MUNICIPAL ASSOCIATION OF VICTORIA

Municipal Public Health and Wellbeing Plans 2021–2025: Report

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Contents

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1. Executive summary

Victoria's 79 councils lead a wide range of initiatives to promote the health and wellbeing of their local communities and have a statutory requirement to prepare a municipal public health and wellbeing plan (MPHWP) every four years. This plan must have regard for the *Victorian Public Health and Wellbeing Plan 2019–2023* (VPHWP). For the 2021–2025 period, 41 councils developed a stand-alone MPHWP and 38 councils incorporated the MPHWP into their council plan.

This review sought to analyse alignment of the municipal public health and wellbeing plans with the priorities in the VPHWP and to highlight additional priorities that have been recognised as significant at local levels. It also included a review of health and wellbeing partnerships and priority groups, inclusion of Aboriginal and Torres Strait Islander communities, and COVID-19 issues and actions. The review included 77 of the 79 plans.

There were four VPHWP priorities that were included in almost all plans: increasing active living (included in 97% of plans), preventing all forms of violence (97%), improving mental wellbeing (96%), and tackling climate change and its impact on health (96%). Increasing healthy eating was a priority in 83% of plans, followed by reducing harmful alcohol and drug use (65%) and reducing tobacco-related harm (53%).

In many cases, councils included additional health and wellbeing priorities that were not named in the VPHWP but were important in their municipality. The most common of these priorities was social connection/inclusion, followed by equity and diversity, housing and homelessness, and service access.

All plans included statements about the importance of partnerships and on working with local partners. The most common local partners named were Primary Care Partnerships and community health. Other partner organisations included women's health services, hospitals, community service organisations, neighbourhood houses, Aboriginal community controlled organisations, police, sports organisations and family violence services.

About a third of plans chose to identify priority population groups, either via a list or through targeted priorities. The most common priority populations were Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people with a disability, LGBTIQA+ communities, young people, older people and children.

The majority (84%) of plans included Aboriginal and Torres Strait Islander communities either through partnerships, priority groups or targeted strategies. There were 57 plans that included one or more strategies to strengthen Aboriginal and Torres Strait Islander health and wellbeing, with a total of 153 strategies/actions across all plans. Many of these strategies related to reconciliation, strengthening partnerships and recognising Aboriginal cultural heritage and connection to land.

The significant impact of COVID-19 on community health and wellbeing was seen across the plans, with 94% of plans including discussion of the impact of COVID. Forty-six linked specific health and wellbeing issues to COVID. Of the issues linked to COVID, the impact on mental health and wellbeing was the most frequently listed concern, followed by social isolation and loneliness, financial stress, family violence, food insecurity, unemployment and widening inequality.

2. Introduction

Victoria's 79 councils lead a wide range of initiatives to promote the health and wellbeing of their local communities. Actions are based on local health and wellbeing indicators and state policy, and determined in consultation with community members and local partner organisations. Initiatives are diverse, such as the provision of quality open space encouraging walking and cycling, community-based programs to foster community connection and mental wellbeing, education and food system changes to promote healthy eating, future planning to reduce the impacts of climate change on health, and initiatives that prevent family violence and create safer communities.

Councils have a statutory requirement to prepare a municipal public health and wellbeing plan (MPHWP) every four years. The plans must have regard for the *Victorian Public Health and Wellbeing Plan 2019–2023* (VPHWP) and meet the requirements of the *Public Health and Wellbeing Act 2008*. Councils have the opportunity to seek exemption from providing a stand-alone plan by including the health and wellbeing matters in a council strategic plan.

In late 2021, councils completed their plans for 2021–2025. Thirty-nine councils prepared a stand-alone plan and 38 prepared a council plan that incorporated the health and wellbeing plan, with two stand-alone plans under development. Some plans stated that they incorporated other significant plans, such as the Disability Action Plan, COVID recovery, climate change, or early years plans.

The MAV supports councils in their work to progress the development of healthy, diverse and thriving communities with their key partner agencies. To support this work, the MAV commissioned a review of the 2021–2025 health and wellbeing plans. This review incorporates a high-level thematic analysis of health and wellbeing priorities and partners and alignment with the VPHWP, as a resource for the MAV, councils and state government.

