

Collaborative population health planning between Australian primary health care organisations and local government: lost opportunity

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'Population health' refers to actions that improve the health of an entire population and the equitable distribution of health access and outcomes.¹ Comprehensive population health planning is grounded in a social model of health that emphasises a continuum of action from treatment to disease prevention, as well as health promotion and action on social determinants of health.² Given the complexity and breadth of social factors affecting health,³ the involvement of sectors outside health is essential for effective planning for population health. Rigorous population health planning is central to the implementation of comprehensive primary health care (PHC) that emphasises treatment, rehabilitation, prevention, promotion (including action on the social determinants), equity and localised collaborative decision making.⁴ Collaborative planning is based on shared goals, clear roles, mutual trust, effective communication, and identification of links between inputs and processes with population health impacts and outcomes.⁵ Collectively, integrated population health planning makes it possible to share resources to identify priority health needs, improve infrastructure, avoid duplication and assist in addressing complex health and social problems.^{5,6}

In Australia, federally funded PHC organisations have been established to conduct population health planning within defined geographical regions. These structures are called regional primary health care organisations (the term 'primary health care organisation' used in this study refers

Abstract

Objective: To examine the strength and extent of collaborations between primary health care organisations and local government in population health planning.

Methods: Methods included: a) online surveys with Medicare Locals (n=210) and Primary Health Networks (n=66), comparing the two using two-level mixed models; b) interviews with Medicare Local (n=50) and Primary Health Network (n=55) executives; c) interviews with members of local government associations and Primary Health Network board members with local government experience (n=7); and d) review of 54 Medicare Local and 31 Primary Health Network publicly available annual reports.

Results: Despite partnership being a policy objective for Medicare Locals/ Primary Health Networks, they reported limited time and financial support for collaboration with local government. Organisational capacity and resources, supportive governance and public health legislation mandating a role for local governments were critical to collaborative planning.

Conclusions: Local government has the potential to tackle social factors affecting health; therefore, their inclusion in population health planning is valuable. Legislative mandates would help to achieve this, and PHNs require a stronger Federal Government mandate backed by sufficient resources and a governance structure that supports collaboration.

Implications for public health: Improving primary health care and local government collaboration has great potential to improve the quality of health planning and action on social determinants, thus advancing population health and health equity.

Key words: regional PHC organisation, local government, collaborative planning, population health

to the specific structure in charge of a geographical region in both metropolitan or rural areas). The current Primary Health Networks (PHNs) and previous Medicare Locals (MLs) have been mandated to undertake needs assessment and population health planning.⁷ The MLs' guideline stated: "It is essential that Medicare Locals' priorities are determined through transparent processes that appropriately engage stakeholders"⁸ PHNs' policy documents and guidelines focus

on collaboration with state departments of health, for example Local Health Networks (LHNs), and public and private health services in planning and commissioning cycles with little reference to sectors outside health.⁹ Using 'local government data', as part of needs assessment is the sole reference to local governments in PHNs' planning guidelines.¹⁰ This includes data sourced by local governments themselves or collated from state or commonwealth agencies.

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Local governments (LGs) are widely recognised as playing an important role in leading local planning and developing initiatives that can influence health outcomes and equity.¹¹ Furthermore, LGs are well-positioned to engage with local communities and partner with other levels of government in considering local options for education, transport, urban planning and housing to address selected social determinants of health.¹² In some countries, such as the UK and Netherlands, LG has been given more responsibility for public health and the ability to act on some local social determinants.^{13,14} The involvement of LGs in public health planning may lead to an increased emphasis on disease prevention, health promotion and efforts to reduce health inequities.¹⁵ LGs can, however, take positions that reflect their local political priorities, and their community and socioeconomic composition, which can make it more difficult for them to collaborate with other organisations.¹⁴

In Australia, there is growing evidence and increased legislative innovation supporting the role of LGs in public health.¹⁶ Although the implementation of healthy environment and health protection interventions (including sanitation and communicable diseases) have traditionally been allocated to LG through Public Health Acts in the late 19th century,¹⁷ some states have since made major updates and/or adopted new legislation that strengthens the role of LGs as a major partner in public health planning (Table 1).

