

Getting into the Act

Local government and public health in 2013 and beyond

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Executive summary

Local government is one of the most important and powerful influences on the health and wellbeing of communities and populations. The decisions local government makes affect the determinants of health. As such, local government has the ability to improve population health and reduce inequalities in New Zealand.

This thinkpiece describes the changes to the local government legislation and discusses their potential impact on public health. It examines opportunities and mechanisms to strengthen participation and representation of Māori in local government, and concludes with ideas for building stronger partnerships between local government and public health.

The *Local Government Act 2002* (LGA) sets out the purpose of local government, its duties, and many of its functions. Recent amendments to the Act were made in 2012, and have significantly changed the purpose statement of local government. They have removed local government's focus on promoting the social, cultural, economic, and environmental wellbeing of communities – the “four wellbeings”. The legislation has reoriented local government towards cost-effectiveness and financial prudence. The amendments have also reduced obligations on councils to consult with communities in developing community outcomes, made it more difficult for communities to voice their opinion on reorganisation proposals for their councils, and increased the power of the Minister of Local Government to intervene in local government affairs.

These changes to the legislation may jeopardise councils' ability to positively affect the determinants of health. They may also present a threat to democratic participation which in itself is essential for well-being. Legislation such as the *Health Act 1956* and the *Resource Management Act 1991*, however, may safeguard local government's role in protecting and promoting health.

Importantly, the Treaty of Waitangi continues to provide the framework for relationships between the Crown, mana whenua and taura here. The amendments to the LGA have not altered the statutory duties of local government to take into account the principles of the Treaty. There are, however, opportunities to enhance

local government's commitment to the Treaty of Waitangi, for instance through the creation of Māori wards and constituencies to ensure representation of Māori at the governing table.

Presently, it is at the discretion of individual councils to determine which services and activities they will provide to their communities, and which ones they will not. The full impact of the legislation changes will become apparent over time and the public health sector will need to account for this new and changing context in its work.

There are several actions for public health practitioners to consider. Fundamentally, public health must prioritise local government as a key stakeholder, invest in stronger relationships and establish concrete partnerships between the two sectors. At the same time, public health practitioners will need to stay closely connected to local communities. Practitioners can support communities, particularly those that experience a disproportionate burden of ill-health, to have their voices and aspirations heard and accounted for in local government decision-making.

Public health practitioners can also strive to raise the understanding and profiles of both public health and local government within government agencies and society. Framing public health arguments in terms of value for money, to match the outlook and language of the present governing approach, could be a key part of this strategy.

In light of the forthcoming elections, public health practitioners can consider standing for election to their local council, supporting candidates who have a public health interest, and importantly, raising awareness of candidates' positions on significant local public health issues to enable informed voting.

The ever changing context in which public health operates will continue to present challenges to improving population health and reducing inequalities. Being vigilant of these changes, being adaptable, and being vocal, will enable the public health sector to step closer to this goal, and support and empower individuals and communities to lead the lives they value.

Introduction

“When we focus on the social determinants of health, rather than the medical cause of some specific disease, we see that local government services are health services. It is no exaggeration to say that without local government, adults and children would die sooner, would live in worse conditions, would lead lives that made them ill more often and would experience less emotional, mental and physical well-being than they do now.” (Campbell 2010)

Purpose of the thinkpiece

The purposes of this thinkpiece are to:

1. provide an analysis of how recent amendments to local government legislation may impact the role of local government in promoting broad social and health objectives
2. demonstrate continuing opportunities to improve population health through joint public health and local government action within this new context

Health has many dimensions. It has been defined as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO 1948). The challenges to achieving completeness aside, health is much more. It relates to not only individuals but communities and collectives, and encompasses spiritual and family dimensions of life (see Te Whare Tapa Whā, Durie 1999). Health also has environmental, temporal, and contextual components (see Fonofale Model of Health, Pulotu-Endemann 2001).

These concepts of health speak to the fact that health cannot be purchased or found in a doctor’s office.

Rather, our health is created by the conditions around us, the conditions in which people are born, grow, live, work, and age (CSDH 2008). As such, many of the influences on health lie beyond the control of the health sector. Several in fact reside within the realm of local government, and local government is a major determinant of health.

In New Zealand, the legislative structure for local government is set out in the Local Government Act. This Act determines what local government must do – its obligations, and what it may do – its powers. The Act is supported by a range of specific enactments (such as

the *Health Act 1956* and the *Resource Management Act 1991*) and takes into account the principles of the Treaty of Waitangi.

Local government legislation in New Zealand was transformed through passage of the *Local Government Act 2002*. This provided a mandate for local government to take action on broad social, economic, environmental, and cultural objectives. The 2002 Act was amended in 2010 and again in 2012 with the effect that this broad scope has been limited.

There is uncertainty within the public health community about the implications of these changes and the range of opportunities still available to work with local government to achieve public health objectives.

Therefore, Part 1 of this thinkpiece outlines the changes to local government legislation and their potential impact on public health.

Part 2 explores the opportunities for local government to take into account the principles of the Treaty of Waitangi and increase meaningful participation and representation of Māori in local government.

Finally, Part 3 provides suggestions as to how public health practitioners and local government can work together within the new context to achieve improvements in population health and wellbeing.

Local government as a determinant of health

Local government in New Zealand takes the form of territorial authorities – city councils and district councils, of which there are presently 11 and 50 respectively, regional councils of which there are 11, and six unitary authorities (territorial authorities which also have



Diagram 1. The social determinants of health and well-being. How local government can make a difference. (Campbell 2010)

regional council responsibilities). Councils may also set up local or community boards.¹

Local government councillors and the mayor are elected every three years by the population within their boundaries, and are mandated to act in the best interests of their communities (LGNZ 2013a).

Local government has many functions. Councils make decisions regarding the services they will provide and the level of rates or fees they charge to their constituents to fund these services (LGNZ 2013b). Councils also have the responsibility for making bylaws to protect the public from nuisance, to protect, promote and maintain public health and safety, and to minimise the potential for offensive behaviour in public places (Section 145 *Local Government Act 2002*).

