PUBLIC HEALTH IN NSW LOCAL GOVERNMENT

Results of Local Government Public Health Survey 2004

Local Government Association of NSW

Shires Association of NSW

NSW HEALTH

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1. Executive Summary

Local Government plays an important role in public health and the Local Government and Shires Associations of NSW want to help councils improve their capacity to improve public health outcomes for their communities by working with other levels of government.

The Associations have therefore established a partnership with NSW Health to research and document the approach and extent of Local Government activity in public health protection and promotion. The Associations and NSW Health's Centre for Chronic Disease Prevention and Health Advancement are investigating existing approaches to improving public health outcomes through social/ community planning and enhancing links between council Management, strategic and statutory planning processes.

As part of this initiative a Local Government Public Health Survey was designed and conducted to improve the available information in these and other areas, to enable the Associations, councils and NSW Health to work more effectively together. This report documents the results of the Survey, which was distributed to all NSW councils in late 2004, with a 70% response rate from a broad cross-section of councils.

Planning for public health

Survey results reveal that councils have a good level of awareness of public health issues and significantly incorporate these into their major planning processes. For example 75% of respondent councils included public health issues in their first mandatory Social Plan, 80% deal with it in the State of the Environment Report and 86% incorporated it into their 2003/04 Management Plan.

Although councils are more likely to consider health promotion than protection issues in Social Plans, the latter have a stronger focus in Management Plans. It is also the case that health service provision and access issues are a focus in Social Plans, often receiving greater emphasis than population wide preventive initiatives in public health. Overall, health service provision and protection issues are more likely to be the focus for rural councils, who tend not to concentrate on health promotion functions to the same extent as urban metropolitan councils.

Urban councils are more likely to have the resources and expertise to plan to address health promotion issues, such as minimising the harm associated with alcohol and other drugs, cancer prevention, mental health promotion, injury prevention and safety promotion, and promoting physical activity, nutrition and addressing obesity. Although some councils have Public Health Plans, they are in the minority. However 19% of respondents indicated that they intend to produce such plans in the future.

Regulatory activities

Survey responses reveal that councils are highly active in performing their regulatory roles in public health, particularly in regard to food safety, on-site sewage management, water quality monitoring, prevention of Legionella and vector borne disease control. The Local Government role in and commitment to food safety is particularly strong, with a significant food safety workforce and capacity in this area. Fifty-five per cent (55%) of respondents described their capacity to address food safety issues as good. The Survey has revealed that there is considerable variation among councils in regard to inspection programs in place under the *Public Health Act 1991* and Regulations, due to factors including variations in local conditions. At the same time, councils have themselves identified scope for improvement and expansion of activities, with further access to resources. Survey results make it clear that the regulatory health protection functions that councils deal with are extensive, and change in response to emerging issues, such as grey-water reuse. Respondents also identified a range of structural challenges associated with performing this regulatory role, such as a lack of financial and staff resources, and suggested strategies to address these issues.

Role in health promotion

Local Government planning and provision of basic infrastructure and facilities that enables residents to participate in physical activity, including as part of daily life, is widespread. Such activities include planning for connectivity, provision of street lighting, foot and bicycle paths, seating, children's playgrounds, other active and passive open space, swimming pools and other sports centres and facilities. However involvement in key health promotion initiatives in areas such as injury prevention and safety promotion, cancer prevention (particularly skin cancer prevention), and active community (physical activity promotion and nutrition) is not as common or consistent as work in the mandatory health protection functions. Councils gave highest priority in their responses to the following health promotion areas: injury prevention and safety promotion, cancer prevention and drug and alcohol harm minimisation. Given its importance in preventing chronic non-communicable disease, there is some scope for councils to take a more active role in promoting physical activity and addressing obesity by targeting nutrition and food access and affordability (food security).

Best practice and Awards

In regard to best practice in public health, councils were most likely to identify food safety initiatives, followed by physical activity related programs and safety promotion/ injury prevention. The health related Award most frequently won by councils was the Heart Foundation Kellogg Local Government Award, for programs and projects in the area of physical activity.

Partnerships with Area Health Services

Partnerships in health promotion and protection are common across all council classifications (urban metropolitan, urban fringe, regional and rural councils). However partnerships are more developed in health protection and their importance in enhancing the work of councils in this area is widely recognised.

For example while 20% of respondents had a Memorandum of Understanding with an Area Health Service (AHS) in health protection, only 9% had a similar Memorandum in health promotion. Partnerships with Area Health Services (AHS) are stronger among urban metropolitan, urban fringe and regional councils, particularly in health promotion. Aspects of partnerships explored in the Survey include provision of grant funding by the AHS, involvement in joint projects and activities, regularity of joint meetings, whether a Memorandum of Understanding or a Service Agreement exists and consultation in program/ plan/ policy development.

While Memoranda of Understanding and grants to councils are not common, at least 50% of respondent councils responded positively to the other indicators such as involvement in joint projects and activities. Partnerships with NSW Health are generally highly valued by councils, although there is considered to be room for improvement. Respondents proposed a range of strategies to facilitate this, for example, improved communication, liaison and networking and increased collaboration on joint projects.

Capacity building needs

When asked about how they could further develop their capacity in public health, councils typically responded that access to adequate financial and staff resources are a prerequisite. The challenge faced by councils in performing a wide and increasing range of regulatory functions under budgetary constraints, caused in part by cost-shifting, is repeatedly identified in response to the Survey. Access to additional financial resources such as grants from other spheres of government is given highest priority as a foundation to build capacity, particularly to expand work in non-mandatory areas such as health promotion. The other capacity building requirements given priority are access to other resources such as information, workforce development through staff education and training, and organisational development through improved council planning and coordination and better council policies and

procedures. The need to raise the profile of public health so that it is accorded a higher priority by councils and the community is also identified.

Role of Associations

Councils believe that the Associations have an important role in building the capacity of Local Government in public health. The strategy most commonly identified to achieve this is for the Associations to facilitate additional access to information, networking and financial resources for councils. The Associations are also seen as having a role in facilitating access to training opportunities for council staff, and assisting councils to achieve best practice in policy and planning. Addressing public health workforce issues, such as a shortage of qualified environmental health professionals in rural areas, is identified as a further task for the Associations. The Associations are also seen as having a role in building the capacity of councils in both health protection and promotion, focusing on issues such as physical activity promotion and obesity prevention, community safety and injury prevention, food safety and nutrition and prevention of skin cancer and other cancer.

Survey results indicate that Local Government is keen to protect and promote the health of residents, but recognise this is a whole of government task. Councils are therefore cautious about taking on roles that are more appropriately the responsibility of other spheres of government and are clear that they require adequate resources to perform existing and future activities in public health.

2. Context: Local Government's Role in Public Health

Local Government in NSW has a historic role in the protection of public health through planning for safe and healthy urban development and the provision of a range of services to communities. Public health has been defined as "the organised response by society to protect and promote health and to prevent illness, injury and disability", (www.nphp.gov.au/about/mou.htm). Its distinguishing feature is its focus on the health and well-being of an entire population rather than an individual.

Public health has three components: health protection, health promotion and disease prevention. Health protection is the "enforced regulation of human behaviour to protect health". It includes preventing, identifying and managing outbreaks of communicable diseases and minimising health risks arising from the built environment. Health promotion is the process of enabling people to increase control over, and to improve their health. Examples include information campaigns such as Quit campaigns, programs to reduce falls and programs to increase physical activity. Disease prevention involves interventions to reduce the incidence and prevalence of disease or injury: for example infant and child health screening and breast and cervical cancer screening, (NPHP: 2002:24/5).

Local Government has an important regulatory role in health protection, set out in legislation such as the *Public Health Act 1991* and Regulations and the *Food Act 2003* and Regulations. In addition to activities of Local Government such as land use planning that have an indirect impact on public health, there area a range of direct roles performed by staff such as Environmental Health Officers in areas such as food safety, potable and recreational water safety, preventing the spread of Legionella through microbial control, preventing the spread of blood-borne disease through monitoring of skin penetration premises and sharps disposal, preventing the spread of vector-borne disease such as Ross River Fever, and tobacco control activities. Councils also have a history of providing childhood immunisation services.

More recently, state and national health authorities have also identified Local Government as a key setting in which action can be taken to prevent current public health problems in the area of chronic non-communicable disease that are major causes of morbidity and mortality in the contemporary Australian context. Chronic non-communicable diseases such as cardio-vascular disease, cancer (i.e. skin cancer and lung cancer), injury (i.e. fall injury among older people and road injury among young people), mental health problems, diabetes and asthma may to some extent be prevented through a range of strategies in which Local Government can play a part (NSW Health: 2000). Local Government has a role in promoting health through urban planning that facilitates increased physical activity, access to affordable, healthy food, less reliance on the private motor vehicle and thus improved air quality and reduced injury, attention to the provision of shade and staff sun protection, and consideration of how to reduce injury in the urban environment through appropriate design. These goals are not only promoted through good urban planning but effective social planning, policy development and community service provision.

Local Government also has a direct role in provision of a range of community services that impact on health and/ or target vulnerable groups, such as Meals on Wheels and Home and Community Care Services, recreation and youth centres and child care services. An historic overview of Local Government's role in community services provision is available as Appendix 1 of the Associations' 2000 report, *Resourcing Communities, the 1999 Community Planning & Services Audit.*

In addition some councils are direct providers of health promotion programs and information. These programs may focus on Social Plan target groups and/or key health issues in the community at large such as reducing the harm associated with alcohol and other drugs, reducing injury, improving diet, encouraging physical activity and promoting mental health. The *NSW Local Government Act 1993* also gives councils a particular responsibility for considering and planning for the welfare of children. Local Government staff who have an impact in these areas include urban planners and designers, social planners, recreation officers, road safety officers, community safety officers, community development and community services staff, including children's services staff and youth officers, and staff working specifically in the area of health promotion.

3. Background

In recognition of Local Government's role in public health, the Local Government and Shires Associations of NSW received funding in 2004 from NSW Health's Centre for Chronic Disease Prevention and Health Advancement, to employ a Policy Officer Public Health to focus on issues of health protection and health promotion in Local Government. Key initial tasks of this position, set out in the funding contract, were to do the following:

- Research and document Local Government public health activities (regulatory/ health protection and non regulatory health promotion roles) and partnerships with Area Health Services (AHS);

- Research and document existing Local Government planning processes in the area of public health, including integration with planning processes such as Social Plans and Management Plans;

- Identify strategies to assist councils focus on public health in social planning and links with council management, strategic and statutory planning;

- Obtain information to analyse existing partnerships with Area Health Services, and develop options to enhance these.

In addition to the above rationale, this data was considered important to:

- Provide direction and assist in priority identification for the Policy Officer Public Health.

- Resource councils, other government agencies and non-government organisations by providing information about Local Government's policies and practices in public health.

- Provide information about Local Government's existing capacity and challenges in undertaking public health functions to inform the Associations' advocacy on behalf of Local Government.

Given the scope of the information required, covering Local Government across NSW, it was decided that the key instrument to obtain this information would be a questionnaire.

4. Methodology

Preliminary activities

- Prior to developing the survey a literature search was undertaken to determine the availability of existing information on Local Government's role and activities in public health. It was established that there was limited relevant literature, nor could current data be easily obtained from other sources. The literature search involved reviewing health protection, health promotion and capacity building literature.

- Relevant regulatory frameworks such as the *Public Health Act 1991* & Regulations, *Local Government Act 1993*, *Protection of the Environment Operations Act 1997*, *Environmental Planning and Assessment Act 1979* and the *Food Act 2003* were reviewed to determine scope of the mandatory and non-mandatory public health activities of councils.

- Council Social Plans and websites were reviewed to investigate other types of services and activities undertaken in the area of public health, particularly activities that directly or indirectly facilitated health promotion objectives.

Survey Development

Survey questions were developed through:

- Identification of information required;

- Identification of existing Local Government public health roles;

- Reference to other similar surveys such as that undertaken by the National Public Health Partnerships for the report *The Role of Local Government in Public Health Regulation*: *2002*, and the survey developed by the Associations for *Resourcing Communities- The 1999 Community Planning and Services Audit*.

- The draft Survey was send out to council staff, staff with the NSW Health Environmental Health Unit, staff with the NSW Health Centre for Chronic Disease Prevention and Health Advancement and the Australian Institute of Environmental Health for comment. A range of amendments were made as a consequence of the responses received.

Description of Local Government Public Health Survey

The Survey consists of fifteen pages of open and closed questions and explanatory notes. A copy is included in this document as Appendix 1.

- It has seven sections:
  - Council information (i.e. name of council and details of officer completing)
  - Public health issues and council planning processes (i.e. way public health dealt with in plans, reports & strategies both mandatory & voluntary)
  - Public health activities in health protection, promotion and disease prevention. Nature of partnerships with Area Health Services. Health promotion programs with population target groups
  - Job titles & activities of staff engaged in public health
  - Capacity building strategies for councils
  - Priority issues for Associations' Public Health Project
  - Further comments

Survey distribution and timeframe for completion

- The survey was distributed electronically to all councils in NSW. It included instructions on how to complete and an introductory letter from the presidents of the Associations.

- Councils were asked to nominate a senior officer to coordinate completion, with the task of obtaining input from a range of council departments.

- Councils were given four weeks to complete the survey. This timeframe was extended to two months, in response to requests for extensions of time to complete the lengthy survey. Two to three follow up phone calls were made to councils that did not complete by the due date to track progress with the survey and a copy of the survey and cover letter were resent, as required.

Response rate

One hundred and seven out of one hundred and fifty-two NSW councils completed the survey, a response rate of 70.4%. As the table below illustrates, responses were received from all classifications of NSW councils, apart from remote, of which there are only two.

Table 1. Characteristics of respondents on basis of council classification*:

	Number of respondents	**% of survey respondents by classification**	**Total number of Councils**	**Response rate by classification**
Urban metropolitan developed small & medium councils	11	10.3 %	17	64.7 %
Urban metropolitan developed large & very large councils	13	12.1 %	15	86.7 %
Urban regional small & medium councils	24	22.4 %	33	72.7 %
Urban regional large & very large councils	4	3.7 %	5	80 %
Urban fringe small & medium councils	3	2.8%	3	100 %
Urban fringe large & very large councils	8	7.5 %	8	100 %
Rural agricultural small & medium councils	18	16.8 %	25	72 %
Rural agricultural large & very large councils	26	24.3 %	44	59.1 %
Rural remote medium and large	0	0 %	2	0 %
Total	107	100%	152	N.A.

** Draft council classification system produced by Department of Local Government for Comparative Information* on *NSW Local Government Councils* 2004/05 *(unpublished) used in above Table as it includes amalgamated councils. The City of Sydney has been classified as a large-very large urban metropolitan council on basis of population size, rather than Capital City.*

As Table 1. shows, the Associations received a 100% response rate from urban fringe councils, and a response rate of above 70% from all councils apart from small-medium metropolitan developed councils and large to very large rural councils, who returned a response rate of 59.1%. No responses were received from remote rural councils, of whom there are only two: Central Darling and Cobar. Although rural councils comprised a significant proportion of respondents, this reflects their numerical significance, with nearly 50% of councils in NSW classified as rural. The spread of respondents

across the state was broad, with no significant gaps, apart from Central Darling and Cobar, remote councils that cover large geographic areas in the far west of NSW.

Survey Analysis

- Analysis of closed questions was undertaken by Iview, a data analysis company, using excel, while coding of open questions was undertaken internally using content analysis, and data stored in excel.

- Responses to closed questions were categorised using a variation of the Australian Classification of Local Government categories. This classification categorises councils on the basis of population size, whether they are developed urban metropolitan centres, regional towns, a developing LGA on the margin of a developed or regional urban centre called a fringe council, a rural agricultural or a rural remote council. The population of a small-medium urban metropolitan council, small medium regional town/ city and small-medium urban fringe council is up to 70,000, while that of a large-very large urban metropolitan council, regional/ town city and urban fringe council is up to 120,000. The population of a small-medium rural agricultural council is up to 5,000 and a large-very large rural agricultural council is up to 20,000, on the basis of the Department of Local Government's *Comparative Information on NSW Local Government Councils 2003/04*.

5. Planning for Public Health in NSW Local Government

Public Health and Urban Planning

Councils were asked a series of questions to attempt to determine the extent to which they consider public health in urban planning processes. Their responses are set out in the Tables below.

Table 2. Consideration of Public Health in Urban Planning processes

Activity	Yes	No	Not answered	Totals
Included in strategic plans	71%	28%	1%	100%
Included in Local Environment Plans (LEP) and Development Control Plans (DCP)	61%	37%	2%	100%
DCP for sun protection	11%	87%	2%	100%
Section 94 plan for open space, recreation facilities & community centres	76%	23%	1%	100%
Considered in development application assessment	92%	7%	2%	100%
Considered in Environmental Impact Statements	71%	22%	7%	100%

NB- 107 respondents

It is clear that councils are taking public health into account in urban planning, particularly in regard to considering it, in descending order, in the assessment of development applications, Section 94 Contribution Plans, in Environmental Impact Statements and Strategic Plans such as Local Environment Plans and Development Control Plans. However there was significant variation in consideration of public health in urban planning processes on the basis of council classification, with rural councils generally not including these issues in planning processes as frequently as urban metropolitan and urban fringe councils. For example 41% of respondents from rural large-very large councils and 33% of small-medium rural council respondents stated that they did not consider public health in the preparation of strategic plans. Thirty-three per cent (33%) of urban fringe small-medium council respondents answered in the same way. Again, rural councils were much more likely not to consider public health issues in Local Environment Plans (LEP) and Development Control Plans (DCP): 67% of respondents from small-medium rural councils and 48% large-very large answered in the negative. Respondents from urban metropolitan councils were much more likely to have a DCP for sun protection, apart from large-very large urban fringe councils, three out of eight having a DCP. Only one of the 45 rural councils who completed the survey had a DCP for sun protection/ shade provision.

Similar variations existed in regard to whether councils had a Section 94 Contributions Plan that required contributions for facilities likely to impact on public health such as open space, recreational facilities and community centres. Eighty-three per cent (83%) of small–medium rural councils responding to the Survey indicated that they did not have a Plan that required contributions for these purposes, while 26% of large-very large rural councils answered similarly. However 100% of urban metropolitan councils required contributions for these purposes in their Plans. There were not significant variations on the basis of council category in regard to whether public health issues were considered in the development application process or whether councils encouraged developers to consider public health impacts in the preparation of Environmental Impact Statements.

Councils were also asked to indicate how they integrated health promotion objectives such as encouraging physical activity into the urban planning process through an open question where they were free to nominate their own responses, the results of which are reported below. Strategies such as creating supportive environments for physical activity, falls prevention, shade provision, transport

planning for road safety and activities other than car travel were provided as examples of possible approaches.

