy process, not only including those LG that have already applied HiAP, through investigating factors that influence policy agenda setting, development and implementation of the HiAP approach, as well as the factors that are enabling and challenging the sustainability and evaluation of this approach. Furthermore, this scoping review takes a specific interest in the different contexts of LG and the role of political science as a theoretical lens in explaining the policy process.

The objective of this scoping review is to establish an understanding of what is currently known of how and why LG adopt (or do not adopt) a HiAP approach, including how and why HiAP gets on to the policy agenda (or why it does not) and what the barriers and enablers are to the initiation, implementation or evaluation of the approach, including across different LG contexts and jurisdictions. The aim is to also identify the extent to which the literature has utilised theories from political science to explore and explain the policy process.

### Review question

The research question proposed for this review is:

*"What are the critical factors in the policy process that enable and/or challenge local government in initiating, implementing or evaluating a HiAP approach to achieve population health and wellbeing outcomes?"*

Some additional sub-questions of interest include:

- *Are these identified policy factors different across various local government contexts and jurisdictions?*
- *How does the literature related to HiAP approaches in LG apply theories from political science?*

### Keywords

Policy process, local health policy, health in all policies, determinants of health, healthy public policy

## Eligibility criteria

### Participants

For the purposes of this research, the participants are not a defined part of the population, and so this aspect of the PCC framework becomes less relevant. However, the focus of HiAP as a concept is framed on population health and wellbeing, as opposed to individual health services or health outcomes.

### Concept

The concept of HiAP represents a policy process that is underpinned by addressing structural determinants of health and addressing health inequity across a range of policy areas. The term 'HiAP' is a relatively new term in the last decade, so the underlying intent of the approach will be taken into account in the inclusion of sources, including if there is reference to policy processes related to structural determinants of health (political, social, environmental (built or natural)) or concepts such as health equity. These are concepts that impact on population health and wellbeing, rather than healthcare treatment services or practices, or individual behavioural approaches to health and wellbeing. For this reason, sources will be excluded if they define health related to a biomedical or healthcare approach/setting (e.g., delivery of healthcare services), or individual behavioural approaches (e.g., physical activity).

This includes the exclusion of sources related to urban planning or the built environment that focus on specific behavioural approaches (e.g., physical activity) or disease (e.g., obesity). It is recognised that the research on urban and neighbourhood planning is likely more advanced than that of other determinants. Built or natural environment research that focus on technical aspects of zoning and urban planning or make recommendations on what urban planners should do to improve health and wellbeing outcomes will be considered out of scope. Research related to a relevant determinant of health (e.g., built environment, housing, social strategies) will be included where it relates to population health and health inequities, and is clear that the study is related to how/why health is incorporated into policy decisions at a local level.

Sources where the definition of 'population health' or 'health determinants' is not clearly defined (e.g. the term used is 'public health') will be included in the review if it is apparent the focus of the research is on population health, not health care.

Given the goal of the research is to understand the policy process that makes HiAP feasible or not, all sources to be included in the review need to address at least one of the key factors that relate to the policy process (Appendix IV). This includes both explicit use of theories of the policy process (e.g., Multiple Streams Framework) or in the absence of a specific theory. For this reason, sources will be excluded if the focus is solely on policy analysis (e.g., discussing content within policies), policy impact or policy outcomes (e.g., what resulted due to policy), in the absence of understanding the processes that led to these decisions being made.

## Context

The context for this research is the LG policy sub-system. The sub-system is focussed within the structures of LG, including both organisational systems and the individual decision makers. However, the policy actors can extend to other local stakeholders that influence the policy sub-system such as community-based organisations and civil society. The role of senior tiers of government will be considered where they include or relate explicitly to the influence on LG. Studies that include multiple tiers of government will be included where a clear role for LG is evident.

Given the variability in LG systems across the globe, studies within middle-high income countries will be included. Consideration will be given for studies in low-income countries where the reviewers agree there is value in their inclusion.

## Types of Sources

All types of empirical and theoretical studies will be considered in the review. The scoping review will include studies published in academic peer-review journal articles and thesis dissertations, along with grey literature such as government reports. It is considered appropriate to include government reports and thesis dissertations, as the concept of HiAP is relatively new and the academic literature may not capture all of the information that best informs this research topic. Opinion papers, such as commentaries and debates, will be considered in the review. Newspaper reports and conference abstracts will be excluded from the review.

Due to language and resource constraints, only sources written in English language will be included. Articles published between 2001 and 2020 will be deemed eligible for inclusion, reflecting 20 years of possible practice in the area of LG health and wellbeing policy. is considered necessary as the

policy process can be a long-term change process and research may extend beyond several years prior to publication.

## Methods

The proposed scoping review will be conducted in accordance with the JBI methodology for scoping reviews (Peters MDJ, 2020).

### Search strategy

The proposed database search terms have been chosen based on the PCC framework (Peters MDJ, 2020). An initial limited search, conducted in collaboration with a librarian and several of the authors, was undertaken across several databases (Scopus, Proquest, Web of Science, EBSCO), using key search terms such as 'health in all policies', 'healthy public policy', 'local government' and 'municipality'. This search strategy identified other useful terms for local government, including 'city government'. On an initial scan of the literature and chosen key index terms, it was apparent that some language around HiAP extended to the underlying concepts, with terms used such as 'determinants of health' and 'health inequity' being a focus of the policy process, sometimes with and sometimes in the absence of the term HiAP. More general terms such as 'healthy public policy' returned largely irrelevant articles related mostly to health services or behavioural approaches to health policy action. Within Proquest, the full term of 'policy process' will be used instead of 'polic*' as this returned fewer though more relevant sources. A search on Informit database for 'health and all policies' and 'local government' was undertaken, returning nil results so this database was considered irrelevant for the search. Sources returned in Web of Science were limited and duplicated other databases, so was also considered irrelevant for the proposed search strategy.

A full list of final search terms is outlined in Table 1, with a summary of the search strings for each database and their results in Appendix I.

*Table 1: Key words and search terms, using a PCC framework as a guide.*

| PCC | Key Terms | Alternative terms included |
|---|---|---|
| Context | Local government* | "Local council", Municipality, "city government" |
| Concept 1<br>**AND** | Health in all polic* | "determinants of health" or "health *equit*" |
| Concept 2 | "polic*" | "policy process" |

In addition to the database searches, a second strategy will be used to manually scan the included article references for further relevant sources that may not have been identified in the database searches, along with a general scan of the first 150 sources in Google Scholar using terms such as 'health in all policies' and 'municipality' or 'local government'.

### Study/Source of Evidence selection

Following the search of databases, all identified citations will be uploaded into EndNote X9 and duplicates removed. The titles and abstracts from the final list of sources will be imported to

Rayyan[1] software, in preparation for screening by two reviewers for assessment against the eligibility criteria of the review (Appendix II). Any disagreements for inclusion at this first stage will be discussed and main reasons for exclusion of sources noted.

All sources that are considered for further review will be retrieved in full text and assessed against the inclusion/exclusion criteria by two independent reviewers. The primary reason for exclusion of sources will be documented in a separate Microsoft Excel file and reported in the scoping review. Any disagreements on the inclusion of sources will be resolved by discussion in the first instance by the two reviewers or escalated to other reviewers if a decision cannot be reached. The results of the inclusion and exclusion process will be fully reported in the final scoping review.

### Data Extraction

Data extraction will include source reference, level of government, country, concept focus, use of political science theory, methodology, key findings and relevance to the review questions (Appendix III). Any limitations or quality assessment of studies will be noted, though a formal quality appraisal will not be undertaken. A data extraction template is attached (Appendix II). The data extraction will be piloted by two reviewers using a sample of 3-4 sources. Any disagreements that arise will be discussed or escalated to other reviewers if required. Following this, the data extraction table will be refined if required. All further data extraction will be undertaken by one researcher and discussed with the second reviewer if there is any ambiguity.

## Data Analysis and Presentation

The data will be presented in a diagrammatic and narrative form, including a bar chart representing the year sources were published, country in which the source was authored and use of political science theory within the research. A narrative account of the critical factors involved in the policy process will be themed into subheadings and discussed in relation to the evidence.

## Acknowledgements

Courtney Moran, Liaison Librarian for the University of the Sunshine Coast, for her assistance with the search strategy.

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# Appendices

## Appendix I: Factors considered in the policy process

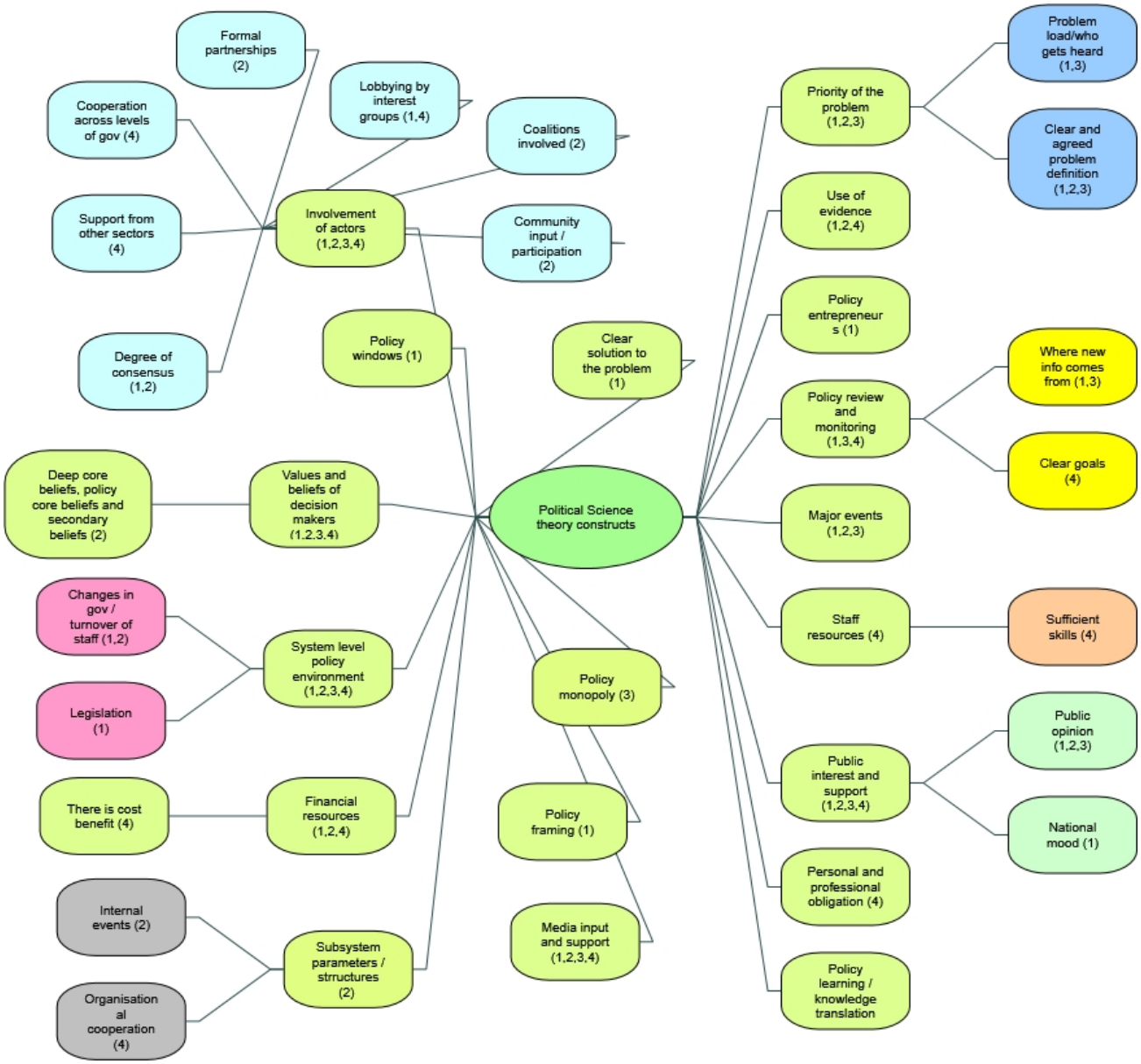


*Figure 1: Factors considered in the policy process, based on the theoretical lens for the research*

## Appendix II: Search strategy

| Database | Search string used | Limits | Number of sources |
|---|---|---|---|
| Proquest | ("local government" OR "municipality" OR "local council" OR “city government”) AND ("health in all polic*" OR "determinants of health" OR "health inequit*" OR "health equit*") AND ("policy process") | **Year:** 1 Jan 2001-1 Jan 2021 **Language:** English **Sources:** Dissertations & Theses, Scholarly Journals and Reports | 593 |
| Scopus | ("local government" OR "municipality" OR "local council" OR “city government”) AND ("health in all polic*" OR "determinants of health" OR "health *equit*") AND ("polic*") | **Year:** 2001-12 March 2021 **Language:** English **Sources:** Articles and Reviews | 208 |
| EBSCO | ("local government" OR "municipality" OR "local council" OR “city government”) AND ("health in all polic*" OR "determinants of health" OR "health *equit*") AND ("polic*") | **Year:** 2001-Jan 2021 **Language**: English **Sources:** Academic Journals, Journals, Dissertations | 234 |

## Appendix III: Exclusion and inclusion flow chart

Database settings: Restrict to limits: English, 2001-2020, exclude newspapers and conference abstracts

| | Include | Exclude | Examples for exclusion |
|---|---|---|---|
| Does the source refer to HiAP or a related concept e.g. health inequities? | Yes | No | Focus on biomedical or lifestyle factors e.g. obesity. |
| Does the source describe the policy process? (e.g. getting policy onto political agenda, factors enabling or challenging the development or implementation of policy) | Yes | No | Discusses content in policy documents or policy impacts/outcomes. |
| Is the study/case study focussed within the LG setting? (either solely or in conjunction with other tiers of gov) | Yes | No | Set in State or Federal tiers of government. Set in local healthcare settings or community-based organisations. Not in any particular context. |

## Appendix IV: Data extraction instrument

| Study details and characteristics: | |
|---|---|
| Study citation: | |
| Year: | |
| Country: | |
| Level of government(s): | |
| Key concept of focus: | |
| Aim/objective of the research: | |
| Research methods: | |
| Research participants: | |
| Applied theory: | |
| Application of political science theory: | |
| Key findings - barriers and/or enablers identified in the policy process: | |
| Comparison of different context/jurisdictions: | |
| Study limitations: | |

# APPENDIX C: DATA EXTRACTION TABLE

**Literature review data extraction table**

The following data extraction table includes a summary of all sources included in the scoping review. Sections on country, level of government and key concept are collapsed into one column and the application of political science theory, different LG contexts are removed for brevity. Acronyms used include Health in All Policies (HiAP), Local Government (LG), Health Impact Assessment (HIA) and Social Determinants of Health (SDoH).

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| Bagley, P., Lin, V., Keating, T., Wise, M., & Sainsbury, P. (2007). In what ways does the mandatory nature of Victoria's municipal public health planning framework impact on the planning process and outcomes? *Australia and New Zealand Health Policy, 4*(1). https://doi.org/10.1071/HP070404 | Australia<br><br>Local<br><br>Public health | To identify the strengths and weaknesses of the implementation of mandatory municipal public health plan (MPHP) in Victoria. | Qualitative semi-structured interviews.<br><br>No theory applied. | 10 management staff involved in public health planning in Victorian LG, plus 4 interviews with state-based public health staff. | Majority agreed that legislation improved planning. Some felt it increased the visibility of public health, others saw it as responsibility passed on by the State.<br>Different LGs approached the process in different ways e.g., in selecting priorities and engaging community. There was not a shared understanding of the nature of the MPHP.<br>Factors such as management support, organisational culture, community expectations and the skills of staff were enabling the process.<br>Only half of the councils had an implementation plan for their MPHP. The process is strategic, as opposed to operational for some councils.<br>Staff can identify local priorities, but be overridden with political decisions and demands, or community pressure. Specific legislation (e.g., food safety) get higher priority than other public health activities and actions.<br>Concern regarding 'cost shifting' by state/national government.<br>Regulation is not enough for effective public health planning in LG, although may act as an influencing factor.<br>Legislative change needs to be consultive with LG, the scope should be clear, senior management support is critical, capacity of the workforce needs to be considered in planning, integration of |

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| | | | | | LG and State planning is required, investment needs to be in implementation as well as development. |
| Baldwin, L., Dallaston, E., Bennett, B., McDonald, F., & Fleming, M. L. (2021). Health in all policies for rural and remote health: A role for Australian local governments? *Australian Journal of Public Administration, 80*(2), 374-381. https://doi.org/10.1111/1467-8500.12460 | Australia<br><br>Local<br><br>HiAP | To discuss possible challenges to a HiAP approach for rural and remote LGs | Controversy paper.<br><br>No theory applied. | N/A | Barrier proposed: Rural and remote LGs may have less capacity for policy development due to greater responsibilities and more time travelling, less access to public health experts to collaborate with.<br>Authors recommend that legislation be enacted for LG to address health and wellbeing where this does not already exist. Authors recommend that LG in rural and remote areas require more support by higher tiers of government, including expertise and funding. |
| Bekken, W., Dahl, E., & Van Der Wel, K. (2017). Tackling health inequality at the local level: Some critical reflections on the future of Norwegian policies. *Scandinavian Journal of Public Health, 45*(18_suppl), 56-61. https://doi.org/10.1177/1403494817701012 | Norway<br><br>Local<br><br>HiAP | To identify the 'opportunities and obstacles' for municipalities to take action on health inequalities. | Discussion - Government documents and research.<br><br>No theory applied. | N/A | National level policy support for addressing health inequities seems to be reducing over time, making local level policy more difficult to achieve.<br>Many municipal level initiatives are not evaluated, are not scientifically rigorous enough and may lack scientific and political influence/value.<br>Poor access to local level data, making it difficult for LG to know where to invest. Translation of national policy to local policy requires the problem and solutions to be viewed from the perspective of local policy actors.<br>Each municipality will respond differently to addressing health inequities, based on local adaptations. |

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| Bhatia, R., & Corburn, J. (2011). Lessons from San Francisco: health impact assessments have advanced political conditions for improving population health. *Health Affairs, 30*(12), 2410-2418. https://doi.org/10.1377/hlthaff.2010.1303 | USA<br><br>Local<br><br>HIA | Focus on how HIA affect broader political conditions for health. | Not stated: Based on experience of the authors.<br><br>No theory applied. | Communication and dialogue with public and private organisational stakeholders and decision makers and public involved in HIA, along with government documents, media reports and personal observations. | Planners were concerned that doing a HIA (in addition to an Environmental Health Assessment) would increase the timeframes and budget.<br>The validity of HIA was often questioned.<br>HIA is not institutionalised into any systematic approach within LG.<br>Health staff limited involvement in Environmental Health Assessments and instead focussed on plans and actions that could influence health.<br>HIA has likely increased awareness of the SDoH amongst stakeholders and the community, sustained for use across other projects.<br>Health staff conducting HIAs were further trained and skilled in assessing possible health impacts.<br>The process of conducting a HIA provided opportunities for learning across multiple stakeholder groups and helped strengthen existing advocacy coalitions.<br>Engaging with policy planners and stakeholders has helped health staff learn more about engaging in the policy process and influencing different policy sectors.<br>Completing HIA built trust and working relationships between different stakeholders and the health department, allowing for more communication and information sharing.<br>HIA is technical as well as political.<br>HIA may only be effective when it is aligned to the political environment. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
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| Browne, G. R., Davern, M., & Giles-Corti, B. (2017). What evidence is being used to inform municipal strategic planning for health and wellbeing? Victoria, Australia, a case study. *Evidence and Policy, 13*(3), 401-416. https://doi.org/10.1332/174426416X14655655062000 | Australia<br><br>Local<br><br>SDoH | To describe the types of evidence that Victorian LG utilise to inform municipal health plans.<br>To explore sources of evidence, what evidence describes and how specific evidence is within documents. | Content analysis.<br>Included: MPHPs or Community Plans of Victorian LGs – obtained from websites or council contacts.<br><br>No theory applied. | Included 116 LG documents across 79 LGs in Victoria. | LG does not have the capacity to undertake reviews of evidence.<br>Local evidence-informed intervention research is hypothesised as possibly non-existent and difficult to obtain. Where available it may not be cited or might not be appropriate for a local level.<br>Type of evidence categories: not specific, demographics, epidemiology, health behaviours, domains of public policy.<br>In 26% of occurrences, the source of evidence was unable to be determined.<br>ABS was the most highly cited source, followed by local council (e.g., community consultations) and State government documents.<br>46% of evidence referred to 'domains of public policy' e.g. 17% referred to "social connectivity, cohesion and democracy".<br>Epidemiology and behavioural health categories had highest citings related to mental health (18%) and nutrition (21%).<br>Majority of the evidence referred to the situation, rather than on evidence for action (4% of all occurrences).<br>Evidence for action was mostly 'council-generated', including via community consultation.<br>Academic sources were some of the least cited sources of evidence for evidence-based action.<br>It is possible that information is sought more informally through professional networks and colleagues.<br>A combination of peer-to-peer communication, informal networking and advice from population health experts is playing a role in MPHWPs. |

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| Browne, G. R., Davern, M., & Giles‐Corti, B. (2019). 'Punching above their weight': a qualitative examination of local governments' organisational efficacy to improve the social determinants of health. *Australian and New Zealand Journal of Public Health, 43*(1), 81-87. https://doi.org/10.1111/1753-6405.12847 | Australia<br><br>Local<br><br>SDoH | To describe how LG in Victoria conceptualised their organisational efficacy to address public health with reference to their statutory obligations.<br><br>To what extent LG consider the State priorities when developing MPHP and how effective they feel they can address SDoH. | Qualitative interviews.<br><br>No theory applied. | 16 interviews with health planners (background in HP, community development, EH). These staff are responsible for developing the MPHP. Across rural, regional and city areas. | LG planners had good understanding of socio-ecological model of health and demonstrated upstream strategies that impact HWB.<br>Good recall and use of the 'Environments for Health' resource made available to LG.<br>Community wellbeing and upstream initiatives were LG responsibility and important. Across the four key action areas, addressing SDoH was the top priority (2nd – health protections and 3rd – behavioural program and 4th – preventive healthcare).<br>Behavioural programs (e.g., walking groups) were more 'politically attractive'.<br>LG see 'upstream' investments more cost effective than behavioural programs.<br>Victorian LG do not get funding to implement public health plans, so feasibility needs to be considered. Duplication of other sectors is avoided.<br>Consultation with community members was perceived as reverting to behavioural programs as suggestions for HWB, rather than thinking upstream, which perpetuates the cycle of what is the local priority.<br>LG adopted socio-ecological model of health. The state priorities were considered but less influential than considering local needs.<br>Planners felt that the State priorities were missing key social factors.<br>There needs to be more collaboration between state and LG to identify health priorities. |