Councils provide a vast array of services, including, but not limited to, those which relate to land use and planning, natural and physical resource management,

road and transport infrastructure, waste management, drinking water, sewage collection and treatment systems, recreational areas and parks, smokefree and alcohol-free zones, social housing, and emergency preparedness.

These factors interact with each other to shape the context and environments in which individuals and communities live, and therefore the many functions and services provided by local government synergistically protect and promote health. It has been recognised, therefore, that:

“the modern role of local government can be described as ‘place-shaping’ – the creative use of powers and influence to promote the general well-being of a community and its citizens... the ultimate purpose of local government should not be solely to manage a collection of public services, but rather to pursue the well-being of a place and

1. Local boards were originally designed for Auckland Council, which, in a new structure for New Zealand local government, shares decision making between the boards and the governing body of councillors and the mayor. Government has signalled the intent to enable the Local Government Commission to establish local boards in some other circumstances.

the people who live there by whatever means are necessary and available” (p. 60, 61 Lyons 2007).

The extensive influence of local government on health is illustrated in the diagram above.

This diagram supports the recognition by the Ministry of Health in New Zealand of “local government as a key local influence on public health and the contribution of its work to national public health outcomes” (MoH 2009). The diagram demonstrates the sheer multitude of services and activities that local government can or does provide, how these craft the places we live, work, grow and play in, and therefore how local government holistically influences health and wellbeing. For example, preventing the contamination of drinking and recreational water through the maintenance of sewage collection and treatment systems and waterways protects communities from waterborne infectious diseases.

Some councils may provide social housing and evidence demonstrates that if housing is warm and dry through insulation and/or effective heating, respiratory health, particularly that of children, improves, as does their subsequent attendance at school (Howden-Chapman *et al* 2007, Howden-Chapman *et al* 2008).

Urban design and planning are particularly important in the context of the burden of noncommunicable diseases, such as cardiovascular disease, respiratory disease, diabetes, obesity and mental illness, and their risk factors. In reviewing the evidence, the Public Health Advisory Committee (2010) in New Zealand noted poor urban design or form can indirectly and directly be related to several health risks and conditions. These include physical inactivity and obesity from reliance on motor vehicles for transport, poor diets through limited access to food shops, road traffic injuries through road speeds and traffic volumes, and respiratory diseases and cardiac conditions from vehicle emissions. Poor urban form can also be related to social isolation from low density development and reliance on motor vehicles, stress and anxiety from traffic congestion and delays or lack of green spaces, and alcohol-related harm including injury and crime through the location and density of alcohol outlets.

In its recommendations on how to improve urban form to achieve positive health outcomes, the Public Health Advisory Committee (2010) consistently recognised the importance of working with local government as a key agency with multiple responsibilities in this area (PHAC 2010).

Local government is a key determinant of health not only through the services it provides for and on behalf of its communities, but also as an important mechanism by which individuals participate in society. Of political freedom, Sen writes, “exercising civil and political rights is a crucial part of good life and wellbeing. To be

prevented from participation in the political life of the community is a major deprivation.” Furthermore, he contends, “democracy has an important instrumental value in enhancing the hearing that people get in expressing and supporting their claims to political attention” and that “the practice of democracy gives citizens an opportunity to learn from one another, and helps society to form its values and priorities” (Sen 1999 p. 10). Democracy can therefore be considered an important determinant of health in its own right, but also a means through which we may be able to create a better society.

Through democracy and the power of local government to affect wellbeing, there is significant potential for the disparities in health between ethnicities and between socio-economic groups (MoH, UoO 2006) to be accounted for and addressed through fair representation of communities in local government and through local government decision-making, particularly in partnership with national government and civil society (CSDH 2008). New Zealand’s duties to honour the Treaty of Waitangi and to respect, protect, and fulfil its people’s economic, cultural, and social rights, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN 1966), provide the foundation for this to occur. In doing so, the essential and central role and potential of local government to protect and promote the health and wellbeing of its communities may be realised.

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Part 1: The potential impact on public health of changes to the *Local Government Act 2002*

This section discusses the key changes to the Local Government Act 2002 and the resulting implications for public health and local democracy. The alterations include the change to the purpose of local government; the increased focus on financial “prudence” and cost-effectiveness; the increased potential for ministerial intervention in local government; the redefinition of community outcomes and the changes to the process for the reorganisation of councils. Legislation, specifically the Health Act 1956 and the Resource Management Act 1991, which protects local government’s involvement in public health, is also described.

The purpose, functions, duties, and structures of local government bodies are determined by an array of national and also region-specific legislation. Most specific to local government is the *Local Government Act 2002* (LGA) which outlines the purpose of local government, its powers, roles and accountability. The LGA has undergone two significant sets of amendments since it was enacted – in 2010 and in 2012.

The 2010 amendments fundamentally altered local government’s focus, prescribing it to five categories of “core services”.

The 2012 amendments from the *Local Government Act 2002 Amendment Act 2012* narrowed local government’s purpose and changed several key processes. The 2012 Amendment Act arose from the government’s continuing agenda for “building a more productive, competitive economy and better public services” and is part of the eight point reform programme for local government which intends to achieve improved efficiency and more responsible financial management in local government (Smith 2012).

The key 2012 alterations to the *Local Government Act 2002* include the change to the purpose of local government; the increased focus on financial “prudence” and cost-effectiveness; the increased potential for ministerial intervention in local government; the redefinition of community outcomes and changes to the process for the reorganisation of councils. Importantly, however, there is legislation which protects local government’s involvement in public health. Specifically discussed here are the *Health Act 1956* and the *Resource Management Act 1991*, though there are other relevant Acts, as identified in Part 3.

Purpose of local government

The purpose of local government, as stated in the LGA 2002 prior to the 2012 amendments, was:

- a) to enable democratic local decision-making and action by, and on behalf of communities
- b) to promote the social, economic, environmental and cultural well-being of communities in the present and for the future (see LGNZ 2003 p. 15).

Of this purpose, Local Government New Zealand (LGNZ) noted that the introduction of the four wellbeing signalled a commitment to sustainability for which local authorities would need to consider social, economic, environmental and cultural wellbeing as they relate to each other.