Table 3. Integrating health promotion into urban planning

Activity	Number of responses
Planning & provision of cycleways and walkways	22
Objectives & provisions in planning instruments i.e. LEPs & DCPs	19
Provision of active & passive open space & access to natural environment	13
Shade provision	10
Model planning in new developments (i.e. linkage planning, open space, recreation & sporting facilities, walkability & cycling)	9
Transport planning (including planning for access & mobility)	8
Use Section 94 to provide open space and community recreational facilities in residential areas	8
Locating residential development close to transport, open space & commercial centres	5
Designing for safety & crime prevention	5
Provisions in Masterplans	4
Development of open space & recreational strategy	4
Town centres give priority to pedestrians	4
Provision & upgrading of footpaths & walkways	4
Condition Development Consents as appropriate	4
Designing for older people & people with disabilities	4
Development of other plans (i.e. plans of management for community land & parks)	4
Infrastructure provision (i.e. footpaths, skateboard ramp, playground equipment & softfall)	3
Specific planning to encourage physical activity (i.e. use of Supportive Environments for Physical Activity (SEPA) Guidelines)	3
Not done or not significant consideration	12
Other	4
Total	149

The most common response was that planning occurs for the provision of cycleways and walkways, which is both a transport and mobility strategy and a way of encouraging physical activity. Councils were at various stages of endeavour in this regard: some were investigating provision, others developing strategies and others implementing an existing cycleway plan. Some provide shared walking and cycling paths and others bike only paths. Walking trails, including paths suitable for jogging may also be provided. In planning cyclepaths and walkways, consideration is given to promoting connectivity, including pedestrian links and access to public transport, which enables better access to services. Requiring the provision of bicycle storage facilities in some developments was also mentioned.

Another common response was that public health was incorporated in the urban planning process through formal inclusion of objectives and provisions in Local Environment Plans (LEP) and Development Control Plans (DCP). Councils indicated that planning instruments incorporated the provision of safe and useable open space and community land, discouraged car usage and encouraged use of other modes of transport or modal mix such as cycling and walking, encouraged walkability, encouraged landscaping and shade provision, encouraged safe pedestrian access and road safety, provided for sun and shade access through design controls, and encouraged higher density residential development, in which public transport is more frequently used.

Other formal urban planning related strategies include consideration of public health in Masterplans and in consideration of Development Applications, including the imposition of conditions of consent. For example buffer zones may be imposed to prevent negative effects of industry such as chemical spray drift. In regard to Masterplans, the types of activities/ provisions mentioned above are considered in masterplanning for new release areas by some respondents. General consideration of provision of open space and playgrounds was also said to occur in Masterplanning. Some councils also indicated that they referred relevant Development Applications to Environmental Health Officers and major developments to NSW Health for comment.

Respondents placed particular emphasis on their role in planning and provision of open space, both passive and active. This includes open space requirements in subdivision of new developments, zoning of land open space and zoning other land community land. Providing access to green belts, maintaining active and passive reserves and providing parkland with gym equipment in all new subdivisions were among the activities mentioned. The development of open space strategies was also discussed. These strategies included planning for recreational opportunities in the locality, the council's role in promoting these opportunities and planning for improvements to existing facilities, new facilities and access.

Some respondents indicated that they did model planning in new developments likely to have a positive impact on public health. This included planning for pedestrian and cycleroutes including linkage planning, improved subdivision layout to encourage walking and cycling, planning for the provision of open space, planning for recreational and sporting facilities and considering factors such as location of schools and shops and improved connectivity to public transport. Some councils have included provisions in Development Control Plans for new developments to ensure pedestrian and cycle links to open space and community facilities, while one council mentioned a DCP that requires footpaths on both sides of the road.

Councils indicated that they planned for shade provision through design controls for both shade and sunlight and gave particular attention to providing shade at children's playgrounds, child care centres and swimming pools in the form of trees and shade structures. Some indicated they had a street tree planting program and a sun protection policy which detailed shade requirements.

Some respondents also considered social objectives like promoting health and wellbeing as a part of transport planning. Cessnock Council indicated that they have produced a Transport Mobility Plan as part of the Cessnock Community Renewal Scheme, funded through the NSW Premiers' Department. Newcastle Council has also developed Mobility Maps and Plans, while other councils indicated that transport access planning is done in conjunction with the development of new release areas.

In regard to safety, a number of respondents indicated that they incorporated Crime Prevention through Environmental Design Principles in LEPs and considered these issues in assessment of Development Applications. Safety by design principles were also mentioned. Consideration of lighting and road safety, including safety at levels crossings and main street upgrades to encourage greater safety, was also mentioned. In terms of designing for older people and people with disabilities, one council indicated that they had an Access Policy that was considered in urban planning, while another indicated that they had a Falls Prevention Plan. Another respondent indicated that they wished to support ageing in place by assisting older people to remain active and connected to the community.

Other Plans, Policies, Reports & Strategies

Table 4. Public Health Plan

Council has	Yes	No	Not answered	Total
Current Public Health Plan	9%	90%	1%	100%
Previously produced Public Health Plan	9%	88%	3%	100%
Intends to produce Public Health Plan	19%	74%	7%	100%

NB- 107 respondents

Councils currently develop Public Health Plans on a voluntary basis. Of the ten councils that indicated they had Public Health Plans, only one was a rural council. This is likely to be indicative of the very low level of this type of planning among rural councils. However of the twenty councils that indicated they intend to produce such plans in the future, nine of these were urban fringe and rural councils who had never before produced such a plan.

Table 5. Public Health issues in Public Health Plans

Issue	Number of responses
Miscellaneous Health protection i.e. Misc. health protection comprised the following responses- air quality, infectious disease prevention, microbial (Legionella) control, noise monitoring, drinking water quality (4), recreational water quality, on-site sewage management (OSM), waste, animal management, sharps monitoring, arbo-virus monitoring	24
Promoting physical activity, nutrition, food security and addressing obesity	8
Food safety	7
Cancer prevention- Sun protection and tobacco control	7
Other	6
Miscellaneous health promotion i.e. breastfeeding, drug and alcohol, injury & falls prevention, indigenous health	5
Immunisation	3
Total	60

Councils were asked to provide details of the five key issues identified in their Public Health Plan. The results are set out in the Table above, and show that councils primarily identified health protection issues, including food safety, in these Plans. This is reflective of the dominant public health role of councils in these areas. The key health promotion issues identified were encouraging physical activity and healthy eating and preventing health problems associated with inactivity, overweight and obesity and cancer prevention, particularly skin cancer and diseases associated with tobacco use.

Public Health Policies

Councils were also asked to name any policies that they may have in the area of public health. The results are set out in the Table below.

Table 6. Public Health Policies

Policy Area	Number of responses
Tobacco, alcohol & other drugs (i.e. OH&S policies, prohibition smoking council facilities such as halls, pools, playgrounds & sportsgrounds, PROOF-preventing cigarette sales to minors; alcohol free zones, alcohol use council premises, alcohol accord, binge & underage drinking & other drug & alcohol harm minimisation)	28
Sun protection (i.e. OH&S strategies & shade provision public places, sun smart for child care centres, shade provision outdoor pools)	24
Miscellaneous health protection (i.e. aircraft noise, contaminated land, asbestos disposal, backyard burning, regulated premises, microbial control, mosquito control, drinking water, keeping of animals, hazardous substance disposal, contaminated waste management, telecommunications & radiocommunications DCP)	23
Food safety (i.e. temporary stalls & mobile vending, food premises construction & fit out, food premises code, local food policy)	17
Community Safety & Crime Prevention (i.e. road safety plan, community safety plan, crime prevention plan, falls prevention plan, safer by design)	10
On site sewage management (i.e. policies & DCPs)	9
Contaminated land management policy	7
Communicable Disease Prevention (i.e. HIV/Aids, Blood Borne Communicable disease policy, infectious disease, immunisation)	5
Other O H & S	4
Child health related (i.e. playground strategy, immunisation, baby care room DCP etc)	4
Miscellaneous health promotion (Nutrition policy, Active Bankstown, gambling action plan)	3
Total	134

Policies were evenly divided between initiatives with a health protection and health promotion emphasis. The largest numbers of policies in a specific area were in the areas of prohibitions on smoking in council buildings and cars for reasons of occupational health and safety, and the provision of alcohol free zones. Policies designed to prevent diseases arising from physical inactivity and poor diet, such as cardiovascular disease, were not numerous.

Consideration of Public Health in Council Plans and Reports

Respondents were asked to indicate whether public health issues were considered in the development of mandatory plans, and in the development of other plans and initiatives that are not mandatory. The results are set out below in Table 7.

Table 7. Consideration of Public Health in Council Plans and Reports

Activity	Yes	No	Not answered	Total
Included in State of Environment Report	80%	19%	1%	100%
Included in Agenda 21 Initiatives*	35%	57%	8%	100%
Included in first mandatory Social Plan	75%	21%	4%	100%
To be included in next Social Plan	87%	7%	6%	100%
Included in 03/04 Management Plan	86%	13%	1%	100%
Included in 03/04 Annual Report	78%	20%	3%	100%
Included in the Transport Plan	23%	62%	15%	100%
Does Transport Plan include walking/ cycling	36%	50%	14%	100%

NB – 107 respondents

** Agenda 21 is a global blueprint for sustainability agreed at the United Nations Conference on Environment and Development in 1992. It calls upon local authorities to develop a local plan for sustainability, integrating environmental, economic and social goals, www.deh.gov.au/esd/la21/ .*

Table 7. shows that the vast majority of respondents are considering public health in the development of major statutory plans and reports. Most Councils indicated that they intend to include public health in their next Social Plan, had included it in their 03/04 Management Plan, in the current State of the Environment Report, in the 03/04 Annual Report, and in their first mandatory Social Plan. Councils were less likely to consider public health in non-mandatory plans and initiatives such as Agenda 21 Initiatives and Transport Plans. This could simply reflect the fact that preparation of these documents is less common.

There were a number of significant differences on the basis of council classification with regard to inclusion of public health issues in the plans and reports listed in the table above. Small-medium rural councils were less likely than other councils to include public health in the above documents, apart from Social Plans. There was no significant difference on the basis of council classification in the inclusion of public health issues in the first mandatory Social Plan, or the next mandatory Plan. Significantly less rural councils included public health issues in Agenda 21 initiatives, however involvement in the latter is not mandatory. Similarly consideration of health issues in the development of Transport Plans was not universal, with 50% of respondents indicating that they did not consider walking and cycling in these Plans.

Social Plans

Social plans are mandatory plans that NSW councils must submit to the Department of Local Government (DLG) every 5 years indicating how social issues in localities, particularly those affecting the seven identified population target groups, are to be addressed. These target groups are children, young people, older people, women, people with disabilities, culturally and linguistically diverse communities and Aboriginal & Torres Strait Islander people. Consideration of health issues is suggested in the *Social and Community Planning and Reporting Guidelines 2002*, published by DLG, but is not required.

Table 8. Main Public Health issues in Social Plans

Issue	Number of responses
Health service provision issues	23
Tobacco, alcohol & other drugs (education, harm-minimisation, addressing anti-social behaviour etc)	19
Crime prevention & safety promotion (domestic violence, road safety, water safety, suicide prevention, crime prevention, safe infrastructure, injury & falls prevention)	19
Miscellaneous health protection (food safety, waste management, regulatory services, microbial control, air quality, recreational water quality, onsite sewage management, etc)	18
Mental health (improvements to mental health services, dementia, youth suicide, depression, development of support networks)	18
Facilitating and promoting physical activity	15
Planning & provision of infrastructure (bike paths, walking tracks, shaded areas, parks, playgrounds, sporting facilities etc)	14
Older people's health (encouraging healthy & active ageing, falls prevention, provision of aged services, facilities for seniors)	14
Health service access issues	11
Aboriginal & Torres Strait Islander People's Health (need for culturally approp services & outreach)	11
Child health (immunisation, child protection, playgroup provision, obesity)	11
Promoting healthy lifestyle & wellbeing	10
Other (equity & social determinants of health, access to health information, promote existing health services etc, sun protection, dental health)	10
Youth health (drug & alcohol harm minimisation, suicide prevention & other mental health, sun protection, smoking prevention, sexual health, obesity)	9
Women's health (maternal, mammogram, teenage pregnancy, child minding for sports participation)	8
Health of other population groups (men, CALD)	7
Sexual health (reduction sexually transmitted infections, health promotion in sex services)	5
Nutrition	5
Other chronic disease prevention (cardio-vascular, diabetes)	4
Total	231

Survey results indicate that public health issues are widely considered by councils in the development of Social Plans. Seventy-five per cent (75%) of respondents did so in their first mandatory plan and 87% intend to do so or have done so in the second plan. However rural and some regional councils tend to focus on the numerous problems experienced by their communities in regard to access to and provision of health services, rather than strategies that are primarily preventative in nature. For example, rural councils tend to focus on problems in the area of attracting and retaining health professionals such as general practitioners and dentists, lobbying to improve funding and facilities at local hospitals, access to specialists, and other services such as an ambulance service and 24hour palliative care. Problems such as a lack of bulk-billing general practitioners are also a focus. In urban areas and some regional centres there is more of a focus on health promotion.

Table 8. shows that respondent councils were more likely to consider health service provision and access issues and health promotion issues and strategies in Social Plans than health protection issues, such as those which are a focus in Public Health Plans and Management Plans. Although not able to be defined as a population wide health initiative, such as an anti-smoking campaign, the fact that

councils have singled out health service provision and access issues as areas of attention is useful information of itself, as it demonstrates that this is an area in which councils feel it is necessary to direct efforts. It is possible that efforts may be directed towards these more immediate concerns rather than broader health promotion goals, especially by rural councils with limited capacity to work in a range of areas.

Other health issues prominent in Social Plans include preventing harm and health and safety concerns arising from use of tobacco, alcohol and other drugs, injury prevention/ safety promotion and crime prevention, addressing mental health issues and promoting physical activity, nutrition and addressing obesity. While not dominant, health protection issues are also mentioned, with a focus on food safety, waste management, childhood immunisation, and a range of regulatory functions such as microbial control, water quality monitoring and on-site sewage management. In addition, as might be expected there is also a focus on preventive health and health service provision issues for population target groups that councils must consider in development of Social Plans. Consideration of the health issues of older people is most prominent, with a focus on encouraging active ageing, falls prevention and provision of services and facilities. Other groups quite frequently identified are Aboriginal peoples, children, young people and women. The response 'promoting healthy lifestyle and wellbeing' was also quite common, but no further details were provided.

In addition to identifying the public health issues that were included, councils were asked to name the organisations they consulted on public health in Social Plan development. The most common response was that councils consulted with the local Area Health Service or the NSW Department of Health, with 56 councils responding in this way. Councils also specifically mentioned individual health units of Area Health Services/ NSW Health such as the Multicultural Health Unit (2), Mental Health Service (including child & adolescent) (5), Health Promotion Unit (5), the local hospital (7), Aboriginal Medical Service (9) and the local Community Health Centre (17). Only one council indicated that they intended to consult with the local Public Health Unit.

Councils also indicated they consulted with the Division of General Practice in their area (9), and individual medical practices (3), non-government organisations such as the Heart Foundation, the NSW Cancer Council and Diabetes Australia (4), and consumer networks (i.e. mental health support group). Other government departments were also mentioned, primarily the Department of Ageing, Disability and Homecare plus individual Home and Community Care (HACC) services, (17), the Department of Community Services (5) & NSW Police (5). Consultation with community organisations servicing the Social Plan target groups was fairly common (47): these included sporting organisations, drug and alcohol services, Aboriginal and Torres Strait Islander service providers, service providers for culturally and linguistically diverse communities (CALD), youth services, disability organisations and children's services.

Management Plans

The *Local Government Act 1993* requires councils to produce Management Plans yearly: they represent the yearly funded commitments of councils to activities identified as a priority.

Table 9. Public Health Issues in Council Management Plans

Issue	Number of responses
Miscellaneous health protection (i.e. regulated premises & systems, recreational water quality, waste, complaints, animal management, respond pollution incidents, education programs)	98
Food safety	40
On-site sewage management	21
Potable water provision & monitoring	17
Injury & crime prevention (i.e. water safety including swimming pool fencing, road safety, falls prevention)	16
Health service provision & access	15
Health promotion and services for target groups (i.e. women, children, Aboriginal & Torres Strait Islander people, youth, aged, homeless)	14
Infrastructure provision (i.e. recreation & leisure services, bike paths, walking tracks, sportsgrounds etc)	12
Other (i.e. implement health & leisure plans, develop health policy etc)	11
Childhood immunisation	9
Other health promotion (i.e. mental health, dental health, nutrition, food security, sun protection & tobacco control)	9
Promoting physical activity (i.e. use of parks, playgrounds, facilities & fitness programs)	5
Drug and alcohol misuse	5
Promoting healthy lifestyle (i.e. health promotion programs & education)	4
Total	276

There was an emphasis in Management Plans on identifying regulatory health protection initiatives for which councils have a statutory responsibility. This means that in terms of the funded public health commitments of councils, funding is primarily directed at regulatory health protection functions.

The most numerically significant health promotion goal identified was safety/ injury prevention, while provision of infrastructure that facilitates physical activity and health promotion and service provision issues for Social Plan target groups were also among those issues more frequently identified.

Integrated Planning

Councils were asked how they carried out integrated planning on public health issues. There was a low response rate to this question (79 responses). The most common response (40 councils) was that integrated planning was undertaken by consulting with external service providers. This was done in a range of contexts. The examples given were that the local Area Health Service was consulted in planning for new land release areas, by relevant development applications being referred to NSW Health, in the process of plan preparation (i.e. Social Plans) and through meetings with the Public Health Unit. Councils also indicated that they consulted with the NSW Food Authority and the Department of Environment and Conservation on public health issues. Involvement in networks and committees with other government and non-government agencies, such as Safe Communities Committees, Falls Prevention Groups, Hospital Actions Groups, and regional planning groups such as the Hunter Local Area Planning Team and the Central Coast Regional Environmental Health Plan Steering Committee, were other ways in which integrated planning was achieved, including on a regional level with other councils.

Integrated planning was also undertaken internally, through regular interdepartmental meetings, through Social Plan, Environmental Health Plan and Management Plan development, through internal referral of Development Applications and was facilitated by internal council structures which included a range of functions within one council department. For example several councils indicated that they had multi-disciplinary teams, and that the community development department incorporated transport, social, landuse and cultural planning.

Table 10. **Development of other Plans, Policies, Reports & Strategies with a public health relevance**

Other plan, policy, report or strategy	Yes	No	Not answered	Total
Crime prevention/ community safety plan	50%	45%	5%	100%
Road Safety Plan	60%	36%	4%	100%
Sports Injury Prevention Plan	4%	93%	4%	100%
Transport Plan	34%	63%	4%	100%
Bicycle Plan	71%	27%	2%	100%
Swimming Pools Policy Statement	29%	66%	5%	100%
Swimming Pools Study/ Plan	33%	63%	5%	100%
Parks & Gardens Policy Statement	41%	55%	4%	100%
Parks & Gardens Management Plan	83%	13%	4%	100%
Open Space Needs Study	50%	45%	5%	100%
Sporting Grounds Policy Statement	45%	51%	4%	100%
Plans of Management for Sporting Grounds	77%	20%	4%	100%
Sport & Recreation Needs Study & Plan	41%	55%	4%	100%
Immunisation Policy Statement	12%	84%	4%	100%
Early Childhood Health Centres Policy Statement	13%	82%	5%	100%

NB- 107 respondents

As Table 10. shows, respondents were most likely to have developed Plans of Management for Parks and Gardens, followed by Plans of Management for Sporting Grounds, a Bicycle Plan, Road Safety Plan, Crime Prevention/ Community Safety Plan and an Open Space Needs Study. They were least likely to have developed a Sports Injury Prevention Plan, Immunisation Policy Statement and Sports Injury Prevention Plan. Rural councils, particularly small-medium councils, were much less likely than other councils to have developed the plans listed above. For example only 22% of small-medium and 30% of large-very large rural councils had a Crime Prevention or Community Safety Plan, while the range for other councils was 62-83%, with an average of 50% for all respondents. Similarly while Road Safety Plans were common among urban councils, only 28% of small-medium and 41% medium-large rural councils had these Plans. All urban fringe councils had these plans. As the above Table shows, Sports Injury Prevention Plans were rare and all respondents with such plans were urban metropolitan councils.