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| Collins, P. (2012). Do great local minds think alike? Comparing perceptions of the social determinants of health between non-profit and governmental actors in two Canadian cities. *Health Education Research, 27*(3), 371-384. https://doi.org/10.1093/her/cys009 | Canada<br><br>Local<br><br>SDoH | To analyse the perceptions of SDOH amongst staff in community-based organisations and local municipalities. | Mail administered survey.<br>Two surveys were conducted separately – Community Based Organisations (CBO's) in 2003 (Ontario) and government (GOV) (municipalities) in 2008 (Vancouver).<br><br>No theory applied. | 241 CBO, and 345 GOV participants, response rates 55% and 54% respectively.<br>CBO participants mostly volunteers.<br>GOV participants mostly city staff.<br>Approximately half of respondents in each sample held positions of power e.g., manager. | Both GOV and CBO participants identify that they have influence over living conditions of populations.<br>Structural determinants of health were given the least priority by both CBO and GOV participants.<br>Lack of access to resources to take action.<br>Competes with level of priority given to healthcare.<br>Both CBO and GOV participants rated 'healthy lifestyles' and 'clean air and water' as having a high level of influence over health. These determinants were also rated as the highest priority.<br>The lowest level of priority was given to 'income'.<br>Both CBO and GOV participants were similar for most of the determinants.<br>Perception of influence did not match level of priority. The determinants of 'income', 'social supports' and 'healthy lifestyles' were reported as having a higher level of influence over health than priority given. Except 'healthcare', which was assigned less influence compared to priority.<br>The high level of priority for determinants such as 'clean air and water' were given for different reasons, with CBO respondents from a heavily polluted region, and GOV respondents largely responsible for this in their role in local government.<br>Conclude that shared understandings between CBO and GOV participants increases likelihood of collaborations, the priority would likely be given to healthy lifestyles that have minimal influence on health equity. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
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| Collins, P., & Hayes, M. (2013). Examining the Capacities of Municipal Governments to Reduce Health Inequities: A Survey of Municipal Actors' Perceptions in Metro Vancouver. *Canadian Journal of Public Health. Revue Canadienne de Santé Publique, 104*(4), e304-310. http://www.jstor.org/stable/canajpublheal.104.4.e304 | Canada<br><br>Local<br><br>Health inequity | To measure understanding of SDoH, perceived role of LG, policies that could impact on health inequity, and barriers to addressing inequity. | Mail survey to 637 politicians and staff in 17 Municipal governments in Metro Vancouver.<br><br>No theory applied. | 345 participants, 56% non-elected officials and 54% elected officials. | LG felt little empowerment to reduce health inequity with little autonomy, insufficient funding from senior governments, insufficient collaboration with higher tiers of government and reluctance to increase property taxes to increase funding.<br>Study demonstrated respondents were willing to discuss health inequity, even if limited perceived power to influence.<br>There were no consistent differences in responses based on role or sector within a municipality.<br>Of all respondents, 44% reported a high priority to addressing health inequity.<br>The highest priority areas for addressing health inequity were given to parks and recreation facilities, community centres and citizen engagement, as ways for municipalities to address health inequity. Property taxes were given the least priority.<br>Respondents identified a broad range of policies, plans and programs that address health inequity in their jurisdictions. Homelessness and affordable housing were most commonly identified, following by fitness, parks and recreation programs.<br>Results indicated the respondents viewed the sectors responsible for addressing health inequity in the following order (highest to lowest): provincial government, federal government, regional health authorities, individuals, regional governments, municipal governments, non-profit sector, market. This ranking may reflect participant concerns about shifting of responsibilities from higher to lower levels of government. |
| Corburn, J., Curl, S., Arredondo, G., & Malagon, J. (2014). Health in all urban policy: city services | USA<br><br>Local<br><br>HiAP | To describe the processes in the development of HiAP in Richmond, California. | Interviews. Document analysis of minutes, public meetings, | 25 LG and community-based organisations. | Enabling factor was initiation of a long term General Plan in LG, required by law with a section on 'community health and wellness'.<br>The LG applied and received a grant to incorporate a ‘community health and wellness’ component within the General Plan. Over |

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| through the prism of health. Journal of urban health, 91(4), 623-636. | | | emails, reports and other publicly available documents.<br>Used community surveys from 4 time points in 2007, 2009, 2011 and 2013 (resident perceptions of community wellbeing) (randomly administered to 3000 households).<br><br>No theory applied. | | time goals linked to HiAP strategy were costed in the LG budget.<br>A HiAP leadership group was formed.<br>Locally acquired data was used from community surveys.<br>Ongoing community development work increased the priority of health equity and created a 'value shift'.<br>A community and government collaborative group is a positive outcome of the process.<br>Use of a 'cumulative toxic stress' model to identify the community health needs during community consultations, which demonstrated the multiple stress points that needed to be addressed (e.g., racism, violence, pollution) using an integrated approach .<br>Indicators were developed for each intervention area that could be used to monitor progress over time. Data had to be existing and publicly available.<br>Reluctance of LG departments to be involved as they perceived it to add to their work.<br>There was resistance from those in and outside of LG that did not share the values of environmental and social justice.<br>Difficulty in getting local level health data (which made indicators difficult to measure).<br>The three key factors to healthy community development: community involvement from the bottom up, coupled with LG support and willingness to engage; pilot place-based actions, engage community and see tangible changes; learning by doing, building of partnerships that could apply for grants to continue the work.<br>Citizen "activists groups" advocated for environmental and social justice to be included in the General Plan. |

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| de Blasio, A., Girán, J., & Nagy, Z. (2012). Potentials of health impact assessment as a local health policy supporting tool. *Perspectives in Public Health, 132*(5), 216-220. https://doi.org/10.1177/1757913910391039 | Hungary<br><br>Local<br><br>HIA | To describe experience of using HIA as a 'health filter' in one city, a designated healthy city in Hungary (Pecs). | Case study (narrative): Pecs (a designated Healthy City).<br><br>No theory applied. | Not stated. | With no legal obligation to do a HIA, there was limited motivation. Other barriers were short timeframes, a weak preparation phase (which led to officials not being confident to fulfill the role of HIA in decision-making) and lack of support from political decision makers.<br>Description of the attempts to systemise HIA as part of a plan to address determinants of health in a healthy city.<br>Specialist training was provided to 32 officials of different departments within the city administration. This was based on the already available human resources that were working within the policy decisions and had a good understanding of the operation of the council.<br>HIA is not only a technical component of decision-making, though requires high level political support. |
| de Goede, J., van Bon-Martens, M. J., Mathijssen, J. J., Putters, K., & van Oers, H. A. (2012). Looking for interaction: quantitative measurement of research utilization by Dutch local health officials. *Health Research Policy and Systems, 10*(1), 1-12. https://doi.org/10.1186/1478-4505-10-9 | Netherlands<br><br>Local<br><br>Public health | To understand how local health officials use epidemiological research and identify the factors that influence this use. | Online questionnaire to possible 339 local health officials. Initial contact by phone for consent to participate.<br><br>Conceptual framework on research utilisation (authors developed). | 155 local health officials responsible for the development of local health policy. Representing 35% of municipalities. | Involvement of local officials in the research process was related to instrumental and symbolic use of research.<br>Unawareness of media publication about epidemiological data related to less instrumental use of research.<br>Epidemiologist presenting the data via a presentation (rather than another staff member) related to conceptual use of research.<br>Although this decreased as score for 'barriers to interaction' increased. Research was more commonly used for conceptual use, rather than instrumental or symbolic use.<br>This supports the complexity of the use of evidence-based research in policy, as local officials also deal with other actors, opinions and interests. |

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| Dhesi, S. K. (2014). Exploring how Health and Wellbeing Boards are tackling health inequalities with particular reference to the role of environmental health. The University of Manchester (United Kingdom). | England<br><br>Local<br><br>SDoH | Research Q#2: Do (and how) Health and Wellbeing Boards (HWB) tackle health inequalities and does this vary between areas? | Qualitative case studies (n=4), longitudinal approach using observation, interviews and document analysis.<br><br>Harrison's Design to Doodle conceptual framework. | 31 interviews with members of HWB.<br>19 interviews with EH managers and staff across different contextual sites (outside case study sites).<br>Observation of 23 HWB meetings.<br>Documents of meeting minutes, reference lists and HWB strategies. | Marmot report was an initiator.<br>Issue-focussed priorities gained the most consensus. Children and young people were also a priority.<br>Shared commitment to addressing health inequities amongst HWB members.<br>Some sites saw health inequalities as a low priority, or outside of their control at a local level.<br>Tools to address health inequities at a local level were seen to be lacking.<br>The understanding of health inequities was not shared between HWB members.<br>Difficulty of measuring actions on health inequities.<br>Tensions existed between different policy actors e.g., officers, elected officials, General Practitioners and different tiers of local authorities. Some debate was classified as healthy, where there were relationships built on trust. Some reported that debates created tensions within meetings (although this was not observed). |
| Didem, E. K. E., Filiz, E., Orhan, O., Gulnur, S., & Erdal, B. (2012). Local decision makers' awareness of the social determinants of health in Turkey: a cross-sectional study. *BMC Public Health, 12*(1), Article 437. https://doi.org/10.1186/1471-2458-12-437 | Turkey<br><br>Local<br><br>SDoH | To look at awareness of social determinants of health amongst decision makers in the Aydin Province, Turkey. | Questionnaire (faxed to 53 Mayors and done as interviews face to face with 22 Headman).<br><br>No theory applied. | 50 Mayors, 22 Headmen | Mayors were aware of SDoH, though they were unsure how to action this in practice. Headmen were not aware of SDoH and equally unable to determine how to action this in practice. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
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| Exworthy, M., Berney, L., & Powell, M. (2002). 'How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. *Policy & Politics, 30*(1), 79-96. https://doi.org/10.1332/0305573022501584 | UK<br><br>Local<br><br>Health inequalities | To describe how health inequalities gets onto the local and national policy agendas and how it is being actioned. | Three case studies (rural, urban and mixed suburbs): incl. interviews, documentation and meeting observations.<br><br>Multiple Stream Framework. | Majority local and some national policymakers.<br>45 interviews, including senior managers, Directors of Planning, Public Health doctors, managers in Health Authorities and networks, including local authorities, NHS, voluntary sector. | Having national policy explicitly refer to health inequalities gave local legitimacy.<br>'Crowded' policy agenda meant health inequalities was not being prioritised amongst other local and national issues.<br>National expectations of LG were not met - largely reported as a lack of structures in place for joined up government. Policies were then not technically feasible.<br>There were no performance measures for health inequality or they were vague, though LG reported to national government measures such as waiting lists.<br>Action on health inequalities is reliant on policy entrepreneurs.<br>Application of MSF:<br>Problem, policy and politics streams had been partially coupled at national and local levels. The problem was on the agenda, some actions were taken and politics 'uncontroversial'. At a local level, health inequalities were not seen as an urgent problem, did not have performance monitoring targets attached to it and was less a priority than other issues such as waiting lists. Within the politics stream, the national policy helped shape local policy, but required local policy entrepreneurs. Policy stream still developing, with some action across agencies, but may be difficult to sustain over the long term, particularly if it continues to be seen as a 'health' problem. |

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| Fisher, M. (2018). Challenging Institutional Norms to Improve Local-Level Policy for Health and Health Equity: Comment on" Health Promotion at Local Level in Norway: The Use of Public Health Coordinators and Health Overviews to Promote Fair Distribution Among Social Groups". *International journal of health policy and management, 7*(10), 968-970. https://doi.org/10.15171/ijhpm.2018.67 | n/a | Response to Hagen et al 2018, discussing the idea of place-based policy action for public health, as opposed to the inter-sectoral, whole of government approach taken in Norway. | Commentary | N/a | 'Interventions' for health action are implemented because they remain comfortable for all of the stakeholders involved.<br>Approaches that empower and involve communities are likely to be uncomfortable, for three possible reasons:<br>1) organisations are not in control<br>2) no tangible 'delivery' and about a longer term 'process'<br>3) requires organisations to view people as capable, not merely passive consumers.<br>Government could learn from research on community-based social development and empowerment. |
| Fosse, E., & Helgesen, M. K. (2015). How can local governments level the social gradient in health among families with children? The case of Norway. *International Journal of Child,* | Norway<br><br>Local<br><br>HiAP | To explore if the national policy influences local level policy and how LG address social inequalities that influence services for family and children. | Two surveys (2011 and 2014) and focus groups in 6 municipalities.<br><br>No theory applied. | CEOs and relevant staff in the municipality.<br>2011 survey (n=361)<br>2014 survey (n=303)<br>Focus groups (in six municipalities, | National funding did not always match local priorities.<br>Development of a health overview increased from 13% to 24.5% between 2011-2014.<br>Many public health themes were raised in municipality plans despite not having a health overview.<br>Established intersectoral working groups decreased from 95% in 2011 to 62% in 2014. Except for in areas of schools, CEO office and planning department, where there was an increase. |

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| *Youth & Family Studies, 6*(2), 328-346. https://doi.org/10.18357/ijcyfs.62201513505 | | | | number of participants not stated) | The employment of a public health coordinator increased from 74% (of 347 municipalities) to 85% (of 307) between 2011 and 2014.<br>In 2011, 43% of municipalities reported that health inequalities was a goal.<br>In 2014, 51% of municipalities reported they are capable of reducing health inequalities, identified as through strengthening welfare services and targeted measures for vulnerable groups.<br>Interviews support the approach to universal, as well as targeted measures to reduce social inequalities in economic plans.<br>Conclude that each municipality addresses social inequalities differently, based on how the problem is defined. There needs to be explicit support from the national policy, including funding. |
| Fosse, E., Helgesen, M., Hagen, S., & Torp, S. (2018). Addressing the social determinants of health at the local level: Opportunities and challenges. *Scandinavian Journal of Public Health, 46*(20_suppl), 47-52. https://doi.org/10.1177/1403494817743896 | Norway<br><br>Local & National<br><br>HiAP | To answer 1) how municipalities could contribute to reduce social inequalities and level the social gradient and 2)How can municipalities contribute to develop intersectoral responsibility and achieve a HiAP approach to public health? | Synthesis of information from 5 other articles, in addition some reports. (all five studies are already included in the literature review).<br><br>No theory applied. | National policymakers (interviews), municipal CEOs (survey), municipality policymakers (interviews) | Municipalities are responding to the national public health act to address health inequities, though most focused on behavioural and healthcare actions and few described a gradient approach.<br>A public health coordinator is identified as a 'intersectoral facilitator', although of those that employed a PHC, only 22% were employed full time. This might limit the impact these coordinators can have.<br>Health overviews were not used to guide the policy process by many municipalities - used to prioritise action program (12%) or the Master Plan (4%). |

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| Fosse, E., Sherriff, N., & Helgesen, M. (2019). Leveling the Social Gradient in Health at the Local Level: Applying the Gradient Equity Lens to Norwegian Local Public Health Policy. *International Journal of Health Services, 49*(3), 538-554. https://doi.org/10.1177/0020731419842518 | Norway<br><br>Local<br><br>HiAP | To describe how LGs have implemented the national Norwegian Public Health Act 2021. | Uses 2 other primary data sources including survey data from 2011, 2014 and 2017, along with qualitative interviews from 6 municipality case study sites.<br><br>Gradient evaluation framework | CEOs, policymakers | The proportion of municipalities that completed a health overview report increased from 39% in 2014 to 85% in 2017.<br>Awareness of the national public health act was high amongst public health coordinators in municipalities.<br>In 2017, policy areas covering SDoH had a low priority. 36% of municipalities gave priority to these areas, as opposed to 58% prioritised individual mental health issues amongst children (which was also a nationally funded program at the time which could influence this prioritisation).<br>Few interviewees were aware of the social gradient of health.<br>Between 2014 – 2017 more municipalities had established intersectoral working groups, from 62% to 72%. Between 2011 to 2014, CEO staff and planning department staff increased in participation on intersectoral working groups (CEO up from 22% to 68%; Planning staff up from 16% to 65%), though this dropped in 2017 (56% for both).<br>Municipalities are increasingly reporting capability in addressing health inequities, up from 83% in 2014 to 95% in 2017.<br>There was a good understanding of the investment in the early years to address health inequities later in life, such as investing in kindergartens and childcare.<br>Most municipalities still prioritise individual lifestyle issues, 34% in 2011 and 71% in 2014. In 2017, mental health problems were prioritised by 62%. |

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| Freire, M. d. S. M., Sá, R. M. P. F. d., & Gurgel, I. G. D. (2017). Healthier Sairé: a intersectorial policy as a turning point for local equity. *Cienci saude coletiva, 22*, 3893-3902. https://doi.org/10.1590/1413-812320172212.25052017 | Brazil<br><br>Local<br><br>Health equity | To explain how intersectoriality has contributed to local equity policy within Sairé municipality, including motivations for collaboration, facilitators and challenges, uncertainties and controversies for local policy actors. | Case study, incl participant observation, analysis of documents, interviews, reports of significant events, creation of a timeframe.<br><br>Actor-Network Theory | 11 municipal managers, local authority powers and local civil society. Majority had training in health promotion or healthy municipalities. | Participation in the Pernambuco Healthy Municipalities Network, with recognised value in training.<br>Strategic leadership was reported by promoters of Healthy Municipalities.<br>Critical events can support health equity e.g., Social Capital Assessment Survey coordinated by a University, Training of Healthy Municipality Promoters.<br>Healthier Sairé intervention brought together actors to create concrete actions towards health equity. |
| Guldbrandsson, K., & Fossum, B. (2009). An exploration of the theoretical concepts policy windows and policy entrepreneurs at the Swedish public health arena. *Health Promotion International, 24*(4), 434-444. https://doi.org/10.1093/heapro/dap033 | Sweden<br><br>Local<br><br>Child health promotion | To identify if the concepts of 'policy window' and 'policy entrepreneur' could be empirically evidenced within existing policy cases. | Qualitative interviews and document analysis. Nine measures related to child and youth health across three municipalities.<br><br>Multiple Streams Framework | 50 interviews with municipality staff, managers and politicians; along with NGO representatives. Documents included action plans, political meeting minutes, evaluations, NGO documents. | In eight of the nine cases included, there was evidence of policy, problem and politics streams that opened a policy window.<br>There was evidence of different types of policy entrepreneurs in all cases, politicians that could speak for others and make a claim in a position of decision-making power (7 of 9 cases); LG staff with political connections and negotiation skills (8 of 9 cases); 'sheer persistence' evidenced in 8 of 9 cases - including both politicians and staff.<br>Conclude that being able to better predict the opening of policy windows would make public health decision-making more 'straightforward', along with 'storing' policy solutions ready for when the problem and politics streams allow the window to open. |
| Hagen, S., Helgesen, M., Torp, S., & Fosse, E. (2015). Health in All Policies: A cross- | Norway<br><br>Local | To describe baseline data of the use of public health coordinators in | Used statistical data on municipalities from database | Surveys sent to CEOs and Administration Managers | Municipalities with the following characteristics were more likely to employ and use a PHC: collaborated with the county council; collaborated with private and voluntary sectors; developed a health overview; were of low median income. |

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| sectional study of the public health coordinators' role in Norwegian municipalities. *Scandinavian Journal of Public Health, 43*(6), 597-605. https://doi.org/10.1177/1403494815585614 | HiAP | Norwegian municipalities prior to a new national, mandated public health act. | sources, along with two online questionnaires (2011 and 2012) distributed to all 428 Norwegian municipalities.<br><br>No theory applied. | Good response rate from questionnaires 79% and 58% respectively. | Factors not associated with employment of a PHC included: size of municipality; political profile; revenues. |
| Hagen, S., Øvergård, K. I., Helgesen, M., Fosse, E., & Torp, S. (2018). Health promotion at local level in Norway: the use of public health coordinators and health overviews to promote fair distribution among social groups. *International journal of health policy and management, 7*(9), 807-817. https://doi.org/10.15171/ijhpm.2018.22 | Norway<br><br>Local<br><br>HiAP | To understand whether the use of public health coordinators has changed since the introduction of the public health act (2012), to what extent municipalities prioritise health inequities/social justice and whether this changes their health overviews. | Questionnaires used from two previous studies in 2011 and 2014 (considered pre and post the PHA 2012). All 428 municipalities were included. | Not stated | Having a health overview, either developed before or after the PHA, was positively associated with prioritising fair distribution among social groups in political decision-making.<br>An additional 16% of municipalities employed a PHC (a majority of 70% already had a PHC, bringing the total to 86%).<br>An additional 30% of municipalities developed a health overview (only 12% had one prior bringing the total to 42%). |
| Hagen, S., Torp, S., Helgesen, M., & Fosse, E. (2017). Promoting | Norway<br><br>Local | To determine if municipalities believe they are | Questionnaire (from previous study) | Mostly CEOs and public health coordinators | Prioritising living conditions was mostly associated with having a health profiles, cross-sectoral working groups, inter-municipal |

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| health by addressing living conditions in Norwegian municipalities. *Health Promotion International, 32*(6), 977-987. https://doi.org/10.1093/heapro/daw052 | HiAP | capable of reducing social inequalities, whether they see living conditions as a priority in local plans, and to explore if structural factors, guidance and incentives from national and regional levels and local HiAP strategies are associated with designating living conditions as a main challenge or priority. | distributed to all 428 Norwegian municipalities. Also used register data from Statistics Norway and Norwegian Social Science Data Services.<br><br>No theory applied. | responded.<br>75% response rate (n=361) | collaborations and reporting that the municipality was capable of reducing social inequalities.<br>82% of municipalities reported being capable of reducing social inequalities in health.<br>48% reported living conditions as their main priority.<br>Political affiliation and incentives from national and regional government had no impact on prioritisation of living conditions. |
| Helgesen, M. K., Fosse, E., & Hagen, S. (2017). Capacity to reduce inequities in health in Norwegian municipalities. *Scandinavian Journal of Public Health, 45*(18_suppl), 77-82. https://doi.org/10.1177/1403494817709412 | Norway<br><br>Local<br><br>Health inequity | To determine factors that influence capacity of municipalities to address health inequities. | Synthesis of articles and reports using the survey data in 2011 and 2014.<br><br>No theory applied. | CEOs, civil servants<br>Survey 2011: 361 municipalities<br>Survey 2014: 325 municipalities | Public health capacity was identified as:<br>Financial resources: LG priorities are determined by national government and county municipalities. Any locally identified priorities must be funded within municipality budgets. Municipalities that have done some public health planning are most advantaged in accessing funds from higher tiers of government.<br>Partnerships: vertical governance structures rely on municipalities partnering with county municipalities in a project (incentive of funding).<br>Horizontal cooperation within a municipality: 62% of municipalities have intersectoral working groups related to public |

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| | | | | | health. 41% of municipalities have planning, environmental or technical department involved in these working groups.<br>Organisational structure: 62% of municipalities have intersectoral working groups. Those that employ a Public Health Coordinator, most are positioned within the health sector which can be difficult to work with other sectors, 27% are employed in the Chief Executive office, which is more cross-cutting across policies, 7% in technical department which includes planning.<br>Workforce and competence: Employing a PHC has increased from 76% in 2011 to 85% of municipalities in 2014. Preference for these to be employed in positions with some power.<br>Development of health overview reports increased from 18% to 38% of municipalities between 2011-2014.<br>Within municipality control regarding capacity to address health inequities is the ability to employ a Public Health Coordinator and establish intersectoral working groups. PHCs would preferably have skills to develop local health profiles. |
| Hendriks, A.-M., Jansen, M. W. J., Gubbels, J. S., De Vries, N. K., Molleman, G., & Kremers, S. P. J. (2015). Local government officials views on intersectoral collaboration within their organization-a qualitative exploration. *Health Policy and* | Netherlands<br><br>Local<br><br>Health determinants | To explore LG official's views on intersectoral collaboration – related to public health outcomes. | Two municipalities (small sized), 19 interviews with local officials across 10 different policy areas; observed meetings.<br><br>COM-B theory. | Local officials across policy areas | Understanding that most policy issues had multiple impacts, including health.<br>Communication is an important skill.<br>Motivations and emphasis on a good outcome for citizens<br>Hierarchal structures create barriers.<br>Different disciplines, described as 'soft' (more social services) and 'hard' (technical/tough legislative environment) differed in views on how easy collaboration was to achieve. Hard disciplines were more likely to resist change.<br>Need to reframe the health problem to other disciplines. |