Further, LGNZ proposed that social wellbeing might include consideration of education, health, community networks, financial security, and equity, amongst others; that economic wellbeing included the capacity of the economy to provide for “many of the prerequisites for social wellbeing”; that environmental wellbeing related to the capacity of the natural environment to sustainably support community activities and life; and that cultural wellbeing included expression through “language, stories, experiences, visual and performing arts, ceremonies, and heritage” (LGNZ 2003 p. 15).

In effect, the LGA was succinctly expressing local government’s ability to enable individuals, whānau and communities to fulfil their aspirations, and the essential role and power of local government to affect the multiple determinants of health and reduce inequalities.



In early 2012, the New Zealand Government published its eight point reform programme, Better Local Government, which stated that the four wellbeings were unrealistic, citing educational achievement, greenhouse gas emission reduction, and child abuse as issues that were not councils' responsibility.

The 2010 and 2012 amendments

In 2010, the LGA was amended as part of the government's drive to achieve "better transparency, accountability and financial management of local government," and core services for local government were introduced to obtain "better control of council costs, rates, and activities" (p. 2-3, Hide 2010).

Local authorities are to have particular regard to:

- a) network infrastructure
- b) public transport services
- c) solid waste collection and disposal
- d) the avoidance or mitigation of natural hazards
- e) libraries, museums, reserves, recreational facilities, and other community infrastructure.

(Section 11A *Local Government Act 2002*, post 2010 amendments)

The 2012 amendments to the LGA reinforced this refocusing of local government activities. In early 2012, the New Zealand Government published its eight point reform programme, *Better Local Government*, which stated that the four wellbeings were unrealistic, citing educational achievement, greenhouse gas emission reduction, and child abuse as issues that were not councils' responsibility (New Zealand Government 2012). Subsequently, the second part of the purpose statement of the Act was changed. It is now local government's purpose to:

meet the current and future needs of communities for good-quality local infrastructure, local public

services, and performance of regulatory functions in a way that is most cost-effective for households and businesses.

(Section 10 (1) (b) *Local Government Act 2002*, post 2012 amendments)

The combined effects of the 2010 and 2012 changes to the purpose of local government have several potential implications for public health. The 2010 emphasis on core services and the 2012 removal of the four wellbeings may lead to undervaluation of local government's contribution to population health and subsequent contraction of involvement in activities which could improve wellbeing. Cultural, social, and community activities may no longer be viewed as fitting with the spirit of the Act (SOLGM 2012). For example, the future involvement of councils in social housing could be questioned, particularly with present moves by central government to shift housing to community providers. Without the four wellbeings, councils may not have the mandated framework through which to consider the wider impact of their decisions on health, for example the impact of transport, urban design or land use planning on mental, spiritual, and physical wellbeing, or generally to consider their decisions within the holistic integrated framework which the four wellbeings provided.

There is evidence of councils questioning the need for restrictions on gambling licenses and fluoridation of water in light of the removal of the four wellbeings from their purpose. For the former, Ruapehu District Council made the decision not to implement a sinking lid policy on Class 4 (pokie machine) venues¹ in light of

Box 1: Matamata-Piako District Council

In its draft annual plan for 2013/14, Matamata-Piako District Council acknowledges the change in the purpose statement and the need to work within the legislation, but remains committed to continuing its present activities:

“While arguably the new purpose of Local Government narrows the scope of activities that a local authority can undertake, we believe that we have a mandate to continue to provide our current services. In some areas, such as the grants that we provide to community groups, we will need to be more explicit as to why the services they provide for our community fall within the scope of the new purpose.” (Matamata-Piako District Council 2013)

Box 2: Dunedin City Council

Dunedin City Council recently developed Dunedin’s Social Wellbeing Strategy 2013-2023, taking into account the changes to the *Local Government Act 2002*. The strategy acknowledges the health and wellbeing challenges Dunedin faces, including the ageing population, low income levels, housing stock, lifestyle diseases, and funding constraints, and sets out the pathways to improve the social wellbeing of Dunedin residents by working with communities and local organisations. Acknowledging the change in the purpose statement of the Act, Dunedin City Council expresses commitment to taking a leadership role in improving social wellbeing. It resolves to focus on areas of wellbeing it can influence, and where it is not the provider of those services which improve social wellbeing outcomes, to advocate for such services and to collaborate with other agencies or community members to achieve those outcomes (Dunedin City Council 2013).

these changes.² The purpose of the new Class 4 Venue Policy for Ruapehu is to “meet the purpose of Local Government by providing good quality public service of its regulatory function and is appropriate to present and future circumstances of the District (*Local Government Act 2002, Amendments 2012*)” (Ruapehu District Council 2013).

It is important to note the Auckland region is presently an exception. Though the Department of Internal Affairs (DIA) states that the new purpose statement applies to Auckland Council and its local boards, the *Local Government (Auckland Council) Act 2009* continues to reference the four wellbeings, particularly with regard to the purpose of Auckland Transport, and the Spatial Plan for Auckland.

The purpose statements of Auckland’s 21 local boards also acknowledge that they have been established to promote social, economic, environmental and cultural wellbeing. According to the DIA, while the new purpose will not affect the Spatial Plan for Auckland, local boards must account for their new purpose when next reviewing their plans (DIA 2013).

1. Class 4 venues are non-casino venues with gaming machines, commonly termed “pokie” machines. Under the *Gambling Act 2003*, territorial authorities (councils) must adopt a Class 4 venue policy which considers the social impact of gambling within the district, and determines whether venues can be established, their location, and the number of gaming machines that may be operated at the venue.

2. Written communication between Ruapehu District Council and Waikato District Health Board.

Essentially, the revised LGA provides legislative support for those councils which do not wish to engage in activities beyond the core services, or consider they do not have the required capacity to do so. At the same time, it will become more challenging for local councils who are wanting and able to offer ‘additional’ services or activities, to justify their decisions. While giving due regard to the new parameters, recognising these challenges and potential limitations, some councils remain committed to continuing as they have done previously (see Box 1 and 2).