3. Review scope and process

The review included 77 plans, with two plans under development at the time of review. Three of the 77 were draft plans. The scope of the review included only the main document that formed the health and wellbeing plan for each council (either stand-alone plan or council plan) and did not include associated action plans or outcomes frameworks published as separate documents.

All 77 plans were reviewed as follows, and data entered into a spreadsheet (attached). The focus of the review of priorities was to determine their alignment with the priorities of the VPHWP and to highlight priorities that may not be focus of state plan but have been recognised as significant at local levels.

The process included:

- Document was scanned and key content located.
- Priorities were reviewed and recorded in the spreadsheet (full wording and yes/no).
    - Where a clear list of priorities was included in the plan, this was used as the basis for the review.

    - Where priorities were unclear, a review of the objectives/strategies was conducted. Word searches using key terms from the VPHWP priorities were used to check for their inclusion.
    - In cases where a VPHWP priority was referenced in the plan, but there was only minimal information and no corresponding objectives/strategies, this was marked as 'acknowledged'.
- Key partners were reviewed. If there was not a clear section on this, a word search was used, including 'partners', 'stakeholders', 'community health', 'primary care' and the names of the local community health service and Primary Care Partnership.
- The inclusion of priority populations was reviewed. Only plans that clearly stated a focus on priority populations with a list of groups were considered to have included this, or where a high-level goal or priority targeted a specific group.
- Aboriginal and Torres Strait Islander inclusion was reviewed using word searches: Aboriginal, traditional (owners/custodians), indigenous, first nations, reconciliation, and name of the local groups (e.g. Wadawarrung). The inclusion of partners and priority groups was noted, and number of related strategies. For consistency, only the number of 'strategies' were counted (not more detailed actions or outcomes, as this varied across plans). If another plan was referenced, this was noted.
- The inclusion of issues or actions related to COVID was reviewed using a word search for 'COVID' and 'pandemic'.
- The level of detail and clarity was considered by noting the method the plan used to identify priorities, whether the plan stated an accompanying action plan would be developed, and the method used to identify health and wellbeing strategies.
- Finally, a review of the plans funded under the VicHealth Partnership or Healthy Kids program was conducted to note how the plans aligned or referred to this work (see notes in the spreadsheet).

4. Findings

4.1. Priorities

Victorian Public Health and Wellbeing Plan priorities

Councils determine health and wellbeing priorities for their municipality through a process that considers local health data, the broader evidence base for current and emerging health issues, state and federal policy and legislation, community consultation and collaboration with local partner organisations. The focus of this review was to analyse alignment of the municipal public health and wellbeing plans with the priorities in the VPHWP and to highlight priorities that may not be focus of state plan but have been recognised as significant at local levels.

All 77 plans in the review included priorities from the VPHWP. There were four VPHWP priorities that were included in almost all plans: active living (n=75), preventing violence (n=75), improving mental wellbeing (n=74), and tackling climate change and its impact on health (n=74).

In addition to the priorities and actions in MPHWPs, councils conduct many other health and wellbeing protection activities, such as maternal and child health services and monitoring food safety and tobacco sales. These are often not included in MPHWPs because they are considered part of standard council operations.

VPHWP priority	Number of MPHWPs that include the priority	Percentage	*Acknowledged (see note)*
Increasing active living	75	97%	*2*
Preventing all forms of violence	75	87%	*2*
Improving mental wellbeing	74	96%	*2*
Tackling climate change and its impacts on health	74	96%	*1*
Increasing healthy eating	63	82%	*5*
Reducing harmful alcohol and drug use	50	65%	*4*
Reducing tobacco-related harm	41	53%	*7*
Reducing injury	12	16%	*4*
Improving sexual and reproductive health	9	12%	*8*
Decreasing the risk of drug-resistant infections	1	1%	*5*

Note: In cases where a VPHWP priority was referenced in the plan, but there was only minimal information and there were no corresponding objectives/strategies, this was marked as 'acknowledged'.