Public Health Acts have the potential to encompass a range of public health concerns. These include traditional interventions such as sanitary issues, and responses to emergencies and communicable diseases, through to broader public health interventions such as health promotion and healthy communities, although not all LGs cover this breadth. The Victorian and South Australian Public Health Acts have a broader remit than traditional roles on sanitation and

communicable diseases, as LGs are appointed as public health authorities with a role that covers ‘the spectrum of health preservation, protection and promotion’.²³ Similarly, the Western Australian Public Health Act identified a health promotion approach as being essential to ‘enable local governments to effectively improve health and address the determinants of health’.²⁴

This paper examines the strength and extent of collaboration between regional PHC organisations (MLs and PHNs) and LGs in planning for population health, and policy and organisational factors that enable or inhibit collaborative planning in Australia. Lessons or gaps identified from our analysis can suggest avenues to enhance future collaborative population health planning between PHNs and LGs and consequently improve population health and equity.

Methods

As part of a four-year project funded by the National Health and Medical Research Council, we examined the strength and extent of collaboration between PHC organisations and LGs in population health planning. The study included both quantitative and qualitative methods:

- Online survey of 61 MLs and 31 PHNs – quantitative data were collected through an online survey with MLs in 2014 and PHNs in 2016.
- Telephone interviews – qualitative data were collected from senior members, executives and board members of MLs (n=50) and PHNs (n=55). Telephone interviews were also conducted with former or current members of LGs on PHN boards (n=3) and members of state Local Government Associations (LGAs) across Australia (n=4).
- Document review – publicly available annual reports from 54 MLs (2012-2013 or

2013-2014) and 31 PHNs (2015-2016) were reviewed for examples of collaboration with LG (study methods are summarised in Figure 1).

Online survey

An online survey of ML executives and board members was conducted between September and November 2014. The ML survey was developed and refined in a series of research team discussions and included a 4- or 5-point Likert scale for the quantitative questions. The survey also included open-ended questions and comment boxes that provided participants a chance to further expand on issues such as engagement strategies, and the effort invested in and capacity to implement population health activities. After MLs were replaced with PHNs, a second survey of PHN executives, board members, clinical councils and community advisory councils was conducted (July to October 2016). The ML survey instrument was adapted for PHNs and included comparable items on effectiveness of collaborations and efforts and capacity on collaborative planning. We used the Dillman²⁵ method to maximise the response rates by sending an advance notification letter to the CEOs providing project information followed by an email containing the survey link and three follow-up emails in three-week intervals. We received 210 survey responses from 52 MLs (85% of MLs), and 66 responses from 17 PHNs (55% of PHNs). To account for data being nested by ML or PHN, quantitative responses from PHNs and MLs were compared using a two-level mixed model in IBM SPSS. Qualitative data from open-ended survey questions were transferred to QSR NVivo software and coded using thematic analysis.²⁶ Codes were developed to categorise participant responses for each question and identify emerging themes. Themes were discussed and debated in research team meetings.

Table 1: Public health legislation and local government in Australia.

State/ territory	Legislation	Requirement
NSW	Public Health Act 2010 ¹⁷	LGs are not mandated to do public health planning; the Act has a focus on the control of infectious diseases and sanitation.
VIC	Victorian Public Health and Wellbeing Act 2008 ¹⁸	LGs are mandated to develop and implement public health plans every four years. The Act recognises that LGs are responsible for protecting public health and requires them to work in partnership with internal and external stakeholders to accomplish strategies to maximise community health and wellbeing.
QLD	Public Health Act 2005 ¹⁹	LGs are not mandated to do public health planning and do not have a designated statutory role. They do have statutory responsibilities in regards to health protection and risks such as mosquitos, vermin, water quality and waste.
WA	Public Health Act 2016 ²⁰	LGs are mandated to produce a local public health plan over five planning stages ²⁰ (currently at early stages). Establishing partnership with internal and external stakeholders is identified as one of the key stages in planning process.
SA	Public Health Act 2011 ²¹	LGs are mandated to develop public health plans and act to improve health and wellbeing. ²¹ According to the Act ‘The protection and promotion of public health requires collaboration and, in many cases, joint action across various sectors and levels of government and the community.’
ACT, NT, TAS	No amendments to the Public Health Act	LGs are not mandated to do public health planning; the Act has a focus on the control of infectious diseases and sanitation.