Only 6% of small-medium and 11% of large-very large rural councils had a Transport Plan, while the average was 34%. The picture was similar for Bicycle Plans, with only around 50% of rural councils having such plans in contrast to an average of 71%. Again small-medium rural councils were 12% less likely to have a Swimming Pools Policy Statement, and were much less likely to have a Swimming Pools Study or Plan. There were no significant differences on the basis of council classification in regard to Parks and Gardens Policy Statements. Plans of Management for Parks and Gardens were the most common type of Plan.

However the urban/ rural disparity re-emerged in differences among respondents in regard to Open Space Needs Studies: only 6% of small-medium and 30% of large-very large rural councils had these studies as opposed to 64-88% of urban councils. Rural councils were again below the overall average in development of Plans of Management for Sportsgrounds, while they were in fact more likely to

have a Sports Ground Policy Statement. Development of a Sports/ Recreational Needs Study/ Plan was much less common in small-medium and large-very large rural councils, with 17% and 22% respectively, developing these Plans. Immunisation and Early Childhood Health Centres Policy Statements were not common across all council classifications, however the latter were significantly less common among rural councils.

Highlights of results in planning

Survey results have revealed that councils have a good level of awareness of public health issues and widely incorporate these into their planning processes. Public health is considered, as required, in assessment of development applications and is incorporated into LEPs and DCPs. Furthermore facilities that provide opportunities for physical activity and recreation are commonly part of Section 94 Plans. However these planning practices are less common among rural councils, sometimes significantly. Public health is also commonly considered in other mandatory planning and reporting documents such as the State of the Environment Report, Social Plan, Management Plan and Annual Report.

Respondent councils were more likely to consider health service provision and access issues and health promotion issues and strategies in Social Plans than health protection issues, which are the primary focus of Public Health Plans and Management Plans. Rural councils tend to focus on health service provision issues in Social Plans such as problems in attracting and retaining health professionals, the need for better funding for health facilities such as hospitals, and lack of access to bulk-billing general practitioners, sometimes to the exclusion of other issues. Urban metropolitan and regional councils were more likely to focus on health promotion issues in Social Plans, such as preventing health problems arising from use of tobacco, alcohol and other drugs, injury prevention and safety promotion, promoting physical activity and nutrition and addressing obesity. Addressing health issues associated with Social Plan target groups was also a feature of Social Plans.

Management Plans tend to focus on regulatory health protection initiatives for which councils have a statutory responsibility, with the implication that the funded public health commitments of councils are primarily directed at regulatory health protection functions. The most commonly identified health promotion goal in Management Plans is safety/ injury prevention, while provision of infrastructure that facilitates physical activity and health promotion and service provision issues for Social Plan target groups are also among those issues more frequently identified.

While development of Public Health Plans was not common at the time of the survey, 19% of respondents indicated that they intend to develop this voluntary plan in the future. Health protection and communicable disease prevention issues such as food safety, microbial control, sharps monitoring, immunisation and water quality monitoring issues are most frequently identified as features of these Plans. Health promotion issues such as promoting physical activity and nutrition, injury prevention/ safety promotion and cancer prevention accounted for 33% of responses. In regard to other non-mandatory plans with a public health relevance respondents were most likely to have developed a Bicycle Plan, Road Safety Plan and a Crime Prevention/ Community Safety Plan.

6. Local Government Public Health Activities

Section six of this document provides data from survey questions that set out to obtain baseline data on the service provision activities of councils in both health protection and promotion. Information is provided on activities that have both a direct relevance to public health, for example, through roles in the area of food safety, and an indirect relevance, for example through the provision of social and physical infrastructure that contributes to physical activity and social engagement.

6.1 Regulatory Activities

Food Safety

Table 11. shows the average results for all respondents to a series of questions designed to provide information about council capacity and range of activities in the area of food safety. For example, Councils were asked about numbers of staff in certain roles and numbers of inspections of food premises undertaken over a twelve month period.

Table 11. Food Safety Staff and Activities

Food Safety Staff & Activities	Mean response
Number of authorised officers under the *Food Act 2003*	4
Number of approved food safety auditors	.7
Number of food premises in the LGA	281.8
Number of inspections of food premises in 2003/04 financial year	346.9
Number of complaints about food premises in 2003/04 financial year	31.8
Number of improvement notices issued in 2003/04 financial year	7.1
Number of prohibition orders issued in 2003/04 financial year	.5
Number of food premises staff trained in 2003/04 financial year	40

NB- 107 respondents

Only one of the 107 councils that responded to this question indicated that they did not have at least one authorised officer. The total number of authorised officers among respondents was 428. Fifty-nine per cent (59%) of councils had 1, 2 or 3 officers. While the average number of authorised officers at respondent councils was 4, there was significant variance on the basis of council classification. Larger urban councils tended to have more authorised officers than smaller urban councils, while rural councils, both small and large had less than half the statewide average. Small-medium rural councils had only one staff member in this role on average.

The Table above shows that among respondent councils across NSW as a whole, there was less than 1 officer per council who was an approved food safety auditor. In fact 74 councils or nearly 70% of respondents did not have a food safety auditor. Seventeen per cent (17%) of councils had one auditor. Again rural councils were under the state average. There was a total of 75 food safety auditors among councils responding to the survey.

On average there were 282 food businesses per Local Government Area. However this figure is not particularly informative as there was considerable variation in the number of food businesses on the basis of council classification and thus population size. Among urban councils, the average number of food businesses was between around 300 - 600. On the other hand small – medium rural councils had less than 30, while large and very large rural councils had under 80 businesses.

The numbers of inspections of food premises undertaken over a twelve month period had a relationship to the size of the council, whether the council was urban or rural and as would be expected, was strongly related to the number of food premises in the LGA. Comparing the number of inspections with the number of food premises shows that respondent councils inspected most food businesses at least once in the 2003/04 financial year. Four of the eight groups of council classifications inspected some businesses more than once: all urban metropolitan councils fell into this

category. There was a total of 37,118 inspections of food premises conducted by respondent councils in the 2003/04 financial year.

There was an average of 31.8 complaints about food premises to respondent councils in the year specified. Again numbers of complaints corresponded to the numbers of food premises, apart from small-medium regional councils who had among the lowest number of businesses but received the third highest number of complaints at 47.6. While the average number of complaints received by respondents was 32, 15% of respondents received no complaints, 44% received 10 or under, 7 % received 20, and more that 20 complaints was not common on a statewide basis. There were a total of 3,403 complaints about food premises received by respondent councils in the 2003/04 financial year.

Table 11. shows that issuing improvement notices to food premises was not common, with a mean of 7.1% across respondent councils. However 68% of respondents issued no notices, while 8% issued only 1 and 5% issued 2. A total of 760 notices were issued by respondents. The rate of issue of such notices was higher among small-medium urban councils. Issuing of prohibition orders is even rarer, with 93% of councils issuing no orders. Only 53 orders were issued by respondent councils in the year specified.

Fifty-eight (58%) per cent of respondents did no food handler training. No involvement in this activity was particularly high among rural council respondents, with 83% small-medium and 67% large-very large rural councils in this category. Urban fringe small-medium council respondents, of whom there were only three, did no food handler training. Between 30-50% of urban council respondents also did no training. Of those who did engage in training, the average number of handlers trained per council was 40, however this varied significantly on the basis of council size and location, with urban metropolitan and regional councils engaging in significantly more training than rural councils. Large-very large urban fringe councils also did more training than the average. A total of 4,280 food handlers were trained by respondents in the 2003/04 financial year.

Additional Food Safety Activities

Councils were asked to identify activities in the area of food safety not covered in the multiple choice question above. The following table summarises the type of answers they provided.

Table 12. Additional food safety activities

Activity	Number of responses
Seminars/ workshops for food handlers (including community organisations)	25
Other educational activities (i.e. multilingual publications, newsletter, calendar, food safety awareness week, open day)	19
Inspect temporary food stalls/ mobile vans	11
New food premises- advice to operators, comment DAs, inspect fitout	8
Participate in external training	4
Participate in network	3
Run food safety awards	3
Food sampling	3
Action food recalls	3
Prosecutions	3
NAFSIS registrations and maintain council register	3
Participate in external training i.e. assist TAFE	2
Other	7
Total	94

Capacity to improve food safety

Councils were asked to describe their capacity to address food safety, using the options poor, fair, good and very good. Their responses are set out in the Table below.

Table 13. Capacity to address food safety

	Urban met small & medium council	Urban met large & very large council	Urban fringe small & medium council	Urban fringe large & very large council	Urban regional small & medium council	Urban regional large & very large council	Rural agricult. small & medium council	Rural agricult. large & very large council	Average
Poor	0%	0%	0%	0%	0%	0%	17%	11%	6%
Fair	23%	18%	67%	13%	29%	0%	39%	30%	27%
Good	69%	55%	33%	63%	67%	50%	33%	56%	55%
Very Good	8%	27%	0%	25%	5%	50%	6%	0%	10%
Not answered	0%	0%	0%	0%	0%	0%	6%	4%	2%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%

NB- 107 respondents

The most common response (55%) was that capacity to address food safety was good, however 6% indicated that their capacity was poor, and 27% only fair. All of those indicating that their capacity was poor were rural councils. Again rural councils were also disproportionately represented in the fair category. This is likely to be a consequence of factors identified in response to this survey such as resource limitations, including lower numbers of staff engaged in food safety in rural areas and difficulty in recruiting qualified staff.

Table 14. Strategies to improve capacity and approach to addressing food safety

Strategy	Number of responses
Additional staff	40
Increased resources	27
Additional training for food handlers	16
Improved planning and procedures	11
More training council staff (EHOs)	11
Improved cost recovery	8
Closer liaison and more support NSW Food Authority	8
Additional training for culturally & linguistically diverse (CALD) food handlers	4
Better educational materials and information	4
Better inspection practices i.e. more frequent, regular & longer inspections	3
Appoint specialist officer i.e. Food Inspector, upgrade officer to auditor status, fully trained authorised officer	3
Contract out food safety	2
Mandate role for local government	2
Other	3
Total	142

This question was interpreted as referring both to what was required for councils to improve their internal capacity and how they could improve their performance in regard to this function. Councils indicated that they required additional staff and increased resources to enable them to perform their role more effectively. A number of councils considered it desirable to have the resources to enable them to do more food handler training, including training for CALD food handlers.

Some councils provided significant detail under each of the responses in the Table above. For example under improved cost recovery councils suggested the following strategies: annual registration fees for food businesses, capacity to charge an administration fee, external funding for councils for activities such as inspection of food premises and capacity to issue penalty notices for offences. The problem of non-payment of fees by food businesses was also identified, and the lack of effective strategies to address this (i.e. one council reported that 15-20% businesses do not pay).

Under improved planning and procedures, respondent councils identified the desirability of introducing a risk based approach to inspections, development of a health plan, improved computer software, improved management practices (i.e. linking food safety to staff performance appraisals), allocating more time to food safety and use of standard templates for forms and letters.

Having additional staff was considered a key priority, as this would enable more inspections of food businesses to be undertaken, assisting councils to perform more than a minimum role in this area. For example some councils indicated that if they had sufficient staff they would undertake food sampling. Additional staff, including staff who were exclusively dedicated to food safety, would enable additional food safety education such as training of food handlers, and would allow councils to work with businesses rated unsatisfactory. It would also enable councils to develop new initiatives and programs.

There was also a consistent series of responses dealing with the relationship between councils and the NSW Food Authority. Councils identified a need for improved relationships and communication with this agency. Clear communication of premises to be inspected by the Authority was considered necessary to avoid duplication, as was improved and simpler delegations and directions. Better links were said to be required, although strategies to achieve this were not identified. Councils also indicated that they wanted further support from the Authority in terms of provision of resource materials, such as materials for conducting education with food handlers. Most of these issues have in fact been raised in the consultations on food regulation reform run by the Food Regulation Partnership during 2004/05 and attempts are being made to address them.

Potable and recreational water

Councils were asked a series of questions about their activities with regard to ensuring the safety of drinking water and recreational water such as swimming pools and spas. The questions and responses are set out in the Tables below.

Table 15. Potable & recreational water activities

Activity	Yes	No	Not answered	Total
Intend to fluoridate	14%	34%	52%	100%
Inspect public pools & spas	32%	28%	40%	100%
Samples pool & spa water taken for testing	29%	36%	36%	100%
Inspections private swim pool fencing conducted	49%	32%	20%	100%
Installing private swimming pool fencing require develop consent	70%	24%	6%	100%

NB- 107 respondents

Table 16. Frequency of inspections and testing

	Daily	Weekly	Fortnightly	Monthly	Biannually	Annually	Other	NA*	Total
Potable water samples taken for testing	1%	42%	3%	14%	2%	4%	4%	31%	100%
Council swim pools inspected	8%	30%	6%	16%	6%	21%	3%	11%	100%
Water samples council pools taken for testing	14%	33%	1%	14%	4%	17%	3%	15%	100%
Other public pools & spas inspected	0%	6%	2%	8%	4%	28%	4%	49%	100%
Samples other public pools & spas taken for testing	0%	6%	1%	9%	3%	18%	6%	58%	100%
Inspections private swimming pool fencing conducted	0%	3%	1%	1%	3%	21%	16%	56%	100%

**NA = Not Answered.*
NB- 107 respondents

The most common response to a number of the above questions asking about the frequency with which inspections occur and samples are taken, was that this occurred weekly. This was the case with regard to testing of potable water, inspection of council swimming pools and taking of samples of pool water for testing. The most common response in regard to the frequency of inspections of other pools and spas open to the public and the taking of samples was that this occurred annually, although most councils did not respond to these questions. There was also a very high non-response rate to the question as to the frequency of inspections of private swimming pool fencing. The most common response from councils who did complete this question was that this task was undertaken annually.

Other Regulatory Functions

Microbial control (Legionella)
Councils were asked to provide details of their practices in regard to inspection of regulated systems**,** (i.e. water-cooling systems), to prevent outbreaks of Legionella. Sixty-one per cent (61%) of respondents indicated that they had a system of regular inspections: 50% (n = 54) indicated that they conduct inspections annually, 9% biannually and 2% quarterly, with a non-response rate of 36% (n = 38).

Councils without a program of regular inspection were more likely to be in rural areas, small-medium urban fringe councils and small-medium regional councils, who were all in excess of the average in this regard. In understanding responses to this question, it should be noted that Legionella is not a problem in all areas of the state, and thus regular inspection programs would not be necessary in all areas. The NSW Health Environmental Health Unit has indicated that there are very few cases of Legionella west of the Great Dividing Range, and that Legionella is only a problem in high rise CBD areas that have cooling towers, rather than evaporation systems.

Councils are required by law to keep a register of regulated systems in their council area: 67% indicated that they updated this register annually, 8% biannually and 10% quarterly, with a non-response rate of 14%.

The issuing of notices to owners that maintenance of regulated systems be conducted was rare, with only 12 notices issued by the 107 respondents in the 2003/2004 financial year. Nine of these notices were issued by urban metropolitan and regional councils.

Practices in regard to Skin Penetration Premises & Mortuaries
Regulated premises include premises such as hairdressers salons, beauty parlours, and tattooists, where skin penetration occurs, and other premises, namely mortuaries and holding rooms, as Local Government has a role in monitoring these premises under relevant public health regulations.

Table 17. Practices in regard to regulated premises

Activity	Quarterly	Biannually	Annually	Not done	Not answered	Total
Register of skin penetration premises updated	13%	3%	71%	2%	11%	100%
Inspections of skin penetration premises conducted	1%	8%	70%	2%	19%	100%
Inspections of mortuaries & holding rooms conducted	0%	2%	43%	1%	54%	100%

NB- 107 respondents

Councils are required to keep a register of skin penetration premises, however there is no set requirement in regard to frequency of inspections of these premises. Approximately 30% of respondents indicated that they primarily conducted inspections of skin penetration premises in response to a request or a complaint. Although not reported on in the above table, 40% of respondents indicated that they did not conduct inspections of mortuaries and holding rooms, for reasons such as there being none in the LGA. Councils who did conduct inspections and who responded to the question about frequency of inspections, were most likely to inspect annually. Again skin penetration premises were most likely to be inspected and the register updated annually.

Vector Borne Disease

Vector borne disease as it relates to Local Government in NSW refers primarily to diseases such as Ross River Fever and related diseases, borne by mosquitos. Twenty-two (22%) of respondents indicated that vector borne disease is a problem in their locality, 73% indicated that it was not a problem, and 5% did not respond. Regional councils and urban fringe councils were more likely to identify vector-borne disease as an issue in their area.

Councils were also asked whether they had a strategy for addressing vector borne disease: 85% responded in the negative, 12% in the affirmative, while 3% did not answer this question. Prevalence of strategies generally corresponded to identification of vector borne disease as a problem by respondents.

Other health protection role

Councils were asked to identify other health protection activities they were involved in addition to those reported on above. Their response are set out in Table 18., below.

Table 18. Other health protection role

Activity	Number of responses
Investigate pollution incidents under POEOA*, including in response to public complaints (tanker spillage, air pollution, water pollution, noise pollution, dust, smoke, odour, stormwater contaminants etc)	35
Investigate On-site Sewage Management complaints & arrange for owners to rectify	14
Recreational and drinking water monitoring	11
Environmental audits of industry/ commercial premises	9
Sharps management	8
Remediate/ manage contaminated sites	8
Asbestos (safe removal & disposal, complaints)	7
Open burning/ woodsmoke reduction campaign	4
Mosquito monitoring & control activities	4
Tobacco control activities (PROOF; bin ya butt, smoking bans on beaches)	4
Investigate environmental health impacts of DAs and condition (lead, asbestos, contaminated soils)	4
Inspect manufactured home estates, caravan parks and places of shared accommodation for overcrowding	3
Education / information to public on health, environment, pollution	3
Childhood immunisation	2
Animal control	2
Other	10
Total	128

** Protection of the Environment Operations Act*

Waste Management

Councils were asked to identify the public health issues associated with their waste management role. Their responses are set out in the Table below.

Table 19. Waste management and public health

Issue	Number of responses
Sharps disposal	63
Vermin/ vector control	40
Odour (sewage, landfill)	34
Garbage storage issues	17
Illegal waste transport & disposal (i.e. asbestos)	15
Chemical disposal (i.e. household & agricultural collection)	5
Water contamination (i.e. sewage etc)	4
Household burning	3
Other	10
Total	191

The major public health issues associated with the waste management role of councils were inappropriate sharps disposal, vermin and vector control and odour from sewage and landfill.

Regulatory arrangements
Councils were asked to identify the critical issues and challenges associated with their regulatory roles. Their responses are provided in Table 20., below.