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| *Technology, 4*(1), 47-57. https://doi.org/10.1016/j.hlpt.2014.10.013 | | | | | |
| Hoeijmakers, M., De Leeuw, E., Kenis, P., & De Vries, N. (2007). Local health policy development processes in the Netherlands: an expanded toolbox for health promotion. *Health Promotion International, 22*(2), 112-121. https://doi.org/10.1093/heapro/dam009 | Netherlands<br><br>Local<br><br>Health determinants | To learn why health policy often fails in LG by using stakeholder and network analysis. | Semi structured interviews (no number specified)<br>Observation<br>Document analysis.<br><br>Multiple Streams Framework F and Network Analysis. | Based on 4 municipalities that were commencing local health policy development.<br><br>Included stakeholders in both professional and non-professional organisations. | Policy actors engage for own agendas, not health issues.<br>Health policy was not important to stakeholders.<br>Whilst the regional health service was communicating and strategically engaging with municipalities in the networks, they were more removed in action.<br>Municipalities were 'central' to networks in all of the 3 networks mapped. However, this does not mean that they acted as an entrepreneur. Others expected them to act as the role of facilitator.<br>Municipalities seemed to be overwhelmed with the wide scope of health included in local health policy.<br>Community groups and organisations were not as closely networked.<br>There was no evidence of a policy entrepreneur. |
| Holt, D. H., Carey, G., & Rod, M. H. (2018). Time to dismiss the idea of a structural fix within government? An analysis of intersectoral action for health in Danish municipalities. *Scandinavian Journal of Public Health, 46*(22_suppl), 48-57. | Denmark<br><br>Local<br><br>HiAP | To examine the role of organisational structure on intersectoral action for health. | Interviews with civil servants in 10 municipalities.<br><br>No theory applied. | 49 interviews with health and non-health civil servants (top and mid-level bureaucracy) across 10 municipalities (of varying size, location, SES etc). | Leadership at all levels of bureaucracy was reported as vital for policy decisions to be put into practice.<br>No ideal organisational structure was found, with any organisational structure having advantages and disadvantages.<br>The two most common examples of structures were 'central unit' and 'intersectoral committee'.<br>Public health staff in central units found their agenda to support other departments overshadowed their public health agenda. This did not achieve any heightened visibility of public health in the organisation and decreased the ability to collaborate with other departments. Public health staff were used to operational roles, and did not have the skills to act in a strategy role. |

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| https://doi.org/10.1177/1403494818765705 | | | | | The municipalities that had intersectoral committees found mixed levels of success. Some did not function well.<br>Health was still not found to be a priority of other non-health sectors Respondents generally reported a lack of commitment and priority across bureaucratic departments.<br>One municipality reported a better functioning structure where there was an intersectoral committee, supported a small public health unit team, supported by 'health groups' in each department. This was matched by a commitment to intersectoral health policy and management support. However, health remained a low priority.<br>Health was reported across all municipalities as important, but not a priority.<br>Conclude that bringing people together does not inherently bring a greater priority to health across sectors, even where structures and resources are well placed to do this. |
| Holt, D. H., Frohlich, K. L., Tjørnhøj-Thomsen, T., & Clavier, C. (2017). Intersectoriality in Danish municipalities: corrupting the social determinants of health? *Health Promotion International, 32*(5), 881-890. https://doi.org/10.1093/heapro/daw020 | Denmark<br><br>Local<br><br>Health determinants | To explore the role of intersectoral policy process in addressing determinants of health as an intervention strategy. | Fieldwork: 10 municipalities of varies size, socio-economic situation, location/region and organisation of public health. 49 interviews, and informal interviews with civil servants. Participant observation, of | Civil servants | Difficulties in engaging with other sectors as health was seen as a separate issue to social issues, resulting in health interventions being more behavioural focussed.<br>SDoH was not a concept used by local municipalities, although a reason for intersectoral action. It was often framed as 'living conditions'.<br>Addressing SDoH does not require anything explicitly related to the concept of health. However, if not framed as health then legitimacy of the involvement of health is lost.<br>Non-health sectors do not need to explicitly address health as their problem.<br>Health should be re-framed to 'strike a balance' between health/social/economic policy objectives. |

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| | | | meetings and informal conversations.<br><br>Theory of organisational neo-institutionalism. | | |
| Holt, D. H., Rod, M. H., Waldorff, S. B., & Tjørnhøj-Thomsen, T. (2018). Elusive implementation: an ethnographic study of intersectoral policymaking for health. *BMC Health Services Research, 18*(1), Article 54. https://doi.org/10.1186/s12913-018-2864-9 | Denmark<br><br>Local<br><br>SDoH | To describe the process from adoption of a local health policy to implementation. | Single case study. Use of ethnographic methodology. Field notes from participation in meetings and interviews.<br><br>Organizational neo-institutionalism. | Municipality senior management and staff, various steering committees. | Having too many objectives and priorities made planning specific activities too difficult.<br>Staff involved in writing the strategy wanted specific and easily communicated actions. Management wanted them vague so that they did not have to commit. This also resulted in responsibilities being less clear for each department given the plan was abstract.<br>The strategy could not have specific activities, as the council would not approve the budget that would be required to implement them.<br>Conflicts over who should make decisions was implicitly raised.<br>Staff wanted greater buy in and political leadership around decisions of what should be in the plan, but also did not want politicians to interfere with the details.<br>Even though the strategy was abstract, it kept the possibility for action on the agenda and kept intersectoral action as a priority.<br>Intersectoral action was a high priority for the municipality.<br>Authors state that this reflects the notion of 'rationalised myth', in that it appears to be the right thing to do. The perception was also that working intersectorally would be cost-efficient.<br>Staff and politicians had good intentions, this was 'decoupled' to the vague actions proposed. |

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| Holt, D. H., Waldorff, S. B., Tjørnhøj-Thomsen, T., & Rod, M. H. (2018). Ambiguous expectations for intersectoral action for health: a document analysis of the Danish case. *Critical Public Health, 28*(1), 35-47. https://doi.org/10.1080/09581596.2017.1288286 | Denmark<br><br>Local<br><br>Health determinants | To determine how intersectoral action is portrayed and utilised in municipality policy. | Document analysis.<br><br>Organisational neo-institutionalism. | 10 documents - based on 2 national level actors that represent Danish municipalities. | The terminology used for intersectoral action for health were mostly elusive and vague.<br>The ideal of intersectoral action was evident, though not specific actions to achieve this, a notion referred to as a rationalised myth.<br>The rationale for intersectoral action for health outcomes was based on efficiencies, economic incentives and improved quality of services.<br>High level management and political support was highlighted in documents as supportive and necessary.<br>This 'decoupling' of organisational ideals with the operational reality might help explain the challenges to intersectoral action. |
| Jansson, E. V., & Tillgren, P. E. (2010). Health promotion at local level: a case study of content, organization and development in four Swedish municipalities. *BMC Public Health, 10*(1), Article 455. https://doi.org/10.1186/1471-2458-10-455 | Sweden<br><br>Local<br><br>Health promotion | To understand the processes in the initiation, development and organisation (including type and content) of health promotion in Swedish municipalities between the 1980's and 2006. | Case study: Four municipalities were purposely chosen to be of similar geographical area, though different internal leadership and governance.<br><br>Multiple Streams Framework and | Document content analysis and interviews (n=36) Interviews included 30 officials (staff) and 6 politicians. | Internal initiators: local issues, champions (particularly those in power), local events, stable leadership.<br>External initiators: national recommendations, funding, statistics on locality, media reports and 'to some extent' general societal health trends.<br>Internal factors were seen as more powerful initiators than external factors.<br>The implementation needs to be supported by management and politicians.<br>The lack of explicit governance for health promotion in municipalities was a challenge. Intent was high but accountability unclear.<br>The external pressures of national health policy are most likely to create action where there is a local champion. Health promotion became more formalised for two case study sites where there were 'champions' with interest in health promotion. |

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| | | | Social Change Theory. | | Cross – department action was dependent on how clear the objectives and measures were for public health action in the operational planning.<br>Content/achievements – whilst initiating and developing health promotion were more conscious choices, outputs were not always intentional or "conscious" strategic choices.<br>Municipalities did not necessarily follow national strategic directions (that were more behaviour focussed). Goals were not measurable, this did not inhibit action.<br>Some level of collaboration was developed with external sectors, across all four municipalities.<br>Over the years, there has be a shift in focus from a behavioural approach to a more holistic view, addressing structural determinants of health. |
| Kneale, D., Rojas-García, A., & Thomas, J. (2019). Obstacles and opportunities to using research evidence in local public health decision-making in England. *Health Research Policy and Systems, 17*(1), 1-11. https://doi.org/10.1186/s12961-019-0446-x | England<br><br>Local<br><br>Public health | To explore how evidence is used in local public health decisions given the reorganisation of public health responsibilities to a LG context. | Qualitative Interviews.<br><br>No theory applied. | 12 public health practitioners (directors, managers) within 3 local authorities. | Enabling factors include stable administration, 'jargon-free' evidence, economic evidence, qualitative research helpful contribution, although some thought is opened opportunities for decision-makers to inflate with anecdote.<br>Local evidence was powerful.<br>Majority felt that political ideologies sometimes contradicted need as they were not seen as favourable for political reputations or election.<br>Time pressures were a barrier to utilising evidence. Release of data by other sources was not always 'timely'.<br>National public health policies were not always seen to translate to a local population.<br>Elected officials relied on anecdote, which was also recognised as important to engage with communities.<br>Evidence was not used in public documents.<br>Community input was seen as overriding evidence. |

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| | | | | | There needs to be a balance between anecdote and evidence and a focus on the creation and use of local data. |
| Kokkinen, L., Freiler, A., Muntaner, C., & Shankardass, K. (2019). How and why do win–win strategies work in engaging policy-makers to implement Health in All Policies? A multiple-case study of six state-and national-level governments. *Health Research Policy and Systems, 17*(1), Article 102. https://doi.org/10.1186/s12961-019-0509-z | Finland<br><br>Local and National<br><br>HiAP | To examine how the Health 2015 policy was affected by changes in the role of the state. | Interviews and literature.<br>10 informant interviews along with peer review and grey literature to support claims. Interviews explored for barriers and facilitators to the implementation of Health 2015.<br><br>No theory applied. | The informants were selected based on their knowledge of HiAP implementation across diverse sectors of national government. | Investment in health promotion decreased when national legislation was restructured so that municipalities have greater freedom with no financial or legislative arrangements remaining in place from the state.<br>More was being outsourced and therefore ad hoc in nature.<br>HIA, which mandatory in 2010, lacked the workforce capacity to be able to meet legislative requirements.<br>The increasing private industry influence had greater lobbying influence on state decision makers (e.g., direct funding, greater access to decision-makers) and has resulted in a lifestyle drift towards an individualistic approach.<br>Ideological interests in economic growth meant that public health objectives got a lower priority. |
| Langeveld, K., Stronks, K., & Harting, J. (2016). Use of a knowledge broker to establish healthy public policies in a city district: a developmental evaluation. *BMC Public Health, 16*(1), | Netherlands<br><br>Local<br><br>Health determinants | To describe how the role of a knowledge broker worked at a local level. | Action research methodology, single case study site – city district within Amsterdam municipality (not quite the same as a constituted | Employees of the city district and the municipal public health service.<br>Researcher acted as the knowledge broker. | Enablers to integrating health into specific policy areas include: health already on the agenda of the policymaker; creation of trust and confidentiality; policymakers with a scientific or research background; policies being broad-brushed; actions that matched the responsibility of the district; knowledge brokers with a strong background in policy agenda setting; presence of a knowledge broker increased awareness of health with other policy sectors; support from middle-senior management and elected officials was built over time.<br>Barriers to integrating health into specific policy areas: |

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| Article 271. https://doi.org/10.1186/s12889-016-2832-4 | | | municipality structure).<br><br>No theory applied. | | knowledge broker not seen as a reliable source of information to make policy suggestions; not building management support first; each sector having their own specific responsibilities; time constraints; actions did not match existing practice; actions not matched with current goals, actions considered too scientific or abstract.<br>Conclude that the role of a knowledge broker was successful to integrate health into some policies, had an impact on organisational change to consider health more broadly across policies. |
| Larsen, M., Rantala, R., Koudenburg, O. A., & Gulis, G. (2014). Intersectoral action for health: The experience of a Danish municipality. *Scandinavian Journal of Public Health, 42*(7), 649-657. https://doi.org/10.1177/1403494814544397 | Denmark<br><br>Local<br><br>HiAP | To determine the challenges and enablers to development and implementation of an intersectoral health policy in Varde, Denmark. | Single case study - used documents and semi-structured interviews (n=9).<br><br>No theory applied. | Stakeholders involved in the development and implementation of the health policy across different municipal sectors. Documents - Meeting minutes and working papers. | Barriers to the process included silo departments that make cross-sector policy difficult, seen as an extra task for staff, no funding (until a Fund for Health was established), lack of ownership, lacked clear objectives and performance indicators, unable to maintain political and public attention.<br>Enablers include local political support when developing policy (which decreased during implementation suggesting it is difficult to maintain the commitment), community participation and involvement, use of local media, information sharing through newly established Health Networks, set up of Fund for Health, having researchers involved, which interviewees perceived gave the policy higher priority, bringing people together in dialogue.<br>The benefits of intersectoral policy action can be difficult to measure and gain an understanding of the cost-benefit. |
| Lawless, A., Lane, A., Lewis, F. a., Baum, F., & Harris, P. (2017). Social determinants of health and local government: | Australia<br><br>Local<br><br>SDoH | To examine the awareness and perceptions of LG staff regarding SDoH and health equity | Online survey to 135 staff at 20 councils (randomly selected) in South Australia | 96 LG staff with public health responsibilities across 17 councils. | The different language used for public health may be a barrier to collaborations across sectors, respondents in South Australia more likely to agree that health promotion responsibility at LG level is due to funding cuts in the healthcare sector.<br>11.6% of respondents had little or no familiarity with the broad determinants of health. |

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| understanding and uptake of ideas in two Australian states. *Australian and New Zealand Journal of Public Health, 41*(2), 204-209. https://doi.org/10.1111/1753-6405.12584 | | | and New South Wales.<br><br>No theory applied. | | 35.8% rated moderately familiar with broad health determinants.<br>73% agreed (strongly or mildly) that SDoH knowledge influenced policy, 81% agreed they were always focussed on improving health when developing policy.<br>56.7% familiar with Ottawa Charter, 52.2% with Commission on SDoH final report.<br>90% agreed that government policy and planning should include action on SDoH<br>27% agreed that organisational incentives were in place to integrate public health.<br>Felt needs by respondents: >75% wanted more practical information on effective interventions, governance structures across sectors, new resources to gather evidence, HIAs.<br>47% strongly or mildly agreed that lifestyle choices affected people's health more than other factors.<br>57% strongly or mildly disagreed that healthcare system could reduce gap between Indigenous and non-Indigenous Australians.<br>All sources of evidence were seen as important including discussions with colleagues and professional contacts (93.3%), government or professional reports (89.9%), professional conferences, meetings (83.1%), research articles or books (83%), LG resources (74.2%) and media (70.8%).<br>Environmental health officers reported having little influence and power to influence policy, with no feedback loop to influence state health policy. |
| Lillefjell, M., Magnus, E., Knudtsen, M. S., Wist, G., Horghagen, S., Espnes, G. A., Maass, R., & Anthun, | Norway<br><br>Local | To understand how to strengthen the capacity of municipalities to work more | Three case study municipalities, incl. document analysis and | Municipal leaders of plans, policies or organisational responsibilities from different | A systematic, knowledge-based and multi-sectoral approach to public health requires: political and community commitment; shared understanding of population health; cooperation across sectors and levels; anchoring public health in municipal planning; identification of relevant sources of knowledge outside of the |

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| K. S. (2018). Governance for public health and health equity: The Tröndelag model for public health work. *Scandinavian Journal of Public Health, 46*(22_suppl), 37-47. https://doi.org/10.1177/1403494818765704 | Health equity | systematically, knowledge-based and multi-sectoral to address health inequities, including presenting a model. | interviews (n=30). Interviews or focus groups at 3 time points (9 at baseline, 1 at mid-point and 20 at completion). Document analysis of strategic and planning documents, meeting minutes from all 3 municipalities at baseline. Observational data of three planning meetings and five project meetings.<br><br>No theory applied. | departments. Researchers also participated in informal meetings with citizens. | health sector; engaging several target groups; fostering participation of citizens; opportunities for knowledge sharing through multi-sectoral governance; evaluation and feedback loop for future decision-making consideration; based on the facilitators identified, authors proposed a model for public health work in municipalities which included seven steps, each to be completed before moving on to the next step:<br>1) Societal mission: 'anchor' point such as Norwegian Public Health Act;<br>2) Defining the knowledge base: from different evidence sources and establishing a common understanding;<br>3) Involving and developing: concrete plan for strategy intervention, involving citizens in planning;<br>4) Planning new initiatives: delegating responsibilities to build local ownership;<br>5) Implementing: processes documented, to allow for adjustments based on budget, political situation;<br>6) Evaluating: Evaluation plan to be done when planning interventions, collaborate with researchers;<br>7) Turning action into new knowledge: Evaluation findings transferred to new policy and planning processes.<br>The model has not yet been tested. |

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| Lilly, K., Hallett, J., Robinson, S., & Selvey, L. A. (2020). Insights into local health and wellbeing policy process in Australia. *Health Promotion International, 35*(5), 925-934. https://doi.org/10.1093/heapro/daz082 | Australia<br><br>Local<br><br>HWB | To investigate factors that enable or challenge the initiation and actioning of LG health and wellbeing policy. | Online questionnaire.<br><br>Multiple Streams Framework, Advocacy Coalition Framework, Punctuated Equilibrium Framework, Analysis of Policy Impact Framework. | 243 CEO's, 1096 elected members, 135 strategic and 160 operational managers and 191 staff in LG. | Enabling factors include good understanding of health and wellbeing as a policy problem, strong council commitment to health and wellbeing, personal and professional obligation for health and wellbeing shared amongst decision makers, sufficient cooperation internally, perceived cost-effectiveness.<br>Barriers included funding resources, support by other sectors, level of support and leadership from higher tiers of government, lack of staff capacity, lack of key champions for health and wellbeing in Australian LG. Combined with lack of lobbying internally could challenge health and wellbeing reaching policy agenda.<br>16% of respondents reported health and wellbeing being considered in a range of policy areas.<br>6.5% were able to respond that 'all policies impact' to an open-ended question on what policy areas are able to improve community wellbeing.<br>58% reported health broadly from a determinants of health and health equity perspective.<br>Health and wellbeing given a high priority - 43% an >=8 on a scale of 10 |
| Lowe, M., Whitzman, C., Badland, H., Davern, M., Aye, L., Hes, D., Butterworth, I., & Giles-Corti, B. (2015). Planning healthy, liveable and sustainable cities: How can indicators inform policy? *Urban Policy* | Australia<br><br>Local<br><br>SDoH | To research current liveability indicators and determine how these are used by decision makers to inform local health, liveability and sustainability policy. | Literature review of liveability indicators and consultation workshops.<br><br>No theory applied. | Urban policymakers, researchers, private and community-sector decision makers. Workshop 1: 80 state and LG policy actors and planners | Indicators were used to determine what the 'problem' was and why it is an issue, and for monitoring trends over time.<br>Indicators were used for developing shared objectives across different departments.<br>It was felt that more neighbourhood-level measures were needed to better inform policy, as well as to compare sub-population groups.<br>Measures of economic impact of policy decisions was also a felt need. |

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| *and Research, 33*(2), 131-144. https://doi.org/10.1080/08111146.2014.1002606 | | | | Workshop 2: 50 planners (mostly LG)<br>Workshop 3: academics and policy actors from all tiers of government. | Indicators needed to be credible, easy to communicate and integrated into relevant policies and plans. |
| Mannheimer, L., Gulis, G., Lehto, J., & Östlin, P. (2007). Introducing Health Impact Assessment: an analysis of political and administrative intersectoral working methods. *European Journal of Public Health, 17*(5), 526-531. https://doi.org/10.1093/eurpub/ckl267 | Slovakia<br><br>Local<br><br>HiAP | To identify the enablers and barriers to adopt a new way of working horizontally and intersectorally using HIA. | Qualitative Interviews. Does not state how many interviews were conducted.<br><br>Multiple Streams Framework | Civil servants and directors, politicians, researchers, representative of local public health institute - who were all involved in the pilot of a HIA approach. | Politicians showed commitment and political will for HIA.<br>HIA was seen as a legitimate approach by the World Health Organization and international organisations advocating the approach at the time.<br>The LG and university had developed linked with the World Health Organization through membership to the Healthy Cities programme. This opened a window of opportunity to draw attention to HIA.<br>Lack of formal cooperation between departments.<br>HIA not institutionalised or a formalised process.<br>Political commitment to HIA was not matched with sufficient resources to implement.<br>Civil servants did not know if data was available or what to do with it and found it difficult to start HIA processes in real context.<br>The main 'problem' that initiated action was the poor health status of the population, combined with lack of intersectoral collaboration, which opened a window of opportunity.<br>Changes to the way Slovakia was being governed (in a major overhaul from authoritarian-egalitarian to liberal-democratic) changed the way health was defined and administrative functions.<br>There were few external stakeholders or public involved. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
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| Marks, L., Hunter, D. J., Scalabrini, S., Gray, J., McCafferty, S., Payne, N., Peckham, S., Salway, S., & Thokala, P. (2015). The return of public health to local government in England: changing the parameters of the public health prioritization debate? *Public Health, 129*(9), 1194-1203. https://doi.org/10.1016/j.puhe.2015.07.028 | England<br><br>Local<br><br>Public health | To identify the influence of values and contexts in priority setting for public health in LG, including the prioritisation of ring-fenced budgets. | Qualitative interviews (n=29).<br><br>No theory applied. | 22 HWB members, four public health staff, one elected member and one representative of the voluntary sector. | Influencing factors for prioritisation of public health investments:<br>Organisational context: LG are accountable to local communities. Local autonomy given to LG allows them to set their own priorities.<br>Priority setting models: difficulty in always agreeing on priority criteria e.g., short term wins for few vs long term gains for many. The ring-fenced budget reflected healthcare service.<br>Views of evidence – there is a tension and a balance needed between scientific evidence and local knowledge/political processes. Traditional evidence had been used at a national level, whereas LG value local knowledge.<br>Understanding of public health: issues raised where public health funding was small and meant different things to different LGs. At a national level of government, conflicts with healthcare budgets were the main concern. In LG, the concern was that budgets could be absorbed into other areas. Directors of Public Health felt that more could be done to change organisational values around integrating health into decision-making across the local authority. A shift of public health responsibilities from national to local level government demonstrates the value of context in what influences priorities. |
| McCosker, A., Matan, A., & Marinova, D. (2018). Policies, Politics, and Paradigms: Healthy Planning in Australian Local Government. *Sustainability, 10*(4), Article 1008. | Australia<br><br>Local<br><br>Healthy planning | To identify the barriers and enablers to the update and implementation of healthy planning and active living initiatives in LG in Australia. | Qualitative semi-structure interviews.<br><br>Multiple Streams Framework | Government employees at regional level (n=6), LG (n=5) and state (n=4), also roles in academic (n=4), NGO's (n=3) and | State level legislation was an enabler. Although this was mixed in terms of level of support for incorporating concepts of health in planning – but beneficial as a mandate particularly where it offered funding or further resourcing.<br>Research and guidelines were considered relevant evidence that supported healthy planning.<br>Advocates played the role of a knowledge broker.<br>There was community demand.<br>Working in partnerships was an enabling factor. |

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| https://doi.org/10.3390/su10041008 | | | | private sector (n=3). | Framing 'health' as something else that is a co-benefit. Terms such as 'liveability' and 'wellbeing' were seen as more marketable than the term 'health'. Advocacy messages needed to be different for each LG.<br>Healthy urban planning more likely to be implemented if there was an economic or political benefit.<br>State and local policies are not sufficient for implementation, local policy adhoc and required motivated staff to deliver on it.<br>It was considered difficult to get local level data.<br>Politicised decision-making, timeframes needed for outcomes did not match short term political elections. Decisions on healthy planning are political – reliance on elected members to decide.<br>Came with a lack of evidence-base and more politically driven decisions based on popularity or marketability. Required policy entrepreneurs or champions to make it happen.<br>The idea of addressing healthy urban environments and developing policy was more politically favourable than actually implementing it – not having specific strategies in the plan that might not be accepted (or be seen as controversial) by community.<br>Community health was seen as a co-benefit, not the reason, for action. It was a barrier if it was seen as something additional to current practice.<br>There was no difference in factors of health planning and active living in different legislative environments. |