On another potentially positive note, in many ways the legislation still provides for a sustainable development approach and physical, spiritual, social and environmental considerations, under the term, “interests”:

In performing its role, a local authority must act in accordance with the following principles:

... (h) in taking a sustainable development approach, a local authority should take into account:

- (i) the social, economic, and cultural interests of people and communities*

- (ii) *the need to maintain and enhance the quality of the environment*
- (iii) *the reasonably foreseeable needs of future generations.*

(Section 14 *Local Government Act 2002* post 2012 amendments)

The concept of “interests” can include the idea of wellbeing. In addition, the term “local public service” in the new purpose statement (Section 10) is not defined within the revised Act. This may enable councils to decide for themselves and their communities what constitutes a local public service, which could include social, cultural, and even economic activities, services or events.

Furthermore, the Act itself intends to “provide for democratic and effective local government that recognises the *diversity* of New Zealand communities” and to provide for “local authorities to play a broad role in meeting the current and future needs of their communities...” (Section 3 *Local Government Act 2002*, emphasis added). This may therefore enable councils to provide services that reduce inequalities by meeting the different needs of their communities.

Overall, it may be too soon to assess the impact of removing the four wellbeings on public health. Councils’ long-term plans made prior to the changes in the Act are still in effect until 2015, and the paradigm of the four wellbeings may still be present in the collective consciousness of current local government staff and councillors.

There are positive indications that the commitment to communities’ wellbeing continues, but also warning signs that the social determinants of health may not be considered in councils’ decisions. While activities to which councils had previously committed may continue, new ones may be examined and tested under the new legislation as they are proposed, to determine whether they are core services, and if not, if they meet the needs of their communities and can be provided in a cost-effective way (see below). This may result in opportunities to improve population health either being taken, or missed. As this approach is likely to differ between councils, due to differences in legislation between regions (as discussed above), or due to differences in the positions of councillors or the capacity of councils, there is also the risk that inequalities between communities may arise or widen.

Financial prudence, cost-effectiveness, and ministerial intervention

Under the revised LGA, the need for good-quality services, functions and infrastructure is to be met by local councils in the most cost-effective way for households and businesses.

“Good quality” is further defined as:

- (a) efficient
- (b) effective
- (c) appropriate to present and anticipated future circumstances.

(Section 10 (2) *Local Government Act 2002*, post 2012 amendments)

While the last clause retains elements of sustainable development, the focus on cost, efficiency, and effectiveness reflects the *Better Local Government* stance and the perception by central government that councils have been spending beyond their means with undesirable rising debt (New Zealand Government 2012). These criteria of good quality intend to “[encourage local authorities] to reduce red tape and compliance costs; minimise rates; lower debt and provide high quality infrastructure in a cost-effective way” (DIA 2013). In keeping with this theme, financial benchmarks can now be set for councils’ performance. These are intended to increase financial discipline and address concerns about rising rates and council debt (DIA 2013). (It has been stated by the Society of Local Government Managers, however, that the increase in local government costs is due to providing network infrastructure, and that “the sector as a whole is not heavily indebted, nor will it be heavily indebted for at least the next seven years” (SOLGM 2012)).

Adding weight to the emphasis on fiscal discipline are the amendments to the LGA which have increased the power of the Minister of Local Government to act when a local authority has a “problem”. This includes “a failure by the local authority to demonstrate prudent management of its revenues, expenses, assets, liabilities, investments, or general financial dealings” (Section 256 *Local Government Act 2002*). Furthermore, through the amendments, central government now has the power to prescribe “parameters or benchmarks for assessing whether a local authority is prudently managing its revenues, expenses, assets, liabilities, investments, and general financial dealings” (Section 259 *Local Government Act 2002*). Draft benchmarks for consultation are expected to be announced in the latter half of 2013.

The reality of financial constraints is undeniable. This cost-focused context, however, raises multiple concerns for population health.

Having benchmarks for expenditure may lead to an underinvestment in infrastructure in order to remain within thresholds (LGNZ 2012). If this translates into delays in maintaining or repairing the infrastructure of core services, such as sewage collection and treatment systems or water supply systems, population health may be jeopardised through the contamination of drinking water or recreational water leading to gastrointestinal illness and outbreaks. If core activities are preserved, the perceived pressure to keep rates low may come

at the expense of cultural, social, and even economic activities, unless these are clearly revenue generating or can pass the test of cost-effectiveness which councils will need to develop.

If cost-effectiveness is short-term focused, or more oriented towards businesses than households (due to government's agenda to create a more productive and competitive economy), this may constrain local government's ability to respond to communities' aspirations in the present and future.

As recognised by Matamata-Piako District Council, it may be more challenging to obtain community grants which will come under greater scrutiny due to changes in the purpose statement, but potentially also through pressures on funding and the need to demonstrate cost-effectiveness.

The cost-effectiveness drive could also result in services presently provided by councils being privatised as the direct provision of such services is at the discretion of councils. Privatisation could have positive or negative impacts on public health, depending on the quality of provision and safeguards for quality assurance.

With increased fiscal pressures and the general increased powers of the Minister to intervene, the accountability of local government may shift. One view is that local government is still accountable to its communities, as stated in the purpose of the LGA which is to "[promote] the accountability of local authorities to their communities" and in the purpose of local government which is "to enable democratic local decision-making and action by, and on behalf of, communities" (Section 3 and Section 10 *Local Government Act 2002*).

On the other hand, in the context of augmented potential for ministerial intervention, local government is more accountable to central government. This raises a possible situation of councils being mandated to be accountable to their communities through legislation, but communities unable to hold their local councils responsible for the decisions they make, if these decisions have been driven by central government.

It has been noted that "willingness of Cabinet ministers to give themselves the power to overturn local government decisions" is the biggest threat to local government, and that "if ministers [override] the decisions of local councillors, it [removes] local accountability" (Reid 2013). Such a precedent has already been set prior to the 2012 amendments, with the dismissal of the councillors of Environment Canterbury (regional council) by the Minister of Local Government in 2010, their replacement by commissioners appointed by the Minister, and the continuing suspension of local elections. This causes grave concern for local democracy, particularly now that there is clear legislative power for such intervention to

occur nationally. In effect, these changes to the Act may serve to undermine local democracy: "a diminution of the health and autonomy of local government weakens not just local democracy but democratic institutional arrangements and processes" (Cheyne 2012). This may impact wellbeing if local authorities make decisions which negatively affect population health and widen inequalities, and are unaccountable for doing so, but also and especially if communities' aspirations to improve their health are unable to be upheld, supported and fulfilled.