Table 20. Critical issues and challenges in performing regulatory role

Issue	Number of responses
Food surveillance/ safety	30
On-site sewage management	30
Grey water re-use	24
Resource constraints	25
Qualified staff shortages	22
Too many regulatory requirements & cost-shifting	17
Mosquito control	11
Lack of regulatory clarity & adequate legislation	7
Potable water quality	4
Microbial control (Legionella)	6
Waste minimisation & management	3
Low priority/ profile public health in council	3
Asbestos management	2
Reduction health protection staff, NSW Health	2
Other	25
Total	211

Councils were also asked how they thought these issues and challenges should be addressed. The strategies they suggested are set out in Table 21.

Table 21. Strategies to address regulatory issues and challenges.

Strategy	Number of responses
Appropriate resources to enable council to perform minimum and optimal regulatory role	44
Workforce development	13
Better research and planning (Local & State Government)	11
Training for existing staff	10
Coordinated approach to grey-water reuse management	10
Legislative improvement	8
Mandate Local Government regulatory role	6
Closer liaison Public Health Units	6
More staff & funding for On-Site Sewage Management	5
Better community education through promotion & information provision	5
Regular inspection programs to ensure compliance (DAs & regulated premises & systems)	4
Improved coordination & surveillance vector borne disease	4
Improved food safety monitoring	3
Greater focus on regional and rural NSW	2
Other	9
Total	140

Some of these categories require further explanation to give a clearer picture of the range of council responses grouped under them. The most common response was that further resources were necessary to enable councils to perform their basic regulatory roles effectively and to develop these activities to an optimal level. Respondent councils suggested a number of ways that further resourcing could occur, for example through better cost recovery mechanisms such as the capacity to issue Penalty Infringement Notices for food safety matters. However PINS are more accurately defined as a fine rather than a resourcing measure. The Food Amendment (Penalty Notices) Regulation 2004, gazetted on 3rd December 2004, now enables councils to issue penalty notices for offences under the Food Act 2003 and the Food Standards Code.

Better cost recovery associated with giving effect to orders, such as charges against land, was also put forward as a strategy. Research funding and seeding grants to develop new projects were suggested, as was a resident levy for health services. Councils repeatedly made the point that new roles should not be mandated or devolved from the State Government without first consulting with councils and planning for how new functions were to be resourced.

A number of councils made the point that other spheres of government should also be responsible for providing increased financial support to Local Government to perform roles in this area: food safety and on-site sewage management (OSM) were repeatedly mentioned in this regard. Under OSM the need for funding to extend sewer lines to outlying areas was identified. Respondents argued that the focus of increased resources should be on functions such as inspection, assessment and staff training. The need for further resources for rural councils, particularly those in outlying areas, to enable them to effectively perform their regulatory roles was identified. A sustainable system for financing the Local Government regulatory role was believed to be needed: some councils, such as Wagga Wagga, indicated that they were not able to cover costs at present. The State Government was called upon to develop a service provision and funding model for councils' regulatory role in consultation with Local Government.

Responses to the question of how regulatory issues and challenges could be addressed grouped under the heading of workforce development were also common. The need for additional staff (EHOs and Building Surveyors) and the need to make the environmental health profession more attractive through strategies such as upgrading salaries and providing continuing professional development was suggested. Addressing EHO shortages by training more EHOs, offering traineeships, and developing strategies such as incentives to attract and retain qualified staff to rural areas were all identified. The need for adequate access to training in rural and regional areas for existing staff was also noted, and it was suggested that the State Government fund training in these areas. The issue of the difficulty of attracting and retaining qualified staff in rural and regional NSW was repeatedly identified: suggestions were made about how to address this such as providing students with mentoring and financial support on the proviso that they commit to work in a rural area upon graduating. The reintroduction of a TAFE course in environmental health was suggested by one respondent.

Another group of responses fell under the heading of better research, planning and coordination by both Local and State Government agencies with whom councils share responsibilities in this area. Research and planning to enable councils to better address emergency outbreaks, such as Legionella, was said to be needed. Better coordination and planning for health protection on a state wide level was called for. The State Government was called upon to develop a service provision and funding model that would lead to surety that a base minimum regulatory role could be delivered by Local Government. Integrated planning and coordination was considered to be the responsibility of all levels of government. In addition, a state wide assessment of what can reasonably be expected and achieved by the Local Government environmental health professional was suggested. Basing programs on a broadly accepted risk management system and the introduction of standard reporting was suggested.

These responses are closely related to another category of responses: those calling for improvements in legislative frameworks and for a mandated Local Government regulatory role. At present the Acts and Regulations setting out Local Government's regulatory role in public health are phrased in language which enables the role rather than making most activities compulsory (mandatory). Nor is the frequency with which tasks are to be carried out specified. This has potential to create statewide variations and inconsistencies in the way that regulatory activities are conducted. A number of councils thus called on the State Government to mandate Local Government's regulatory role, particularly in the area of food safety. In this process clarification of the roles to be performed by councils and by the NSW Food Authority was called for. However councils believed that a mandated role should be accompanied by appropriate resourcing. A number of councils called for consistent statewide policy and legislation and for existing legislation to be clarified and simplified. A clearer delineation of roles and responsibilities between Local and State Government regulators was suggested.

The need for a co-ordinated State Government approach, policy and clearer guidance in the area of grey-water re-use was repeatedly identified. Councils have called for simplified legislation and guidelines on this issue, research and testing on the effects of grey water reuse and water treatment systems that can be retro-fitted and are able to provide water to the quality required. They also repeatedly called for NSW Health to provide training and education for council officers on this issue. Seminars by leaders in the field, and training that identifies areas of concern regarding treatment systems and emerging issues was called for.

Similarly, in regard to OSM, funding, support and coordination by the State Government was believed to be necessary, including further funding for council staff to monitor OSM. One council suggested the development of more innovative and better practices to treat waste water to an acceptable level before it is discharged into waterways.

In regard to vector borne disease, a coordinated regulated approach was called for. Councils also indicated that further recognition of the seriousness of the public health risk posed by mosquitoes was needed by NSW Health, as was assistance in the form of development of education and awareness programs for the community. Increased surveillance of mosquito borne disease vectors was considered desirable.

In regard to relations with Area Health Services, several councils called for closer relations, cooperation and assistance, upsizing the State Government as specialists again, an increase in regional forums between NSW Health and councils and joint inspections and targeted projects with Public Health Units.

In addition the State Government was called upon to take the lead in the development of public health educational materials to be made available to councils for distribution. An improved profile and better promotion of regulatory health protection activities was considered desirable so that these activities are more highly valued by councils and the general public.

Highlights of results in health protection

Responses to the Survey revealed that councils are highly active in performing their regulatory roles in public health, with particular emphasis on food safety, on site sewage management, water quality monitoring, addressing the emerging need for effective greywater reuse systems, legionella prevention and vector borne disease control. Local Government's role in and commitment to food safety is particularly strong, with a significant food safety workforce and capacity in basic roles such as inspection of premises, and an interest in expanding activities in areas such as food handler training. Most councils (55%) identified their food safety capacity as good. At the same time a range of strategies were identified to improve capacity, such as provision of additional staff and resources, more Environmental Health Officer training, appointing a specialist food safety officer and improved council planning and procedures.

Councils commonly have regular programs of inspection of council swimming pools and sample taking of recreational and potable water, these tasks most frequently performed weekly. The majority of respondents also indicated that in addition to keeping a register of regulated systems, inspections of water-cooling systems to control Legionella were undertaken regularly, in most cases annually. Councils without a program of regular inspections were more likely to be outside of urban metropolitan areas, where climatic conditions and the type of system used can make outbreaks of Legionella unlikely. Inspection of skin penetration premises was also most likely to occur annually.

Vector borne disease was identified as a problem by only 22% of respondents, most of these being regional and urban fringe councils, however not all councils identifying this issue as a problem had a strategy for addressing it. There was also a vast array of other health protection activities undertaken by council officers, too numerous to mention, in terms of investigating and addressing pollution incidents, activities related to on-site sewage management, and activities associated with waste management such as sharps management and management of asbestos disposal, for example.

Respondents identified a range of issues and challenges associated with performing their regulatory roles in health protection. They consistently identified resource constraints, qualified staff shortages, too many regulatory requirements and cost-shifting as major challenges faced. Other challenges were considered to be a lack of regulatory clarity and adequate legislation and the low profile and priority attached to public health within council and the community as a whole. In terms of issues and functions that were identified as challenges, the top four, in descending order, were food safety, on-site sewage management, grey-water reuse and mosquito control. Councils indicated that the most effective way to address these regulatory issues and challenges was the provision of appropriate resources to enable Local Government to perform both a minimum and optimal public health regulatory role effectively. Other key strategies identified included workforce development such as staff training, organisational development through improved research and planning and improved practices such as more regular inspection programs. A greater focus on the needs of rural and regional NSW was considered important.

6.2 Facilities, activities and programs to promote health

Unlike the regulatory role of Local Government in public health discussed above, councils do not have set functions mandated through legislation in the area of health promotion. Nevertheless Local Government plays an important role in promoting the health of communities both directly through strategies such as those developed to address issues for Social Plan target groups, and indirectly through its functions in social and physical infrastructure provision and environmental planning.

As discussed at the beginning of this report, under Section 2, *Context: Local Government's Role in Public Health*, there is potential for Local Government to contribute to promoting health and preventing disease in a range of ways. For example, councils can develop strategies that focus on the health of employees (such as sun safety), sun protection strategies to prevent skin cancer in the broader community, strategies in the area of safety and injury prevention, and strategies that facilitate healthy eating and greater levels of physical activity. Local Government, because of its role as a provider of services for children, ranging from playgrounds to child care services, also has potential to have a positive impact on the health of children. Because Local Government must plan to meet the needs of seven population target groups through a Social Plan, there is also potential to focus on promoting the health and wellbeing for these groups (discussed in Section 2 of this report under the heading *Social Plans*).

However as there has previously been little statewide research on the role of councils in a range of health promotion areas, little was known about current activity levels. Therefore the Local Government Public Health Survey asked councils a series of questions to determine current activities with potential to have an impact on chronic disease and promote health, the level of priority attached to health promotion issues, partnerships with Area Health Services and strategies required to build council capacity to address these issues more effectively. The responses to these questions are set out

below, starting with an assessment of the importance councils attach to addressing various chronic health issues and contributing factors, and preventing some communicable diseases.

Table 22. Priority given to chronic and communicable disease prevention by councils

Activity	Low priority	Medium priority	High priority	Not answered	Total
Mental health promotion	56%	25%	10%	8%	100%
Drug and alcohol harm minimisation	14%	53%	27%	6%	100%
Vaccine preventable diseases i.e. Childhood immunisation	43%	20%	26%	11%	100%
Physical activity	13%	40%	21%	26%	100%
Food affordability & nutrition	64%	16%	8%	11%	100%
Injury prevention/ safety promotion	13%	33%	48%	7%	100%
Cancer prevention	23%	34%	30%	13%	100%
Preventing blood borne diseases & sexually transmitted infections	61%	22%	8%	8%	100%

Respondents attached highest priority to injury prevention and safety promotion, followed by cancer prevention, reducing harm and anti-social behaviour associated with drug and alcohol use, childhood immunisation and promoting physical activity. Drugs and alcohol were the top medium priority issue, followed by promoting physical activity. Food affordability and nutrition, and preventing blood borne diseases and sexually transmitted infections were more likely to be identified as low priority issues by respondents.

Rural councils were significantly less likely to identify encouraging physical activity as a high priority than other councils. They were more likely to rate it a medium priority issue. Injury prevention and safety promotion was also rated a low priority by more rural councils, 28% of small-medium and 22% large-very large rural councils responding in this way. In regard to cancer prevention, urban metropolitan councils were more likely to identify this issue as a medium or high priority. Similarly this group of councils tended to identify mental health promotion as a medium priority issue, while all other groups of councils were more likely to give it a low priority. Childhood immunisation was again more likely to be accorded a low priority by rural and urban fringe councils, as was preventing blood borne diseases and sexually transmitted infections. However the latter two issues were ranked quite highly by small-medium urban metropolitan councils and large-very large regional councils. There were no distinct variations on the basis of priority identification according to council classification in regard to alcohol and other drugs or food affordability and nutrition.

Physical Activity

Table 23. Infrastructure, facilities & programs for physical activity

	Yes	No	Not answered	Total
Lighting provided	93%	3%	4%	100%
Seating provided	95%	2%	3%	100%
Children's playgrounds	94%	3%	3%	100%
Bicycle/ walking paths provided	92%	5%	4%	100%
Sports grounds	93%	4%	4%	100%
Sports and leisure centres	53%	43%	4%	100%
Outdoor courts	89%	7%	4%	100%
Swimming pool	94%	2%	4%	100%
Heated swimming pool	62%	35%	4%	100%
Swimming classes	53%	42%	5%	100%
Skateboard ramps	79%	18%	4%	100%
Halls/ centres for exercise classes	93%	4%	4%	100%
Walking groups	13%	85%	2%	100%
Participate in walk to work/ school day	56%	41%	3%	100%
Walking school buses	6%	92%	3%	100%
Recreation grant/ donations program	67%	26%	7%	100%
Planning for sun protection in outdoor areas	81%	16%	3%	100%
Accessible to disabled	93%	4%	3%	100%
Plan for safety in outdoor areas	92%	4%	5%	100%
Plan for journeys by foot & bicycle	68%	27%	5%	100%

NB- 107 respondents

Table 23. shows that provision of basic infrastructure that facilitates physical activity such as travel by foot and bicycle is very common, with the vast majority of local authorities providing lighting, seating and cycle and walking paths. The vast majority also provided children's playgrounds, sports grounds, swimming pools, outdoor courts, and halls/ centres in which exercise classes can be conducted.

Provision of some of these facilities was marginally lower by rural councils, for example 11% indicated that they did not provide bicycle and walking paths, 11% small-medium rural councils did not provide sportsgrounds and 56% of small-medium rural councils did not provide sports centres. Rural councils were much less likely to provide heated swimming pools, while small-medium rural councils were significantly less likely to run swimming classes. The same disparity existed in regard to provision of halls/ centres where exercise classes could be conducted and provision of skateboard ramps by small-medium rural councils. However all rural councils provided (unheated) swimming pools, and there was no significant difference in regard to provision of outdoor courts.

The Table above shows that in excess of 80% respondents overall facilitated use of outdoor areas by planning for sun protection, safety and disabled access and that 68% planned for journeys by foot and bicycle. Planning for sun protection was less common in rural areas, with 67% small-medium and 78% large-very large rural councils indicating that they did so. Similarly only 50% small-medium rural councils indicated that they planned to encourage local journeys by foot and bicycle.

Just over half of the respondent councils indicated that they provided sports centres. Although 56% indicated that they participated in walk to work/ school day, only 28% small-medium and 35% large-very large rural councils did so. Involvement in walking school buses and provision of walking groups was low across the board, but particularly so in rural areas. Small-medium rural councils were about 10% less likely to offer grants for recreation programs than other councils. These results show that while provision of basic infrastructure that facilitates physical activity such as bicycle/ walking paths, lighting, seating, sports grounds, children's play areas and equipment and (unheated) swimming pools

was high by all councils, rural councils, particularly small-medium rural councils, were less likely to provide other types of facilities or run programs to encourage physical activity.

Additional recreational infrastructure and facilities were identified in response to an open question that gave respondents the opportunity to mention facilities not covered above. These included indoor courts (for a range of ball sports), sports stadiums, gymnasiums, golf courses, active and passive open space such as parks and botanic gardens, children's playgrounds, maintenance of beach & foreshore areas, lakes & estuaries and provision of a range of walking tracks such as bushwalking tracks, coastal walkways, heritage walks and boardwalks. Councils were also given the opportunity to identify additional physical activity programs and events that they were involved in through an open question. The responses are provided below in Table 24.

Table 24. Additional physical activity programs provided by councils

Activity	Number of responses
Physical activities for children in vacation & after-school care	10
Physical activity related community events i.e. Bankstown Games, Walk to Work Day, Bike Week, Walk it Kiama, Big Ride	10
Staff health programs i.e. subsidized gym membership	9
Activities/ programs for older people	8
Misc. classes/ activities in council centres i.e. aerobics, gentle exercise, yoga, marshal arts, personal training	9
Activities for young people i.e. sports, skateboard competitions	5
Swimming activities including swim safety programs	3
Partnerships with local sporting groups & direct provision basketball/ netball comp	3
Physical activity programs for other population target groups (i.e. mothers, disabled)	2
Other	3
Total	62

The information provided in the Table above should be taken as an indication or example of the types of physical activity programs provided by councils, rather than a comprehensive summary, as the level of response to this open question was not high.

Injury prevention/ safety promotion

Table 25. Council involvement in injury prevention and safety promotion

	Yes	No	Not answered	Total
Involved in injury prevention/ safety promotion	71%	25%	4%	100%
Involved in falls injury prevention for aged/disabled	67%	28%	5%	100%
Crime prevention or community safety committee	68%	27%	5%	100%
Provide home modification & maintenance service	20%	78%	3%	100%
Involved in road safety activities	91%	7%	2%	100%

Involved in recreational water safety activities	61%	36%	4%	100%
Involved in sports injury prevention activities	24%	71%	5%	100%
Involved in suicide prevention	41%	57%	2%	100%
Involved in other community safety activities	74%	23%	3%	100%

NB- 107 respondents

Injury prevention/ safety promotion was a high priority for 48% of respondent councils and a medium priority for 33%. However, as stated above, rural councils were more likely to identify this issue as a low priority. Seventy-six (76) per cent of respondents indicated that they were involved in injury prevention/ safety promotion, however this was the case for only 33% small-medium rural councils.

Involvement in road safety was almost universal, 67% of respondents engaged in falls prevention for the aged and disabled, 61% were involved in water safety, 77% indicated that they attempted to prevent crime through environmental design and 41% reported that they were involved in suicide prevention. Only 24% of respondents were active in sports injury prevention.

There were significant differences in responses to these questions on the basis of council classification. Involvement in recreational water safety was much lower among small-medium rural and small-medium urban fringe councils: the latter were also much less likely to do crime prevention through urban design or sports injury prevention, while 55% medium-large urban metropolitan councils were in fact engaged in this activity. Involvement in suicide prevention was also lower among rural councils, particularly small-medium rural councils, as was falls prevention for the aged and disabled (39%). Rural councils, particularly small-medium, were also significantly less likely to have a Crime Prevention/ Community Safety Committee. However there were no significant differences in involvement in road safety which was high across the board, but particularly among regional and urban fringe councils.

Cancer Prevention- tobacco control & sun protection

Table 26. Cancer prevention activities

Cancer prevention	Yes	No	Not answered	Total
Involved in tobacco control activities	30%	64%	7%	100%
Involved in cancer prevention through sun protection policy	71%	24%	5%	100%
Involved in cancer prevention through OH & S practices	95%	1%	4%	100%
Other cancer prevention activities	26%	69%	5%	100%

NB- 107 respondents

Cancer prevention was a high priority for 30% of respondent councils and a medium priority for 30%: urban metropolitan councils were much more likely to identify this as a medium or high priority issue than other councils. Councils engaged in cancer prevention through tobacco control, sun protection, encouraging healthy eating and physical activity and participating in health promotion campaigns.

Seventy-one (71) per cent of respondents indicated that they had sun protection policies, and there was no urban-rural disparity in responses. Again implementation of Occupational Health and Safety skin cancer prevention was almost universal. However information provided as to the type of sun protection policy indicates that there was considerable variation among councils in this regard, with some only having staff sun-protection policies, and others implementing a full range of policies, such as shade provision at child care centres, playgrounds, sports facilities and pools, development control plans, and sun protection policies for groups using council facilities.