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| McGill, E., Egan, M., Petticrew, M., Mountford, L., Milton, S., Whitehead, M., & Lock, K. (2015). Trading quality for relevance: non-health decision-makers' use of evidence on the social determinants of health. *BMJ open, 5*(4), e007053. https://doi.org/10.1136/bmjopen-2014-007053 | UK, Brazil, USA, Canada<br><br>Local<br><br>SDoH | To identify how information and evidence are defined and utilised by local decision-makers working in the built environment space. | Focus groups 2 in the UK one international (Brazil, USA, Canada).<br><br>No theory applied. | 15 senior LG decision makers, purposely selected in built environment roles. | Lack of access to local level data, with inability to compare with other local authorities or national indicators.<br>'Evidence' included a wide range of sources from routine data, geographic information systems, anecdotes, case studies and academic research.<br>Being able to demonstrate 'viability' was very important.<br>Interventions needed to align to national strategic objectives, politicians and the public.<br>Need to demonstrate viability through cost-effectiveness / value for money.<br>Decision makers also rely on personal knowledge of the local area.<br>Local evidence that fits the local context was seen as far more important than rigorous academic research. |
| Morrison, J., Pons-Vigués, M., Bécares, L., Burström, B., Gandarillas, A., Domínguez-Berjón, F., Diez, È., Costa, G., Ruiz, M., & Pikhart, H. (2014). Health inequalities in European cities: perceptions and beliefs among local policymakers. *BMJ open, 4*(5), e004454. http://dx.doi.org/10.11 | Europe<br><br>Local<br><br>Health inequality | To determine public policymakers beliefs and perceptions of health inequalities in reference to policymaking. | Semi-structured interviews.<br><br>No theory applied. | 19 public policy/decision makers across 13 cities, either elected councillors or senior non-elected officials. (Sample involved in the INEQ-Cities project). Health and non-health sectors. | Challenging factors included organisational constraints/resistance from other levels of administration, budget restrictions and miscommunication with private sectors.<br>Access to data that highlighted health inequalities was more likely to see action to address them.<br>Some respondents highlighted the opportunity of working with community groups to get access to 'hard to reach' groups.<br>There were mixed understandings of health inequalities. Most were aware of the concept and related this to differences in health as a result of various SDoH e.g., neighbourhood where they lived.<br>A few did not understand health inequalities, believing that health outcomes are impacted by individual responsibilities.<br>Most reported that health inequalities were a priority - responded that addressing health inequalities was an objective of the city |

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| 36/bmjopen-2013-004454 | | | | | government. Two did not consider it to be a priority, one citing that it was not in their responsibility at a local level.<br>Most conduct or rely on regular surveys to measure health outcomes.<br>Most reported policy actions as individual level behavioural actions (e.g., smoking, poor diets).<br>Some had partnerships established for intersectoral collaboration, while others saw this as more difficult to get things done. |
| Morrison, J., Pons-Vigués, M., Díez, E., Pasarin, M. I., Salas-Nicás, S., & Borrell, C. (2015). Perceptions and beliefs of public policymakers in a Southern European city. *International journal for equity in health, 14*(1), Article 18. https://doi.org/10.1186/s12939-015-0143-5 | Spain<br><br>Local<br><br>Health inequality | To describe the beliefs and perceptions of public policymakers on healthy inequalities and the policies to reduce them. | Qualitative study: semi-structured interviews (n=12).<br><br>No theory applied. | LG decision makers (both elected and non-elected) | Barriers to policy implementation included insufficient funding, opposition by the public, private society on some services or strategies.<br>An enabler was bringing people together to collaborate.<br>All informants agreed that Barcelona experienced health inequalities. Politicians tended to report health outcome differences (e.g., life expectancy). Others reported different aspects of health inequalities, social exclusion, effect of neighbourhoods. Non-health informants were aware of policies that indirectly impacted on health.<br>Politicians and officers went beyond a biomedical focus, with politicians more likely to report structural determinants as the cause, whereas officers focussed on health behaviours and healthcare.<br>All politicians agreed health inequalities was a priority. Whilst not clearly defined, health inequalities was considered. The health officer and opposition party disagreed, reporting health inequalities was not a priority of the city council.<br>Most felt that health inequalities were part of the city council role, however informants from public health, welfare and education thought it was beyond the authority of local councils.<br>Politicians referred to an Annual Health Report, provided by the |

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| | | | | | Barcelona Public Health Agency to gain information on health inequalities. Non-health officers considered that there is a lack of information.<br>All reported little intersectoral collaboration and coordination.<br>Officers identified that they work with other sectors, usually around specific issues. |
| Mundo, W., Manetta, P., Fort, M. P., & Sauaia, A. (2019). A qualitative study of health in all policies at the local level. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 56*. https://doi.org/10.1177/0046958019874153 | USA<br><br>Local<br><br>HiAP | To describe how Colorado local public health agencies are implementing HiAP, as well as successes, tools and challenges associated with the implementation. | Qualitative interviews (n=13).<br><br>No theory applied. | Eight Directors and Deputy Directors of Local Public Health Authorities (LPHA), five experts in local public health policy. | Developing trust with external agencies through regular contact or finding shared values.<br>Lack of understanding of health determinants and the role of LG to address. Also needed to educate partners outside of health.<br>Limited staff to be able to implement HiAP. Some agencies have a specific role for implementing HiAP.<br>Resourceful to have access to decision-makers.<br>Directly liaising with community that were affected by policies, to generate personal stories.<br>Lack of funding. Funding is usually earmarked for specific health priorities, making it difficult to be responsive to structural determinants. High staff turnover, insufficient community spaces for engagement and lack of technology and equipment.<br>Lack of direction from the state government.<br>Lack of political will. Mostly as the framing of messages from the state and public health community was lacking, which meant HiAP did not get raised on the political agenda.<br>Tools such as data sharing platforms, community health assessment tools (although these require staff time and expertise which may not be available in all LPH<br>as) were enablers.<br>The state government needs HiAP to be a higher priority for this to filter down to local level. Colorado currently has no state mandate for HiAP. |

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| Tallarek née Grimm, M. J., Helgesen, M. K., & Fosse, E. (2013). Reducing social inequities in health in Norway: Concerted action at state and local levels? *Health Policy, 113*(3), 228-235. http://dx.doi.org/10.1016/j.healthpol.2013.09.019 | Norway<br><br>Local and National<br><br>Social inequity | To see if local municipalities action the public health policies intended by the national public health act, explore the understanding of health among different policy sectors, and to explore the role of public health coordinators and resources in HiAP. | Includes 2 datasets:<br>Qual: content analysis of national level documents and interviews<br>Quant research: electronic questionnaires to a possible 430 local municipalities.<br><br>No theory applied. | Interviews with staff in Directorate of Health<br>Online survey with CEO of local municipalities (n=374) | 6% of municipalities explicitly consider underlying determinants of health. Most define challenges as drug abuse, mental health, nutrition and physical activity. Data suggests that municipalities prioritise lifestyle related health issues.<br>Whilst required to do HIAs, 67% have not applied HIAs, 71% report a lack of health overviews.<br>Funding of municipalities supports the voluntary recruitment of public health coordinators. The intention of these coordinators is to establish partnerships to address health. 74% of municipalities have established positions. 46% of these are under the direction of a medical officer.<br>Most funding for health comes from within municipalities. Some funding from national for 'earmarked' grants. National funding was not seen as a critical source by most municipalities.<br>Overall, municipalities have not adopted the legislative public health act of the national government. |
| Pettman, T. L., Armstrong, R., Pollard, B., Evans, R., Stirrat, A., Scott, I., Davies-Jackson, G., & Waters, E. (2013). Using evidence in health promotion in local government: contextual realities and opportunities. *Health Promotion Journal of Australia, 24*(1), 72-75. | Australia<br><br>Local<br><br>Health promotion | To describe and advocate for what is needed to plan and implement evidence-based health promotion in LG. | Facilitated discussions during group training sessions.<br><br>No theory applied. | Academics and LG practitioners/staff in Victoria, Australia. | There are LG staff capable and interested in evidence-informed health promotion practice.<br>Horizontal cooperation is lacking across LG departments, particularly in larger councils.<br>Senior decision makers need to be supportive.<br>LG need internal champions for evidence-informed decision-making.<br>LG need access to academic journal databases.<br>Suggestions for institutionalizing evidence-based health promotion is for 'prompts' in meeting agendas or 'toolkits' available for guiding use of evidence. |

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| https://doi.org/10.1071/HE12902 | | | | | |
| Phillips, G., & Green, J. (2015). Working for the public health: politics, localism and epistemologies of practice. *Sociology of Health and Illness, 37*(4), 491-505. https://doi.org/10.1111/1467-9566.12214 | England<br><br>Local<br><br>Health determinants | To examine how LG officers make decisions that impact on determinants of health. | Organisational ethnography approach.<br>Participant and non-participant observation in 6 local authority offices (eight weeks), including attending meetings, informal and formal conversations; using alcohol policy as a case study.<br>Included range of city and county authorities.<br><br>No theory applied. | LG officers | Useful if staff built relationships to mediate conflicting views and were able to manage multiple stakeholders; are able to balance the use of 'hard' data, with local knowledge, experience and intuition.<br>Health outcomes were not the primary goal but could be an added benefit strategically to gain external funding or support other goals.<br>Emphasis was given to the uniqueness of the local authority region, rather than just adopting best practice from elsewhere.<br>Multiple forms of evaluation are required, to balance community perceptions, accountability and organisational credibility. All actions had to be able to be defended in some way, so nothing could really 'not work'.<br>Concludes that decision-making on actions in LG that impact on determinants of health requires a balance of local and national politics, public opinion and funding considerations.<br>Evidence-based paradigms that dominate the healthcare service were largely absent regarding LG addressing determinants of health.<br>Suggests that LG has always been managing population health and wellbeing, in the absence of medical public health specialists. |

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| Scheele, C. E., Little, I., & Diderichsen, F. (2018). Governing health equity in Scandinavian municipalities: The inter-sectorial challenge. *Scandinavian Journal of Public Health, 46*(1), 57-67. https://doi.org/10.1177/1403494816685538 | Denmark, Norway, Sweden<br><br>Local and Regional<br><br>HiAP | To analyse the factors that influence implementation of Health Equity in All Policies (HEiAP ) governance. | Qualitative interviews (n=20).<br><br>Multiple Streams Framework. | Local and regional government administration and politicians. Interviewees were selected across different departments (horizontal) and different levels of management (vertical). Municipalities were included from Norway (n=3), Sweden (n=4) and Denmark (n=3) and a regional government from Sweden (n=1). | Political commitment: Whilst all of the municipalities had a written commitment to HEiAP, there was not always the action to follow it through.<br>Political level budgeting: There is a lack of evidence on the cost-effectiveness of action, making it difficult to advocate for health equity interventions.<br>Horizontal coordination: Municipalities that framed health inequity outside the health discourse were more successful at horizontal cooperation (e.g., social sustainability), although may lose sight of the health issues.<br>Vertical coordination: Regional and local level coordination is difficult as there are a lot of municipalities in each region, each unique with their own needs.<br>Evidence: Having data that reflects health inequities is a motivator for municipalities to take action. Evidence for interventions/actions is limited. Monitoring action on health equity is difficult. There lacks a 'common language' to be able to report against.<br>One of the key challenges to inter-sectoral policy making in LGs is the structure of LG administrations.<br>The authors recommend that health equity impact assessments can help maintain a focus on health across sectors. |
| Schmidt, M., Joosen, I., Kunst, A. E., Klazinga, N. S., & Stronks, K. (2010). Generating political priority to tackle health disparities: a case study in the Dutch city | Netherlands<br><br>Local<br><br>Health inequity | To determine facilitating factors to gaining political priority of health disparities within The Hague municipality. | Single case study design including semi-structured interviews, document analysis and observations. | 14 people interviewed (the program leader interviewed 23 times). Other participants included councillors, | There were committed councillors willing to tackle health disparities, based on their political ideology.<br>Framing of health inequities as 'unfair' gained little political attention and support.<br>Needed to reframe the issue (e.g., agreeing with the debate that individuals were responsible for their own health, though highlighting how environmental structures made this difficult.) and linking the issue to visions of the local municipality (e.g., all |

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| of The Hague. *American Journal of Public Health, 100*(S1), S210-S215. https://doi.org/10.2105/AJPH.2009.168526 | | | Prospective study, based on a four year research program.<br><br>Shiffman and Smith framework. | managers and policymakers. Documents included program documentation, meeting minutes, political documents. Observed 17 project steering group meetings. | of us together).<br>Enabling factors included presenting disaggregated data, gaining credibility to the issue; framing solutions to existing policies that were already receiving political attention, involving academic researchers working on health equity research programs; and supporting the program goal of engaging and involving citizens in policymaking, which received attention by the municipality executive team. |
| South, E., & Lorenc, T. (2020). Use and value of systematic reviews in English local authority public health: a qualitative study. *BMC Public Health, 20*(1), Article 1100. https://doi.org/10.1186/s12889-020-09223-1 | England<br><br>Local<br><br>Public health | To determine the use of systematic reviews as evidence in policy making amongst public health directors/staff in local authorities. | Semi-structured qualitative interviews.<br><br>No theory applied. | 14 Directors of Public Health or public health trained consultants (across 10 Local Authorities) | Barriers to using systematic reviews included: lack of availability; limited focus (particularly on determinants of health); elected politicians might value other sources of evidence (e.g., anecdotal evidence); lack of training in critiquing quality of evidence by other staff in Local Authorities; lack of time.<br>Interviewees used systematic reviews and valued the evidence from this source. They also used other sources of information, particularly reports from trusted institutions e.g., National Institute for Health and Care Excellence. |
| Spiegel, J., Alegret, M., Clair, V., Pagliccia, N., Martinez, B., Bonet, M., & Yassi, A. (2012). Intersectoral action for health at a municipal level in Cuba. *International* | Cuba<br><br>Local<br><br>Health determinants | To determine how models of intersectoral action for health across municipal governments help explain health achievements in Cuba. | Mixed method design in two phases.<br>Phase one: Questionnaires (pre-focus group) and focus groups in 2 municipalities | Municipal staff, healthcare sector, non-health sectors and community organisations. | The local level primary health services (polyclinics) reinforce a 'place-based' approach to health.<br>The organisational structures generally were very formal and well established, including 'Health Councils' that engaged with non-health sectors at a local level. There are multiple intersectoral committees existing at the municipal level.<br>There is a high level of political support in Cuba for health-oriented outcomes. |

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| *journal of public health, 57*(1), 15-23. https://doi.org/10.1007/s00038-011-0279-z | | | (one city and one rural)<br>Phase two: In depth interviews with municipal staff on specific policy case studies (e.g., healthy children).<br><br>No theory applied. | | Engaging with other sectors on a regular and consistent basis was a common theme in both municipalities studied.<br>Intersectoral collaboration was strongest for programmes related to healthy lifestyles, when compared to healthcare or healthy child development programmes. |
| Steenbakkers, M., Jansen, M., Maarse, H., & de Vries, N. (2012). Challenging Health in All Policies, an action research study in Dutch municipalities. *Health Policy, 105*(2), 288-295. https://doi.org/10.1016/j.healthpol.2012.01.010 | Netherlands<br><br>Local<br><br>HiAP | To determine the effectiveness of a coaching program in HiAP with municipalities in the Dutch region. | Participatory action research over 30 months. Internet questionnaire pre and post + interviews with stakeholders. Logbook of all activities.<br><br>No theory applied. | 32 municipalities were involved in the research. 9 volunteered to be in the coaching program.<br>13 in depth interviews with public health managers in municipalities (8 within the coached sites) | Coached municipalities showed greater outcomes in HiAP than non-coached. Interventions related to obesity prevention increased in the coached municipalities, but their intentions to continue this in the future decreased.<br>At a strategic level, political priority for HiAP decreased in the coached municipalities.<br>At a tactical level, manager support for HiAP decreased in the coached municipalities.<br>At an operational level, no difference in knowledge, attitudes, self-efficacy of perceived expectations towards HiAP between coached and non-coached municipalities.<br>Intersectoral action requires management support, health might not be the primary goal but community-oriented such as social cohesion. |
| Stoneham, M., & Dodds, J. (2014). An exploratory study | Australia<br><br>Local | To identify what categories/types of evidence were | Online survey to five of 140 LGs in Western | 49% RR (n=533). Staff included were in | Respondents indicated that they used observational data of risks they observed in the community (24.5%), information in state-wide plans (e.g., state-wide government plans (17.7%), locally |

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| identifying where local government public health decision makers source their evidence for policy. *Health Promotion Journal of Australia, 25*(2), 139-142. https://doi.org/10.1071/HE14012 | Public health | being used by LG staff to inform public health plans. | Australia. Chosen as they had commenced new public health plan (included 3 metro and 2 regional LGs).<br><br>No theory applied. | professional roles eg. corporate services, community development, planning departments. | derived evidence from stakeholders and key community groups (17.6%) and media sources (16.2%).<br>Others included organisational priority (6%), directorate priority (6%), hunch (5.2%), complaints and enquiries received (5.1%) and 'other' (1.7%).<br>Authors recognise the risk of using media as a valid and reliable source of evidence.<br>Acknowledgement given for the limitations of time and availability of evidence that LG staff have readily accessible and that is locally applicable. |
| Storm, I., den Hertog, F., Van Oers, H., & Schuit, A. J. (2016). How to improve collaboration between the public health sector and other policy sectors to reduce health inequalities?–A study in sixteen municipalities in the Netherlands. *International journal for equity in health, 15*(1), Article 97. https://doi.org/10.1186/s12939-016-0384-y | Netherlands<br><br>Local<br><br>Health inequality | To understand the level of collaboration between public health and other social and physical policy sectors. | Qualitative descriptive analysis, incl. document analysis, questionnaires and interviews.<br><br>16 of a possible 50 municipalities were included, all active in the field of HiAP.<br><br>No theory applied. | Health policy documents at each municipality site. Online questionnaires (n=98) with mostly policy workers in public health, social and physical policy sectors. Some program managers, policy developers, projct leaders or heads of department also responded. Interviews (n=32) with policy | Addressing health equities was a low priority for staff in the physical policy sector, with lack of awareness of how their work was related and lack of clear objectives.<br>Staff were more likely to consult across policy sectors to achieve a program outcome, rather than to address an issue.<br>Having a coordinator to support collaboration was reported important, a role the public health sector reported they played.<br>Support from politicians and management was important for collaboration (e.g., departmental managers and elected members) or through the encouragement of the municipality. Interviewees reported that the current support was more apparent in the social policy sector. Social sectors include youth affairs, education and sport. Physical policy sectors include housing, spatial planning and environment.<br>Some municipality health policy documents addressed multiple determinants of health e.g., addressing lifestyle, along with the social and physical environment. Interviewees report that the intent is not always to address health inequities.<br>Municipalities policy documents give less attention to SDoH e.g., |

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| | | | | workers in public health , education/youth affairs, sport, social affairs, housing/spatial planning (operational staff). | unemployment.<br>Public health and the social policy sector worked together to explicitly address health inequities, in particular a large proportion of public health policy workers reported that they collaborate with sport policy staff (86%).<br>Public health were least likely to collaborate with physical policy sector.<br>Authors suggest the use of HiAP tools to support health integration other policy sectors. |
| Storm, I., Harting, J., Stronks, K., & Schuit, A. J. (2014). Measuring stages of health in all policies on a local level: The applicability of a maturity model. *Health Policy, 114*(2–3), 183-191. http://dx.doi.org/10.1016/j.healthpol.2013.05.006 | Netherlands<br><br>Local<br><br>HiAP | To determine if a maturity model can measure stages of HiAP growth. | Mixed method. Document analysis (health policy), Digital questionnaires (n=123, RR 79%) and interviews with policy officers in health, education, social affairs, planning and housing (n=32). Of a possible 50 eligible municipalities<br><br>Various maturity models (management). | Policy officers in health, education, social affairs, planning and housing (n=32). Across 16 different sized municipalities involved, with varying populations of advantage/disadvantage. | All municipalities had activity in health inequities or HiAP.<br>Enablers in early stages: good relationships, positive experiences with intersectoral collaboration and shared interests.<br>Enablers in implementation/as progress: sufficient resources, sense of urgency to address health inequities, support by council and municipal councillors. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
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| Synnevåg, E. S., Amdam, R., & Fosse, E. (2018a). Intersectoral planning for public health: Dilemmas and challenges. *International journal of health policy and management, 7*(11), 982-992. https://doi.org/10.15171/ijhpm.2018.59 | Norway<br><br>Local<br><br>HiAP | To describe the experience of planning as a tool to implement HiAP in Norwegian municipalities. | Case study (n=3) of different size (geographical and population).<br><br>Davoudi's four properties of planning. | 30 interviews with employees and politicians (included CEOs, mayors, politicians, public health coordinators, managers of other departments, planners). | A balance is needed between quantitative evidence and qualitative discussions.<br>Need for top-down support (e.g., goals in master plans), but also support from operational staff as they need to be able to implement the action. It is acknowledged that sometimes this is difficult.<br>Putting public health first might be met with distrust by other departments and be counterproductive to action on HiAP. Respect and power must be shared across sectors to find common ground.<br>Structures of municipalities do not always promote intersectoral participation e.g., vertical communication between operational and executive level staff.<br>There is tension between the need for instrumental, structural planning processes, such as having clear goals included in higher level planning documents or routine HIAs or similar procedures, with the need for more process-oriented procedures that involved discussions and dialogue between departments. Debate was whether to frame the planning action as public health and have a separate public health plan, or whether to integrate public health into the master plan. Having a specific public health plan helps to bring attention to the issue, although can be seen as public health being 'special' or have some extra power (and be experienced as threatening to some). Conclude that 'health imperialism' is a barrier to HiAP. |