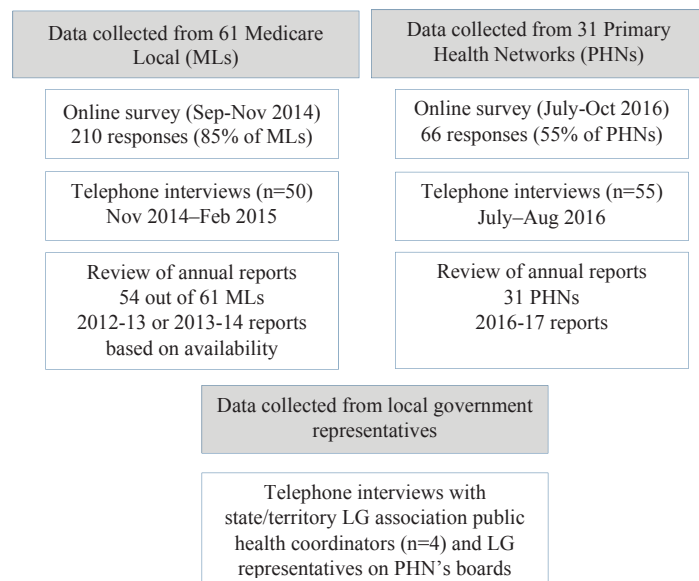
Telephone interviews

Different approaches were employed to recruit interview participants in MLs and PHNs. In the ML survey, participants were offered the option of including their details for a follow-up interview. A total of 106 people took this option. The final selection of interview participants was based on their seniority and involvement in population health planning, and on the inclusion of both urban and rural MLs. Fifty-one people were invited, with one person declining due to a role change. Fifty semi-structured interviews were conducted between November 2014 and February 2015. PHN participants were purposively selected from six PHNs. These six PHNs were selected based on their geographical region (metro vs. rural), and their jurisdiction, as well as their willingness to participate. Of a total of 82 people invited from the six PHNs, 55 people (67%) agreed to participate in an interview session. Interviews were conducted in July and August 2016. The purpose of using geographical location as one of the criteria to stratify interview participants was to ensure data would cover issues specific to rural as well as metropolitan and whole-of-state organisations.

Supplementary data were collected from members of the state LG associations, plus PHN board members who had former or current involvement in LGs. The biographies of PHN board members were publicly available from their websites and five PHNs (three in Victoria [VIC], one in New South Wales [NSW] and one in Tasmania [TAS]) were found to have members with LG experience on their board. Invitations were sent to CEOs to be forwarded to potential participants and three PHN board members (60%) agreed to be interviewed. We also invited public health coordinators from the seven LG associations across Australia and four members agreed to participate. Interviews were conducted during June and July 2017. These interviews explored viewpoints on existing opportunities and challenges for LG involvement in collaborative population health planning.

Interviews were audio-recorded, transcribed and de-identified for further analysis. Qualitative thematic analysis was undertaken using NVivo software. A coding framework was developed that was initially based on themes emerging from literature on PHC planning and population health,^{12,22,27,28} and then expanded with key emerging concepts. These concepts included the strength and

Figure 1: Summary of the research methods.



nature of collaboration between LGs and PHC stakeholders in planning processes; governance structure and factors that enable or constrain collaborative planning; and examples of where MLs/PHNs successfully collaborated with LGs. The evolving coding framework was discussed and revised during research team meetings. Eight ML and four PHN interviews were double-coded by members of the team to ensure consistency of coding, and any differences found resolved by discussion. Data that were collected on engagement with LGs were discussed in analysis meetings with the internal team as well as with members of the project's critical reference group comprising practitioners and government and non-government organisations' representatives.