Thirty (30) per cent of respondents were involved in tobacco control. Programs include monitoring sales to minors (PROOF), and implementing non-smoking policies near playgrounds and other outdoor areas. Urban metropolitan councils and large-very large urban fringe councils were more likely to be involved in tobacco control than other classifications of councils.

Nutrition & food security

Table 27. Involvement in nutrition and food security*

	Yes	**No**	**Not answered**	**Total** (107 respondents)
Meals on Wheels provided	33%	67%	0%	100%
Children's Services where food provided	39%	61%	0%	100%
Food affordability programs	19%	79%	2%	100%
Community garden	29%	70%	1%	100%
Produce & other markets	17%	81%	2%	100%
Food sold at swim pools & sports centres	94%	5%	1%	100%
Work in partnership with Area Health Service in food security	24%	69%	7%	100%

* *Food Security has been defined as "Access by all people at all times to enough food for an active, healthy life. Its essential elements are availability of food and ability to acquire it. … [It] includes the following requirements: adequate supply, stable supply, and access to the supply (including adequate consumption, adequate income in relation to food prices and access to employment). Food insecurity, in turn is the lack of access to enough food. There are two kinds of food insecurity: chronic food insecurity which results in a continuously inadequate diet, and acute food insecurity which is a temporary decline in a household's access to enough food www.cwserp.org/training/CWSEMT/KCmodulea.php.*

Although food safety is a high priority area for councils, respondents indicated that they had limited involvement in the area of nutrition and food security. As set out in Table 27., 64% identified nutrition and food security as a low priority, 16% as a medium priority and 8% as a high priority. Twenty-four (24) per cent indicated that they were working with the Area Health Service on food security. Thirty-three (33) per cent provided Meals on Wheels and 39% coordinated children's services where food is provided, such as child care centres. However it appears that nutrition was only considered in the preparation of food for people who receive Meals on Wheels and children who use children's services. Councils indicated that food for these client groups was prepared under advice from a nutritionist or dietician, and in accordance with government guidelines and the Australia and New Zealand Food Standards Code. Although 95% of respondents sold food at swimming pools and/ or sports centres,

only one council indicated that they were considering adjusting leisure centre kiosks to reflect school canteen policy.

There were some significant differences in the way issues of nutrition and food security are dealt with on the basis of council classification. For example, small-medium urban metropolitan and urban fringe councils were more likely to work in partnership with the Area Health Service in food security. Again urban metropolitan and medium-large urban fringe councils were more likely to provide Meals on Wheels, while rural councils were much less likely to run children's services where food is provided, or to assist those unable to afford food. There were no differences on the basis of council classification in regard to sale of food at swimming pools and sports centres.

Other Health Promotion & Protection Activities

Councils were also asked about their involvement in other health promotion and protection roles, in the area of mental health, preventing harm associated with alcohol and other drugs, vaccine preventable diseases and assisting to prevent the transmission of blood-borne diseases and sexually transmitted infections (STIs). The responses are set out below in Table 28.

Table 28. Involvement in other health promotion and protection activities

Activity	Yes	No	Not answered	Total
Mental health promotion activities	40%	54%	6%	100%
Drug & alcohol issues				
Alcohol free zones	90%	7%	3%	100%
Involved in harm minimisation activities	71%	26%	3%	100%
Vaccine preventable disease				
Provide vaccine depot/ approved distribution point	10%	86%	4%	100%
Immunisation clinics	31%	65%	4%	100%
Blood borne diseases & STIs				
Education, information & other service provided	26%	70%	4%	100%
Provide needle disposal bins	66%	28%	6%	100%

NB- 107 respondents

Table 28. reveals that respondent councils were highly involved in harm minimisation activities for alcohol and other drugs and provision of alcohol free zones and that many were involved in activities to promote the mental health of residents. Urban metropolitan councils were more likely to be involved in mental health promotion activities than other categories of councils. Less than 20% of rural councils were involved in the latter. However preventing harm associated with alcohol and other drugs was considered a significant issue by all classifications of councils, although small-medium rural councils were 8% less likely to provide alcohol free zones. Although considered important, involvement in activities to minimise harm arising from use of alcohol and other drugs was significantly less common among rural councils.

While involvement in provision of education, information and other services to prevent the spread of blood borne diseases and sexually transmitted infections was quite high among small-medium urban metropolitan and large-very large regional councils, it was significantly lower than the average among rural councils. Regional councils were somewhat more likely to indicate they provided needle disposal bins.

Immunisation clinics were less likely to be provided by rural councils, with only 17% small-medium and 15% large-very large rural councils indicating that they offered this service.

Additional Health Promotion Activities

Respondents were also asked to identify any other health promotion activities in which they were involved not covered above. In answering this question, some respondents gave answers that fell within categories already identified. Although somewhat repetitive, this information has been included as it provides further evidence of the health promotion activities of importance to councils and also provides some new data. For example alcohol and other drug harm minimisation, sun protection and community safety and injury prevention emerged strongly although already identified above.

Table 29. Additional health promotion activities

Activity	Number of responses
Drug and alcohol harm minimisation & anti- social behaviour reduction	13
Sun protection- council staff and community	12
Community safety promotion & injury & violence prevention	8
Mental health promotion	5
Tobacco control and other anti-smoking initiatives	5
General health promotion- focus on information provision	5
General health promotion- focus on programs	5
Other staff health promotion/ OH& S	4
Cardio-vascular disease prevention	4
Total	61

Councils provided examples of the range of different activities they were involved in under the above categories. For example in regard to alcohol and other drugs, several councils mentioned involvement in local liquor accords. Involvement in the Community Drug Action Team, the provision of information and referral, drug and alcohol education through seminars and provision of alcohol free zones was also mentioned.

The next most common response was sun-protection, both staff sun protection and protection for the wider community. Two councils mentioned joint initiatives with area health services (Hunter and Greater Murray AHS), including a program focusing on young people.

Initiatives falling under the heading of safety promotion and injury and violence prevention included domestic violence and elder abuse awareness and prevention, road safety initiatives such as a family fun day promoting safe cycling including use of helmets, interagency planning in the area of child safety, and safety in regard to late night transport options.

Mental health promotion involved activities such as support for carers of the frail aged and people with disabilities, information and referral and mental health seminars and forums. Tobacco control and other anti-smoking activities in which councils indicated they were involved included provision of smoke-free outdoor areas such as children's playgrounds, joint projects with the Area Health Service, PROOF and promotion of World No Tobacco Day.

The types of activities categorised under the heading of General Health promotion (Information Provision) included local Health Expos, Health Orientation Tours for culturally and linguistically diverse residents, provision of information through council websites, through libraries and regular newspaper columns.

Health issues experienced by Aboriginal residents

Councils were specifically asked to identify the health issues experienced by Aboriginals people in their locality, and how they were addressing these issues. This was the only population group specific question asked in the Survey. It was included because of the significantly poorer health status experienced by the Aboriginal community compared with the rest of the population, requiring an appropriate response from all levels of government. Councils are required to consider the needs of

Aboriginal residents in their Social Plans, as they are one of the mandatory target groups under the *Local Government (General) Regulation 1999*.

Table 30. Health issues experienced by Aboriginal people in respondent's LGA

Issue	Number of responses
Not known (i.e. may not be considered important because of small size of the Aboriginal population, or not a council responsibility)	28
Drug and alcohol misuse & tobacco	23
Mental health issues	18
Diabetes	16
Service provision issues*	16
Healthy lifestyle issues leading to chronic non-communicable disease (i.e. poor nutrition, lack physical activity & obesity)	16
Higher levels morbidity including other health problems**	14
Cardio-vascular disease	12
Maternal & infant health (i.e. underweight babies)	9
Safety, injury & violence (i.e. domestic violence, other assault, injury & self-harm)	6
Otitis media	6
Premature mortality	6
Housing related environmental health***	6
Sexual Health	5
Other child health (i.e. low levels immunisation)	3
Unemployment	3
Other	10
Total	197

** Service provision issues i.e. lack of awareness of health and community services, lack of access to services for reasons such as cultural inappropriateness, general shortage of services & lack of Aboriginal specific services & workers.*

*** High level morbidity- other health problems i.e. liver and kidney disease, asthma, eye diseases, poor dental health, respiratory problems.*

**** Housing related environmental health- substandard & unsanitary housing, overcrowding, waste disposal, water & sewage services and animal control.*

Table 31. Strategies for addressing Aboriginal people's health issues

Strategy	Number of responses
Not applicable or no significant effort	24
Partnerships, networking and liaison with Aboriginal community, Aboriginal people's organisations, networks & Area Health Service	17
Employment of specialised staff i.e. Aboriginal liaison officer, Aboriginal environmental health officer, Aboriginal community development officer	14
Lobby & advocate as need arises	9
Development & implementation of Social Plan	8
Formation Aboriginal Advisory Committee & working through it to achieve goals	7
Conduct research and planning i.e. needs analysis, service review	7
Environmental health activities by Council i.e. dog control, require essential services i.e. water, sewage thru DA process & education on waste disposal	4
Assist in planning for, &/ or provision Aboriginal Medical Centre	3
Education, information provision & awareness raising i.e. through NAIDOC week, education programs, provision health information	3
Domestic violence, safety & crime prevention projects	2
Grant funding for projects	2

Other i.e. Council Statement of Commitment to Aboriginal community with action plan & Council MOU with Aboriginal community which includes health.	3
Total	103

The key health issues identified by respondents as impacting on Aboriginal people were drug and alcohol misuse and tobacco use, mental health, diabetes, health service provision and access issues and issues related to healthy lifestyle and chronic non-communicable disease. However 14.2% of respondents (n=28), indicated that the health issues of Aboriginal people were not known, not considered a priority because of the small size of the population or not considered a council responsibility.

Respondents also identified the range of strategies used to address the health issues experienced by Aboriginal people, the top one being partnerships, networking and liaison with Aboriginal people's organisations, networks and the Area Health Service. The second most commonly identified response was that councils employed specialised staff, such as an Aboriginal Liaison Officer, Aboriginal Environmental Health Officer or Aboriginal Community Development Officer. However 23.3% (n= 28) of respondents indicated they were not addressing Aboriginal people's health issues or that there was no significant effort in this regard. These findings suggest that there is considerable awareness of the types of health issues affecting Aboriginal people among councils and a wide range of strategies being implemented to address these. However a significant minority of councils are not aware of and are not addressing Aboriginal people's health issues, or making no significant effort in this regard although Aboriginal people are identified as a Social Plan target group.

Population targeted health programs

Councils were asked if they targeted any particular population groups, such as those identified in the Social and Community Planning and Reporting Guidelines (2002), in the provision of health promotion and protection programs.

Their responses suggest that councils were most involved in providing health promotion and protection programs to older people (65 years and over) and young people (12-24 years). The types of health programs that were mentioned were as follows: targeted health programs for older people included road safety, falls prevention, dementia education, dementia respite programs, gentle exercise and exercise for the frail aged, and healthy ageing programs. Programs for young people included physical activity programs like skateboard workshops and vacation programs, a range of safety related programs such as sexual assault cards, drug, alcohol & road safety programs, other harm minimisation programs and other unspecified health programs through the local youth centre.

Programs offered to children were in the area of safety and injury prevention such as bicycle safety, health information provision to parents through children's services (e.g. obesity, sun safety, dental care, child protection) and a collaborative project promoting healthy lifestyles to primary school children in the Campbelltown area. Programs offered to people with disabilities were primarily in the areas of access to recreational activities. Population targeted health programs were also provided for women and people from Culturally and Linguistically Diverse communities.

Highlights of results in health promotion

When asked to prioritise health promotion issues, respondents gave highest priority to injury prevention and safety promotion, followed by cancer prevention, reducing harm and anti-social behaviour associated with drug and alcohol use, childhood immunisation and promoting physical activity. Drugs and alcohol were the top medium priority issue, followed by promoting physical activity.

While provision of basic infrastructure that facilitates physical activity such as bicycle/ walking paths, lighting, seating, sports grounds, children's playgrounds and equipment, outdoor courts, halls/ centres suitable for exercise classes and (unheated) swimming pools was high by all councils, rural councils,

particularly small-medium rural councils, were less likely to provide other types of facilities or run programs to encourage physical activity.

Councils indicated that they had some involvement in a wide range of health promotion issues. For example 76% indicated that they were involved in injury prevention/ safety promotion, however this was the case for only 33% of small-medium rural councils. Safety/ injury prevention issues that councils were involved in, in descending order, were road safety, crime prevention through environmental design, falls prevention for the aged and disabled and recreational water safety. There was a relatively low level of involvement in sports injury prevention. Apart from road safety, rural councils were less likely to be involved in these activities.

There was considerable involvement in cancer prevention, particularly sun protection and tobacco control, but also through encouraging healthy eating and physical activity. Seventy-one (71) per cent of respondents indicated that they had sun protection policies, and there was no urban-rural disparity in responses, while 30% indicated that they were involved in tobacco control. Urban metropolitan councils and large-very large urban fringe councils were more likely to be involved in tobacco control than other classifications of councils. However there appears to be a lack of overall consistency across councils in the application of sun protection and tobacco control policies.

Involvement in nutrition and food security was not as common, with 64% of respondents identifying it as a low priority. Around a third of councils indicated that they provided food programs such as Meals on Wheels and ran children's services where food is provided, with almost one quarter involved in partnerships with the Area Health Service on food security. While provision of food at swimming pools and sports centres was almost universal, rural councils were less likely to be involved in other food related initiatives (apart from food safety, which is discussed under Health Protection). However councils were highly involved in activities to minimise the harm caused by alcohol, tobacco and other drugs (71%) and 40% of respondents indicated that they were active in mental health. Again, rural councils were less likely to be involved in these activities.

Councils were also asked to indicate whether they provided specific health programs for population target groups, such as those identified in Social Plans. There was not a high level of response to this open question, however the councils that did respond most commonly identified older people and young people as the groups for whom health promotion programs were provided. Although some councils are aware of and are addressing Aboriginal people's health issues in a proactive way, these issues are overlooked by other councils for reasons such as the small number of Aboriginal people living in the locality, despite Aboriginal people being identified as a Social Plan target group.

7. Partnerships in Public Health

Councils were asked a series of questions to attempt to determine the nature of partnerships with other agencies, primarily Area Health Services, in health promotion and protection. The two tables immediately below give details as to the organisations consulted on public health in Social Plan development and the agencies that councils work in partnership with to promote the health and wellbeing of residents.

In summary, involvement in partnerships with Area Health Services in health protection and promotion is common across council classifications. However less extensive partnerships tended to exist between rural councils and AHS. Collaboration is on the whole highly valued by councils, as it is believed to facilitate more effective service provision. However partnerships are stronger in health protection than health promotion, which is to be expected given the regulatory role of councils in this area and their history of service provision.

Table 32. Organisations consulted on public health in Social Plan development

Organisation	Number of responses
Community Health Centres/ Area Health Services/ NSW Health*	91
NGOs, community groups, residents, consumer networks	34
Department of Ageing, Disability & Homecare, Home and Community Care Services, other aged care & disability services	17
Aboriginal & Torres Strait Islander Medical Centre/ Health Service	10
Other government departments	10
Division of General Practice	9
Local Base Hospital	7
Department of Community Services	5
NSW Police	5
Culturally & linguistically diverse community representatives & organisations	4
Aboriginal Land Councils and Aboriginal community	4
National Heart Foundation, NSW Cancer Council & Diabetes Australia	4
Individual General Practitioners	3
Local Health Forum or Committee	3
Women's Health Centre	2
Total	208

** NB- While respondents simply indicated that they consulted the AHS or NSW Health, some identified specific units such as the Rural & Remote Medical Service (1 response), Public Health Unit (2), Youth Health Service, Multicultural Health Unit (2), Drug & Alcohol Service, Mental Health Services (5) and AHS Health Promotion Unit (5) .*

As might be expected respondents overwhelmingly consulted with Area Health Services on public health in the development of Social Plans, with an emphasis on contact with Community Health Centres. The range of different AHS teams consulted indicates the challenge councils face in planning to address health issues in their localities and suggests that a more streamlined approach may be needed. The other government department most frequently consulted on health was the Department of Ageing, Disability and Homecare, including individual Home and Community Care Services**.** Councils also indicated that they consulted with Divisions of General Practice.

Table 33. Agencies councils work with to promote health

Organisation	Number of responses
NSW Health (including AHS, Public Health Unit, Community Health Centre)	15
Non-government organisations, community groups & churches	13
Other NSW government departments/ agencies	11
NSW Department of Education/ TAFE/ individual schools	7
NSW Department of Tourism, Sport & Recreation	6
NSW Police	6
NSW Roads & Traffic Authority	5
NSW Premiers Department	5
NSW Food Authority	4
Local sporting clubs and associations	4
NSW Cancer Council	3
Home & Community Care Services	3
Children's Services	3
Divisions of General Practice	3
Other councils	3
Healthy Cities	2
NSW Department of Community Services	2
National Heart Foundation	2
Department of Environment & Conservation	2
Other	7
Total	106

Again respondents worked primarily with Area Health Services in promoting public health, although they also worked closely with non-government organisations, churches, consumer groups and residents as identified in the Table above. The other government departments respondents were most likely to work with were the NSW Department of Education and individual schools, the NSW Department of Tourism, Sport and Recreation and NSW Police.

Table 34. Partnerships with Area Health in Health Protection

Activity	Yes	No	Not answered	Total
Involved in joint projects/ activities with AHS	72%	26%	2%	100%
Consult with AHS in program/ plan/ policy development	64%	32%	4%	100%
Meet regularly with AHS to discuss issues	56%	41%	3%	100%
Meet occasionally with AHS to discuss issues	64%	20%	16%	100%
Involved in networks with the AHS	70%	26%	4%	100%
Memorandum of Understanding or Service Agreement with AHS	20%	76%	5%	100%

NB- 107 respondents

While the data in Table 34. provides responses for all councils there was considerable variation in response on the basis of council size and location. Overall, it was common for respondents to be involved in joint projects or activities with the AHS in health protection (72%), to be involved in networks with the AHS in health protection (70%) and to consult with the AHS in program, plan and policy development (64%) in this area. Respondents were more likely to meet occasionally/ sporadically (64%) than regularly (56%) with the AHS on health protection however MoUs and Service Agreements were not common (20%).

In all council classifications apart from rural, involvement in joint projects/ activities with the AHS in health protection was in the range of 81-100%. For rural councils however, only 56% of respondents in the small-medium classification were involved and 44% of large-very large rural councils. A similar pattern was apparent in regard to consultation with the AHS in program, plan and policy development in health protection with small-medium and large-very large rural councils scoring 44% and 48% respectively.

Similarly only 28% small-medium rural councils and 37% large-very large met regularly with the AHS on health protection, while the figure for urban metropolitan councils was 77% for small-medium and 91% for large-very large. Rural councils were more likely to indicate they met occasionally with the AHS.

It appears that some councils had very limited contact with the AHS, as they met neither regularly or occasionally with these services. Similarly while 81-100% of non-rural councils were involved in networks with the AHS on health protection, this was much less common among rural councils, with 33% of small-medium and 52% large-very large councils involved in this activity. Urban councils, both metropolitan and urban fringe were much more likely to have a MoU or Service Agreement with the AHS on a health protection matter than rural councils.