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| Synnevåg, E. S., Amdam, R., & Fosse, E. (2018b). Public health terminology: Hindrance to a Health in All Policies approach? *Scandinavian Journal of Public Health, 46*(1), 68-73. https://doi.org/10.1177/1403494817729921 | Norway<br><br>Local<br><br>HiAP | To determine if the terms 'public health' and 'public health work' are suitable and transferable terms for municipalities in implementing a HiAP approach. | Case study design (n=3), incl. semi-structured interviews and document analysis.<br><br>Institutional translational theory. | 30 interviews with those been involved in public health planning (included CEOs, Mayors, department leaders). | Enabling factor to reframe the term 'public health', without taking away the intent of what the national plans mandated e.g., case study site 3 used the term 'living conditions'. This term was seen as more relevant to the local context.<br>Some felt that the term 'public health' needed to be used initially so that staff in different departments understood their role and potential impact on health, however the terms then became irrelevant in actual practice.<br>The terms 'public health' and 'public health work' were perceived as complex terms that were difficult to define what they meant.<br>The authors conclude that the terms can be a hindrance to addressing their intent to address HiAP. The terms may be needed initially to understand the reason for considering health impacts, though could be re-framed during the planning process. |
| Synnevåg, E. S., Amdam, R., & Fosse, E. (2019). Legitimising Inter-Sectoral Public Health Policies: A Challenge for Professional Identities? *International Journal of Integrated Care, 19*(4), Article 9. http://doi.org/10.5334/ijic.4641 | Norway<br><br>Local<br><br>HiAP | To discuss how professional identities relates to implementation of intersectoral collaboration. | Case study design (n=3), incl. interviews. Sites of differing geographical areas and population size.<br><br>Scotts theoretical framework of institutional pillors; Suchmans | 31 participants involved in public health policy across 30 interviews. Incl administration positions, politicians, department leaders. | Regulations have supported the legitimising of the HiAP approach.<br>There is motivation in municipalities to develop local regulations and structures for HiAP (e.g., HIA).<br>Lack of awareness of how public health goals relate to the daily work within different sectors.<br>Many respondents, outside of public health departments, did recognise that public health was part of their responsibility. However, they report that health is not always the reason, drive or issue that is most important to them in their work.<br>Conflicts with professional identities may inhibit the intersectoral collaboration required to achieve HiAP.<br>Perception that staff outside public health were 'being told what to do', without consideration of actions already being done (e.g., from a cultural perspective). |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| | | | legitimacy types. | | *Regulative legitimacy* (laws) was apparent in all 3 municipalities. The national public health act legislates HiAP and locally there are regulations and structures in place e.g., integration into local public health policies, health impact assessments.<br>*Normative legitimacy:* (values, norms) was mixed. At both political and administrative levels, respondents reported public health as an 'issue of interest' and important. There were still doubts if politicians and/or administrative employees really understood the integration of public health.<br>*Cognitive legitimacy*: (understanding and knowledge) In one municipality, understanding was clear and shared amongst informants, though most commonly referred to as 'living conditions'. In one municipality, the understanding of the HiAP approach was less clear, with no apparent understanding of social inequalities in health.<br>*Pragmatic legitimacy*: (perceived usefulness) All municipalities report HiAP as useful, particularly to the community, although less useful to their own day-to-day work.<br>Conclude that regulative legitimacy is less challenging to achieve than cognitive and normative legitimacy. |
| van der Graaf, P., Cheetham, M., Redgate, S., Humble, C., & Adamson, A. (2021). Co-production in local government: process, codification and capacity building of new knowledge in collective reflection | UK<br><br>Local<br><br>Population health | To explore perspectives from LG staff in co-developing, using and applying evidence in the commissioning of public health services. | Mixed method research.<br>This paper reports on findings from workshops (n=54).<br><br>Created their own model of | Included representatives consisting of LG staff stakeholders e.g., universities, voluntary organisation. | Barriers to use of evidence include: data needed at a local level did not match data available, or data required to be collected for national government; data was collected by different departments or organisations and not shared, difficult to compare, not available at a geographical level; priority given in one case study site for quantitative data, unsure how to use qualitative data from community; lack of value for evaluating programs for impact, rather than just whether they were delivered or not; differing cultures between LG and academia; LG averse to negative evaluation findings, academic research takes too long, academics |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| spaces. Workshops findings from a UK mixed methods study. *Health Research Policy and Systems, 19*(1), Article 12. https://doi.org/10.1186/s12961-021-00677-2 | | | co-production of research evidence in LG. | | prioritise peer review publications and funding grants; lack of shared, collaborative space for reflection on evidence across LG departments; departments are siloed in LG, each with their own culture; researchers lacking awareness of LG policy processes. Enabler for evidence use included academics having trusted contacts in LG. |
| Van Vliet, J. (2018). How to apply the evidence-based recommendations for greater health equity into policymaking and action at the local level? *Scandinavian Journal of Public Health, 46*(22_suppl), 28-36. https://doi.org/10.1177/1403494818765703 | Sweden<br><br>Local<br><br>Health inequity | To reflect on the process of local municipalities implementing regional health policy recommendations. | Discussion: personal reflection and experience of author.<br><br>No theory applied. | N/a | The politicians from the 13 local municipalities in the region came together and agreed on 10 priorities of action.<br>Documents in the municipalities demonstrated that the priority areas were incorporated/prioritised into local budget plans. These were established during the regional commission process, drawing on the evidence-based recommendations.<br>Norrkoping was already investing in social service and cross sectoral interventions prior to the commission efforts (e.g., education, childcare). This included significant financial investment in social services.<br>It is acknowledged by the author that local municipalities could not just add more priorities to their list, though needed to integrate recommendations into existing political priorities, allowing for local region needs.<br>In the instance of Norrkoping, many of the 10 agreed priority areas were already invested in. The author was able to map these to existing investments. It is acknowledged that advocating for this to happen may result in a more 'tick and flick' exercise.<br>Action on health equity risks just targeting the most disadvantaged, rather than distributed across level of advantage. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| Von Heimburg, D., & Hakkebo, B. (2017). Health and equity in all policies in local government: processes and outcomes in two Norwegian municipalities. *Scandinavian Journal of Public Health, 45*(18_suppl), 68-76. https://doi.org/10.1177/1403494817705804 | Norway<br><br>Local<br><br>HiAP | Identify enabling factors to the implementation of HiAP in LG policy (Health and equity in all policies). | Case study (x2) time series account.<br><br>Multiple Streams Framework. | Strategic municipal staff (also the authors) | There are 2 key success factors:<br>*System capacity:* Leaders did not refer to policies as they did not know they existed, and they did not get implemented. Staff put in place a governance system tool that interconnected the different municipal plans and culminated in the Municipal Master Plan. A learning was the need to engage stakeholders. Ongoing co-creation of goals is built on trust between different policy actors. Evidence often included citizen voices and sharing of their stories of disadvantage.<br>*Human capacity:* Municipal leaders established a strategic development unit (before the Public Health Act was in place) that focused on a range of professions, including health. The strategic unit had the role of working on governance systems and building connections between stakeholders and across departments.<br>The authors are strategic development staff within the municipalities who proposed public health as integrated into master planning, rather than having a separate plan.<br>Used data that were analysed to represent social gradients and research on social inequalities in health.<br>Also at a time where the National Public Health Act (2012) was passed, which focused on the HiAP approach. This was considered important to keep the plan focused on equity.<br>These 'change agents' developed a 'framing document', which created some mutual understanding of health, using a salutogenic and human rights focus. The proposal focused on 'whole of government', 'whole of society', 'determinants of health' and 'ecological' perspectives, which also aligned to the World Health Organization Health 2020 agenda.<br>The 'framing document' was brought up consistently with politicians and other stakeholders, creating shared knowledge |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| | | | | | across many sectors.<br>The Municipal Master Plan was adapted to focus on its interconnection between all plans and policies, with health and wellbeing at the core of societal development.<br>The staff came up with a range of indicators, aligned with annual reporting processes and access to local, disaggregated data (of which there was a large public health study making this available at the time).<br>The case study sites became members of the Healthy Cities Norwegian Network to help support them with their implementation process. The case study sites were also part of other national and regional projects related to health promotion and health literacy.<br>The authors conclude that knowledge about health determinants is not the most important thing, but also understanding of the policy process amongst policy entrepreneurs. |
| Willmott, M., Womack, J., Hollingworth, W., & Campbell, R. (2016). Making the case for investment in public health: experiences of Directors of Public Health in English local government. *Journal of Public Health, 38*(2), 237-242. https://doi.org/10.1093/pubmed/fdv035 | England<br><br>Local<br><br>Health determinants | To identify what Directors of Public Health advocate for public health in LG, the components of their cases and what evidence they use for this. | Semi-structured telephone interviews for all 16 Directors of Public Health.<br><br>No theory applied. | 13 Directors of Public Health in LG | The Directors of Public Health identified two main issues that they need to advocate for, the control of the public health grant budget and to address broader determinants of health.<br>Evidence was useful, synthesised evidence is useful, having a cost-effective argument was seen as important.<br>Challenge is to 'sift' through the literature for good practice evidence. The types of evidence used included peer review literature, examples of what other councils had done.<br>Evidence for LG was seen as different than in public health generally, with the focus on making sure the case was a normative argument in line with current priorities, doing the 'right thing' as well as being 'politically acceptable'. If this was the case, then other evidence was not required.<br>Any evidence needed to be made locally relevant by the DPHs. |

| Study citation | Country, Level of government ; Key concept | Aim of the research | Research methods & theory | Research participants | Key findings - barriers and/or enablers |
|---|---|---|---|---|---|
| | | | | | Telling local stories was also effective.<br>The authors raise concern over the lack of evidence that the determinants of health has in terms of economic impact, and role of LG.<br>Authors confirm that evidence is only one part of the determinant of public policy. |

# APPENDIX D: RESEARCH INFORMATION SHEET (QUESTIONNAIRE)

# Research Study: Health in All Councils

***Research Information Sheet***
**Research study: Health in All Councils**

You are invited to participate in a research study to explore the decision making process of policy in local government of Australia related to impacts on health. The study has received ethics approval from the Curtin University Human Research Ethics Committee reference number SPH-88-2014.

1. **What is the study about?**

The purpose of the study is to explore how health, wellbeing and related factors are considered by local government policy decisions. The study will describe this process of healthy public policy using political science theories.

2. **Why have I been invited to participate in this study? Do I have to take part?**

You are invited to participate in this study as an elected or non-elected staff member of local government in Australia. Participation in the study is completely voluntary. While we would be pleased to have you participate, we respect your right to decline. If you decide not to participate this will not affect your relationship with any of the organisations involved.

If you do decide to take part, you will be asked to complete an online questionnaire. Completion of the questionnaire will be considered your consent to participate in the study.

3. **What does this study involve?**

If you decide to participate in the study, you will be asked to complete an online questionnaire. This will take approximately 10-15 minutes to complete. The questionnaire will ask about how health and wellbeing is considered as part of Council decisions, particularly through various factors such transport, sustainability and housing. The survey will also ask you about enablers and barriers to the healthy public policy process in local government.

Once the data is collated and analysed, several forums will be held by the research team, inviting participants across Australia to discuss the findings. The information will be used to inform local council staff and stakeholders of the current understanding and feasibility of integrating health and wellbeing into local government policy.

4. **What are the possible risks of participation?**

There are no foreseen risks in participating in the study. All data will remain confidential and de-identified. For ethical, safety and data accuracy purposes, you will be asked to be excluded from the study if you meet any of the following criteria:

- Are aged 17 years or younger
- No longer work for local government in Australia

If you are eligible to participate, the research team would appreciate your time in completing the questionnaire.

5. **What will happen with my results of the research study?**

Any information you give during the study is confidential. At no stage is your name or any contact details required. In all instances, the data will be reported at a collective level of local councils across Australia, your state/territory or by geographical or size category. The results of the study will be circulated in hard copy and via email to local council CEOs and various Local Government Association networks. Any publications or presentations that result from this research will not include any information that might identify individuals involved.

6. **What if I require further information?**

If you would like to discuss any aspect of this study please feel free to contact Kara Lilly (Principal Researcher) by email kara.lilly@postgrad.curtin.edu.au or Associate Professor Suzanne Robinson (Research Supervisor) at Curtin University by phone (08) 9266 4921 or email Suzanne.Robinson@curtin.edu.au. Either of these staff would be happy to talk about the research study with you.

7. **What if I have a complaint or a concern?**

The study has received ethics approval from the Curtin University Ethics Committee, approval number SPH-88-2014. If you have concerns or complaints regarding the conduct of this study, please contact the Human Research Ethics Committee on phone (08) 9266 2784, email hrec@curtin.edu.au or by written letter to C/O Secretary, Human Research Ethics Committee, Office of Research and Development, Level 1, Building 100, Curtin University of Technology, GPO Box U1987, Perth 6845.

***Thank you for taking the time to consider your participation in this research study.***
***Please keep a copy of this information sheet for your reference.***

# APPENDIX E: ONLINE QUESTIONNAIRE

Qualtrics questionnaire - FINAL

This research study, Health in All Councils, aims to explore how health, wellbeing and factors that can influence health, are integrated into the policy process of local governments. You are invited to participate in this study as an elected or non-elected staff member of a local government in Australia. The research team are interested in hearing of your experience in working for local government, including the varying success, enablers and barriers you may have faced in attempting to initiate policy that addresses health and wellbeing of the local community.

If you have not previously seen the Research Information Sheet, please follow the link to read and view an outline of the research study: [Research Information Sheet].

The questionnaire is comprised of five (5) sections. You can move between questions by pressing on 'Next page' or 'Previous page'. It will take approximately 10 minutes to complete. Involvement in the study is completely voluntary. By completing this questionnaire, you are consenting to be involved in the study. Any information you provide in this questionnaire is strictly confidential. At not stage are you required to provide your name or any other personal details.

Your time and support in completing the survey is appreciated. As the research team would like to hear from as many local government staff in Australia, please feel free to also forward this survey link to other staff to complete the questionnaire, particularly to staff who may have some responsibility for policy decisions in your council.

## Part 1: Information about you and your council

*The following five (5) questions ask about you and/or your council.*

1. **What State or Territory is you Council in?**
   - ☐ Western Australia
   - ☐ Northern Territory
   - ☐ South Australia
   - ☐ Tasmania
   - ☐ Victoria
   - ☐ New South Wales
   - ☐ Australian Capital Territory
   - ☐ Queensland (please only continue if you haven't previously completed this survey)

2. **From the terms below, what best describes your council?**
   - ☐ City
   - ☐ Regional
   - ☐ Rural/shire
   - ☐ Indigenous council

3. **What is your role in your local council?**
   - ☐ CEO / Executive Leader
   - ☐ Elected Councillor / Mayor
   - ☐ Manager (strategic)
   - ☐ Manager (operational)
   - ☐ Other staff

4. **What area of council do you mainly work in, or have responsibility for? (tick as many as apply)**
   - ☐ Town planning and building assessment
   - ☐ Economic development
   - ☐ Environmental health
   - ☐ Road / footpath construction and maintenance
   - ☐ Rubbish collection
   - ☐ Sport and recreation facilities and programs
   - ☐ Community development
   - ☐ Arts and culture programs
   - ☐ Information services or administration
   - ☐ Parks and open space
   - ☐ Local events and/or tourism
   - ☐ Environment and sustainability
   - ☐ Strategy and corporate planning
   - ☐ Other

5. **How long have you been working in local government ?**
   - ☐ 0-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

## Part 2: Health and wellbeing in your Council

*This section comprises two (2) parts. It refers to both how you personally define health and wellbeing and how your Council currently defines health and wellbeing. It also asks how Council invests in health and wellbeing, including whether health and wellbeing is a priority.*

**6. Councils have to deal with many issues of concern to their community members. Where does addressing health and wellbeing in your region fall among all of the other priorities you have to consider?**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

Not a priority at all — Somewhat of a priority — A top priority

**7. In your personal opinion, where should health and wellbeing fall as a priority for your Council?**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

Not a priority at all — Somewhat of a priority — A top priority

**8. From the following list of definitions, how do you think that <u>your Council</u> defines health and wellbeing?**

- ☐ Health is about being free from disease and it is up to individuals to take responsibility for their choices.
- ☐ Health is about being free from disease and is impacted by individual behaviours, though also impacted by built and social environments.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environments, family, individual circumstances and socioeconomic position.
- ☐ Other (please explain)

**9. From the same list of definitions, how do <u>you personally</u> define health and wellbeing?**

- ☐ Health is about being free from disease and it is up to individuals to take responsibility for their choices.
- ☐ Health is about being free from disease and is impacted by individual behaviours, though also impacted by built and social environments.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environment, family, individual circumstances and socioeconomic position.
- ☐ Other (please explain)

**10. From the list of definitions, how do you think that <u>your community</u> define health and wellbeing?**

- ☐ Health is about being free from disease and it is up to individuals to take responsibility for their choices.
- ☐ Health is about being free from disease and is impacted by individual behaviours, though also impacted by built and social environments.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing.
- ☐ Health is being not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environments, family, individual circumstances and socioeconomic position.
- ☐ Other (please explain)

**11. How does your council currently prioritise investments in health and wellbeing?**

| | No priority | Very little priority | Some priority | High priority |
|---|---|---|---|---|
| Investment in behaviour and lifestyle programs (e.g. physical activity) | ☐ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| Investment in mental and social wellbeing programs (e.g. community connectivity) | ☐ | ☐ | ☐ | ☐ |
| Investment in addressing determinants of health (e.g. transport, housing, sustainability) | ☐ | ☐ | ☐ | ☐ |
| Investment in urban planning and design (e.g. parks and pathways) | ☐ | ☐ | ☐ | ☐ |
| Other (please list) | ☐ | ☐ | ☐ | ☐ |

**12. There are a range of factors that can have an impact on health and wellbeing. What policy areas of local government do you believe have the potential for improving health and wellbeing of your community? (List as many as possible)**

## Part 3: Initiation and development of health and wellbeing policy

The next few questions ask how health and wellbeing is raised as a topic in Council and how it is considered in the decisions that Council has to make in developing relevant plans and policy. While your Council may not have a specific 'policy' for health and wellbeing, the term refers to any formal way that health and wellbeing is raised in planning and making policy decisions, which includes the development of strategic or operational plans.

**13. Thinking about how health and wellbeing policy is <u>raised as a topic for discussion</u> by your Council, how true would you say the following factors are?**

| | Not true at all | Rarely true | Somewhat true | Mostly true | Definitely true |
|---|---|---|---|---|---|
| Personally, I feel obliged to do something in the field | ☐ | ☐ | ☐ | ☐ | ☐ |
| The action is part of my professional duties | ☐ | ☐ | ☐ | ☐ | ☐ |
| Scientific results demand the action | ☐ | ☐ | ☐ | ☐ | ☐ |
| The community demand the action | ☐ | ☐ | ☐ | ☐ | ☐ |
| Council is obliged to the community to act in this area | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| Staff agree on what action needs to be taken to address health and wellbeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is a key leader/champion in health and wellbeing in our council | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is strong leadership from other levels of government to act | ☐ | ☐ | ☐ | ☐ | ☐ |

**14. To what extent does your Council currently consider health and wellbeing outcomes in the <u>development</u> of the following plans and policies?**

| | Not applicable | Never | Rarely | Sometimes | Most of the time | Always |
|---|---|---|---|---|---|---|
| Transport | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Urban planning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Housing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Energy and sustainability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sport and recreation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Health care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Economic development | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other (please describe) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**15. Thinking broadly about how health and wellbeing is integrated into the <u>development of policy</u> (includes overarching plans, strategy documents) in your Council, how true are the following statements?**

| | Not true at all | Rarely true | Somewhat true | Mostly true | Definitely true |
|---|---|---|---|---|---|
| The approach to health and wellbeing is clear in policy | ☐ | ☐ | ☐ | ☐ | ☐ |
| The goals for health and wellbeing are concrete enough | ☐ | ☐ | ☐ | ☐ | ☐ |
| The actions centre on improving the health and wellbeing of the community | ☐ | ☐ | ☐ | ☐ | ☐ |
| The council has the necessary staff capacity | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| There are sufficient financial resources | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is sufficient cooperation within council | ☐ | ☐ | ☐ | ☐ | ☐ |
| The local political climate supports health and wellbeing of the community | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is support from other sectors | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is cooperation between different political levels involved | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is cooperation between public and private organisations | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is current lobby for action on health and wellbeing within Council | ☐ | ☐ | ☐ | ☐ | ☐ |
| The community is involved in decisions around health and wellbeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| The community supports the Council's approach to health and wellbeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| The media supports the Council's approach to health and wellbeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is sufficient evidence available to support Council decisions | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is strong support and leadership from within council | ☐ | ☐ | ☐ | ☐ | ☐ |

## Part 4: Implementation and evaluation of health and wellbeing policy

**Nearly there! Just a few important questions to go. This next section relates to the capacity of your Council to put any developed health and wellbeing policies into action.**

**16. How true are the following statements regarding your Council's capacity to action health and wellbeing policy strategies?**

| | Not true at all | Rarely true | Somewhat true | Mostly true | Definitely true |
|---|---|---|---|---|---|
| Various health and wellbeing strategies and/or activities are implemented | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is clear Council commitment | ☐ | ☐ | ☐ | ☐ | ☐ |
| The Council has the staff time and capacity to implement actions | ☐ | ☐ | ☐ | ☐ | ☐ |
| Staff are provided with skills and knowledge necessary for implementation | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is support from other sectors when implementing actions | ☐ | ☐ | ☐ | ☐ | ☐ |
| There are formal collaborative partnerships established for health and wellbeing action | ☐ | ☐ | ☐ | ☐ | ☐ |
| There are sufficient financial resources | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is sufficient cooperation internally within my Council | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is cooperation between different political levels involved | ☐ | ☐ | ☐ | ☐ | ☐ |
| The legislative environment is favourable for health and wellbeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| The community is engaged effectively in implementing action | ☐ | ☐ | ☐ | ☐ | ☐ |
| The community supports the action | ☐ | ☐ | ☐ | ☐ | ☐ |
| The media supports the action | ☐ | ☐ | ☐ | ☐ | ☐ |
| There is ongoing monitoring and review of policy in Council | ☐ | ☐ | ☐ | ☐ | ☐ |
| Policy reviews consider health and wellbeing impacts | ☐ | ☐ | ☐ | ☐ | ☐ |
| Council uses performance indicators to measure health and wellbeing impacts | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | |
|---|---|---|---|---|---|
| Considering cost-benefits, the action was worthwhile | ☐ | ☐ | ☐ | ☐ | ☐ |

## Part 4: Future of health and wellbeing in local governments

*This final section of the questionnaire is interested in how local governments may respond to health and wellbeing of their communities in the future.*

**17. Over the next 5 years, what investments in health and wellbeing are likely to be a priority for your Council?**

| | No priority | Very little priority | Some priority | High priority |
|---|---|---|---|---|
| Investment in behaviour and lifestyle programs (e.g. physical activity) | ☐ | ☐ | ☐ | ☐ |
| Investment in mental and social wellbeing programs (e.g. community connectivity) | ☐ | ☐ | ☐ | ☐ |
| Investment in addressing determinants of health (e.g. transport, housing, sustainability) | ☐ | ☐ | ☐ | ☐ |
| Investment in urban planning and design (e.g. parks and pathways) | ☐ | ☐ | ☐ | ☐ |
| Other (please specify) | ☐ | ☐ | ☐ | ☐ |

**18. Is there anything related to health and wellbeing policy in local government that you would like to have the opportunity to add? Please provide your comments below.**

Thank-you for completing the survey.

# APPENDIX F: RESEARCH INFORMATION SHEET (CASE STUDY SITE)

# Research Study: Health in All Councils

***Research Information Sheet***
**Research study: Health in All Councils**

You are invited to participate in a research study to explore the process of healthy public policies in local governments of Australia. The study has received ethics approval from the Curtin University Human Research Ethics Committee reference number SPH-88-2014.

1. **What is the study about?**

The purpose of the study is to explore how health, wellbeing and related factors are considered by local governments. The study will describe this process of healthy public policy using the lens of political science theories.

The study has three stages. The first stage involved an online questionnaire to gain a picture of how health and wellbeing is considered in local government decisions. You may already have completed this questionnaire. The second stage of the study includes two case study sites. These sites have been chosen to further explore the factors that impact on health and wellbeing policy.

2. **Why have I been invited to participate in this study? Do I have to take part?**

You are invited to participate in one of the case study sites, either as an elected or non-elected staff member, or a relevant stakeholder in local government policy processes. As part of the case study site, you have been nominated by your peers and/or colleagues as a person that can either comment on how health and wellbeing influences Council's policy decision making and practice.

Participation in the research study is completely voluntary. While we would be pleased to have you participate, we respect your right to decline. If you decide not to participate this will not affect your relationship with any of the organisations involved. Signed written consent for the participation in the case study will be sought at the time of interview or focus group.

3. **What does this study involve?**

If you agree to participate, you will be advised by phone and email to arrange either an interview time suitable for you, or to organise to participate in a focus group. The interview / focus group will take approximately one(1) hour.

Once the data is collated and analysed, forums will be held by the research team, inviting participants across Australia to discuss the research findings. The information will be used to inform local council staff across Australia and interested stakeholders of the current understanding and feasibility of integrating health and wellbeing into local government policy.

4. **What are the possible risks of participation?**

There are no foreseen risks in participating in the study. All data will remain confidential and de-identified. For ethical reasons you will be asked to be excluded from the study if you are aged 17 years or younger. If you are eligible to participate, the research team would appreciate your time.

5. **What will happen with my results of the research study?**

Any information you give during the study is strictly confidential. Names and contact details will be removed from any data recorded. At no time will individual names be disclosed to anyone outside of the research team. Reference to staff positions in local government (eg. senior manager) will be used where relevant, though specific titles will be removed.

The results of the study will be circulated in hard copy and via email to local council CEOs and various Local Government Association networks. Any publications that result from this research will not include any information that might foreseeably identify individuals or organisations involved.

6. **What if I require further information?**

If you would like to discuss any aspect of this study please feel free to contact Kara Lilly (Principal Researcher) by email kara.lilly@postgrad.curtin.edu.au or Associate Professor Suzanne Robinson (Research Supervisor) at Curtin University by phone (08) 9266 4921 or email Suzanne.Robinson@curtin.edu.au. Either of these staff would be happy to talk about the research study with you.