Review of ML/PHN annual reports

To supplement the survey and interview data, we reviewed annual reports released by MLs/PHNs on their websites. This included 54 out of 61 ML (2012-2013 or 2013-2014, depending on availability) and 31 PHN (2015-2016) reports. We conducted a word search using 'local government' and 'local councils' to find examples where collaboration with LGs was reported. These examples included the involvement of LG representatives on ML/PHN boards, data sharing for needs assessment, joint planning through formal structures, and/or examples of specific programs that were jointly implemented or financed.

Results

Findings are presented below on the strength and extent of collaboration between MLs/PHNs and LGs, jurisdictional differences and factors that influenced collaborative approaches to planning.

Level of engagement

Among ML survey respondents, 41% and 42% reported 'somewhat' or 'very' effective engagement with LGs, respectively. A further 12.4% were neutral, while almost 4.5% reported 'somewhat' or 'very' ineffective engagement, and only 0.5% reported 'no engagement' with LGs. PHN survey respondents reported less engagement with LGs, with 40% stating a 'somewhat' effective engagement, and 19% reporting 'very' effective engagement. A total of 28.5% were neutral, 7.8% reported 'somewhat' or 'very' ineffective engagement, and almost 5% of PHN respondents stated 'no engagement' with LGs.

The average level of engagement with LG was significantly higher for MLs than for PHNs, $F(1,38.0)=19.4, p<0.001$. There was no significant difference between states on engagement with LG, for PHNs ($F(1,12.7)=0.1, p=0.75$), or MLs ($F(1,24.5)=0.13, p=0.72$).

Strength and extent of collaboration

Twenty-one out of 54 (38%) of ML and six out of 31 (19%) of PHN (19%) annual reports (three in NSW, one in VIC, one in Queensland [QLD], one in South Australia [SA]) mentioned

evidence of partnerships with LGs. Examples drawn from interviews and documents ranged from solely collecting population and health data from LGs as part of the needs assessment process, to consultation with LGs on priority health needs, and to more structural collaboration such as joint planning through the establishment of leadership groups and alliances involving LGs. The extent and nature of collaboration in different jurisdictions is shown in Table 2.

Factors enabling or hindering collaboration

Interview respondents from both MLs/PHNs and LG sectors identified a number of factors enabling or hindering collaborative planning that may explain jurisdictional variations. Three areas were apparent in the themes arising from the data that were also supported from the literature^{29,30}: factors from the policy environment; factors concerning governance and leadership; and factors related to organisational capacity and resources. Findings are organised by the broad domains in the following sections.

Policy environment

Our study reinforced the importance of how the broader policy context shapes the functioning of and collaborative action on population health planning between PHC organisation and LG. PHC organisations reported a focus on curative services in their agreement with the Federal Government. This limited the scope for population health approaches and collaboration with non-health sectors, including LG. One PHN staff member from the Northern Territory (NT) noted: "PHNs are driven by a fairly narrow Commonwealth agenda away from population health".

An LG interviewee suggested that the capacity for population health action is less for the PHN than it was for the MLs: "I think some of the language had changed around Primary Health Networks [compared to MLs] from population planning to much more around service gaps". A focus on "broader remit around population health planning rather than service gap or commissioning" was stated as "the opportunity to go back to having more collaboration with councils" by another LG interviewee.

We found jurisdictional differences in PHC–LG collaboration in population health planning. This was partially explained by public health legislation. Some jurisdictions (VIC, SA and Western Australia [WA]) have adopted legislation that requires LGs to play a stronger role in population health planning (Table 1). Participants from both ML/PHN and LG sectors in these states cited the positive impact of legislation as a driving force facilitating collaborative planning. An executive from a South Australian ML stated:

Local government was having to undertake public health planning as part of the shifts in the South Australian Health Care Act [sic] so we've been working very much in partnership with our local governments.