Table 35. Partnerships in Health Promotion with Area Health

Activity	Yes	No	Not answered	Total
Receive grant funding from AHS	16%	77%	7%	100%
Involved in joint projects/ activities with AHS	60%	35%	6%	100%
Consult with AHS in program/ plan/ policy development	63%	33%	5%	100%
Meet regularly with AHS to discuss issues	48%	47%	6%	100%
Meet occasionally with AHS to discuss issues	61%	28%	11%	100%
Involved in networks with AHS	70%	24%	6%	100%
Memorandum of Understanding with AHS	9%	85%	6%	100%

NB- 107 respondents

Respondents were significantly more likely to be involved in joint projects and activities with the Area Health Service in health protection than promotion (72% v 60%), and were somewhat more likely to meet regularly with the AHS to discuss health protection issues (56% v 48%). Respondents were significantly less likely to have a MoU or Service Agreement with the AHS in health promotion (20% v 9%). However other involvement such as participation in networks with the AHS, consultation in program, plan and policy development and meeting occasionally with the AHS to discuss issues was virtually identical in health protection and promotion. Overall, partnerships based on these measures could be described as well-developed, although there is clearly room for these to be developed further, particularly among rural councils.

There were no significant differences on the basis of council classification in regard to receipt of grant funding from the AHS for health promotion**.** However rural councils were generally much less likely to engage in partnerships with the AHS on the basis of the indicators above. For example 82-92% of urban metropolitan councils consulted with the AHS in regard to program, plan or policy development in health promotion, while only 39% of small-medium and 44% of large-very large rural councils did so. In regard to meeting regularly with the AHS, urban metropolitan councils were significantly more likely to do so than regional or rural councils. While no real pattern emerged in regard to occasional meetings with the AHS on health promotion issues, medium-large rural councils were more likely to answer in the negative. Similarly, urban metropolitan councils and medium-large urban fringe councils were much more likely to indicate that they were involved in networks with the AHS (i.e. 85 – 91% answered in affirmative). While MoUs on health promotion were not common, eight of the ten respondents who had these were urban metropolitan or urban fringe councils.

Benefits of health protection and promotion partnerships

Councils were asked to identify the ways in which partnerships with local Area Health Services were positive and effective. Council responses have been grouped into the categories set out in the Table below.

Table 36. Positive and effective aspects of partnerships with Area Health Services

Positive aspects	Number of responses
Facilitates information sharing	47
Enables access to AHS expertise, technical support & legislative updates	24
Facilitates joint project planning, coordination & implementation	16
Efficient & leads to better outcomes through resource pooling	10
Reduces duplication & provides clarification/ agreement as to respective roles	9
Increases impact of efforts, particularly on a regional level	9
Leads to greater collaboration, including on a regional level	8
Networking opportunities with other councils & peer support	8
Successful in leading to increased/ improved health service provision (esp regional/ rural)	7
Leads to consistency & uniformity in approach to health protection	4
Assists in impact of health promotion activities associated with mental health awareness week, HIV Awareness Day & youth week etc	2
Ineffective or negligible effect	5
Total	149

Partnerships were valued by respondents for leading to access to information and AHS expertise, increasing effectiveness including on a regional basis, and resulting in opportunities for peer support. While the responses are essentially self-explanatory, it is worth noting that access to Area Health expertise and technical support was particularly valued in health protection, and that there was also an emphasis on regional initiatives in this area. Working in partnership with relevant AHS staff and other councils was considered important to be effective and to contribute to a consistent approach regionally. The response that collaboration reduced duplication and increased clarity and agreement as to respective roles also referred to the regulatory health protection role of councils. A minority of respondents (4.6%) expressed negative views about partnerships, indicating that they either did not exist or were ineffective.

Table 37. Strategies for improving health protection & promotions partnerships

Strategy	Number of responses
Improved communication, liaison, networking & collaboration with AHS	36
Adequate council funding	17
Additional AHS resources for work with councils	12
Establishment of formal partnerships with AHS i.e. regular meetings, MOU	13
Clarification of structure & roles AHS & councils	8
More assistance from AHS	7
Improved planning & support from AHS & NSW Health senior management	9
Maintain commitments following AHS restructure	5
Development of new initiatives	5
More understanding by AHS of implications of council funding/ staff limitations	5
Better planning & coordination	3
Other	8
Working well- no improvement needed	10
Total	138

The majority of councils responding to this question thought that there was significant scope for improving existing partnerships with the AHS, primarily through improved communication, liaison and networking and through increased collaboration on joint projects. Councils thought that more frequent meetings were a key way to enhance communication and that more commitment from the AHS towards collaboration was required. A number believed that partnerships should be formalised through establishing regular meeting arrangements attended by a senior AHS officer/s, and developing a Memorandum of Understanding. While some councils supported the notion of regular meetings, others indicated that lack of staff would impose restrictions on capacity to participate. Some respondents suggested improvements to existing regular meetings with the Public Health Unit through better organisation, planning and administrative support to ensure that meetings are professionally valuable. Clearer objectives and better outcomes from existing regional health forums were suggested.

As partnerships at present are stronger with Public Health Units, some councils thought that partnerships with other parts of health, such as Health Promotion Teams, could be expanded. As the AHS is the key health agency, it was considered to be their primary responsibility to initiate contact with councils on health issues and develop partnerships. Further involvement in joint health promotion projects with councils was requested, and that AHS regularly attend relevant interagency meetings. One council suggested that the AHS provide mortality and morbidity data to councils and meet with them to plan for programs to address factors that contribute to ill-health. It was believed that provision of assistance of this nature by the AHS would strengthen partnerships.

Provision of training and resource materials was requested, as was the opportunity to participate in AHS planning meetings. One council identified Families First as an exemplary partnership model that could inform council/ AHS partnerships in public health. More access to AHS staff, participation in networks, access to resources such as health data and more input from the AHS into the planning process, for example through comment on development applications, was requested. Improved relationships would ensue from treating councils as equals in dealings with them relating to public health. The importance of improving partnerships on a regional basis was emphasised, and that strategic links, joint planning and endorsement of partnerships occur at senior levels, such as Directors of Public Health and Health Promotion Units and the General Manager, Directors and Managers within councils.

Greater understanding between the AHS and councils would be fostered if there was greater mutual understanding of organisational structures and functions and the roles of staff, for example of AHS staff that might be available to work with councils on health promotion projects. A mechanism for updating each other on such matters and staff changes was believed to be needed. There was thought to be a need for clearer delineation of the roles of Local and State Government public health regulators. It was also considered important for AHS to have reasonable expectations of the level of resources that it was possible for councils to commit to health, given that this is only one area of operation by councils, unlike the AHS.

However councils understood that the capacity of AHS staff to offer assistance, particularly the PHU, was restricted by lack of funding and pressure on staff time. Concern was expressed about the possibility that the current restructure of AHS may lead to a reduction in the number of AHS staff, a lessening of commitment to work in partnership with councils and less contact with AHS staff due to the larger geographic areas covered by the new AHS. Councils called for AHS to be provided with adequate resources to enable them to work in partnership with and provide assistance to councils in this new environment. More State Government environmental health professionals were requested. The issue of the resourcing of health services, including those with a preventive role like Early Child Health Centres was believed to be inadequate in some areas. A council in Sydney's south-west requested more health promotion resources, indicating it had experienced a drop in staff and resources available for such activities.

Similarly councils were of the view that adequate provision of resources, both staff and financial, would assist them to work in partnership with AHS. Adequate state government funding, particularly project specific funding, was requested. The priority given to this issue reflects the importance of the issue of resourcing as a barrier preventing councils from expanding their role in public health, discussed elsewhere in this report. Devolution of health protection roles from State to Local Government, without provision of funding, a practice referred to as cost-shifting, was also critically mentioned in this context.

Improvement of partnerships through development of new initiatives, such as a local interagency committee with health promotion goals and an annual public health conference were suggested.

Highlights of results in partnerships

In summary, involvement in partnerships with Area Health Services in health protection and promotion is common across council classifications, but much more common among non-rural councils. Collaboration was on the whole highly valued by councils, as it was believed to facilitate more effective service provision. However partnerships are stronger in health protection than health promotion, which is to be expected given the regulatory role of councils in this area and their history of service provision.

As might be expected respondents overwhelmingly consulted with Area Health Services on public health in the development of Social Plans, with an emphasis on contact with local Community Health Centres. The other government department most frequently consulted on health was the Department of Ageing, Disability and Homecare, including individual Home and Community Care Services**.** Again respondents worked primarily with Area Health Services in promoting public health, although they also worked closely with non-government organisations, churches, consumer groups and residents. The other government departments respondents were most likely to work with were the NSW Department of Education and individual schools, the NSW Department of Tourism, Sport and Recreation and NSW Police.

Respondents were significantly more likely to be involved in joint projects and activities with the Area Health Service in health protection than promotion (72% v 60%), and were somewhat more likely to meet regularly with the AHS to discuss health protection issues (56% v 48%). Respondents were significantly less likely to have a MoU or Service Agreement with the AHS in health promotion (20% v 9%). However other involvement such as participation in networks with the AHS, consultation in program, plan and policy development and meeting occasionally with the AHS to discuss issues was virtually identical in both areas. Overall, partnerships based on these measures could be described as well-developed, except for rural councils, although there is clearly room for these to be developed further among all categories of councils.

Partnerships with Area Health Services were generally highly valued by councils, particularly in health protection. Respondents tended to regard access to AHS expertise in the form of information, advice and updates on legislative changes, and also joint planning, coordination and project implementation as essential in performing their roles effectively. This was particularly the case in health protection. Other important benefits of partnerships were that they led to greater resource efficiency and better public health outcomes, particularly on a regional basis.

There was also a good response to the open question asking councils to identify strategies for improving partnerships with Area Health Services. The majority of councils responding to this question thought that there was significant scope for improving existing partnerships with the AHS, primarily through improved communication, liaison and networking and through increased collaboration on joint projects. Councils thought that more frequent meetings were a key way to enhance communication and that more commitment from the AHS towards collaboration was required. A number believed that partnerships should be formalised through establishing regular meeting arrangements attended by a senior AHS officer, and by developing a Memorandum of Understanding.

8. Best Practice in Public Health within Local Government

Respondents were asked to identify work in the area of health protection and promotion at their council that they considered to be innovative or best practice. Their responses are set out in Table 38.

Table 38. Self-assessment of best practice in public health

Activity	Number of responses
Food safety	17
Physical activity programs and plans	16
Safety promotion and injury prevention	12
On-site sewage management	8
Pollution related initiatives	6
Health promotion initiatives for target groups	4
Partnership programs with AHS	4
Staff sun protection policies & procedures	4
Childhood immunisation	4
Public health planning (including links with sustainability)	4
Tobacco control & staff quit smoking policy	3
Vector borne disease prevention	3
Food security and healthy eating projects	3
Computer aided technology for on-site reporting of regulatory activities	3
Sharps disposal program	3
Infrastructure provision/ improvement (i.e. park refurbishment, cycleways; recreation & heated aquatic centre)	3
Other staff OH & S practices	2
Inspection program for regulated systems (i.e. cooling towers)	2
Successful in working for additional health service provision	2
Other	12
Total	115

Respondents most frequently identified food safety initiatives, followed by physical activity related programs and initiatives, and safety promotion/ injury prevention, as work in public health at their council they considered to be best practice. With regard to food safety, activities councils were most likely to identify were food safety education initiatives for food handlers and food surveillance/ inspection strategies and programs. Several identified risk based food safety programs, one identified temporary events guidelines and one a food safety awards program. Inspections with prompt follow-up were considered best practice.

Approximately half of the initiatives identified under safety promotion and injury prevention related to road safety such as senior drivers programs and other safe driving programs. Other safety related initiatives were in the area of water safety programs for children, a late night transport strategy and status as a World Health Organisation Safe Community.

Table 39. Awards received by Councils in the last 5 years for health promotion activities

Award	Number of Awards	Council	Project
National Heart Foundation Kellogg LG Award	19	See text below	See text below
Greater Murray Area Health (GMAHS) Service Public Health Award	1	Tumbarumba	Not specified
GMAHS Public Health Award	1	Tumut	Not specified
GMAHS Public Health Award	1	Wagga Wagga	Not specified
Water Safety Award- (AustSwim & Department of Tourism, Sport & Recreation)	1	Port Stephens	Not specified
Water Safety Award (AustSwim & Department of Tourism, Sport & Recreation)	1	Warringah	Water Safety program for CALD adults
Major Contribution to Local Sports Award (NSW Department of Tourism, Sport & Recreation & Australian Society of Sports Administrators)	1	Parramatta	Unspecified
Ausport & Australian Sports Commission National Award for Local Government	1	Port Stephens	Unspecified
Road Safety Award (Institute of Public Works Engineering Australia)	1	Wollongong	Night owl bus to prevent drink-driving
Road Safety Award (IPWEA)	1	Wyong	Drink Walking Project, Rugby World Cup
Other	14	See footnote	See footnote
Total	42		

Table 39. shows that respondents most frequently nominated the Heart Foundation Kellogg Local Government Award as the award they had won in the area of public health. There was also a diverse array of other awards won by councils including awards in the area of water safety, road safety, sport, sports injury prevention, waste disposal, mental health, parks and leisure facilities, risk management, and awards offered by area health services and regional organisations of councils.

Respondent councils indicating that they had won a National Heart Foundation Award were Albury Council (Healthy Heart Award 2003 project unspecified); Baulkham Hills Council (Staff Sports Competition); Bankstown Council (Healthy Heart Award 2000 project unspecified); Bellingen Council (Healthy Heart Awards, Dorrigo Active Community project); Campbelltown Council (Best National Community Recreation Project, 1997, Challenge Walk); Cessnock Council (Healthy BBQ Tips Cookbook in partnership with Coalfields Healthy Heartbeat, 2004 State Awards); Fairfield Council (CALD Health Orientation Tour); Greater Queanbeyan Council (Pram Walking for Wellbeing); Holroyd Council (Healthy Heart Award 2004, Peer Support Exercise Program for people with intellectual disabilities); Junee Council (Recreation & Aquatic Centre); Kempsey Council

(Therapy Walk); Leeton Council (Shotball Tournament for aged people); Leichhardt Council (Walk to School Project); Parramatta Council (Highly commended 2004, Ponds Walk Program); Penrith Council (Penrith Food project); Sutherland Council (Outstanding Heart Week Activities Award 1999) and Sydney City Council (Healthy Heart Award for local food policy).

Under the other category, a range of Awards were mentioned once only. These included the NSW Sports Safety Award Scheme (Safe Sporting Grounds Project), LGSA Excellence in Environment Awards (Medical Waste Collection Service, Highly Commended), NSW Parks & Leisure Australia Award (Lakeside Sports & Leisure Complex), Australian Professional Ocean Lifeguard Association Award (Beach awareness & road safety education for school age children & CALD adults); NSW Sporting Injury Committee (Outstanding sports injury prevention and reduction); Risk Management Excellence Awards (Statewide Good Risk Management Practices), Mental Health Week Award; Local Government Managers' Association & Sydney Morning Herald Management Excellence Awards for Local Government ('Skip to the Beat' aspect of Neighbourhood Community Renewal program); Quality Improvement Award; Mid North Coast Area Health Service (Great Lakes Safe Community Project); South Sydney Regional Organisation of Councils' Awards (Mum's on the Move Project-walking group for mothers).

Highlights of results in best practice

Respondents most frequently identified food safety initiatives, followed by physical activity related programs and initiatives, and safety promotion/ injury prevention as areas of work in public health that they considered to be best practice. In regard to awards for work in public health, respondents most frequently nominated the Heart Foundation Kellogg Local Government Award as the award they had won. Projects for which awards were received were most often in the area of physical activity, such as walking facilities or programs, and sport and recreation programs. There was also a diverse array of other awards won by councils including awards in the area of water safety, road safety, sports injury prevention, waste disposal, mental health, parks and leisure facilities, risk management, and awards offered by Area Health Services and regional organisations of councils.

9. Capacity Building in Public Health

Capacity building has been defined as "an approach to the development of sustainable skills, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over" (Hawe et al: *Indicators to help with capacity building in health promotion*: 1999). It covers areas such as organisational development, workforce development, resource allocation, leadership and partnerships. In practice capacity building may involve strategies in the area of communication/ access to information, staff education and training opportunities, better planning and coordination, better policies and procedures, and closer work with partners through formalising partnership arrangements and other strategies.

Councils were asked a series of questions to give an indication of current capacity, such as numbers of staff with a public health role, the ways in which they could build capacity, and what would assist them in doing so. The responses are set out below.

Table 40. Council Staff with Public Health Functions

Staff position title	Yes	No	Total
Environmental health officer	93%	7%	100%
Recreation officer	42%	58%	100%
Swimming pool staff/ life guards	76%	24%	100%
Road safety officer	62%	38%	100%

NB- 107 respondents

The vast majority of councils indicated that they had at least one Environmental Health Officer, the 7% that did not have a staff member in this position all being small-medium regional and small-medium rural councils. The average number of EHOs per council was 4.6, while the average number of full-time equivalent staff was only 3.

Recreation Officers were much less common in rural areas with only 22% small-medium rural councils (4 councils) and 33% large-very large rural councils (9 councils) indicating that they had a staff member in this role. The average number of fulltime equivalent staff employed in recreation functions was two. The majority of respondents had only one Road Safety Officer, however rural councils were significantly less likely to have a staff member in this position. Urban metropolitan councils tended to have less swimming pool staff/ life guards, perhaps because they were more likely to contract out this function.

Councils were also asked to identify staff other than the above with public health functions. The responses are set out on the following page in Table 41.

Table 41. Other Council staff with a public health role

Staff position title	Number of responses
Community services officers e.g.- Aged & disability officer, Youth officer	38
Social planner	9
Community safety officer	8
Health promotion officer/ manager *	5
Immunisation staff i.e. coordinator, nurse	3
Rangers	3
Children's services staff	2
Environmental protection officer	2
Onsite sewage management officer	2
Meals on wheels staff	2
Other	8
Total	82

** Staff included in the category Health Promotion Officer/ Manager were Health Promotion Coordinator, Community Project Officer- Health Development, Coordinator Community Health, Community Lifestyle Planner, Healthy Communities Manager.*

Capacity Building

Councils were asked to rank the list of strategies set out in the Table below on the basis of importance in developing their capacity in public health.

Table 42. Strategies for capacity building

Capacity building strategies	Less important	Important	Very important	Not answered	Total
Grants	3%	22%	64%	10%	100%
Information & resources	2%	29%	58%	11%	100%
Staff education & training	7%	31%	51%	11%	100%
Organisational support to treat as priority	7%	34%	46%	13%	100%
Specialised staff	11%	31%	45%	13%	100%
Networking opportunities	13%	39%	36%	11%	100%
Opportunities for partnerships	12%	44%	33%	11%	100%

NB- 107 responses

The fact that councils accorded access to grants highest priority as a foundation to build capacity is in line with the consistent theme running through Survey responses that resource gaps experienced by councils prevent them from addressing public health as fully as possible. Councils indicated that they would be assisted by grants both for specific uses such as new projects and to fund additional staff. The survey has revealed that these resource gaps are marked for rural councils, particularly small-medium councils who have small populations and low rate bases but may cover large geographic areas. The provision of additional resources, including addressing cost-shifting from State to Local Government, was frequently viewed as a prerequisite for expanding respondents' roles in public

health. Other high priority areas for capacity building were access to information and resources and staff education and training.