Increasing active living

'Increasing active living' is one of the four focus areas of the VPHWP. Of the 77 plans, 75 (97%) included 'increasing active living' as a priority, and the remaining two acknowledged it as important for health, although didn't include related strategies. Of the 75, 47 included it as a stand-alone priority, while 28 combined it with other priorities, most frequently 'healthy eating', for example as 'creating healthy lifestyles'.

Preventing all forms of violence

Section 26 (2)(ba) of the *Public Health and Wellbeing Act 2008* requires councils to specify (in their municipal public health and wellbeing plan) measures to prevent family violence and respond to the needs of victims of family violence in the local community. Of the 77 plans, 75 (97%) included 'preventing violence' as a priority, and the remaining two referred to preventing violence but didn't include it as a priority or focus. Of the 75, 72 included it as a stand-alone priority, while three combined it with other priorities.

The most frequent wording of this priority was 'preventing family violence' (n=24) and 'preventing all forms of violence' (n=17). Other wording included preventing violence against women and children (n=5) and preventing gender-based violence (n=2). There were 25 plans that did not use the word 'violence' in the naming of the priority but it was clear from the description that it focussed on preventing violence. These 25 used words like 'respect', 'safety' and 'equity'. Gender equality was frequently combined with preventing violence, recognising the gendered nature of family violence. There were 15 plans that combined the wording 'preventing violence' and 'gender equity/equality' in one priority, and a further five that included two separate priorities addressing violence and gender equity.

Improving mental wellbeing

Across the 77 plans there was a strong focus on 'improving mental wellbeing', especially when the related priority of social connection/inclusion is considered. 'Improving mental wellbeing' was included as a priority in 74 plans (67 as a stand-alone priority and seven combined with other priorities). Two others included 'social connection/inclusion' as a priority and included a reference to mental health within the actions. Only one plan did not include any reference to mental health or wellbeing in the strategies or actions. Seventeen plans included 'improving mental wellbeing' and 'social connection/inclusion' as two separate stand-alone priorities, giving the broader area of mental wellbeing a greater focus.

Tackling climate change and its impact on health

This priority is one of the four focus areas of the VPHWP. Additionally, section 17 of the *Climate Change Act* requires councils to have regard to climate change in preparation of their municipal public health and wellbeing plans. Councils have clearly responded to this, with the majority selecting it as a priority. Of the 77 plans, 74 included 'tackling climate change and its impact on health' (either as a clear priority, or with a dedicated section) and two others acknowledged it. Only one did not refer to climate change at all (this was a 10-year plan developed in 2017) and one other referred only to protecting the natural environment, but not climate change or its impact on health. This priority was not always approached in the same way as others. In a number of plans, climate change was not included in the list of health priorities—but it was clear that it was a focus because the plan had a prominent discussion section on tackling climate change and included a number of strategies to address this. For the purposes of this review these plans were considered to have included it as a priority. One potential issue identified, but not analysed in this review, was that some plans included climate change mitigation strategies, but did not focus on the 'impact on health'.

Increasing healthy eating

While 'increasing healthy eating' is one of the four focus areas of the VPHWP, it was not as prominent in municipal health and wellbeing plans as the four aforementioned priorities. It was included as a priority in 63 plans (82%), with 34 plans including it as a stand-alone priority and 29 combining it with other priorities. Five others acknowledged it but didn't include related strategies.

Reducing harmful alcohol and drug use, and reducing tobacco-related harm

These two priorities were often combined as one priority. 'Reducing tobacco-related harm' is one of the four focus areas of the VPHWP, however it was included in only 41 municipal health and wellbeing plans (53%). This included 14 as a stand-alone priority and 27 combined with other priorities). Reducing harmful alcohol and drug use was included in 50 plans (65%).

Reducing injury

Only a small number of plans addressed reducing injury (12 plans; 16%), and usually specific to road safety. Only two plans included this priority as a high-level, stand-alone priority using the words 'reducing injury'. Others included it under the broader theme of 'community safety', addressing crime, injuries, road safety and sometimes also family

violence. A closer review of a few plans indicated that in some cases councils may have considered that they covered the 'reducing injury' priority by 'reducing harmful alcohol and drug use' however unless this was very clearly stated, 'reducing injury' was not included as a priority in this review.