Likewise, in Victoria the *Public Health and Wellbeing Act 2008*¹⁹ provided the opportunity for exchanging ideas and joint planning:

I think it's been vital. The health and wellbeing plans that councils prepare, they [PHNs] feed into their community plans as well. (LG interview)

In interviews with LG members in NSW, where there is no mandate for LGs to develop population health plans, concerns were raised

Table 2: Examples of collaborative population health planning between regional PHC organisations and local governments per state/territory.				
State/territory	Sharing population data	Consultation/meetings	Formal structure/joint planning/governance	Planning for health promotion and social determinants of health
NSW	Collecting population and health data from LGs as part of needs assessment (MLs & PHNs)	Meetings with LGs seeking their opinion on health needs (3 MLs) Members of 2 PHNs being in LGs' wellbeing groups	LG representation in Board (one PHN)	No evidence
VIC	Drawing on LGs' public health plan and using their population and health data (MLs & PHNs) Combining resources with LG to collect population data (one ML)	Regular meetings at executive levels (MLs & PHNs) LG involvement in population health forum, population health think tank (3 PHNs)	LG executives' involvement in 'steering group' to identify the health priorities (2 MLs) Collaborative agreements (MOU) with PHC stakeholders including LGs (roles: setting of shared priorities, sharing and utilising population and health data, development of joint strategies to address local needs, area-based planning) (PHNs) LG representation on Board (3 PHNs)	Collaboration with LGs to develop a focus on the social determinants of health (no evidence of action) (one PHN)
QLD	No evidence	Broad mention of collaboration with LG in needs assessment (most MLs & PHNs)	No evidence	No evidence
SA	Sharing population data with LGs as part of the needs assessment (MLs & PHNs)	Meetings with LG as part of needs assessment and identifying service gaps (MLs & PHNs) Participation in LG public health planning forums (MLs) Helping LGs in their public health planning (PHNs)	Strategic leadership group involving LGs in priority setting and decision making (MLs) LG representation on Board (one PHN)	No evidence
WA	No evidence	Consultation with LGs around regional health needs (MLs & PHNs)	No evidence	No evidence
NT	No evidence	Consultation with LGs around regional health needs (MLs & PHNs)	No evidence	No evidence
ACT	No evidence	No evidence	No evidence	No evidence
TAS	Collecting population and health data with LGs (MLs & PHNs)	Providing training, education and forums to LGs assisting their role in public health (MLs)	LGs' involvement in community health planning team to oversee population data collection, make informed decision making and priority setting (ML) Representation of LG on board (PHN)	No evidence

that: “adding extra legislation increases the regulatory or administrative burden onto councils”, [population health planning is a] “tick the box process” and “you end up with more bureaucracy and the money goes to bureaucracy rather than the actual thing you’re trying to deal with”. (LG interviews)

Organisational governance and leadership structure

Organisational governance and leadership support for collaborative approaches in some MLs/PHNs enabled them to collaborate with LGs despite policy limitations. Although ML/PHN boards were/are skills-based rather than representative, the inclusion of people with LG experience was a factor “link[ing] the organisation [PHN] with local government” (PHN interview, VIC) and “bringing in local government view and experience” (PHN interview, TAS). The five PHNs that had members formerly or currently involved in LG on their board all reported stronger involvement with LGs in their region. Inclusive governance, which allows the involvement of multiple stakeholders in organisational governance and decision making, and a history of partnership were reported as enabling factors in Tasmania, even though there was no legislative mandate.

Establishment of formal structures

Although not a common practice, the establishment of formal structures or alliance building had the potential to enhance the involvement of LGs in population health planning in some regions. An example of a formal governance structure in MLs was the establishment of ‘strategic leadership groups’ or ‘steering groups’ comprising key regional players in the planning process. Although the establishment of a strategic leadership group (or similar) was recommended in the ML needs assessment template, only 12 MLs (mainly in South Australia and Victoria) used these groups at executive and strategic levels to engage with external organisations.