Community outcomes and reorganisation

Prior to the 2012 amendments, local councils were legally required to develop community outcomes through a process of consultation and collaboration with their communities and other organisations and stakeholders. As a result of the amendments, community outcomes are now determined by councils themselves. Councils are not precluded, however, from continuing to engage with their communities to develop community outcomes.

Depending on the existing level of commitment to and engagement of a council with their communities, this shift may nevertheless result in one less opportunity for the voice of minority or vulnerable populations, such as ethnic minorities, children and youth, the elderly, and those with disabilities to be heard. As such groups may have specific health needs and/or a higher burden of ill-health, the lack of representation of their aspirations may lead to a widening of inequalities in the community and society as a whole.

In addition to the diminishing of democratic participation from the redefinition of community outcomes, the amendments to the Act changed the process of reorganising local government. A poll is no longer required to determine the population's preference; rather a community must petition first in order to have a poll on a reorganisation proposal. Within this situation again, the representation of the views of those in the minority, or those disenfranchised, may diminish. Additionally, through reorganising councils, there is a risk that the larger resulting amalgamated bodies may become disconnected from their local communities.

The changes in the community outcome development process, the reorganisation process, and also the new ministerial intervention powers, raise fundamental questions about the state of democratic participation in New Zealand. Reflecting on the position taken by Sen (1999), as outlined earlier, participation in society through democratic mechanisms is an important determinant of health in its own right; it may also be a means through which society may become more equitable. As the legislative changes outlined above may erode democratic processes, there is potential



Councils provide a vast array of services, including, but not limited to, those which relate to land use and planning, natural and physical resource management, road and transport infrastructure, waste management, drinking water, sewage collection and treatment systems, recreational areas and parks, smokefree and alcohol-free zones, social housing, and emergency preparedness.

These factors interact with each other to shape the context and environments in which individuals and communities live.

for communities' wellbeing to be negatively affected through diminished opportunities for participation in society and through the widening of inequalities from the lack of representation of their views and voice.

The Health Act 1956 and the Resource Management Act 1991

It is important to remember that there are several other pieces of legislation which provide a direct or indirect mandate for local government to protect and promote health. Two of these are considered presently.

The *Health Act 1956* explicitly states that "it shall be the duty of every local authority to improve, promote, and protect public health within its district" (Section 23 *Health Act 1956*). Hence, the *Health Act* directs local authorities to appoint environmental health officers, to identify and abate nuisances that may be injurious to health, and to make bylaws to protect public health. Furthermore, under Section 25, local authorities are to provide for sanitary works including drainage, sewerage, and water works. As such, the protection of the public's health from infectious waterborne diseases continues to fall under the remit of local authorities, and the *Health Act* is oriented to enable the Director-General of the Ministry of Health to direct local authorities should population health become jeopardised.

A second vital piece of legislation for population health is the *Resource Management Act 1991* (RMA). The RMA guides how our natural and physical resources are to be managed sustainably and how the adverse impact of human activities on the environment may be avoided, remedied or mitigated. The RMA sets out to enable

"people and communities to provide for their social, economic, and cultural wellbeing and for their health and safety" (Section 5 *Resource Management Act 1991*). Through the RMA, regional, district and city councils are responsible for granting resource consents for proposed changes to the use of land, the coast, water ways and discharges to them. With the current proposed reform to the RMA (*Resource Management Reform Bill 2012*), there is concern that the focus may shift from consideration of the environment towards the economy, economic development and employment (Wright 2013). The risk is that this may result in changes to urban form and land use, and degradation of the natural environment, with adverse effects on communities' physical, social, cultural and spiritual wellbeing. Close scrutiny of the proposed changes to the RMA is therefore needed, and the public health community may take available opportunities to provide comments and input into the reform process.

Summary

Ultimately, it is at the discretion of individual councils to determine which activities and services will now fall under their mandate and are within their capability to provide. Some will take a minimalist approach; others will strive to continue as they have been doing to the fullest extent possible within the new legislative parameters.

It is therefore too early to ascertain the full impact of the changes in local government legislation on the activities and services provided by local authorities which affect health and wellbeing. At present, it appears that core public health activities of protection and

regulation will continue under the local government legislation and the *Health Act 1956*. In addition, the *Resource Management Act 1991* continues to provide for the protection of the environmental interests of communities. The protective function of the RMA for population health and wellbeing is, however, at risk through the present reforms.

Finally, within local government legislation, the shift

towards a stronger economic focus, the challenge to local democratic participation, and the potential impact on wellbeing from the undervaluing of local government's role in affecting the wider determinants of health, may jeopardise the health, representation and participation of the present and future generations of New Zealand society.

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Part 2: Local government, the Treaty of Waitangi, Māori representation and participation

This section discusses the aspects of local government legislation pertaining to the Treaty of Waitangi. It also explores local government's potential to protect and strengthen Māori representation and participation in local democracy. In effect, though the statutory requirements for local government to give effect to the Treaty of Waitangi have not changed, there are significant opportunities to enhance both representation and participation of Māori in local government. In doing so, councils can take into account the principles of the Treaty of Waitangi and protect the rights of Māori.

Although local government legislation has been changed, the Treaty of Waitangi continues to provide local government with the framework for the relationships between the Crown and Māori, iwi with mana whenua and taura here.

Under Article 2, the Crown guarantees hapū the right to tino rangatiratanga of their taonga katoa. Under Article 3, Māori are guaranteed the same rights and duties of citizenship as British 'subjects'. In the current context, this would include the right to participate in democratic processes.

Further, the legislative requirement of local government to "recognise and respect the Crown's responsibility to take appropriate account of the principles of the Treaty of Waitangi and to maintain and improve opportunities for Māori to contribute to local government decision-making processes" (Section 4 *Local Government Act 2002*) remains.