7. **What if I have a complaint or a concern?**

The study has received ethics approval from the Curtin University Ethics Committee, approval number SPH-88-2014. If you have concerns or complaints regarding the conduct of this study, please contact the Human Research Ethics Committee on phone (08) 9266 2784, email hrec@curtin.edu.au or by written letter to C/O Secretary, Human Research Ethics Committee, Office of Research and Development, Level 1, Building 100, Curtin University of Technology, GPO Box U1987, Perth 6845.

***Thank you for taking the time to consider your participation in this research study.***
***Please keep a copy of this information sheet for your reference.***

# APPENDIX G: INTERVIEW SCHEDULE

**Interview Schedule and protocol**

Prior to interview: Participants sent a confirmation email regarding the time and venue, along with a RIS.

At time of interview: Participants asked to complete demographics form and consent form

Interview Guide

| | |
|---|---|
| **Introduction** | Thanks for taking the time to meet with me today. My name is Kara and I am currently completing my PhD in Public Health. I would like to talk with you about your experiences in health and wellbeing policy in your local government setting. I am interested in how health and wellbeing is discussed in local government and how this influences policy and planning decisions. I'm particularly interested in how local governments are able to address the underlying determinants of health.<br>The interview should take about an hour. I will be recording the session because I don't want to miss any of your comments. All of your responses will be kept confidential. After the interview has been transcribed you will have the opportunity to review and edit any of your comments. Afterwards, the recording will be deleted and only those in the research team will be able to identify you as the interviewee. Any reference to names will be removed. At times through the interview, I may clarify who people are and what positions and organisations they are with as this will be supportive of the research findings. A reminder that you don't have to respond to every question if you don't want to and you can end the interview at any time.<br>Do you have any questions before we get started?<br>Reminder: Consent and Demographics form<br>• Sign consent form (RIS available)<br>• Complete demographics form (if not completed when sent email confirmation of interview time)<br>• Start voice recorder |
| **Context** | Australian research so far by survey + purpose of case study site |
| **Policy initiation**<br><br>**Responds to survey findings regarding:**<br>• **Problem definition and framing (MSF)**<br>• **Presence of a key champion (MSF),**<br>• **Cooperation and involvement of policy actors including community and media (MSF, ACF, PEF, ADEPT)** | I'm interested in how health and wellbeing is discussed in policy and planning decisions, particularly how Council consider the determinants of health – such as access to transport, housing and social inclusion. *(give example from Council).*<br><br>1. What do you see as Council's role in considering determinants of health in policy decisions?<br><br>2. To what extent are determinants of health brought up in discussions at this Council?<br>*[prompt] Who/when/why?*<br>○ *Key champion* |

| | |
|---|---|
| • **Lobbying efforts (ACF),**<br>• **Use of evidence (MSF, ACF, PEF, ADEPT) and**<br>• **Influence of legislation (MSF).** | ○ *Community demand*<br>○ *Scientific evidence*<br>○ *Lobbying*<br>○ *Stakeholder input*<br>○ *Role of media*<br><br>*{if not previously raised}*<br>What's your views on legislating health and wellbeing as a LG role? |
| **Policy development/implementation**<br><br>**Responds to survey findings regarding:**<br>• **Policy solutions (MSF),**<br>• **Resourcing (ADEPT)** | In your experience, to what extent would you say the determinants of health get integrated into different policies and plans of Council? |
| **Policy review**<br><br>**Responds to survey findings regarding:**<br>• **Use of performance indicators (PEF)**<br><br>**Adds opportunity to discuss policy change/feedback loops (PEF)** | What processes are in place for review of Council's policies and plans?<br>○ What do the performance indicators or reviews measure? Are they measured?<br>○ How is the review process used to feed back into future policy changes?<br><br>*{if not previously raised}*<br>What impact does a change in elected members/Council have on the approach or commitment to healthy public policy planning? |
| **Future** for health and wellbeing policy | What do you see as the future role of local governments in addressing determinants of health? |
| **Other** | Is there anything else you would like to add? |
| **Other contacts / snowball** | Are there other staff in council, or external key stakeholders, who might like to comment on the process of decision making in health and wellbeing policy in local government in this region? |
| **Thank-you** | Thank participant and stop recording. |

# APPENDIX H: FOCUS GROUP SCHEDULE

**Focus Group Schedule and protocol**

Prior to focus group: Participants sent a confirmation email regarding the time and venue for the focus group, along with a RIS.

At time of focus group: Participants have access to RIS and complete demographics and consent form prior to the focus group.

Focus Group participants: 5-6 in a group

| | |
|---|---|
| **On arrival** | • RIS available<br>• Consent form to complete<br>• Demographics form to complete<br>• Blank paper provided to write extra information on or to take notes as participants think of ideas/thoughts. |
| **Introduction**<br><br>Introduction to the discussion group<br>House rules | *Intro* - Thanks for taking the time to join in the group discussion today. My name is Kara and I am currently completing my PhD in Public Health. I am interested in how health and wellbeing is discussed in local government and how this influences policy and planning decisions. I'm particularly interested in how local governments are able to address the underlying determinants of health. The focus of today's discussion is around your experience of how decisions are made around health and wellbeing in this Council and what you think about that. As well as how you might see the future for health and wellbeing policy in this local government.<br>The group discussion should take about an hour. I will be recording the session because I don't want to miss any of your comments. I'll also be taking a few notes.<br>• Introductions – (if don't know each other already)<br>• Cover rules for the session – e.g. confidentiality (e.g. no names to be used, roles are ok), allow everyone chance to talk/listen etc. (participants may want to add some)<br>• Start voice recorder |
| **Opening context**<br>Research process to date<br>Definition of health | • Inform participants – Australian survey completed + purpose of case study site<br>• Health and wellbeing – for the purposes of the discussion, health and wellbeing is defined quite broadly to integrate the determinants of health (raise current policy and some examples) |
| **Consideration of health and wellbeing** in council policy and practice<br><br>Policy initiation | 1. From your experience, what influences the Councils policy decisions around health and wellbeing?<br>o Community demand, scientific evidence, lobbying, stakeholders, media etc |

| | |
|---|---|
| Explore how decisions are made, in particular prompting in response to survey findings regarding:<br>• Problem definition and framing (MSF),<br>• Role of community (ACF),<br>• Role of media (MSF, ACF, PEF, ADEPT)<br>• Involvement of policy actors (MSF, ACF, PEF, ADEPT)<br>• Role of lobbying efforts (ACF) | *{Prompt} I'm particularly interested in how Council consider the determinants of health – such as access to transport, housing and social inclusion (give example from Council).*<br><br>What would you say are the factors that enable Council to incorporate determinants of health in local policy and planning?<br><br>What would you say are the key challenges? |
| **Future** for health and wellbeing in local government<br><br>Explore the influence of key challenges and enablers in response to survey findings:<br>• Staff and financial resources (ADEPT);<br>• Role of local and broader political environment (MSF)<br>• Obligations (ADEPT) | In your opinion, how do you see Council investing in determinants of health in the future?<br><br>o Why? What is the motivation for this?<br>o Resources<br>o Political influences |
| **Other** | Anything to add? Can write on a separate sheet of paper and hand in after the focus group or via email. Details provided in initial email to participants. |

# APPENDIX I: TEMPLATE ANALYSIS MAP

Template Analysis: Iterations of themes and codes using Template Analysis

Template #1

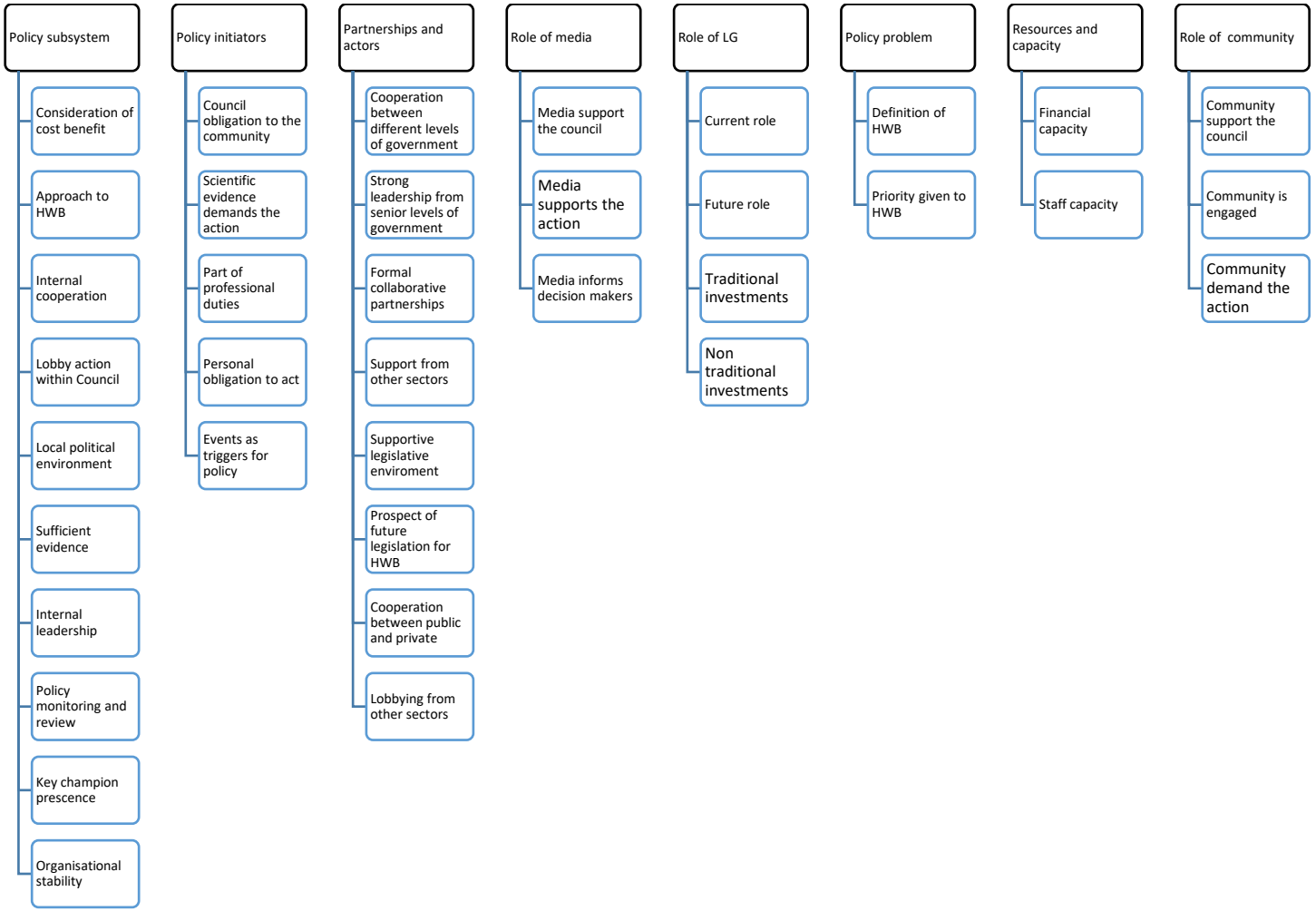



*Figure K 1: Initial template from first read of interview and focus group transcripts (Case study site A)*

Template #2

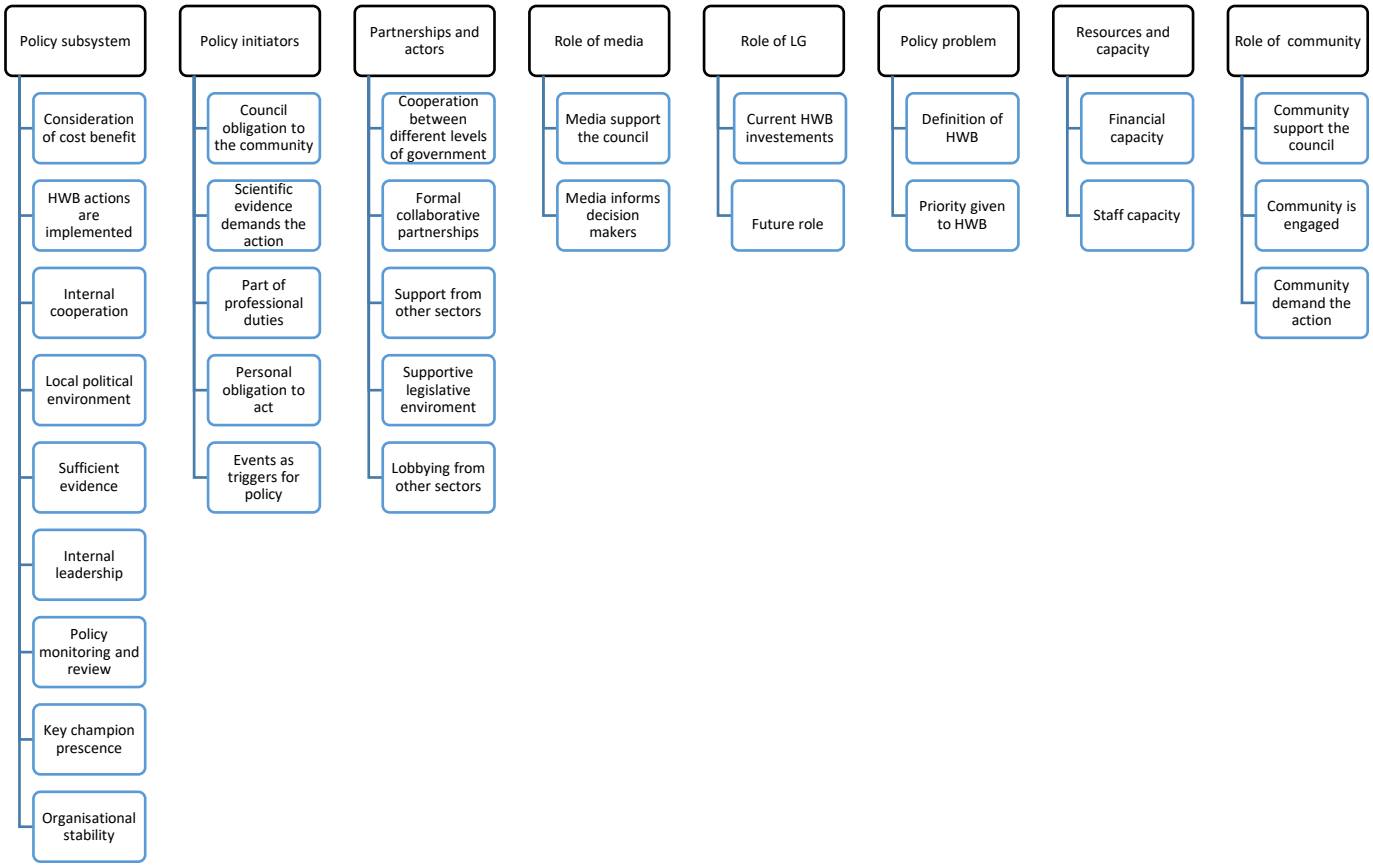



*Figure K 2: Second template used for analysis*

Changes to Template 2:

- 'Approaches to HWB' became 'HWB actions are implemented'
- Discontinued code of 'lobbying action within council'
- Collapsed some of the 'partnerships and actors codes due to duplication' and added data largely to 'cooperation between different levels of government e.g.,'strong leadership from other levels of government' and 'cooperation between public and private'. The code 'prospect of future legislation for HWB' was collapsed with 'supportive legislative environment'.
- Collapsed 'media support the council' and 'media supports the action'.
- New theme created termed 'current HWB investments', which included all of 'current', 'traditional' and 'non-traditional' investments codes.

Template #3

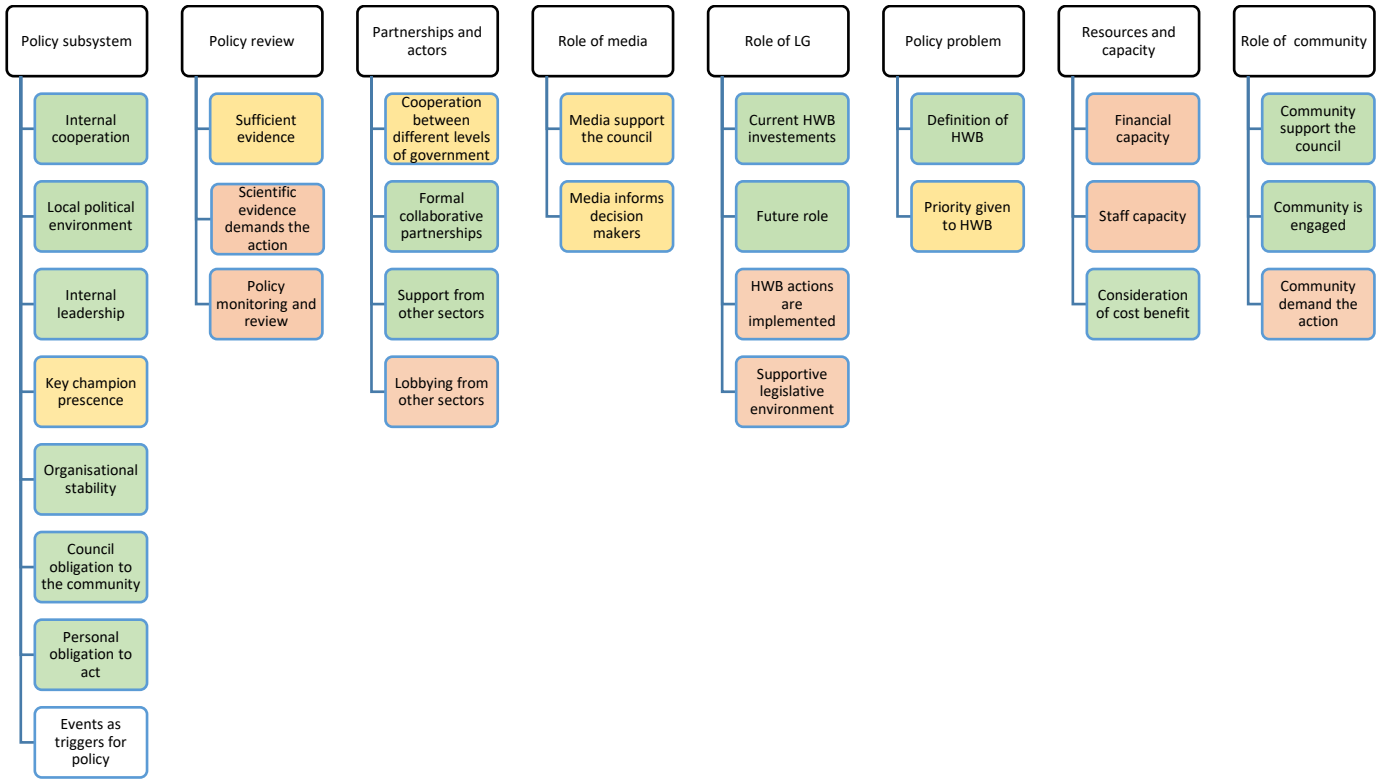



*Figure K 3: Third template used for analysis*

Changes to Template 3:

- One theme, 'policy initiators', which was originally a factor identified from the survey data, was discontinued as the codes could be better mapped to other themes (for example, 'part of professional duties' and 'council obligation to the community' were seen as a policy subsystem examples).
- A new theme was developed, 'Policy Review', as the policy monitoring and use of key performance indicators was considered a central concept on its own, rather than related to various other themes.
- 'Consideration of cost benefit' moved to 'resources and capacity' theme.
- 'HWB actions are implemented' moved from the 'policy subsystem' theme to 'Role of LG'.

Template #4

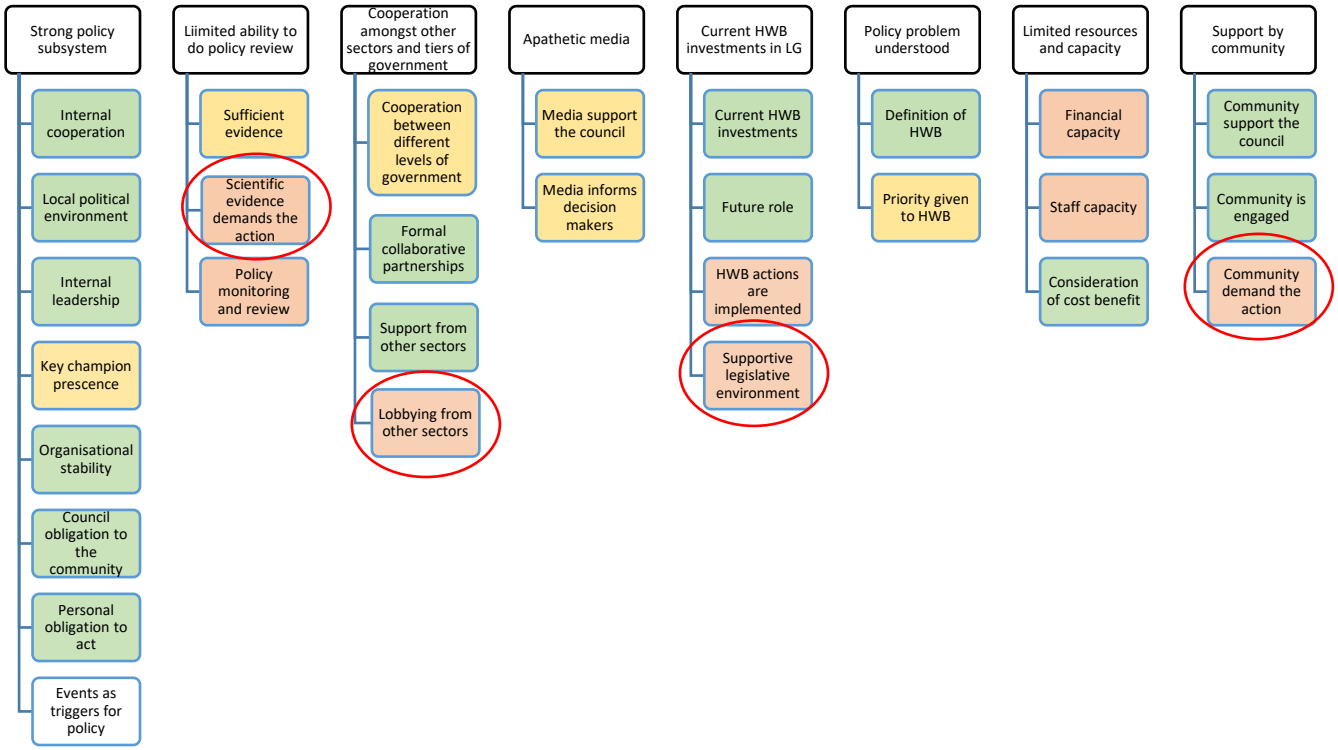



*Figure K 4: Fourth template used for analysis*

Changes to Template 4 & 5:

- Names of themes were further defined for interpretive meaning.
- An integrative theme identified was 'no demand outside of LG', which became its own theme in Template 5 (circled in template 4).