Existing structures in Victoria called ‘PHC collaboratives’ – region-wide platforms of primary and tertiary health providers and organisations, including LGs – enabled PHNs to work together to identify needs and set priorities:

We will have four of those [collaboratives], bringing together in each one the local health district, and a whole lot of agencies and experts such as local government and consumers and so on. And it will be a vehicle

to explore issues, to tap into expertise, to develop ideas. (PHN interview, VIC)

The reports from other states suggest that collaboration was more ad hoc and mainly on specific local projects rather than in strategic planning.

Organisational capacity and resources

Funding models and resources

Funding models for both MLs and PHNs were identified as being unsupportive of collaborative planning with external stakeholders, including LG. One PHN CEO noted:

... there is no articulated funding around our partnership work, and partnership work is the most resource- and time-intensive work that you can do. (PHN interview, NSW)

Sufficiency and flexibility of funding was reported as particularly crucial where broader inter-sectoral collaboration is required:

... I think those collaborative type of initiatives – they’re not clearly funded and we’re in a competitive model and it’s not easy to work; we talk about collaborative impact and backbone organisations and these are good models, but they’re not necessarily funded discreetly. (PHN interview, QLD)

LG also has limited resources for population health planning and is constrained by its boundaries, which differ from those of the MLs/PHNs:

They [councils] are only financed to function within their footprint; it’s quite difficult to get the councils thinking broadly from a regional point of view. (LG interview).

Time

Lack of time was another inhibiting factor for effective collaboration, mainly due to the tight timelines and reporting system for MLs/PHNs set by the federal government:

The short timelines just don’t give you the opportunity to develop good, trusting, well-understood relationships so that people can get on with their work.’ (PHN interview, TAS)

Discussion

Our analysis found that despite increased recognition of the role of LGs in public health planning, regional PHC organisations in Australia have been unable to capitalise on it due to a range of policy, governance, organisational and resource constraints.¹¹

A vital issue in Australia is the presence of ongoing tensions between the three levels of government and difficulties with

the allocation of responsibility between them. Local government, in particular, is suspicious of moves to shift responsibility to them without a concomitant allocation of resources.³²

The study identified several factors contributing to LGs being an underutilised resource in Australia for effective and efficient population health planning. These are discussed below.

Lack of support from PHC policy for collaborative population health planning and action on social determinants of health

The policy context, institutional rules and legal obligations are key driving forces for organisational action.²⁹ For Australian PHC, national policies and legislation could play a critical role in embedding comprehensive and collaborative PHC planning between PHC organisations and LG.³³ Data from our study revealed that collaboration between PHC organisations and LGs in Australia is varied, inconsistent and does very little to address social determinants of health. This is largely a result of macro policies supportive of a biomedical model of health and broader neoliberal ideologies³⁴ shaping ML/PHN priorities. The Federal Government’s policies and guidelines for MLs/PHNs lack a mandate and explicit recognition of the value of collaboration with non-health sectors to facilitate action on social determinants of health, which manifests as a lack of support for collaborative planning. Moreover, the role of LGs in regional planning and their involvement in planning processes are underrecognised.⁹ Given the strong role that LG can play in linking to local communities and engaging with other social sectors such as education and employment¹² to improve population health and equity, the lack of policy support to engage with LGs in identifying and addressing social factors affecting population health is a lost opportunity for Australian PHC.

Our study found some variations between and within Australian states and territories in collaboration with LGs. Findings from the document analysis indicated that Victoria and, to some extent, South Australia appeared to be undertaking more collaborative planning, while in other states/territories collaboration with LGs was ad hoc or limited to local projects rather than broader population health planning. From

the interviews, the existence of LG legislation mandating LG's involvement in population health planning in some states encouraged the two organisations (PHC organisations and LG) to undertake joint planning. However, the survey data did not find a significant difference between states with or without legislation. This may reflect differences in expectations around engagement with LG, with South Australia and Victoria perhaps holding themselves to higher standards because of the legislative imperative, and therefore being more conservative in their quantification of this engagement. This result may also reflect limited statistical power due to the small number of survey respondents.

Greater recognition and promotion of the role of LGs in health planning in both PHC policies and national and jurisdictional legislation will open a window of opportunity for more effective and efficient population health planning.