Therefore, as part of their planning and decision making, councils are still required to take into account the relationship of Māori and their culture and traditions with their ancestral land, water, sites, wāhi tapu, valued flora and fauna, and other taonga, if any of the options identified involves a decision that is significant in relation to land or a body of water (Section 77 *Local Government Act 2002*). Each council must also:

- (a) establish and maintain processes to provide opportunities for Māori to contribute to the decision-making processes of the local authority
- (b) consider ways in which it may foster the development of Māori capacity to contribute to the decision-making processes of the local authority

- (c) provide relevant information to Māori for the purposes of paragraphs (a) and (b).

(Section 81 *Local Government Act 2002*)

The relationship between local government and Māori is also influenced by the *Resource Management Act 1991* (RMA) which, in determining the nature of our interactions with the natural and physical environment, enables councils to exert significant influence on communities' health. In this regard, anyone, including councils, "exercising functions and powers under [the Resource Management Act], in relation to managing the use, development, and protection of natural and physical resources, shall take into account the principles of the Treaty of Waitangi" (Section 8).

Furthermore, the RMA also requires that such persons recognise and provide for "the relationship of Māori and their culture and traditions with their ancestral lands, water, sites, waahi tapu, and other taonga" and "the protection of historic heritage from inappropriate subdivision, use, and development" as matters of national importance (Section 6). Particular regard must be given to kaitiakitanga (Section 7), the "exercise of guardianship by the tangata whenua of an area in accordance with tikanga Māori in relation to natural and physical resources" which includes the ethic of stewardship (Section 2).

Importantly, in addition to these statutory duties to recognise and respect the rights of Māori as described in the Treaty of Waitangi, New Zealand has also endorsed the United Nations Declaration on the Rights of Indigenous Peoples which states in Article 18:

"Indigenous peoples have the right to participate

in decision making matters which would affect their rights, through their own representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own decision making institutions.”
(UN 2008)

New Zealand therefore must enable both the participation of Māori and the representation of Māori in local government. Examples of mechanisms for representation (being part of governance) and participation (through formal arrangements or organisations) (Stuart *et al* 2013) are discussed below.

Representation and participation

In 2001, under the *Bay of Plenty Regional Council (Māori Constituency Empowering) Act 2001*, Environment Bay of Plenty established Māori constituencies and presently has three Māori councillors, in addition to a Māori Committee. Representation of Māori at the table of governance in the Bay of Plenty has been effective and positively embraced by some (see Human Rights Commission 2010). Māori seats are acknowledged by the council and Māori as having “practical effect in giving Māori a voice at the decision-making table” and as being “a symbol of the validation and respect of Māori as tangata whenua” (p. 11, DIA 2009).

Since 2002, under Section 19Z of the *Local Electoral Amendment Act 2002*, all territorial authorities or regional councils may establish Māori wards or Māori constituencies. The public has the right to petition to have a poll on this decision. Only Waikato Regional Council has successfully established Māori wards under this legislation.

Some district councils which have wanted to introduce Māori wards have had the proposal defeated by the public poll. Such was the case in Nelson District Council and Waikato District Council in 2012. In Nelson, as an example, the defeat occurred despite the Council’s acknowledgement that “although the Crown is the Treaty partner, an increasing part of the implementation of Treaty settlement falls to mana whenua iwi and local councils” and the Council’s position that having Māori representation in Council,

“allows Māori input into decisions at a governance level as intended by the Local Government Act, 2002, allows for cultural values to inform decision making, and provides a positive environment for partnership in a post settlement environment.”

(Nelson City Council 2012)

Indeed, under Article 2 of the Treaty of Waitangi, iwi and hapū have the right to tino rangatiratanga (full authority) over their taonga katoa (all their treasured things) (Waitangi Tribunal 2011). The corresponding duty of the Crown is to actively protect this right, and therefore, as Janine Hayward states (Hayward 2011),

with the present local government arrangements and lack of Māori representation, the Crown is failing to meet its duty of active protection of Māori under Article 2, a position affirmed by the Waitangi Tribunal (Waitangi Tribunal 2010).

With the present push towards reorganisation and amalgamation of local authorities, there is a window of opportunity to create Māori wards. In the lead up to the restructure of Auckland Council, the Royal Commission on Auckland Governance recommended three seats for Māori be established on the newly reorganised body. This recommendation, however, was not incorporated into the legislation. The Human Rights Commission stated this was a “missed opportunity” (Human Rights Commission 2010).

Instead, an Independent Statutory Board for Māori has been established through the *Local Government (Auckland Council) Amendment Act 2010*. The primary objective of the board is to “advance the interests of Māori in Tāmaki Makaurau” (Independent Māori Statutory Board 2012). Its legislative purpose is to assist the Auckland Council to make decisions, perform functions, and exercise powers by:

- (a) promoting cultural, economic, environmental and social issues of significance for:
 - (i) mana whenua groups
 - (ii) mataawaka of Tamaki Makaurau;
- (b) ensuring that the Council acts in accordance with statutory provisions referring to the Treaty of Waitangi.

(Section 81 *Local Government (Auckland Council) Act 2009*)

Importantly, as part of its corresponding duties, the Auckland Council must, amongst other measures:

- (b) consult the board on matters affecting mana whenua groups and mataawaka of Tamaki Makaurau;
- (c) take into account the board’s advice on ensuring that the input of mana whenua groups and mataawaka of Tamaki Makaurau is reflected in the Council’s strategies, policies, and plans.

(Section 88 *Local Government (Auckland Council) Act 2009*)

The Board has been an active participant in the development of Auckland plans and in advocating for Māori development. The Board, however, has no direct authority and can only provide advice to the Council. The degree to which such advice is taken into account and reflected in strategies, policies and plans, may depend on the Council.

In New Zealand there is a strong sense that there should be both representation and participation of Māori in all aspects of government (Stuart *et al* 2013). As noted,

opportunities for representation in local government, however, are limited at present, and therefore, mechanisms and arrangements for meaningful participation in this present context are essential.