Improving sexual and reproductive health

Nine plans (12%) referred to improving sexual and reproductive health as a priority. Four named it as a stand-alone priority, and five others combined it with other priorities (either with harm reduction or preventing violence).

Decreasing the risk of drug resistant infections in the community

Only one council included 'decreasing the risk of drug resistant infections in the community' as a priority with a related strategy.

Additional priorities

Through the analysis of local health and wellbeing issues and community needs, councils also consider health and wellbeing priorities that are not named in the VPHWP. Overall, 44 plans (57%) included priorities that were in addition to VPHWP priorities, reflecting their local community needs. The most common of these priorities was social connection/inclusion (n=19).

Additional priorities (not included in the VPHWP)	Number of MPHWPs that included it as a stand-alone health and wellbeing priority	Percentage
Social connection and/or inclusion	19	25%
Equity and diversity / reducing disadvantage	13	17%
Housing and homelessness	13	17%
Service/facility access	12	16%
Education, employment and economic development	11	14%
Gambling	6	8%
Children and young people	6	8%
Public health emergencies	5	6%
Gender equity/equality	5	6%
Health infrastructure (services, facilities, transport)	4	5%
Aboriginal health / reconciliation	4	5%
Community safety	4	5%
Older people	3	4%
Partnerships	3	4%
Food security	3	4%
Other	5	6%

Note: The grouping of these priorities was determined by the consultant based on the wording used and the emerging themes. Some plans included two priorities under the same theme (e.g. a plan that included a priority for equity and a priority for diversity was counted once in this table).

Social connection/inclusion

Social connection/inclusion, and its link to mental wellbeing, was a prominent theme across the plans.

- 17 plans included both ‘improving mental wellbeing’ and ‘social connection/inclusion’ as two separate stand-alone priorities.
- 10 councils combined the words ‘mental wellbeing’ and ‘social connection/inclusion’ in the one priority.
- A further 47 plans included ‘improving mental wellbeing’ as a priority.
- A further two plans included ‘social connection/inclusion’ as a priority.

This focus is likely to be a result of the COVID-19 pandemic. As discussed later in this report, an analysis of the health issues that the plans linked to COVID shows that mental health and social connection/inclusion were the most common concerns for councils.

Other priorities

Other common additional priorities could be grouped as equity and diversity (n=13), which referred to priorities addressing inequalities and discrimination; housing and homelessness (n=13); service access (n=12); and education, employment and economic development (n=11).

It is worth noting that many plans addressed these issues but did not always name them as stand-alone priorities. These figures only include where a plan named these as separate priorities, in addition to the VPHWP priorities. Thus, some of these issues may have a greater focus than these figures indicate.

For example, a review of the wording of the VPHWP priorities showed that:

- 14 plans included **gambling** as a priority: six as a stand-alone priority and eight in the wording of another priority, most frequently with reducing harm from alcohol, drugs and tobacco.
- 6 plans included **food security/food affordability** as a priority: three as a stand-alone priority and three others combined with the healthy eating priority.
- 20 plans included **gender equity/equality** as a priority: five as a stand-alone priority (in addition to preventing violence) and 15 others combined with preventing violence.
- 7 plans included **community safety** as a priority: four as a stand-alone priority and three combined with other priorities.
- 7 plans included responding to **public health emergencies** as a priority: five as a stand-alone priority and two combined with tackling climate change. COVID-19 and bushfires were cited as key concerns.
- Many plans (especially council plans) included actions related to housing and homelessness, although they were not always named as a health and wellbeing priority.

4.2 Partnerships

Working in partnership with local, regional and state organisations is key to councils’ work, especially in promoting community health and wellbeing.

Section 26 of the *Public Health and Wellbeing Act 2008* requires that a municipal public health and wellbeing plan must ‘specify how the council will work in partnership with the Department (of Health and Human Services) and other agencies undertaking public health

initiatives, projects and programs to accomplish the goals and strategies identified in the public health and wellbeing plan'.

While a comprehensive review of partnerships was beyond the scope of this review, information was collected on the ways that councils identified partners, the inclusion of key local health partners, and the role of Primary Care Partnerships.