Template #5

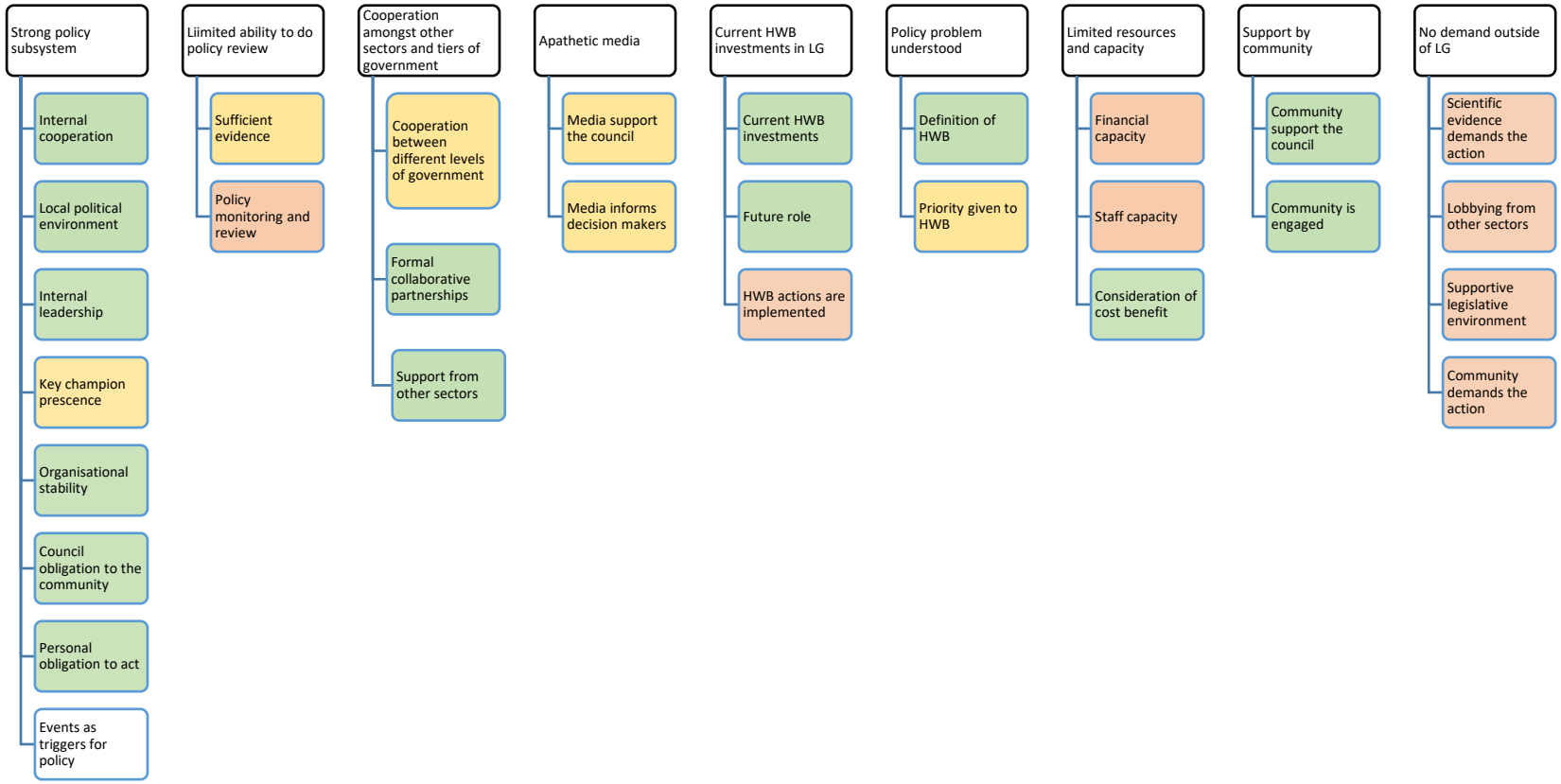
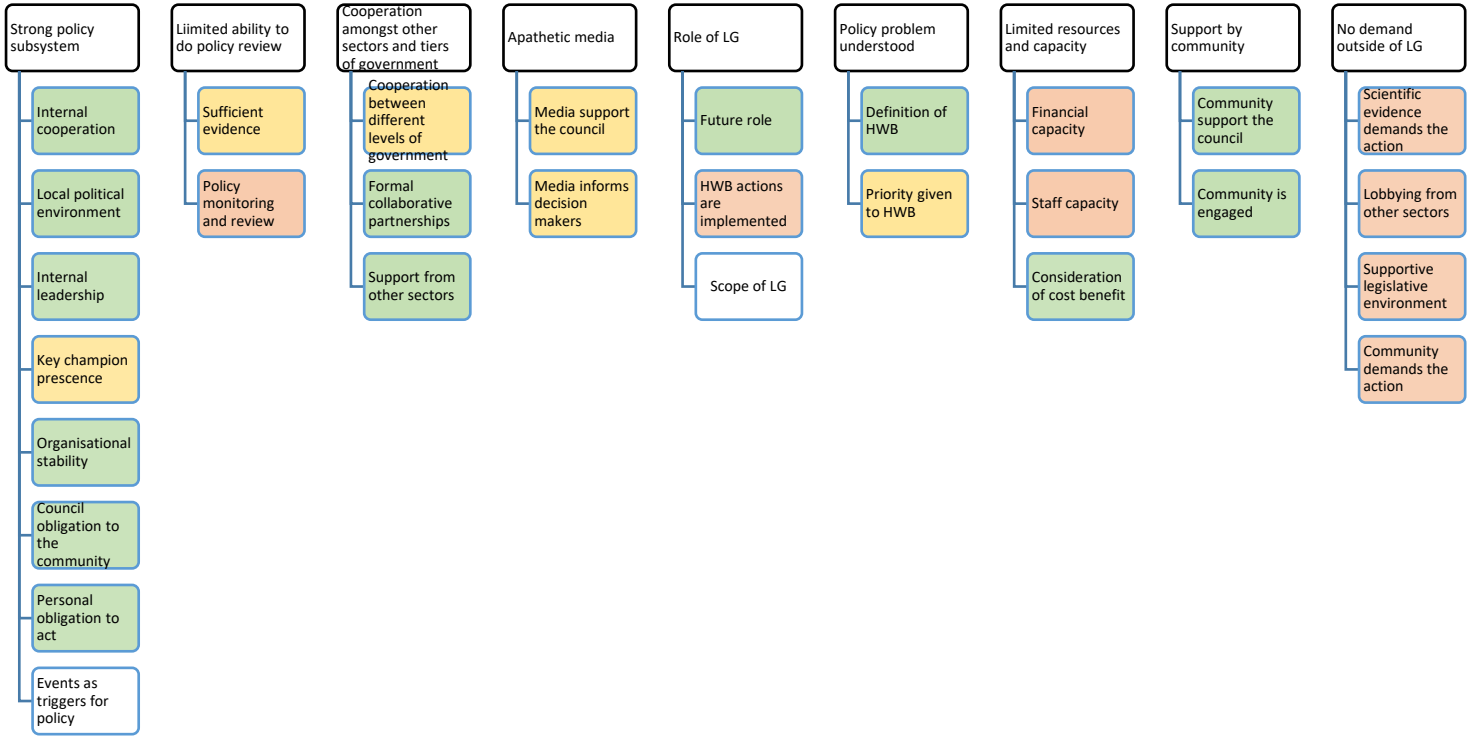



*Figure K 5: The fifth template used for analysis*

Template #6




Changes to Template 6:

- Collapsed 'HWB actions are implemented' and 'Current HWB investments'.
- Addition of code 'Scope of LG' under the theme 'Role of LG'.

*Figure K 6: Template adjusted after analysis of Case Study Site B*

# APPENDIX J: INFOGRAPHIC OF SURVEY RESULTS

Curtin University

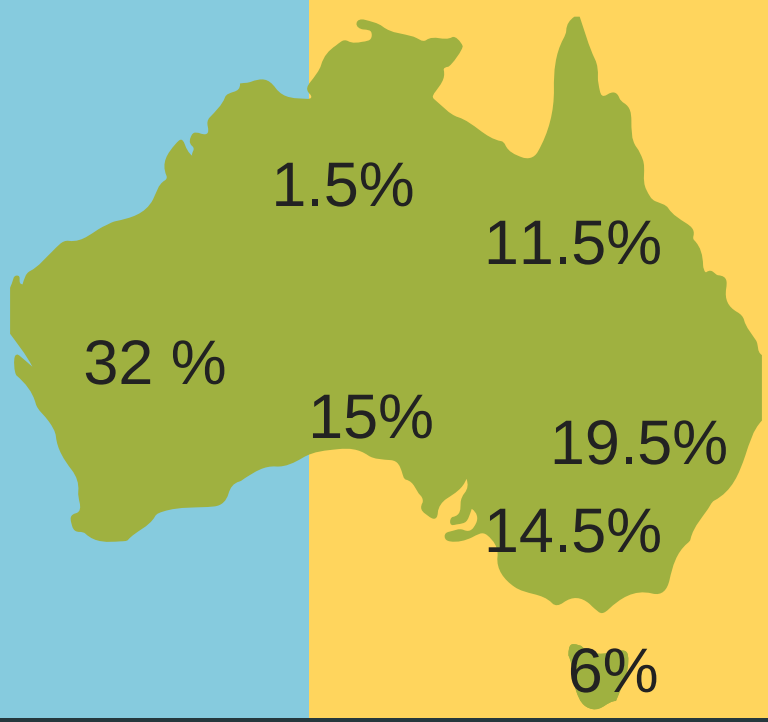
# HEALTH IN ALL COUNCILS

Curtin University Research Survey 2016

## Who responded?

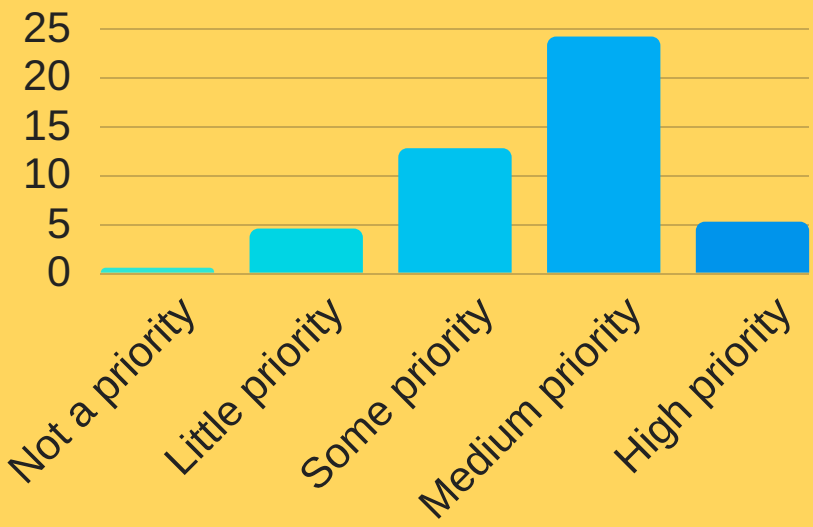
**1.9K**

246 CEO's
1114 Elected members
140 Strategic managers
160 Operational managers
198 Other Council staff




## What did you say?

### HEALTH AND WELLBEING AS A PRIORITY




**68%**

**felt it was definitely or mostly true that they felt personally obliged to do something in the field of health and wellbeing**

**66%**

**felt it was definitely or mostly true that addressing health and wellbeing was part of their professional duties**

Definitely or mostly true....

### INTEGRATING WELLBEING INTO POLICY

**56%** reported sufficient evidence to support health and wellbeing policy development

**54.5%** reported sufficient cooperation in Council during policy development

**48.5%** reported that the local political climate supports wellbeing of the community

**47%** reported goals for health and wellbeing as concrete enough

**OVERALL, RESPONDENTS REPORTED THAT HEALTH AND WELLBEING WAS CONSIDERED IN MOST POLICY AREAS, MOST OF THE TIME**

# HEALTH IN ALL COUNCILS

## Defining health and wellbeing

A majority of respondents defined health and wellbeing as:

***"Health is not only free from disease, though a complete state of physical, mental and social wellbeing, stemming from built and social environments, family, individual circumstances and socioeconomic position"***

**58%**

reported this as how *their Council* define health

**72%**

reported this as how *they personally* define health

Definitely or mostly true....

## CAPACITY TO ACTION HEALTH POLICY

**60%** reported that there is Council commitment
**60%** reported a cost benefit
**55%** reported sufficient internal cooperation
**55%** reported community support for action
**50%** reported that staff are provided with the required knowledge and skills

**22%**

reported that it was definitely or mostly true that there are sufficient financial resources to *develop or action* health and wellbeing policy

**33%**

reported that it was definitely or mostly true that the legislative environment is favourable for health and wellbeing action

**38%**

reported that it was definitely or mostly true that media supports the approach or action to wellbeing

**29%**

reported that it was definitely or mostly true that there is cooperation between different political levels involved

Curtin University Human Research Ethics Approval SPH-88-2014

# APPENDIX K: CONFERENCE ABSTRACTS

# Traditional Abstract Template – 250 words (not including Theme)

**Title:** Health Policy in QLD Local Government

**Theme**

This study 'connects the dots' between the rhetoric of 'building healthy public policy' with the feasibility of policy making processes. It proposes a shift from 'traditional' thinking to a more innovative way to understand healthy public policy decision making of local governments in Queensland. Why? The aim of the research findings is to further understand decision making in enabling local health policy.

**Sub-theme**
Build Healthy Public Policy

**What was the aim of your project or research?**

The study findings aimed to:

- Inform the current health policy investments amongst local government in Queensland
- Explore the feasibility of Queensland local governments adopting a 'Health in All Policies' approach by identifying factors that enable or challenge the current policy environment
- Utilise political science as a theoretical lens to inform this process

**Challenges of issue or topic of concerns**

Addressing determinants of health using a 'Health in All Policies' approach is recognised as good practice internationally in the field of health promotion. The practice of building healthy public policy in a complex policy environment is not well known or understood.

**What did you do?**
An online survey was distributed to elected and non-elected members of Local Governments in Queensland, with 219 responses, mostly Councillors and Mayors (56%).

**What were the outcomes?**
The survey data outlines different understandings of health and wellbeing amongst decision makers in Queensland local governments and differing organisational and personal priorities towards current health and wellbeing investments (*defining the problem*) and highlights current investments in health and wellbeing across policy areas (*solutions*). The data provides insight into the current involvement of the community, media, research, stakeholders, policy entrepreneurs and other senior levels of government in making health policy decisions (*politics*). Given that the problem, solution and politics 'streams' need to theoretically align for policy to occur, this preliminary data demonstrates how political science theory can benefit practitioners and researchers in understanding the policy environment.

**Why does it matter?**
Understanding the current context of policy decisions helps practitioners and researchers to clearly articulate the enablers and challenges to local governments integrating health into local policy.

**Title of Research Presentation** Health and wellbeing policy: perspectives from local government CEOs

**Maximum 2500 characters (including spaces but excluding title)**


**Background/Objectives**

Research suggests that local government is the most feasible level of government to contribute to healthy equity by addressing the determinants of health. However, little is known about how health and wellbeing policy is viewed within local government structures. This research explored the perspectives from CEOs of Australian local governments.

**Methods**

An on-line survey was emailed to elected members and staff of Australian local governments. Using the constructs of political science frameworks, the survey explored how health and wellbeing is prioritised as a policy problem, what current solutions are being actioned and the impacts of local and broader politics in the policy process. Quantitative data were analysed using descriptive statistics and non-parametric tests to identify any differences based on the size of local governments. Qualitative data were themed using NVivo.

**Results**

Of the 246 CEOs that responded, representing 46% of Australian local governments, health and wellbeing was defined by 80% from a socio-ecological perspective and as a medium to high priority, that they have a personal obligation to the community to do something (67%) and that the investment is cost effective (60%). Of respondents, 50% reported that community demand and scientific evidence influence policy decisions and that there is a supportive local political environment, local leadership and community support. Respondents reported it less true that there is lobbying action for health (33%) or leadership from other levels of government (27%). Urban planning and lifestyle programs received most priority in health policy and the determinants of health the least, with 17% of CEOs reporting that health and wellbeing is integrated across all policy agendas. CEOs of city Councils were statistically more likely to report that it is true that there is sufficient staff capacity ($H=21.572$, $p=0.000$) and financial resources ($H=25.248$, $p=0.000$) to plan and implement health policy than regional or rural Councils.

**Discussion**

Amongst all the priorities that CEOs of Australian local governments deal with, health and wellbeing is reported as a priority. The initiation and support of health policy is predominantly locally influenced, though with varied solutions to addressing health and wellbeing. There is an increased need for broader political support and internal resourcing to feasibly integrate determinants of health in local government health policy.



**Keywords**

Local government; health policy

# APPENDIX L: THEMED QUALITATIVE DATA FROM SURVEY

*Table L 1: Summary of additional identified themes in the open-ended question in questionnaire (Phase one) "Is there anything related to HWB policy in LG that you would like to have the opportunity to add?"*

| Theme | Summary | Example quote |
|---|---|---|
| Priority given to HWB (n=45) | Most respondents indicated that health and wellbeing was a priority, but not the highest priority, with the focus being instead on development and economic drivers. Health and wellbeing was also reported as a lower priority when resources are scarce. | "*Unfortunately, the CEO and some Councillors are focussed on rates per household*."<br>[WA, City, Elected member] |
| Definition of HWB (n=30) | There were a mix of responses defining the term 'health and wellbeing', from an individual behavioural perspective, medical oriented or holistic approach. All comments related to medical definitions were from respondents of rural areas, most of the holistic definitions were respondents of city areas. The individual approach was reported by respondents from all locations. | *"Whilst health and wellbeing is important responsibility ultimately falls to the individual."*<br>[TAS, Rural, Elected member] |
| Reinforcement of LG role (n=21) | Respondents commented on the close relationship that local government have with community and the ability to respond to their unique HWB needs, despite lack of resources and competing priorities. | "*In my experience local government is uniquely placed to impact the health and wellbeing of individuals and communities, because of the local knowledge and understanding and contacts that local government should have.*"<br>[NSW, City, Elected member] |
| Role of legislation (n=18) | Comments related to existing legislation in South Australia and Victoria, with comments stating the conflict with financial resources. Others reported the need for new or changes to legislation to focus on health and wellbeing as a priority. | "*Council routinely lobbies for more capacity to increase health and wellbeing requirements in development plans and legislation. More work in this area is needed*."<br>[SA, City, Strategic Manager] |
| Collaboration with other sectors (n=14) | Comments related to health and wellbeing being the responsibility beyond all tiers of government to other sectors and volunteers. This was perceived as the role of local government to facilitate relationships, with examples of where this is being done. However, also recognition that this can be very challenging. | "*In preparing a regional public health plan, the biggest issue has been around the development of partnerships between the various stakeholders within the region, and in implementing the various actions within the plan*."<br>[SA, Regional, CEO] |
| Evaluation and measurement (n=6) | There were comments related to the difficulty in measuring health and wellbeing or determining the effectiveness of local governments' role. | "*Need better measures of health and wellbeing as result of local government programs."*<br>[VIC, City, Elected member] |

# APPENDIX M: KEY FINDINGS THROUGH THE LENS OF POLITICAL SCIENCE

# KEY FINDINGS THROUGH THE LENS OF POLITICAL SCIENCE

| | MSF – Phase 1 | MSF – Phase 2 | MSF - overall |
|---|---|---|---|
| Policy problem<br><br>*Issues that need policy attention.*<br><br>*Attention by policy actors, clarity of the problem, framing, evidence profile, events, media: aligned to decision maker beliefs to gain attention.* | Respondents broadly **defined HWB**, recognising a wide range of policy areas that could influence health outcomes. This was consistent across states/territories and geographical remoteness location.<br><br>Very few respondents were able to recognise that 'all policies' impact on population health.<br><br>Some qualitative comments that understood HWB from a social justice perspective<br><br>HWB was identified as a **priority** for councils. Personally, many respondents believed it should be a higher priority. There were very few differences between states/territories (and none according to CEO's), although city and rural councils reported HWB a higher priority than regional council respondents.<br><br>Lack the **use of performance indicators**. VIC respondents more likely to report the use of performance indicators than most other states. City respondents more likely to use performance indicators than rural and regional counterparts.<br><br>Limited **lobby action** for HWB within council. VIC respondents more likely to have lobby action within council than QLD, NSW and WA. No difference for councils based on geographical remoteness. | Many determinants of health were raised across a range of policy areas. However, participants had difficulty **defining health and wellbeing** and exactly what health determinants meant. Sometimes reverting back to behavioural lifestyle programs.<br><br>Addressing community wellbeing was considered a high **council priority**, although it is **never explicitly raised** on the agenda or discussed. It was felt that HWB become the 'by-product' of other decisions make.<br><br>There were many sources of evidence used to inform policy, with acknowledgement of the reliance on anecdote, community complaints (or lack of) and use of other less **credible sources of evidence**. There was limited, if any, **scientific evidence** informing LG decision-makers.<br><br>Where policy documents referred to 'health' it was usually referring to 'healthcare'.<br><br>Other terms were used interchangeably with health determinants such as 'community cohesion' or 'liveability'.<br><br>'Health' was seen as a **responsibility** of higher tiers of government. | HWB as a policy problem in Australian LG is broad and holistic in its definition and a mix of individual, social, economic, cultural, built, and physical determinants of health. There is also a sense of 'lifestyle drift', whereby respondents understand health in a holistic way, though also easily revert to behavioural approaches. Hence it is quite ambiguous.<br><br>Respondents could report on a broad range of policies that impact on population health, yet few reported 'all policies' (unprompted).<br><br>It was agreed determinants of health was difficult to define and not a policy problem of its own. It was often referred to as a 'by-product' of other decisions.<br><br>HWB was seen as a high priority for councils, although not the highest priority, and never explicitly raised.<br><br>Framing of HWB in LG is important, whereby addressing determinants of health is often referred to as 'community cohesion' or 'liveability'.<br><br>The term 'health' usually referred to 'healthcare', including in conversations and policy documents. With this definition in mind, it was seen as the responsibility of higher tiers of government. |

| | | | |
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| | A majority (just over half) reported that **community demand** the action. | Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues.<br><br>There were reports of **limited advocacy efforts** or pressures from any policy actors to address health determinants, including community, media and other external sectors. | It is unlikely LG is influenced by evidence of the problem of health inequities getting worse, given it is not measured. There is limited, if any, scientific evidence used to inform the decisions, mostly based on anecdote or community complaints (or lack of).<br><br>It is unlikely that there is any strong public opinion pressuring LG to address determinants of health.<br><br>The ambiguity of the issue is likely challenging the policy process given that there are unclear responsibilities or unclear boundaries. |
| Policy<br><br>*Solutions to the problem.*<br><br>*Need to be feasible, acceptable, align to beliefs, gain political support.* | The **approach to HWB is clear**. Some variations in states/territories, though nothing consistent. City council respondents reported a clearer approach than both rural and regional council respondents.<br><br>Respondents reported that actions **centre on HWB of the community**. Some variations in states/territories, though nothing consistent. City council respondents were more likely to report that actions centre on the community, though only moreso than regional counterparts.<br><br>Respondents reported a **professional duty** to act for community HWB. VIC respondents reported a higher professional duty, moreso than WA and SA. City council respondents were more likely to report a professional duty than rural and regional counterparts.<br><br>Respondents reported an **organisational obligation** to act for community HWB. VIC reported a stronger organisational obligation to act, moreso than most other states and | There were many sources of evidence used to inform policy, with acknowledgement of the reliance on anecdote, community complaints (or lack of) and use of other less **credible sources of evidence**. There was limited, if any, **scientific evidence** informing LG decision-makers.<br><br>Recognition was provided on the reliance on **cooperation with higher tiers of government**, including for stability in LG boundaries, collaborative approaches to local issues and for sufficient funding. LG respondents report not always aligning to the **strategic direction** of higher tiers of government.<br><br>The **scope of LG** responsibility to respond to community wellbeing as mixed. There were reports of actions for HWB being in alignment with the local community context, either enabling action, advocating for action from others or mediating the collaboration between multiple policy actors. | Addressing determinants of health is often a solution considered in decision-making, but never framed as determinants of health and never responding to HWB as a problem.<br><br>The action is seen as cost-effective, mostly in the scope of LG and their professional duty, although usually the by-product of addressing other problems.<br><br>Action does rely on cooperation with higher tiers of government, although do not always agree on the policy directions.<br><br>Respondents report the approach to HWB is clear in council.<br><br>Urban planning and healthy lifestyle programs get highest priority for investment, now and into the future.<br><br>It was acknowledged that LG require the support of other sectors for action on HWB. |