There was overall consistency in response to this question across council groups, with some variation. Networking was scored as less important by 22% of rural large-very large councils, while the same group was more likely to score access to grants as very important (81% compared to an overall mean of 64%). Urban fringe councils were more likely to identify opportunities to form partnerships as important, with 88% of large-very large urban fringe councils scoring this as very important and 67% small-medium urban fringe councils as important. Organisational support to treat as a priority also scored very highly among the latter, and was also high among rural councils.

Respondents were also given the opportunity to identify ways they could develop capacity, to supplement responses to the closed question the results of which are set out above. Councils identified the list of directions and strategies in the Table below.

Table 43. Further strategies and directions for capacity building

Strategy	Number of responses
Additional staff and resources	29
Better council policies, procedures, planning & coordination	21
Council staff training and education	9
More health education & information to community in partnership with AHS	7
Develop a Public Health Plan or improve existing Plan	5
More networking, liaison, joint projects & improved relations with AHS	5
Engage more specialised staff i.e. Public Health Officer, Project Officers for sun-protection & community safety	4
Higher profile & priority for public health	4
Improvement to infrastructure and programs in area of physical activity	4
Develop Memorandum Of Understanding with AHS	3
Empower & work with communities to investigate concerns	2
More emphasis on community safety & injury prevention	2
More council funding & support	2
No capacity building required as this primarily State Government responsibility	2
Other	5
Total	104

The most common response was that councils could only develop their capacity in this area through provision of additional resources from other spheres of government, primarily the State Government. Councils complained that public health and other roles have been devolved from the State Government without the concomitant provision of resources, i.e. cost-shifting. Councils indicated that more resources were needed to initiate and maintain programs, including health improvement programs, and the dissemination of information to the community.

The second most common strategy identified to build council capacity in public health was the need for improved council planning and coordination, policies and procedures, a strategy without significant resource implications. Ideas put forward about ways this could be done included better integration between public health staff and staff responsible for strategic planning through preparation of the State of the Environment Report, Social Plan and Management Plan and incorporation of public health issues into these documents. Another council suggested an internal audit of public health service provision and staff expertise, while another suggested the development of public health performance indicators.

Taking a broader view of public health within council was also suggested, beyond the traditional health protection functions. It was proposed that councils conceptualise their desired role in this area, and establish improvements in public health as a strategic organisational goal. The development of a broader policy framework to address public health was suggested. Several respondents also suggested that their council give consideration to developing a Public Health Plan. One respondent proposed that their council prepare a Healthy Ageing Policy.

The third most commonly identified strategy to build council capacity was education and training in public health for staff with health related functions. Training in the form of case studies, seminars and workshops was suggested. Again access to specialist expertise was considered important. This could occur as a consequence of a closer working relationship with the AHS, which was identified as another important capacity building strategy. Councils called for more support from the AHS in the form of grants for specific projects and project staff, improved relations, closer networking and more joint projects.

Councils also thought that they had a role, to some extent in partnership with the AHS, in the promotion of health messages to the community, and in the provision of information and awareness-raising about physical activity and recreational opportunities in the locality to encourage adequate utilisation of services. Respondents indicated that effort was needed to improve physical activity programs (public & private), including those run be clubs. Fees were considered prohibitive for the socio-economically disadvantaged as were language barriers for residents from culturally and linguistically diverse communities. It was suggested that councils need access to additional Recreation Officers to develop physical activity programs for the general public and special population groups.

The perception among Local Government public health professionals that this field, particularly traditional health protection activities, has a low profile within the community and councils came through quite strongly in this research. Respondents suggested that there should be more support for public health from management and councillors and more resources allocated from within council to this work area, and that strategies should be identified to promote and raise the profile of public health.

Highlights of results in capacity building

The existing capacity of councils in public health is to some extent reflected in the nature and number of staff in public health roles. While almost all respondent councils had Environmental Health Officers, and a significant proportion had Swimming Pool Staff/ Lifeguards, Road Safety Officers and Recreation Officers, staff numbers were typically lower in rural areas.

These results suggest that with some exceptions, councils have a significant existing public health capacity in traditional regulatory health protection functions and in safety/ injury prevention areas such as water safety and road safety. The proportion of councils with Recreation Officers suggests that councils have some capacity in the planning and provision of recreation services, with likely beneficial impacts on levels of physical activity in the community. It is also clear that other staff such as Community Services Officers for the aged and young people, play a role in activities such as falls prevention and access, safety in regard to use of public transport and drug and alcohol harm minimisation, coordination of physical activity programs, and mental health promotion, addressing issues such as dementia in the aged and youth suicide. A range of other programs were also identified involving other Social Plan target groups.

A minority of respondents had health promotion specific staff, often funded jointly with the local Area Health Service, addressing issues such as food security, for example. The development of partnership arrangements such as these has great potential to expand the role of councils in health promotion, allowing them to better address key chronic disease issues such as cancer and cardio-vascular disease and prevent injury.

Councils accorded access to grants/ financial resources highest priority as a foundation to build capacity, both for specific uses such as new projects and to fund additional staff. The issue of cost shifting in health protection was given some priority by respondents. Other high priority areas for capacity building were access to information and resources and staff education and training. Areas that were self-identified by councils as significant, rather than emerging from a multiple choice question, included the need for improved council planning and coordination and better policies and procedures within councils. Some respondents identified the need for more extensive and formalised partnerships with the AHS, particularly in the area of health promotion. They also indicated that it was important to raise the profile of public health so that it is accorded a higher priority in council and the community, and attracts more resources. Expanding their role in health promotion was generally of more interest to urban councils, a significant proportion of non-metropolitan councils indicating that managing their regulatory functions was a challenge due to factors such as resource constraints and skilled staff shortages.

10. Role of Associations in building council capacity

Councils were asked to identify the priority health promotion and protection issues and council functions that they thought should be a focus for the Associations' Public Health Project, and also to identify strategies for directing efforts to most effectively build capacity.

Table 44. Key public health capacity building strategies for Associations

Strategy	Number of responses
Facilitate Local Government's access to financial resources for public health	19
Organise and facilitate access to training for existing council staff	15
Facilitate better policy & planning within councils & provide access to model policies, plans & other resources (i.e. resources for community education)	15
Facilitate improved partnerships with AHS	8
Address cost-shifting	8
Special focus on staff and other resource gaps in rural areas	7
Raise profile of public health in council & community	6
Facilitate access to specialised, qualified staff	4
Facilitate clearer definition of health roles of Local and State Government	2
Facilitate networking opportunities	2
Other	2
Total	88

The most frequently identified role for the Associations to enable councils to increase their capacity in public health was to facilitate additional access to financial resources. Councils had a number of suggestions about how this should be done. These included improving the resource generation abilities of councils, promoting resource sharing between councils, identifying funding opportunities and liaising with NSW Health to maximise resource sharing. It was also suggested that the Associations seek grant funding for councils to do public health plans and a range of public health projects, particularly in the area of health promotion. However the most common response was that the Associations should lobby other levels of government, particularly the State Government to address funding gaps. Additional resources for councils in public health monitoring, surveillance and education in the traditional health protection areas were consistently called for, and the Associations were seen to have a role in putting the case for such resources to other spheres of government.

As one council put it, they saw it as the role of the Associations to *"lobby the State Government to ensure that state responsibilities are not moved to Local Government either via legislative change or simple inaction in addressing health problems affecting local communities"*. This process, described above as cost-shifting, is identified as a separate category in the above table, but in fact is primarily about access to adequate financial resources for Local Government. The response dealing with the issue of resourcing and cost-shifting was thus the issue most frequently identified by councils. Councils also indicated that in the process of transferring public health responsibilities from State to Local Government, responsibilities had become unclear, and the Associations were also seen as having a role in addressing this.

The other most common set of responses dealt with a perceived role for the Associations in workforce development by facilitating access to training opportunities for existing council staff and in organisational development by assisting in best practice in council policy and planning in this area. The Associations were seen as having a role in developing model health plans and strategies and best practice guidelines for adoption by councils and providing guidance on preparing plans and policies on public health in an integrated way. Offering examples of new initiatives and projects in this area operated by other councils was also suggested. Advocating the benefits of integrating public health planning with social, strategic and corporate planning, particularly management plans, was

recommended and working with urban planners so that they incorporate public health issues was suggested. It was suggested that the Victorian approach be adapted to public health planning in NSW.

In the development of health plans, identifying local public health issues and according these issues priority as matters to be addressed by councils was suggested. The Associations were encouraged to facilitate consultation between State and Local Government to develop local strategic plans and to enhance a regional focus on public health planning to promote uniform practice on common issues. In regard to the traditional health protection role, development of a by-consensus model identifying an acceptable base minimum service level, funding mechanism and minimum training requirements for Local Government staff performing such roles was suggested.

It was also proposed that the Associations prepare a booklet on preparing funding submissions and offer assistance in this process. Access to other resources such as health related information in both health protection and promotion targeted at the community was also repeatedly identified. Provision of such resources was seen as the role of the State government.

In regard to training of existing staff, the Associations were asked to provide or facilitate provision of training and professional development opportunities for staff performing traditional health protection functions, such as refresher courses, updates on new legislative developments, and training in regional/ rural areas on the Food Standards Code. More broadly, education of council staff on key public health issues, how to promote these to the community and on models for capacity building within Local Government was proposed. Seminars and conferences were believed to be needed to raise the profile of public health and develop the 'New Public Health' in Local Government.

Staff in regional/ rural areas were often considered to lack opportunities for professional development. The need for more traineeships to be available in health protection was also raised, as was the desirability of educating more Environmental Health Officers, particularly to be available to work in regional/ rural areas. A related issue that the Associations were asked to address was to facilitate the adequate availability of specialised, qualified staff, particularly in health protection. A focus on public health in rural areas was believed to be needed, including building capacity of staff, and it was suggested that the Associations lobby the State Government to make specialist public health services accessible to small rural councils. Greater recognition of the increasing demands being placed on Local Government in areas of rural decline and the need to "*think outside the square to survive*" including regional groupings of councils to provide public health services, was suggested. The issue of medical and allied health workforce shortages in rural areas was also identified as an area for attention by the Associations, particularly supporting advocacy by councils in addressing these gaps.

There was also a focus in these responses on the relationship between councils and Area Health Services. As stated above, there was felt to be a lack of clarity in regard to responsibilities in health protection. The Associations were asked to promote and facilitate improved partnerships between AHS and councils based on better communication.

In addition to identifying priority capacity building strategies, some respondents also identified priority public health issues on which they felt the Associations should focus. These are set out below in Table 45.

Table 45. Priority health promotion and protection issues for Associations

Priority	Number of responses
Healthy & active community i.e. physical activity promotion, nutrition & obesity prevention	10
Community safety & injury prevention	9
Food safety & nutrition	8
Sun protection & other cancer prevention (unspecified)	6
Grey water reuse	5
Facilitate Onsite Sewage Management Best Practice	4
Tobacco control & health promotion on tobacco	3
Alcohol & other drugs- focus on harm minimisation	3
Water quality- recreational & potable	2
Mental health	2
Other health protection *	8
Other health promotion	3
Total	63

** Other category comprised 1 response only for each issue identified i.e. vector borne disease, blood borne disease & STIs, waste disposal, skin penetration premises & Aboriginal housing.*

Some councils made specific requests that certain issues under each of these categories be addressed. In regard to community safety and injury prevention, issues raised included safety for the elderly, such as preventing trips and falls, water safety, particularly swimming pool fencing compliance to prevent child drowning, road safety, youth suicide prevention and other issues for youth in rural areas and domestic violence prevention. In regard to road safety, one council suggested that the Associations lobby for a safety first approach to all road activities and for the Roads and Transport Authority to organise localised campaigns.

In regard to grey water re-use, it was suggested that the Associations facilitate access to training for councils in this area and funding for greater water reuse. It was also suggested that the Associations facilitate the updating of hygiene standards for hairdressers and beauty salons and the development of regional vector control strategies.

In regard to tobacco, a focus on tobacco control and education of clubs, hotels and the general public about relevant legislation in this area, was suggested.

Highlights for Associations in building council capacity

The most frequently identified role for the Associations to enable councils to increase their capacity in public health was to facilitate additional access to financial resources in this area. The other most common set of responses dealt with a role for the Associations in facilitating access to training opportunities for public health staff and assisting in best practice in policy, planning and organisational development. The Associations were seen as having a role in developing model health plans and strategies and best practice guidelines for adoption by councils and providing guidance on preparing plans and policies on public health in an integrated way. The Associations were asked to provide or facilitate provision of training and professional development opportunities for staff performing traditional health protection functions, such as refresher courses, updates on new legislative developments, and training in regional/ rural areas.

More broadly, education of council staff on key public health issues, how to promote these to the community and on models for capacity building within Local Government was proposed, through mechanisms such as seminars and conferences. The need for more traineeships to be available in health protection was also raised, as was the desirability of educating more Environmental Health Officers to work in regional/ rural areas. In addition to providing assistance in these areas, respondents also identified specific public health issues that the Associations should build council

capacity in. Most prominent among these were physical activity promotion and obesity prevention, community safety and injury prevention, food safety and nutrition and cancer prevention, particularly skin cancer prevention. The Associations were thus seen as having a role in building council capacity not just in health protection, but also in key health promotion areas.

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Appendix 1. Local Government Public Health Survey

Instructions and Background Information

What is public health?

Public health has been defined as "the organised response by society to protect and promote health and to prevent illness, injury and disability" (MOU www.nphp.gov.au/about/mou.htm). The distinguishing feature is its focus on the health and well-being of an entire population rather than an individual. Public health has three components: health protection, health promotion and disease prevention.

Health protection is the enforced regulation of human behaviour to protect health. It includes preventing, identifying and managing outbreaks of communicable diseases, and minimising health risks arising from the built environment. Health promotion is the process of enabling people to increase control over, and to improve their health. Examples include information campaigns such as Quit campaigns, programs to reduce falls and programs to increase physical activity. Disease prevention involves interventions to reduce the incidence and prevalence of disease or injury: for example infant and child health screening and breast and cervical cancer screening (NPHP: 2002:24-25).

How to complete?

This survey is designed to be completed and returned electronically, by typing responses in the boxes in each section. If more space is required the box will automatically enlarge as you type.

Who should co-ordinate completion?

The Associations recommend that completion be coordinated by a Senior Council Officer and the response approved by the General Manager to ensure that it is endorsed within Council. As it crosses a range of Council functions, the officer responsible for completion will need to seek the input of a range of Council officers to satisfactorily complete this questionnaire. Officers to be consulted will include environmental health staff, urban planning staff, community services staff, the social planner, recreation officer, community safety officer and the road safety officer.

When and how to return?

Please return the completed questionnaire to vanessa.whittington@lgsa.org.au by COB Friday 3 December 2004.

Thank you for participating in this project.

LOCAL GOVERNMENT PUBLIC HEALTH SURVEY

A. Council Information

1. Name of Council :

2. Contact Officer

Please provide the name, position title and contact details of the person coordinating completion of this questionnaire.

Name Position Telephone Fax Email address

B. Public Health Issues & Council Planning Processes

3. Plans, Policies, Reports & Strategies

Instructions: *Type 1 in the Yes column or 2 in the No column*

Plans, Policies, Reports & Strategies	**Yes (1)**	**No (2)**
Urban Planning		
Are public health issues included in Strategic Plans?		
Are public health issues included in LEPs or DCPs?		
Does Council have a DCP that focuses on sun protection/ shade provision?		
Does Council have a Section 94 Plan that requires contributions for open space, recreational facilities and community centres?		
Are public health issues considered in the DA process?		
Does Council encourage developers to consider public health impacts in the preparation of Environmental Impact Statements?		

[1] **Office Use Only**

Council Group	
Urban met small and medium council	
Urban met large and very large council	
Urban regional small and medium council	
Urban regional large and very large council	
Urban fringe small and medium council	
Urban fringe large and very large	
Rural agricultural small and medium	
Rural agricultural large and very large	
Remote extra small and small	
Remote medium	
Remote large	

Plans, Policies, Reports & Strategies	Yes (1)	No (2)
Environmental Reports & Initiatives		
Are public health issues included in the SoE Report?		
Are public health issues included in Agenda 21 initiatives?		
Social/ Community Plans		
Were public health issues included in the first mandatory Social Plan submitted to the Department of Local Government in 1999?		
Are public health issues being considered in the development of the second mandatory round of Social Plans?		
Public Health Plans		
Does Council have a current Public Health Plan?		
Has Council previously produced a Public Health Plan?		
Does Council intend to produce a Public Health Plan?		
Management Plans/ Annual Reports		
Are public health issues identified in the 03/04 Management Plan?		
Are public health issues reported on in the 03/04 Annual Report?		
Crime Prevention/ Community Safety Plan		
Does Council have a current Crime Prevention/ Community Safety Plan?		
Does Council have a Road Safety Plan?		
Does Council have a Sports Injury Prevention Plan?		
Transport Planning		
Does Council have a transport plan?		
Are public health issues included in the Transport Plan?		
Does the Transport Plan incorporate cycling & walking?		
Does Council have a Bicycle Plan?		
Planning activities for Swimming Pools		
Does Council have a swim pools policy statement?		
Does Council have a swim pools Study/ Plan?		
Does the Social Plan incorporate swim issues?		
Planning activities for Parks & Gardens		
Does Council have a parks & gardens policy statement?		
Does Council have Plans of Management for parks & gardens?		
Has Council undertaken an open space needs study?		
Does the Social Plan incorporate open space/ parks/gardens issues?		
Planning activities for Sport & Recreation Planning		
Does Council have a sporting ground policy statement?		
Does Council have plans of management for sporting grounds?		
Does Council have a Sport & Recreation Needs study/ Plan?		
Does the Social Plan incorporate Sport & Recreation issues?		
Planning activities for Immunisation		
Does Council have an Immunisation Policy Statement?		
Planning for Early Childhood Health Centres		
Does Council have an Early Childhood Health Centres Policy Statement?		

Urban Planning

4. How does Council integrate health promotion objectives such as encouraging physical activity into the urban planning process? *(i.e. creating supportive environments for physical activity, falls prevention, shade provision, transport planning for road safety and activities other than car travel etc)*

Social/Community Plans

5. What 5 key public health issues have been or will be included in the second round mandatory Social Plan?

6. What organisations have been or will be consulted on public health in the development of the next Social Plan?

Management Plans

7. What 5 key public health issues are identified for action in the current Management Plan?

Public Health Plan

8. If Council has a current Public Health Plan, what 5 key issues are identified in this Plan?

Public Health Policies

9. Has Council adopted any public health related policies? If yes, please name these policies and the year adopted (policies may be in area of health promotion i.e. sun protection, nutrition or health protection i.e. food safety, tobacco control)

Integrated Planning

10. How does Council undertake integrated planning on public health issues?

C. Public Health Activities of Council

The purpose of this section is to obtain basic data on current Council public health activities in the area of health protection, health promotion and disease prevention.

C.1 Health Protection

The following section will require input from Council's Environmental Health unit.

11. Food safety

Food safety	**Number**
How many Council staff are authorised officers under the *Food Act 2003*?	
How many Council staff are approved food safety auditors?	
How many food premises are there in the LGA?	
How many inspections of food premises were conducted in the 2003/04 financial year?	
How many complaints about food premises were received in the 03/04 financial year?	
How many improvement notices were issued to food premises in the 03/04 financial year?	
How many prohibition orders were issued in the 03/04 financial year?	
How many food premises staff were trained in safe food practices in this period?	