Inclusion of local partners

All plans included statements about the importance of partnerships and on working with local partners, and many plans included prominent sections on their partnerships for health and wellbeing. Common partner organisations include Primary Care Partnerships, community health and women's health, community service organisations, neighbourhood houses, Aboriginal community-controlled organisations, police, sports organisations and family violence services.

Fifty plans (65%) included a list of key health and wellbeing partners. Of these, two plans were shared plans (Bass Coast and South Gippsland), 27 plans included targeted lists of 10 or less key partners, and 21 plans included longer lists of partners (>10), with some including lists of more than 50 partners.

Twenty-four plans stated that the plan was guided or overseen by an advisory/reference group or a consortium of local organisations. (Note, this is a minimum figure, as other councils may have similar reference groups but may not have named them in the plan.)

The most common local partners named were Primary Care Partnerships and community health. Of the 77 plans, 47 (61%) included specific reference (by name) to their local community health organisation/s, and 55 (71%) included specific reference to their regional Primary Care Partnership.

Role of Primary Care Partnerships

Primary Care Partnerships were the most frequently named key partner, other than state government. Of the 55 plans that named the Primary Care Partnership as a partner, 28 of these included it among the most important partners (where ≤10 key partners were named) and 19 included it among a longer list of partners (where >10 partners were named). Eight others included another form of reference to the Primary Care Partnership, such as acknowledging its work in regional planning. Twenty-two plans did not include a reference to the Primary Care Partnership.

The role of Primary Care Partnerships in leading regional planning and developing shared priorities was frequently acknowledged, as was the benefit gained from health data profiles provided by Primary Care Partnerships.

4.3 Priority groups

Population health planning often includes the identification of priority populations or target groups. While not a requirement of municipal health and wellbeing plans, 21 councils (27%) clearly identified priority groups. Eighteen included a section listing priority groups, and three others included health and wellbeing priorities that targeted population groups (e.g. children, young people).

While the other 55 plans didn't include high-level sections listing priority groups, many plans did include information on groups that experienced higher levels of disadvantage, while others named priority groups in the detail under specific strategies. These figures only include plans where there was a prominent section naming priority groups.

The most common priority populations were Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people with a disability, LGBTIQA+ communities, young people, older people and children.

Additionally, 20 plans included 'gender equity/equality' as a priority (three as stand-alone priorities and 17 combined with preventing violence) and many others discussed the importance of applying a gender lens and meeting the requirements of the *Gender Equality Act 2020.*

Priority group	Number of MPHWPs that included this group in a list of priority populations	Percentage
Aboriginal and Torres Strait Islander	18	23%
Culturally and linguistically diverse	17	22%
People with a disability	16	21%
LGBTIQA+	15	19%
Young people	15	19%
Older people	14	18%
Children	13	17%
Women	8	10%
Low-income/financially disadvantaged	8	10%
Homeless/people in social housing	5	6%
Other groups (listed in 1-3 plans) included people with chronic ill health, people experiencing family violence, people who are isolated/living alone, people in remote areas, families, sole parents, people with low education levels, and people experiencing cumulative disadvantage		

4.4 Inclusion of Aboriginal and Torres Strait Islander Communities

The importance of addressing the health and wellbeing of Aboriginal and Torres Strait Islander communities was recognised in many council plans and municipal health and wellbeing plans. As outlined in *Korin Korin Balit-Djak: Aboriginal health wellbeing and safety strategic plan 2017–2027,* at the population level there is a significant gap between the health status of Victoria's Aboriginal population and the non-Aboriginal population, and approaches to address this must be underpinned by Aboriginal self-determination.

The review considered three ways that a plan might have included Aboriginal and Torres Strait Islander communities:

- Naming an Aboriginal Community Controlled Organisation as a partner,
- Including Aboriginal and Torres Strait Islander people as a priority group, and/or
- Including strategies that aim to strengthen Aboriginal and Torres Strait Islander health and wellbeing (including strategies to strengthen partnerships, recognition and/or health).