Limited involvement of LGs in the governance structure of PHC organisations

Effective governance structures can support collaborative planning.³⁵ As noted by Roussos and Fawcett (2000), there is potential to alter governance and leadership structures to improve the effectiveness of partnerships for population health, and negotiation and networking.³⁶ Freiler et al. (2013) indicate the importance of institutional and organisational contexts such as governance in facilitating or impeding collaborative planning.³⁷ Inclusive or "collective" governance that brings "multiple stakeholders together to engage in collective decision making" requires the active engagement of non-state actors in planning processes.³¹ We found that, despite policy forces that in general constrained a collaborative planning approach, some MLs/PHNs had developed governance structures and local innovations that involved external stakeholders and enabled them to include LGs in population health planning. The establishment of formal alliances and agreements appeared to enable a shared understanding of population health needs and joint planning between MLs/PHNs and LGs. However, the establishment of a governance structure inclusive of LGs was not widely practiced (only five out of 31 PHNs). Any effort to strengthen PHC governance structures through stronger links with LGs would have mutual benefits in terms of

improving population health and wellbeing in their regions.

Lack of organisational capacity and resources

Sufficient and sustained resources, including human and financial resources, are essential for collaborative work to improve population health and address social determinants of health at local, regional and community levels.²⁸ Collaborative planning requires good knowledge and skills on engagement strategies, and organisational capacity to build trusting relationships, implement planning strategies and evaluate the impact of collaborative planning.^{6,28}

We found that collaborations between PHC organisations and LGs were constrained by the lack of capacity and resources. Both PHC organisations and LGs noted time, tight deadlines, and resource and funding scarcity as major factors hindering them from building and maintaining collaborations in planning. To gain further opportunities for effective and efficient population health planning, both federal and state governments need to allocate sufficient resources to PHNs and LGs to build on and maintain collaborations for regional-level PHC planning.

Box 1 outlines a list of recommendations drawn from our study to improve collaboration between PHC organisations and LG.

Study limitations

A limitation of the study was that the survey and interviews with PHNs were conducted within the first year of their establishment when they were dealing with transition

and organisational restructuring. Hence, the lower engagement reported by PHNs may be because the PHNs had less time to build collaborative work. In general, there were a small number of survey respondents for PHNs, which caused limitations to the statistical power. Furthermore, the study timeframe and resources did not allow us to engage with a wider range of LGs to document examples of where collaborative planning had worked well and why. LG perspective is limited to LG associations and LG people who have been involved in a PHN Board. Future studies could track positive examples of collaborations between PHC organisations and LG in order to establish benefits that can flow from these collaborations.

Conclusions

Considerable benefits are to be gained from increased collaborative population health planning between PHC organisations and LGs in Australia. We have identified three major barriers to this happening: the absence in most states and territories of uniform public health legislation mandating local government involvement; the absence of a mandate from the Federal Government to require PHNs to engage in such collaborative work; and a lack of dedicated resources to PHC organisations and LG to support collaboration. The positive examples we found, such as the involvement of LG in the governance structure and the decision-making processes of PHC organisations and building connections with stakeholders and agencies through local networks, point to the potential benefits of collaboration between PHC and LG.

Implications for public health

Improving PHC and LG collaboration through appropriate governance and leadership, identification of common goals, and pooling of resources and effort where appropriate would maximise the quality and impact of population health planning and lead to improved action on local social determinants of health. This would have great potential for advancing population health and wellbeing, and health equity.

Box 1: Factors that would encourage improved collaboration between regional PHC organisations and local governments.

Recognition of the role of LG in PHN policies would promote LGs' involvement in population health planning and collective action on the social determinants of health.

The provision of flexibility, time and sufficient funding by federal and state/territory governments to both PHNs and LGs would enable them to build trusting relationships and improve joint planning activities.

Improved governance structures to include representatives of LG on PHN board and advisory committees to bring a LG perspective to population health planning.

Supporting all states and territories to enact legislative initiatives to give LGs a stronger role in public and population health planning, which, in turn would enhance collaboration with regional PHC organisations.

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