12. What other food safety activities was Council involved in over the 2003/04 financial year?

13. How would you describe Council's current capacity to address food safety in the LGA? Please complete the table below by typing 1 if capacity 'poor', 2 if 'fair', 3 if 'good' and 4 if 'very good'.

Food safety	**Poor (1)**	**Fair (2)**	**Good (3)**	**Very Good (4)**
Capacity to address food safety				

14. How could Council's capacity to address food safety be improved?

15. Potable and recreational water

Instructions: *Type 1 for Yes in the Yes column, 2 for No in the No column. In the 'How often' column type 1 if something occurs weekly, type 2 if it occurs fortnightly, type 3 if it occurs monthly, type 4 if it occurs biannually, type 5 if it occurs annually. In the final column indicate the number of times something occurred.*

			How often	
Regulatory function	**Yes (1)**	**No (2)**	**Weekly (1) Fortnightly(2) Monthly (3) Biannually (4) Annually (5)**	**No.**
Potable Water and Grey Water				
How often are water samples taken for testing?				
If Council does not already fluoridate the water supply, does it intend to seek approval to fluoridate?				
How many approvals have been sought under the Local Government Act (Section 68 Part C 6) for the operation of a system of sewage management for: 1. grey water diversion……..				1.
Recreational Water				
How often are Council swimming pools inspected?				
How often are samples of Council swimming pool water taken for testing?				
Are other swimming & spa pools open to the public inspected by Council and how often?				
Are samples of other swimming & spa pool water open to the public taken for testing and how often?				
Are inspections of private swimming pool fencing conducted by Council and how often?				
Does installing of private swimming pool fencing require development consent?				

16. Other Regulatory Functions

Instructions: *Type 1 for 'Yes' in the Yes column or 2 for 'No' in the No column. Indicate if something occurs quarterly by typing 3 in this column, if it occurs bi-annually type 4 in this column and if it occurs annually type 5. In the Number column type a figure indicating how many times something occurred.*

			How often			
Other regulatory functions	**Yes (1)**	**No (2)**	**Quarterly (3)**	**Bi-annually (4)**	**Annually (5)**	**No.**
Microbial Control						
How often is the register of regulated systems updated?						
How often do you conduct inspections of regulated systems?						
Do you conduct inspections only in response to a request or complaint?						
In the last financial year how many notices were issued that prescribed maintenance be conducted?						
Skin Penetration						
How often is the register of skin penetration premises updated?						
How often are inspections of skin penetration premises conducted?						
Are inspections conducted only in response to a request or complaint?						
Mortuaries & holding rooms						
Are inspections of mortuaries & holding rooms conducted and how often?						
Vector Borne Disease Control						
Is vector borne disease a problem in your locality?						
Does Council have a strategy for addressing vector borne disease?						

Other health protection roles

17. Please list any additional health protection activities performed by Council (for example under the Protection of the Environment Operations Act)

Waste Management

18. What public health issues are associated with Council's waste management role?
(i.e. vermin control, odour, sharps disposal)

19. How are these issues being addressed?

20. Partnerships with Area Health in Health Protection

Please use the options below and the Other category to provide details about partnerships between Council and the local Area Health Service in regard to health protection functions

Partnerships	**Yes (1)**	**No (2)**	**Function/ Issue**
Is Council involved in joint project/s or activities with the local AHS?			
Does Council consult with the AHS in program/ plan/ policy development?			
Does Council meet regularly with the AHS to discuss issues?			
Does Council meet occasionally with the AHS to discuss issues?			
Is Council involved in networks with the AHS?			
Does a memorandum of understanding or a service agreement exist with the AHS?			
Other? **Please specify**			

21. In what ways are these partnerships positive and effective?

22. In what ways could these partnerships be improved?

Regulatory arrangements

23. What are the critical issues and challenges facing local government in its involvement in public health regulatory activities? (for e.g. issues may include on site sewage management, grey-water re-use, food safety, vector borne disease control etc)

24. How could these issues and challenges be addressed?

Examples of Best Practice

25. Please identify work in the area of health protection at your Council that you consider to be innovative or best practice, explaining why this is so.

C.2 Health Promotion Activities of Council

The following section will probably require input from Community Services staff, Recreation staff, and Planning staff.

26. Health promotion facilities and activities

Instructions: *In the Yes column type 1 for 'Yes', or type 2 for 'No' in the No column. Type 3 in the low priority column if it is a low priority health issue for Council, 4 in the medium priority column if it is a medium priority health issue & 5 in the high priority column if it is a high priority health issue.*

Physical activity	**Yes (1)**	**No (2)**	**Low Priority (3)**	**Medium Priority (4)**	**High Priority (5)**
What priority is physical activity for Council?					
Does Council provide bicycle/walking paths?					
Does Council provide sports grounds?					
Does Council provide a sports centre?					
Does Council provide outdoor courts?					
Does Council provide a swimming pool?					
Does Council provide a heated swimming pool?					
Does Council run swimming classes?					
Does Council provide skateboard ramps?					
Does Council provide halls/ centres that can be used for exercise classes?					
Does Council run walking groups?					
Does Council participate in Walk to Work/ School day?					
Does Council run or support any Walking School Buses?					
Does Council provide a Recreation Grant/ Donation program?					
Food affordability & nutrition					
What priority is food affordability & nutrition for Council?					
Is Council involved in any food related activities not already identified?					
Does Council work in partnership with the local Area Health Service in regard to food security (i.e. addressing affordability) & nutrition?					
Injury prevention/ Safety promotion					
What priority is injury prevention/ safety promotion for Council?					
Is Council involved in injury prevention/ safety promotion activities?					
Does Council have a Crime Prevention or					

Community Safety Committee?					
Cancer prevention					
What priority is cancer prevention for Council?					
Is Council involved in any tobacco control activities?					
Is Council involved in skin cancer prevention through implementation of a sun protection policy?					
Is Council involved in skin cancer protection through OH & S practices?					
Is Council involved in any other cancer prevention activity?					
Mental Health promotion					
What priority is mental health promotion for Council?					
Is Council involved in mental health promotion activities?					
Minimising drug & alcohol related harm					
What priority are drug & alcohol issues to Council?					
Does Council have alcohol free zones?					
Is Council involved in other activities to minimise drug and alcohol related harm?					
Does Council provide needle disposal bins?					
Vaccine preventable diseases	**Yes (1)**	**No (2)**	**Low Priority (3)**	**Medium Priority (4)**	**High Priority (5)**
What priority is childhood immunisation to Council?					
Does Council provide a vaccine 'depot'/ approved distribution point?					
Does Council provide immunisation clinics?					
Blood-borne disease & STDs					
What priority are theses issues for Council?					
Does Council provide education, information or other services to prevent the spread of blood-borne diseases (i.e. HepB, HepC, HIV) or sexually transmitted infections?					

27. What physical activity programs other than those identified above are provided or coordinated by Council?

28. What recreational and sports facilities other than those identified above are provided by Council?

More Detailed Health Promotion Information

Physical activity

29. Use the list of options below, typing 1 for yes, 2 for no, to indicate how Council promotes and facilitates physical activities, both active and passive, on sportsgrounds, parks or other public land. Use the Other category to list additional ways that Council does this.

Encouraging Physical Activity	**Yes (1)**	**No (2)**
Is lighting provided?		
Is seating provided?		
Are children's play areas/ equipment provided?		
Are bicycle and walking paths provided?		
Does planning for sun protection occur?		
Accessible to people with mobility problems?		
Does planning occur for safety?		
Does planning occur to encourage local journeys by foot/bicycle? i.e. to recreation facility, corner shop, public transport		
Other (**Please Explain)**		

Food programs- nutrition, affordability & accessibility

30. Use the list below to indicate the food related activities, services and programs Council provides or co-ordinates, typing 1for Yes or 2 for No. In the Other category identify any additional food programs.

Food Programs	**Yes (1)**	**No (2)**
Is Meals on Wheels provided by Council?		
Does Council run Children's Services where food is provided?		
Are programs/ assistance offered to people who can't afford nutritional food?		
Does Council have a community garden?		
Does Council have produce/ other markets?		
Is food sold at swimming pools and sports centres?		
Does Council have a catering service?		
Is food provided at Council sponsored festivals/ community events?		
Other **(Please explain)**		

31. How does Council ensure that food provided in the ways set out in Question 26 is of appropriate nutritional value?

Injury Prevention/ Safety promotion

32. Use the list of options below, typing 1 for Yes, 2 for No to indicate how Council works to prevent injury and promote safety in the community. In the Other category indicate other ways that Council does this.

Injury Prevention/ Safety Promotion	**Yes (1)**	**No (2)**
Is Council involved in falls & injury prevention for aged & disabled people?		
Does Council provide a home modification & maintenance service?		
Is Council involved in road safety activities?		
Is Council involved in recreational water safety activities?		
Is Council involved in sports injury prevention activities?		
Does Council implement crime prevention through urban design principles?		
Is Council involved in other community safety activities?		
Is Council involved in suicide prevention activities?		
Is Council involved in drug & alcohol harm minimisation activities?		
Other **(Please specify)**		

Other health promotion activities

33. Is Council involved in any health promotion services, programs or activities additional to those identified above? Please specify, noting if Council has policies & plans in these areas (i.e. Anti-smoking, Sun protection, Drug and Alcohol, Mental Health)

Health status of Aboriginal people & Torres Strait Islanders

34. What are some of the health issues experienced by Aboriginal people and Torres Strait Islanders in your LGA? (Please include environmental health issues if applicable)

35. How is Council addressing the health issues of Aboriginal people and Torres Strait Islanders in your LGA?

Targeted Programs

36. Does Council target any particular population groups, such as those identified in the Social and Community Planning Guidelines, in the provision of health promotion or protection programs? Please provide details

Partnerships in Health promotion with Area Health

37. Use the options below to identify the type of partnerships that exist with the local Area Health Service in performing the health promotion activities set out above in this section. In the Other category identify any other ways of working with the AHS.

Partnerships	**Yes (1)**	**No (2)**	**Issue/ Function**
Does Council receive grant funding from AHS?			
Is Council involved in joint project/ activities with the AHS?			
Does Council consult with the AHS in program/ plan/ policy development?			
Does Council meet regularly with the AHS to discuss issues?			
Does Council meet sporadically with the AHS to discuss issues?			
Is Council involved in networks with AHS?			
Does a Memorandum of Understanding exist with the AHS?			
Other? **Please specify**			

38. Does Council work with any other agency/s (government or non-government) in performing the health promotion activities set out above in this section? Please name the agency, and describe the partnership

39. In what ways are partnerships with the AHS positive and effective?

40. In what ways could partnerships with the AHS be improved?

Examples of Best Practice

41. Please describe work in the area of health promotion at your Council that you consider to be innovative or best practice, explaining why this is so.

42. Has Council received an award for its health promotion activities in the last five (5) years? Please name the award, state who awarded it, the initiative and the year received.

D. Council Staff engaged in Public Health Functions

The purpose of this section is to obtain information about the current role and potential for Council activity in public health, based on the existing staff base.

Instructions: *In the Number of staff column, type in the number of staff performing the specified role/s, in the next column type in the number of full-time equivalent staff (i.e. one full time and one half time staff member type = 1.5), in the next column provide combined details for public health related tasks performed by staff, where there is more than one officer performing an identified role*

43. Council staff engaged in public health functions

	Number of staff	**Number of full-time equivalent staff**	**5 major public health related tasks performed**	**Approximate % of time spent on each task**
Environmental Health Officer/s- Environment Protection Officer/s			1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Recreation officer/s			1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Swimming pool staff/ Life guards			1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Road safety officer			1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

Other Staff with public health role

44. Please specify the job title/s and the public health activities of other staff, including Community Services staff, Social Planning staff and the Community Safety Officer.

E. Capacity Building Strategies

Capacity building has been defined as "an approach to the development of sustainable skills, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over" (Hawe et al; *Indicators to help with capacity building in health promotion*: 1999). It covers areas such as organisational development, workforce development, resource allocation, leadership & partnerships. In practice capacity building may involve strategies in the area of communication/ access to information, education, staff training opportunities, better planning and coordination, better policies & procedures, and a focus on strategic directions.

45. In what ways could Council develop its capacity in the area of public health?

46. What would assist Council to develop its capacity in this area? Please complete the table below, by typing in 1 if item is less important, 2 if important and 3 if very important.

Capacity Building Strategies	**Less important (1)**	**Important (2)**	**Very important (3)**	**Issue/ Function**
Access to education & training for staff				
Access to resources & information				
Networking opportunities				
Specialised staff				
Other resources such as grants				
Opportunities to form partnerships				
Organisational support to treat as priority				
Other **(Please Explain)**				

F. Role of Local Government & Shires Associations of NSW

The Associations have recently commenced a NSW Health funded three-year project focusing on building Local Government's capacity in the area of public health.

47. In your view what health promotion and protection issues and Council functions should the Associations focus on and how should we direct our efforts to most effectively build capacity?

G. Further Comments

48. Do you have any further comments?

Thank-you for taking the time to complete this questionnaire

Appendix 2. List of Council Respondents and Classifications

Council Name	Classification*
Albury City Council	(Urban) regional medium council
Armidale- Dumaresq Council	(Urban) regional small council
The Council of the Municipality of Ashfield	(Urban) metropolitan developed medium council
Auburn Council	(Urban) metropolitan developed medium council
Baulkham Hills Shire Council	(Urban) fringe very large council
Ballina Shire Council	(Urban) regional medium council
Balranald Shire Council	(Rural) agricultural medium council
Bankstown City Council	(Urban) metropolitan developed very large council
Blacktown City Council	(Urban) metropolitan developed very large council
Bathurst Regional Council	(Urban) regional medium council
Bega Valley Shire Council	(Urban) regional medium council
Bellingen Shire Council	(Rural) agricultural very large council
Bogan Shire Council	(Rural) agricultural medium council
Boorowa Shire Council	(Rural) agricultural medium council
Botany Bay Council	(Urban) metropolitan developed medium council
Bourke Shire Council	(Rural) agricultural medium council
Brewarrina Shire Council	(Rural) agricultural medium council
Broken Hill City Council	(Urban) regional small council
Burwood Council	(Urban) metropolitan developed medium council
Cabonne Shire Council	(Rural) agricultural very large council
Camden Council	(Urban) fringe medium council
Campbelltown City Council	(Urban) fringe very large council
Cessnock City Council	(Urban) regional medium council
Clarence Valley Council	(Urban) regional medium council
Coffs Harbour City Council	(Urban) regional medium council
Coolamon Shire Council	(Rural) agricultural medium council
Cooma-Monaro Shire Council	(Rural) agricultural large council
Coonamble Shire Council	(Rural) agricultural medium council
Cootamundra Shire Council	(Rural) agricultural large council
Cowra Shire Council	(Rural) agricultural very large council
Dubbo City Council	(Urban) regional medium council
Eurobodalla Shire Council	(Urban) regional medium council
Fairfield City Council	(Urban) metropolitan developed very large council
Forbes Shire Council	(Rural) agricultural very large council
Gilgandra Shire Council	(Rural) agricultural medium council
Gloucester Shire Council	(Rural) agricultural medium council
Gosford City Council	(Urban) fringe very large council
Goulburn-Mulwaree Council	(Urban) regional small council
Great Lakes Council	(Urban) regional medium council
Greater Taree City Council	(Urban) regional medium council
Griffith City Council	(Urban) regional small council
Gundagai Shire Council	(Rural) agricultural medium council
Gunnedah Shire Council	(Rural) agricultural very large council
Gwydir Shire Council	(Rural) agricultural large council
Hawkesbury Shire Council	(Urban) fringe medium council
Hay Shire Council	(Rural) agricultural medium council
Holroyd City Council	(Urban) metropolitan developed large council
Hornsby Shire Council	(Urban) fringe very large council

Inverell Shire Council	(Rural) agricultural very large council
Junee Shire Council	(Rural) agricultural large council
Kempsey Shire Council	(Urban) regional small council
The Council of the Municipality of Kiama	(Urban) regional small council
Kogarah Municipal Council	(Urban) metropolitan developed medium council
Ku-ring-gai Council	(Urban) metropolitan developed large council
Kyogle Council	(Rural) agricultural large council
Lane Cove Council	(Urban) metropolitan developed medium council
Leeton Shire Council	(Rural) agricultural very large council
Leichhardt Municipal Council	(Urban) metropolitan developed medium council
Lismore City Council	(Urban) regional medium council
Liverpool City Council	(Urban) fringe very large council
Lockhart Shire Council	(Rural) agricultural medium council
Maitland City Council	(Urban) regional medium council
Manly Council	(Urban) metropolitan developed medium council
Marrickville Council	(Urban) metropolitan developed large council
Murrumbidgee Shire Council	(Rural) agricultural medium council
Muswellbrook Shire Council	(Rural) agricultural very large council
Narrabri Shire Council	(Rural) agricultural very large council
Narrandera Shire Council	(Rural) agricultural large council
Newcastle City Council	(Urban) regional very large council
Oberon Council	(Rural) agricultural large council
Parkes Shire Council	(Rural) agricultural very large council
Parramatta City Council	(Urban) metropolitan developed very large council
Penrith City Council	(Urban) fringe very large council
Pittwater Council	(Urban) metropolitan developed medium council
Port Stephens Council	(Urban) regional medium council
Queanbeyan City Council	(Urban) regional medium council
Randwick City Council	(Urban) metropolitan developed very large council
Rockdale City Council	(Urban) metropolitan developed large council
Ryde City Council	(Urban) metropolitan developed large council
Shellarbour City Council	(Urban) regional medium council
Shoalhaven City Council	(Urban) regional large council
Snowy River Shire Council	(Rural) agricultural large council
Sutherland Shire Council	(Urban) metropolitan developed very large council
Sydney City Council	(Urban) Capital City- classified as (Urban) metropolitan developed very large council for purposes of this report
Tamworth Regional Council	(Urban) regional medium council
Temora Shire Council	(Rural) agricultural large council
Tenterfield Shire Council	(Rural) agricultural large council
Tumbarumba Shire Council	(Rural) agricultural medium council
Tumut Shire Council	(Rural) agricultural very large council
Tweed Shire Council	(Urban) regional large council
Upper Hunter Shire Council	(Rural) agricultural very large council
Uralla Shire Council	(Rural) agricultural large council
Urana Shire Council	(Rural) agricultural small council
Wagga Wagga City Council	(Urban) regional medium council
Wakool Shire Council	(Rural) agricultural medium council
Walcha Council	(Rural) agricultural medium council
Walgett Shire Council	(Rural) agricultural large council
Warringah Council	(Urban) metropolitan developed very large council
Warrumbungle Shire Council	(Rural) agricultural very large council

Waverley Council	(Urban) metropolitan developed medium council
Weddin Shire Council	(Rural) agricultural medium council
Wellington Council	(Rural) agricultural large council
Wollondilly Shire Council	(Urban) fringe medium council
Wollongong City Council	(Urban) regional very large council
Woollahra Municipal Council	(Urban) metropolitan developed medium council
Wyong Shire Council	(Urban) fringe very large council
Yass Valley Council	(Rural) agricultural very large council

** Draft council classification system produced by Department of Local Government for Comparative Information* on *NSW Local Government Councils* 2004/05 *(unpublished) used in above as it includes amalgamated councils.*