Of the 77 plans reviewed, 65 (84%) included one or more of these components. Twenty-five plans named an Aboriginal corporation as a key partner organisation and thirty-two plans indicated Aboriginal and Torres Strait Islander people were a priority group. There were 57 plans that included one or more strategies to strengthen Aboriginal and Torres Strait Islander health and wellbeing, with a total of 153 strategies/actions across all plans. Many of these strategies related to reconciliation, strengthening partnerships and recognising Aboriginal connection to land.

Method of including/prioritising Aboriginal and Torres Strait Islander communities	Number of MPHWPs	Percentage
Aboriginal corporation/service named as a key partner	25	32%
Aboriginal and Torres Strait Islander people named as a priority group (in priority group list, in a discussion section, or as an overarching priority/goal)	32	42%
Strategies included that aim to strengthen Aboriginal and Torres Strait Islander health and wellbeing (including strategies to strengthen partnerships, recognition and/or health).	57	74%
Total number of plans that include one or more of the above	65	84%

Note: Section 4.3 states that 18 plans included Aboriginal and Torres Strait Islander groups in a list of priority populations, however the table above states that 32 plans indicated this community as a priority group. This discrepancy is due to a wider interpretation of how a plan might indicate this group as a priority, which included: within a list, within a high-level health priority, with a dedicated section discussing this group, or within a high-level goal.

Many plans included reference to other local or regional plans related to Aboriginal wellbeing, most commonly a reconciliation action plan/strategy (n=38). There were 10 other references to other plans related to Aboriginal wellbeing, including health and safety (n=1), employment (n=2), education (n=1), healthy country (n=3), heritage (n=1) and partnership plans (n=2).

4.5 COVID-19

The VPHWP was published in 2019, prior to the onset of the COVID-19 pandemic. Therefore, the release of MPHWPs offers an insight into the public health and wellbeing priorities emerging as a result of the pandemic. While many councils have separate plans to address COVID response and recovery, the significant impact of COVID on community health and wellbeing was recognised in the majority of health and wellbeing plans.

Of the 77 plans reviewed, 72 (94%) included acknowledgement or discussion of the impact of COVID. Forty-six linked specific health and wellbeing issues to COVID and 19 included a general acknowledgement. Of the issues linked to COVID, the impact on mental health and wellbeing was the most frequently listed concern (n=28), followed by social isolation and loneliness (n=22). Other commonly cited issues (included by 10 or more councils) were financial stress, family violence, food insecurity, unemployment and widening inequality.

Health issue linked to COVID	Number of MPHWPs that made this link	Percentage
Mental health/wellbeing	28	36%
Social isolation/loneliness	22	29%
Financial/economic stress	16	21%

Family violence & elder abuse	16	21%
Food insecurity	13	17%
Unemployment	11	14%
Widening inequality/ compounding disadvantage	10	13%
Housing stress/ homelessness	8	10%
Alcohol use	8	10%
Impact on businesses	7	9%
Reduced volunteering	6	8%
Digital divide	5	6%
Reduced health service access (delayed diagnoses)	6	8%
Impact on young people and education	4	5%
Reduced physical activity	4	5%
Gender inequality/impact on women	3	4%
Unhealthy/take away food	3	4%

Seven plans included responding to public health emergencies (citing COVID) as a high-level priority: five as a stand-alone priority and two combined with tackling climate change. While 40 plans included strategies that specifically linked them to COVID, it is likely that many other strategies addressed the impact of COVID while not naming it in the strategy wording. Actions that specifically referred to COVID were mostly references to general COVID recovery or business support. Six councils included strategies related to increasing vaccination.

4.6 Stand-alone plans and council plans

Councils have the opportunity to seek an exemption from providing a stand-alone municipal health and wellbeing plan by including the health and wellbeing matters in a council strategic plan. In 2021, 38 councils integrated health and wellbeing in the council plan and 41 prepared stand-alone plans (39 of which were included in this review). The review sought to identify any key points of difference between these approaches across the review topics (sections 4.1–4.5) and to consider any issues related to the ease of locating the health and wellbeing matters.