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| | territories. City council respondents reported a stronger organisational obligation.<br><br>Approach is considered **cost-effective**. There are no variations between states/territories. City respondents were more likely to consider action cost-effective, moreso than regional and rural, with rural moreso than regional.<br><br>A majority reported that the **community support** the approach and action taken for HWB. There were no variances in responses by different states/territories. Respondents of city and rural councils reported higher community support than regional counterparts.<br><br>Urban planning was the highest priority for HWB, followed by individual lifestyle programs. Actions outside of traditional health sector were the least prioritised, now and in the future. | HWB was considered a '**by-product'** of addressing other priorities.<br><br>There were examples in policy documents and in the interviews of council taking action on determinants of health, although not responding to 'health' as the policy problem.<br><br>Working with **other sectors** was seen as a way to get things done. | |
| Politics<br><br>*Broader political environment.*<br><br>*Legislation, social norms and community opinions.* | Respondents reported **strong local leadership**. This was particularly the case for VIC, WA and SA where public health planning is mandated, though only moreso than QLD. City and rural councils reported a stronger local leadership than regional council respondents.<br><br>Respondents reported **council commitment** for HWB. VIC, WA and SA reported a stronger council commitment, though only moreso than QLD, and to some extent NSW. City council respondents reported a stronger commitment than both rural and regional council respondents.<br><br>The **legislative environment** was not perceived as supportive. VIC respondents reported a more favourable legislative environment, though only | **Internal leadership** was a seen as important to set the council priorities, along with a **range of champions** amongst elected members and management staff. Although no specific drivers or policy entrepreneurs could be determined. Leadership by Mayors and CEO's was particularly important.<br><br>Organisational obligation was aligned with **personal values and beliefs** of decision-makers.<br><br>Whilst both case study sites weren't experiencing **organisational stability**, both were clear that it was a necessary condition to allow for cooperation between staff and elected members and for planning and recalling longer term commitments. | LG mostly has informal governance structures for cross-collaboration efforts, largely driven by personal values and strong organisational obligations.<br><br>There is local leadership in LG, most facilitative where there is organisational stability. Leadership from higher tiers of government was seen as lacking.<br><br>Local policy decisions are always made in the best interests of the community.<br><br>Councils are challenged by external policy environments and influenced by broader national moods, including events and media. Councils are influenced by their community input, including level of complaints. |

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| | moreso than NSW and QLD. City council respondents reported a more favourable legislative environment than rural and regional counterparts.<br><br>A majority reported a lack of **leadership from higher tiers of government.** VIC, WA and SA reported a stronger level of leadership from higher tiers of government, though only moreso than QLD. There were no variances in responses based on geographical context.<br><br>Many felt there was a lack of external **cooperation with higher tiers of government** during policy development and implementation. There are some variances between states/territories, though nothing consistent. There are no differences in responses based on geographical context.<br><br>A majority (just over half) reported that **community demand** the action. | Participants felt that **legislation** from the state was not needed, as it was reported that councils already responded to determinants of health. Some felt that legislation could be beneficial to bring attention to addressing health determinants, though only if it came with sufficient resourcing.<br><br>Recognition was provided on the reliance on **cooperation with higher tiers of government**, including for stability in LG boundaries, collaborative approaches to local issues and for sufficient funding.<br><br>Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues.<br><br>**Some reliance on level of** community complaints to gauge community opinion. | There were mixed feelings if legislation was/is supportive of action. Many accepted it would be useful to increase the priority on HWB, though felt that it needed sufficient resourcing. |
| Policy entrepreneur<br><br>*An individual working to manipulate the three streams to align.* | Potentially a lack of a **key champion** for HWB. VIC respondents more likely to report a key champion than most other states. City respondents more likely to report a key champion for HWB than rural and regional counterparts. | **Internal leadership** was a seen as important to set the council priorities, along with a **range of champions** amongst elected members and management staff. Although no specific drivers or policy entrepreneurs could be determined. | There is no specific policy entrepreneur within LG manipulating the problem, policy and politics streams.<br><br>There are multiple champions that support decisions related to community HWB. |
| **ACF – Phase 1** | | **ACF – Phase 2** | **ACF - overall** |
| Policy subsystem | Respondents reported **council commitment** for HWB. VIC, WA and SA reported a stronger council commitment, though only moreso than QLD, and to some extent NSW. City council respondents reported a stronger commitment | Whilst both case study sites weren't experiencing **organisational stability**, both were clear that it was a necessary condition to allow for cooperation between staff and elected | Councils have a commitment to HWB and recognise that their scope includes community wellbeing, but definitely not healthcare. This |

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| *Subsystem in this research is the LG organisational system.* | than both rural and regional council respondents.<br><br>There was sufficient **internal cooperation** for the development and implementation of HWB policy, with most states reporting this higher than QLD. City and rural council respondents reported stronger internal cooperation during policy development, though only city respondents remained stronger for policy implementation. This is consistent with results for **staff agree on action to be taken**, with city respondents moreso agreeing than rural and regional counterparts.<br><br>Respondents reported an **organisational obligation** to act for community HWB. VIC reported a stronger organisational obligation to act, moreso than most other states and territories. City council respondents reported a stronger organisational obligation.<br><br>Respondents reported a **professional duty** to act for community HWB. VIC respondents reported a higher professional duty, moreso than WA and SA. City council respondents were more likely to report a professional duty than rural and regional counterparts. | members and for planning and recalling longer term commitments.<br><br>The **scope of LG** responsibility to respond to community wellbeing as mixed. There were reports of actions for HWB being in alignment with the local community context, either enabling action, advocating for action from others or mediating the collaboration between multiple policy actors.<br><br>Respondents expressed that the **responsibility of LG** was on community wellbeing, not necessarily related to 'health'. | includes collaborating with different policy actors that require solutions.<br><br>Staff and elected members most agree on actions to be taken, possibly a result of community elections and staff recruitment strategies that encourage a policy monopoly based on local community values.<br><br>Internal collaboration was more likely where LG administration was stable over a longer term. |
| Advocacy coalitions<br><br>*Policy actors that share values and beliefs and act together to put pressure* | A majority reported that the **community support** the approach and action taken for HWB. There were no variances in responses by different states/territories. Respondents of city and rural councils reported higher community support than regional counterparts.<br><br>Many reported a lack of **community involvement** in decision making and implementation of action. Respondents of city | Understanding the views of the **local community** was seen as centre to the role of LG in every decision that they make, each recognising some of the difficulties in gaining the voices of the diversity in the community and the need to build trust.<br><br>There was very **limited advocacy efforts** or pressures from any policy actors to address | There are no community advocacy groups, individuals, higher tiers of government, or media putting pressure on LG to address determinants of health.<br><br>Survey results suggest that community demand the action. Although the case study sites did not feel there was any demand coming from the community. |

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| *on the policy subsystem.* | and rural councils reported higher community involvement in decisions and implementation than regional counterparts.<br><br>A majority reported a lack of **leadership from higher tiers of government.** VIC, WA and SA reported a stronger level of leadership from higher tiers of government, though only moreso than QLD. There were no variances in responses based on geographical context.<br><br>Many felt there was a lack of external **cooperation with higher tiers of government** during policy development and implementation. There are some variances between states/territories, though nothing consistent. There are no differences in responses based on geographical context.<br><br>There was a lack of **cooperation with other sectors**. VIC respondents reported a higher level of cooperation with other sectors, morseso than QLD, NSW and SA. City council respondents were more likely to report cooperation with other sectors for policy implementation, though there was no difference for policy development.<br><br>Limited **lobby action** for HWB within council. VIC respondents more likely to have lobby action within council than QLD, NSW and WA. No difference for councils based on geographical remoteness.<br><br>A majority reported a lack of **media support** for councils' approach and action to HWB. There were no variances in responses for different state/territories, or for councils based on geographical remoteness. | health determinants, including community, media and other external sectors.<br><br>Participants reported on the important role of LG to facilitate partnerships, with one site drawing on current **support from other sectors** in a formal collaboration to address health determinants.<br><br>Local **media** were apathetic, neither supporting the action or creating controversy.<br><br>Who is invited on to collaborations can determine the outcome – with the reference group an example of inviting mostly '**health services' oriented stakeholders** to inform the policy. | Council can, and do, facilitate to bring stakeholders together to formulate solutions in addressing community wellbeing.<br><br>The results from the case study sites suggest that a lot of power in decision making around policy implementation is being handed back to the local community and community-based services, through processes of engagement and deliberative dialogue.<br><br>Cooperation with higher tiers of government was not always reported as true, consistent across city, regional and rural council contexts.<br><br>Formal partnerships are more likely to be formed around 'wicked' social issues, rather than for HWB. Where 'health' is the focus, it tends to be healthcare oriented.<br><br>There is limited lobby action within council. |

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| | A majority (just over half) reported that **community demand** the action. | | |
| Actor policy beliefs<br><br>*Similar or competing beliefs of policy actors.* | Respondents reported a **personal obligation** to act for community HWB. This was consistent across states/territories, although city respondents reported a higher personal obligation than rural and regional counterparts.<br><br>Respondents reported **strong local leadership**. This was particularly the case for VIC, WA and SA where public health planning is mandated, though only moreso than QLD. City and rural councils reported a stronger local leadership than regional council respondents.<br><br>This is consistent with results for **staff agree on action to be taken**, with city respondents moreso agreeing than rural and regional counterparts.<br><br>Some qualitative comments indicate a tension that health should be a **responsibility of higher tiers of government**, including in regional and rural areas that are delivering health services to respond to gaps in healthcare service provision. | **Obligation** to respond to the community. Organisational obligation was aligned with **personal values and beliefs** of decision-makers.<br><br>Creating 'happy' and 'liveable' communities was a driver for action.<br><br>Where there are a **lack of community complaints and media apathy**, no competing interests put pressure on LG decision-makers.<br><br>LG respondents report not always aligning to the **strategic direction** of higher tiers of government. | The 'deep-core' personal beliefs of decision makers in council, particularly Mayors and CEOs, are well aligned to ensuring the community needs are a priority, whether this be to deliver on 'liveability', 'vibrancy', 'safety' etc.<br><br>In case study site A, these core values were seen to be shared with the community, maintaining a strong policy monopoly.<br><br>The dominant healthcare solutions for community wellbeing remain a competing challenge for LG. This may be particularly the case for rural councils that report a need to 'fill the gap' in health services not currently provided by higher tiers of government. |
| Policy-oriented learning<br><br>*Learning from other policy actors or through new information.* | It was considered that there was **sufficient evidence** to support decision-making. VIC respondents reported more sufficient evidence, though only moreso than QLD. City council respondents were more likely to report sufficient evidence, though only moreso than regional counterparts.<br><br>A majority of respondents reported that **scientific results demand action**. VIC respondents were more likely to report this, moreso than WA, QLD and SA. City council | Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues.<br><br>There were many sources of evidence used to inform policy, with acknowledgement of the reliance on anecdote, community complaints (or lack of) and use of other less **credible sources of evidence**. There was limited, if any, **scientific evidence** informing LG decision-makers. | The use of scientific evidence was reported as mixed. The survey results report that scientific evidence demands action on HWB policy and that it is used to support council decisions. The case study sites suggested that this was not the case, although may be used to generate policy proposals by operational staff.<br><br>Views from the community, or frontline community workers, or broader national debates in the media, anecdote or community |

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| | respondents reported this moreso than rural and regional counterparts, and regional moreso than rural.<br><br>Less than half of the respondents reported that **formal partnerships** were established. | Participants reported the **critical role of community services and organisations** to provide feedback to LG on community needs.<br><br>Participants reported on the important role of LG to facilitate partnerships, with one site drawing on current **support from other sectors** in a formal collaboration to address health determinants.<br><br>Many participants reported that there are **healthy debates**, but mostly that staff agree on decisions made. One felt that a **checklist** for impacts on health might be useful. | complaints were the most likely forms of policy-oriented learning for LG decision-makers. |
| | **PEF – phase 1** | **PEF – Phase 2** | **PEF - overall** |
| Policy feedback loops<br><br>*Negative feedback e.g. public apathy, organisational stability.*<br><br>*Positive feedback e.g. public or media pressure.* | A majority of respondents reported that **scientific results demand action**. VIC respondents were more likely to report this, moreso than WA, QLD and SA. City council respondents reported this moreso than rural and regional counterparts, and regional moreso than rural.<br><br>It was reported that there is **ongoing monitoring and review of policies**. Some variations in states/territories, though nothing consistent. City more than regional. Policy **reviews consider HWB impacts**. Some variations in states/territories, though nothing consistent. City respondents reported that policy reviews consider HWB impact than regional and rural counterparts.<br><br>Lack the **use of performance indicators**. VIC respondents more likely to report the use of performance indicators than most other states. City respondents more likely to use | There were many sources of evidence used to inform policy, with acknowledgement of the reliance on anecdote, community complaints (or lack of) and use of other less **credible sources of evidence**. There was limited, if any, **scientific evidence** informing LG decision-makers.<br><br>Shared values, amongst elected members, staff and community likely creates a **policy monopoly** in site A.<br><br>Difficulty in **measuring health**, due to its complexity of being influenced by a range of determinants, but also difficult to establish the influence that LG has. Investing in measuring health was not considered 'cost-effective'. Without measures for population health, there is no feedback on whether it is a priority. | Policy reviews are undertaken and HWB impacts are considered.<br><br>One of the most common policy feedback loops is reported as the level of complaints from the community. A lack of complaints was interpreted as acceptance by the community of action, creating a negative feedback loop.<br><br>There are no performance indicators or measures available for policy review feedback. It is unsure what the measures for HWB would be and determined as not cost-effective for LG to collect their own data, particularly where it is not an existing issue.<br><br>There are mixed findings if scientific results demand the action or not.<br><br>LG are not immune to external shocks e.g., state/territory changes to geographical amalgamations or LG elections. Where smaller, |

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| | performance indicators than rural and regional counterparts.<br><br>Limited **lobby action** for HWB within council. VIC respondents more likely to have lobby action within council than QLD, NSW and WA. No difference for councils based on geographical remoteness. | Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues.<br><br>No strong **lobbying action** from external stakeholders, community or media.<br><br>LG **amalgamations** were opportunities for new policy, though also disruption to existing policy.<br><br>Whilst both case study sites weren't experiencing **organisational stability**, both were clear that it was a necessary condition to allow for cooperation between staff and elected members and for planning and recalling longer term commitments. | engaged communities exist, the policy monopoly likely withstands some of these shocks.<br><br>National media have influence on certain issues reaching LG policy agendas, particularly where these align to politicians' personal values.<br><br>There is no lobbying pressure internally or externally on LG decision makers to address HWB or health determinants. |
| Policy images<br><br>*Information used to depict the policy problem, emotional appeal.* | Approach is considered **cost-effective**. There are no variations between states/territories. City respondents were more likely to consider action cost-effective, moreso than regional and rural, with rural moreso than regional. | Respondents expressed that the **responsibility of LG** was on community wellbeing, not necessarily related to 'health'.<br><br>The term 'health' created defensiveness as the policy image immediately gravitates to healthcare for some.<br><br>The sense that 'health' was the responsibility of higher tiers of government – seen to be cost-shifting.<br><br>Certain **events**, either local or from **media sources**, were thought to influence decisions made by LG on addressing broader social issues. | There is no clear policy image of health as addressing fundamental health determinants across a range of policies.<br><br>There is little evidence of positive feedback loops as a result of public concern, media coverage or new perceptions and framing of the issue of addressing determinants of health.<br><br>The use of the term 'health' in LG is not well accepted. |
| Policy load<br><br>*Number of policy problems raised at one time.* | Amongst all other issues, HWB was identified as a medium to high **priority** for councils. Personally, many respondents believed it should be a higher priority. There were very few differences between states/territories (and none according to CEO's), although city and | Health of the community is considered at the centre of every decision made.<br><br>A growing region experiences a lot of **competing priorities**.<br><br>Regulatory priorities (e.g. water quality) is perceived to have a higher priority. | Amongst all their responsibilities, HWB is a high priority for many councils, though not the highest priority.<br><br>There are some concerns of priorities from higher tiers of government being 'shifted' to LG without the sufficient resourcing. |

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| | rural councils reported HWB a higher priority than regional council respondents. | There was a perceived **cost-shifting** from higher tiers of government to pass on responsibilities related to health.<br><br>Addressing community wellbeing was considered a high **council priority**, although it is **never explicitly raised** on the agenda or discussed. It was felt that HWB become the 'by-product' of other decisions make. | Councils experiencing large population growth report more competing priorities. |
| **ADEPT – Phase 1** | | **ADEPT – Phase 2** | **ADEPT - overall** |
| Obligations<br><br>*Personal and professional obligations to act.* | Respondents reported an **organisational obligation** to act for community HWB. VIC reported a stronger organisational obligation to act, moreso than most other states and territories. City council respondents reported a stronger organisational obligation.<br><br>Respondents reported a **professional duty** to act for community HWB. VIC respondents reported a higher professional duty, moreso than WA and SA. City council respondents were more likely to report a professional duty than rural and regional counterparts.<br><br>Respondents reported a **personal obligation** to act for community HWB. This was consistent across states/territories, although city respondents reported a higher personal obligation than rural and regional counterparts. | There was a unanimous perception that the council has an **organisational obligation** to the community.<br><br>Understanding the views of the **local community** was seen as centre to the role of LG in every decision that they make, each recognising some of the difficulties in gaining the voices of the diversity in the community and the need to build trust. | Organisational, personal and professional obligations are strong enablers to address determinants of health of the local community.<br><br>Personal obligation was strong, regardless of legislative environment. |
| Goals<br><br>*Goals for HWB exist and are clear.* | Respondents reported that **HWB goals are concrete** enough. Some variations in states/territories, though nothing consistent. City council respondents were more likely to report concrete goals for HWB, though only moreso than regional counterparts. | There were few **performance indicators** in policy documents.<br><br>The reference group considered having **performance indicators**, though these were removed in the final draft. | Goals are visionary, though not concrete or measurable.<br><br>There are no performance indicators or monitoring of strategy success on HWB outcomes. Sometimes this is intentionally not |

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| | Lack the **use of performance indicators**. VIC respondents more likely to report the use of performance indicators than most other states. City respondents more likely to use performance indicators than rural and regional counterparts. | **Measuring population health** outcomes was challenging, and even if possible to measure, not considered cost-effective to do at a local level. | measured due to lack of resources, but also because it is difficult to measure. |
| Opportunities<br><br>*Political (e.g. administration stability and cooperation), Public (e.g. community and media support) & organisational opportunity (e.g. organisational cooperation, structural changes).* | There was a lack of **cooperation with other sectors**. VIC respondents reported a higher level of cooperation with other sectors, morseso than QLD, NSW and SA. City council respondents were more likely to report cooperation with other sectors for policy implementation, though there was no difference for policy development.<br><br>A majority reported that the **community support** the approach and action taken for HWB. There were no variances in responses by different states/territories. Respondents of city and rural councils reported higher community support than regional counterparts.<br><br>A majority reported a lack of **media support** for councils' approach and action to HWB. There were no variances in responses for different state/territories, or for councils based on geographical remoteness.<br><br>There was sufficient **internal cooperation** for the development and implementation of HWB policy, with most states reporting this higher than QLD. City and rural council respondents reported stronger internal cooperation during policy development, though only city respondents remained stronger for policy implementation.<br><br>Many felt there was a lack of external **cooperation with higher tiers of government** | Whilst both case study sites weren't experiencing **organisational stability**, both were clear that it was a necessary condition to allow for cooperation between staff and elected members and for planning and recalling longer term commitments.<br><br>Working with **other sectors** was seen as a way to get things done, with resources being so tight.<br><br>Participants reported on the important role of LG to facilitate partnerships, with one site drawing on current **support from other sectors** in a formal collaboration to address health determinants<br><br>Mixed experiences of working **across sectors internally**.<br><br>Understanding the views of the **local community** was seen as centre to the role of LG in every decision that they make, each recognising some of the difficulties in gaining the voices of the diversity in the community and the need to build trust.<br><br>The extent to which the **community is involved** in decision making was different across case study sites – with site A feeling they already reflect the values of the community and site B | Politically, there was a lack of cooperation reported with higher tiers of government, although this may depend on reliance of higher tiers of government for resources.<br><br>Working collaboratively with other sectors was reported as part of the LG role to facilitate, albeit challenging to achieve.<br><br>New leadership roles presented organisational opportunities for change, though also instability.<br><br>Understanding the views of community and gaining community support was seen as part of the LG role, although sometimes difficult to gain the views of all populations. |

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| | during policy development and implementation. There are some variances between states/territories, though nothing consistent. There are no differences in responses based on geographical context. | establishing more formal collaborative processes.<br><br>Leadership by Mayors and CEO's was particularly important, with **changes in leadership** creating some opportunity for change, though also instability. | |
| Resources<br><br>*Staff capacity and skills, financial resources or cost effectiveness.* | Approach is considered **cost-effective**. There are no variations between states/territories. City respondents were more likely to consider action cost-effective, moreso than regional and rural, with rural moreso than regional.<br><br>**Staff resources** were reported as limited. VIC and WA respondents reported more staff resources, though only morseo than QLD. City councils reported more staff resources than both rural and regional counterparts.<br><br>Less than half of the respondents reported that staff are provided with the **necessary skills and knowledge** to implement HWB in policy.<br><br>**Financial resources** were reported as limited. VIC, WA and TAS were more likely to report more financial resources for policy development, though only morseo than QLD. There were no differences between states/territories regarding financial resources for policy implementation. City councils reported more financial resources than both rural and regional counterparts. | The perceived **cost-shifting** from higher tiers of government and **reliance on funding grants**, and **reluctance to increase property rates** results in **limited financial and staff capacity** for meeting all demands that council would like to do.<br><br>Recognition was provided on the reliance on **cooperation with higher tiers of government**, including for stability in LG boundaries, collaborative approaches to local issues and for sufficient funding.<br><br>Participants reported on the important role of LG to facilitate partnerships, with one site drawing on current **support from other sectors** in a formal collaboration to address health determinants. | Financial and staff resources are limited and in competition with a range of other traditional or mandated roles of LG.<br><br>Revenue raising is limited, and external funding is often short term and/or unpredictable.<br><br>Decision-makers refer to weighing up the 'cost-effectiveness' of any actions taken.<br><br>Staff capacity was also challenged with trying to meet all the demands of the community, and staff not necessarily having the required skills and knowledge.<br><br>Larger, regional councils are more reliant on higher tiers of government for funding.<br><br>City councils are more likely to have financial resources. This remained the case within legislative political environments such as Victoria.<br><br>There were concerns of cost-shifting by higher tiers of government. |

# APPENDIX N: CASE STUDY REPORTS

Case study summary reports have been redacted to maintain confidentiality of the sites.

# APPENDIX O: DETAILS OF MEETING MINUTES

Document analysis of case study site meeting minutes

In Finchville, relevant documentation is noted below:

Recognition was given in council meeting minutes for the collaborative efforts of partnerships in achieving positive social outcomes for the community (Meeting minutes #2).

Issues raised on the agenda regarding the need to further clarify the responsibility of LG regarding poker machine regulations (Meeting minutes #3). There is no elaboration on why the issue was raised by an internal committee. Actions were documented proposing that the case study site provide state/territory leadership on the role and powers of LG over gambling restrictions, acknowledging that decisions would be able to consider the social impacts of gambling, as well as other land use permits (Meeting minutes #5).

The draft HWB plan was proposed to the council for approval. Approval for the draft was given by the council, with minor changes able to be made by the CEO prior to the circulation of the document for community consultation (Meeting minutes #8). The plan was approved by the council 18 months later, following some amendments suggested by executive management to include the impact of climate change on health (Meeting minutes #9).

In Roseford, there was one reference to the term ‘health’, related to a healthcare matter. There were no terms used for community wellbeing, liveability, or determinants of health (e.g., housing, transport). For the duration of the case study, any relevant documentation is noted below:

Request from a public participant for increased traineeships for youth at risk (meeting minutes #2);

Proposal, originated from Mayor and local elected member of a proposal to install red seats in public areas to acknowledge survivors of domestic violence, was re-proposed to establish a report on ways in which LG could address domestic violence, with input to be actively sought from the community (meeting minutes #3).