In addition to the establishment of Independent Boards, there are several mechanisms through which councils presently endeavour to actualise their duties under the Treaty. These include both formal and informal processes for consultation and information sharing, iwi management plans, joint initiatives, co-management arrangements, standing committees, representatives of iwi and hapū on sub-committees or working groups, and iwi liaison staff in councils (Reid 2011). Comparison of results from a 2004 survey with that conducted in 1997, demonstrate that engagement of local councils with Māori through these mechanisms has increased (Reid 2011).

A recent example of local government's commitment to take into account the principles of the Treaty of Waitangi is the Wellington City homelessness strategy. Explicitly acknowledging that Māori disproportionately experience homelessness, the strategy consciously incorporates a Māori cultural perspective based on the principles of Kāwanatanga, Tino Rangatiratanga, and Ōritetanga (WCC 2013) (see Box 1 below).

Ultimately, however, the degree to which councils take into account the principles of the Treaty of Waitangi, apply the framework to their practice and enable participation is at their discretion. It will be determined by the extent to which commitment to the Treaty is woven into the culture of the authority and resides within the collective consciousness of its councillors and staff. Overall, therefore, as noted by Reid (2011), "the [Treaty] provisions in the LGA act as levers that can be used to influence institutional behaviour rather than specific requirements that can be easily monitored"

and "the degree to which councils comply with these provisions will depend on the particular circumstance of each district or city".

The present statutory framework is nevertheless invaluable in initiating and sustaining cooperation at the local level (Salter 2010). As such, there is an important role for public health practitioners to play in encouraging and supporting councils to utilise best practice tools for public participation. Such tools can both identify opportunities and the means by which councils can be more effective in their engagement with Māori (Salter 2010).

Summary

The legislative requirements of local government to recognise and respect the Treaty of Waitangi have not changed, nor has the framework that the Treaty provides for actualising the relationships between the Crown, mana whenua and taura here.

There are many opportunities to enhance local government's commitment to and expression of the Treaty through its work. To protect the rights of Māori and to fulfil the Crown's duty of active protection, local government's structure can evolve to enable Māori representation at the governing table. Participation of Māori, mana whenua and taura here in local government can be augmented and sustained through utilisation and strengthening of the array of partnership mechanisms available. There are examples of both representation and participation occurring in New Zealand which may serve as models of best practice to guide local government in implementing principles of the Treaty in order to fulfil the rights of Māori.

Box 1: Te Mahana: a draft strategy to end homelessness in Wellington by 2020 (from WCC 2013)

This strategy combines two approaches to ending homelessness in Wellington by 2020. The strategy was developed through a "lock in" of practitioners from government and community agencies and those experiencing homelessness, and two hui held by Māori organisations.

The strategy recognises that for Māori, "at the heart of the issue is cultural dislocation and loss of cultural connection" (p. 21). To adequately address homelessness for Māori, "deeper needs such as spiritual, relationships and cultural connection must also be identified, considered and satisfied" (p. 21). In light of this understanding, the first approach within the strategy, the Poutama framework, has three steps: "Te Tiriti: This directs the responsibility of central and local government to address the issues of homelessness; Te Piriti (the bridge): Weaving Māori cultural perspectives through the strategy will provide a bridge between past and current contexts and the future; and Te Whare: outcomes are framed by four pou or corner posts: equitable, strong, culturally referenced and sustainable" (p. 8).

Complementing this approach is a second based on international best practices to stop homelessness happening, deal with homelessness quickly and stop homelessness happening again.

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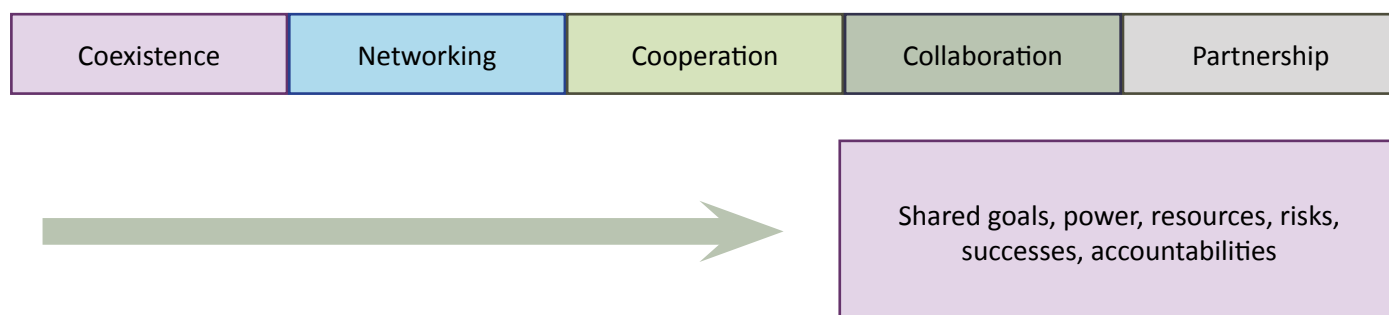
Part 3: The public health sector and local government: working together

Given the new context created by changes in local government legislation, and the challenges and opportunities these changes may present, it is worthwhile to consider how best public health and local government can work together to ensure that population health and wellbeing are improved, the Treaty of Waitangi honoured, and inequalities reduced. The following discussion provides a range of ideas for public health practitioners in this regard and intends to stimulate further discussion about the relationship between the public health and local government sectors.

Working with local government – the toolbox of public health

As described in the introduction, local government is vital to public health. It is in the interest of New Zealand's population, therefore, for public health practitioners and local government to work together.

Actualising the commitment to working together can be achieved in many ways, and can be visualised as progressing on a continuum from coexistence to partnership, as demonstrated in the diagram below.



The Partnering Continuum (Courtney and Craig 2004 in PHAC 2006)

To begin with, public health practitioners can start by mapping their position, or that of their organisation, on this continuum and identifying where they want to be. The options or tools available to public health practitioners can then be utilised to assist in achieving agreed objectives.