Overall, only minor differences were observed between the two styles of plan and there were no notable differences observed in the selection of priorities. Stand-alone plans were more likely to list local partners than council plans: 29 of 39 stand-alone plans (74%) listed local partners, compared to 21 of 38 council plans (55%). Stand-alone plans were also slightly more likely to include priority groups than council plans: 14 of 39 stand-alone plans (36%) included priority groups, compared to 7 of 38 council plans (18%). On the other hand, council plans were more likely to include partnerships, priorities or strategies for Aboriginal and Torres Strait Islander health and wellbeing: 35 of 38 councils plans (92%), compared to 30 of 39 stand-alone plans (77%).

The level of detail and ease of locating health and wellbeing matters was challenging to analyse. The table below shows the methods that plans used to identify health priorities and strategies. Due to the complexity (and subjectivity) in assessing ‘detail and clarity’, these results should be treated with caution.

The majority of plans (n=59, 77%) clearly identified both their health priorities and the related health strategies. There was only a small difference between stand-alone plans and council plans, with six stand-alone plans considered to be lacking clarity and/or detail, and 12 council plans lacking clarity and/or detail. There were three issues identified affecting detail and clarity—all of which could be easily addressed.

- The first was that health priorities were stated and described, but this didn't extend to stating strategies to address them. However, it is likely this detail is contained in forthcoming action plans.
- The second issue was where priorities were clearly stated, but the related strategies were not identified. This was only an issue for council plans, where an extensive number of strategies meant that the line of sight from health priorities to commitments was not clear. This could be addressed by adding icons next to the corresponding health strategies, as per other council plans.
- The third issue arose where a plan discussed health and wellbeing priorities in general and clearly marked or identified health and wellbeing *strategies*, but did not include a clear statement listing the council's chosen health priorities. Again, this could be easily remedied by adding a list of priorities.

Method of identifying health priorities and strategies	Rated clear/unclear	Stand-alone MPHWP	Council plan
Health priorities stated, with strategies under each	Clear	29	4
Health priorities stated and integrated under different themes, with health strategies identified	Clear	4	22
Health priorities stated, but without strategies	Unclear	5	0
Health priorities stated and integrated under different themes, but health strategies not identified	Unclear	0	8
Health priorities not stated, but health strategies identified	Unclear	1	4
Total		39	38

5 Limitations

This review has been conducted using consistent processes and all data has been double-checked. However, there were several challenges that may mean some information has been missed or where a council's intention in their plan has been misinterpreted.

One limitation was that the review only included the main document that formed the health and wellbeing plan (either stand-alone plan or council plan). It did not include accompanying documents, such as action plans or outcomes frameworks, unless they were published as one document with the main plan. Some of the plans indicated that important detail would be included in accompanying action plans, for example, lists of key partners. Thus some councils may consider they have included this information, but it is not captured in this review because it was not included in their main plan.

The difference in content between a council plan and stand-alone health and wellbeing plan is significant and posed another limitation in this review. The different types of plans were

not easily compared and it was not always possible to distinguish health and wellbeing content from broader council plan content. It is important to note that it was not within the scope of this review to consider or compare the value of these different approaches (stand-alone and council plan) and the review makes no statements regarding this, other than considering the clarity issue under section 4.6.

The diversity of plan length was another factor that made comparisons challenging at times. Plans ranged in length from four pages to over 80 pages. In the case of long plans, the review was more reliant on word searches (as outlined in section 3). While every effort has been made within the allocated time to collect comprehensive data, it is possible some information was missed.

The diverse methods that plans used to identify priorities (as discussed in section 4.6) was another challenge that may have affected the accuracy of the data. This was particularly an issue for the five plans where health priorities were not clearly listed, or where there were many priorities. The number of priorities chosen by councils ranged from three to 27, with six plans listing more than 12 priorities. Compared to councils that chose 3–5 priorities, there would be a very different level of focus on 27 priorities, however in this review they are given the same weight.

There was also a minor limitation in collecting data on whether a community health service or Primary Care Partnership had been named as a partner in the plan. In some cases, the health service or Primary Care Partnership has an unusual name which may not appear in the usual word searches. The lists on the following websites (https://www.health.vic.gov.au/community-health/community-health-directory and https://www.health.vic.gov.au/primary-care/pcp-locations) were used to cross-check for local service names, but despite this it is possible some may have been missed.