Coexistence

To establish a relationship between public health and local government and to develop a meaningful coexistence, common understanding of each other's purpose, goals, structure and functions is necessary. Immense value may be gained from appreciating the

often similar challenges that each other faces. Important challenges for local government that public health practitioners may be cognisant of include the following:

- Although local government may be better placed to respond to local needs, it is always situated within a wider legislative context that creates the conditions that shape its ability to act.
- Localisation, decentralisation and delegated powers may bring tension between different levels of government (vertical conflicts) or between different local government agencies (horizontal conflicts). Problems in securing the alignment of overall national policy objectives

with subnational interventions and local project objectives may undermine coherence and synergy.

- It cannot necessarily be assumed that local government has sufficient capacity and resources to maximise health gain through the social determinants of health and to carry out policies for the social determinants for which they are responsible.

(World Health Organization 2012)

Understanding each other's challenges and gaining a deeper knowledge of the work of both sectors can also be facilitated by public health practitioners attending local government conferences, and conversely, inviting local government staff to attend similar public health events.

Through deepening knowledge of each other's work, public health and local government can also importantly identify common ground. Public health and local government share a common essential interest – namely, their local communities. Indeed, the focus of local councils on concerns such as community resilience may encompass public health concerns that range from the physical health of community members to broad issues of social capital. This common foundation ensures it is realistic to work towards harnessing the synergistic potential of possible partnerships.

Networking

The value of good relationships between staff of local government and the public health workforce cannot be emphasised enough. Though it sounds simple, making the effort to meet, spend time with, and know colleagues in different sectors is the keystone to establishing effective networks and successful collaboration. Once networks are established, the possibilities to cooperate and collaborate with each other open up.

Cooperation and collaboration

With the loss of the four wellbeings, public health practitioners may have one less lever in working with local government to advocate for population health considerations to be incorporated into their decision-making. There are, however, many tools still available to work together. Public health and local government can also take opportunities as they arise and create new opportunities where feasible.

One of the main tools for cooperation and collaboration still available and discussed earlier is that of existing legislation. There is a body of legislation which relates to public health in which local government has an important role. This includes, for example, the *Building Act 2004*, the *Civil Defence Emergency Management Act 2002*, and the *Sale and Supply of Alcohol Act 2012*.

As mentioned in Part 1, the *Health Act 1956* and the

Resource Management Act 1991 are vital elements of public health legislation which continue to enable public health practitioners to support local government to protect and promote health. Under Section 23 of the *Health Act 1956*, local authorities are directed “to furnish from time to time to the medical officer of health such reports as to diseases, drinking water, and sanitary conditions within its district as the Director-General or the medical officer of health may require.”

Furthermore, under Section 127 of the *Health Act 1956* the medical officer of health may attend meetings of local authorities or any committee, at their request, or with their consent, to participate in “discussion of any matter relating to public health or to the powers and duties of the local authority under this Act”. These are both constructive mechanisms for public health and local government to engage and work with each other on public health issues.

Some legislative mechanisms, however, particularly the *Health Act 1956*, may be underused. Health agencies may be wary of taking opportunities to employ the full range of mechanisms available within the legal framework. For example, it might be appropriate on some occasions to seek judicial review of council decisions when there is clear evidence of potential for adverse health outcomes. District Health Boards, however, may be mindful of actions which may be seen as adversarial, and conscious of the cost implications. There may also be times when local authorities may appreciate presentation of a public health perspective in a judicial setting. These may include occasions when local authority action is challenged in court (for example, in relation to bylaws) and when local authorities would consider it helpful for public health evidence to be given in support of councils' actions.

Public health practitioners can also take opportunities to provide feedback on council policies and decisions. Council and committee meetings are open to the public. In the first part of such meetings, there is an opportunity for the public to speak on issues pertaining to the terms of reference of the council or committee. Public health practitioners can provide a voice for public health by being aware of councils' agendas, capitalising on opportunities to attend, and importantly, speaking at these meetings. In addition, public health organisations can continue to be active in providing feedback through submissions on new policies and strategies, statutory plans such as annual plans and long-term plans, and decisions on resource consents. For example, the new *Sale and Supply of Alcohol Act 2012* presently provides a golden opportunity to address alcohol related harm and associated inequalities in local authorities which have chosen to develop local alcohol policies in accordance with this Act.

The public health sector has also previously demonstrated success on the issue of reducing harm

from second-hand smoke. Over the past decade, District Health Boards and non-governmental health and community organisations such as the Cancer Society have been instrumental in collaborating with multiple councils to create smokefree outdoor areas across New Zealand (Hyslop and Thomson 2009). Most recently for example, such efforts have contributed to the finalisation of Auckland's Smokefree Policy.

Importantly, public health practitioners can also support community members to engage with the policy development, submission and hearing process, especially to ensure that a balanced view is taken by councils with regards to community interests versus business interests. The latter, with more resources including time and money, may have a more visible presence and exert a significant influence.

It is optimal that, where feasible, public health practitioners and local government collaborate as early as possible in developing council policies. Submissions can be very effective, but there is real risk that after a draft policy or strategy has been created and opened for public feedback, achieving major revision will be unlikely. Early collaboration with local government in the process of developing these policies is therefore desirable, but initiation relies on existing strong connections between public health and local government.

Partnership

The transition from collaboration and cooperation to partnership may involve the formation of formal mechanisms of working together such as working groups or strategic networks (see, for example, Box 1 below).

A possible step further would be to establish staff secondments and shared positions of local government staff in public health organisations and public health practitioners within local government. In enhancing understanding of each other's work and allowing each sector to benefit from the other's perspectives and experiences, such positions are a natural means by which to collaborate and also build sustainable partnerships. Joint positions also inherently have the

potential to improve capacity and capability across sectors (PHAC 2006) (see Box 2 below).

One of the most important reasons for public health services to advocate for secondments or shared positions is that, fundamentally, the determinants of health lie outside the health sector. As such, so must public health practitioners. If an integrated multi-disciplinary and multi-sectoral approach to improve wellbeing is viewed as best practice, if there is a desire to discourage siloed thinking amongst sectors of society and government, public health practitioners must leave the health silo.

There is a strong precedent of public health and local government working together, and there are multiple examples of positive action arising from successful partnerships (see Box 3 below). To encourage further joint initiatives to be undertaken, and to learn from those already implemented, it is important to ensure that such existing programmes are reviewed and evaluated, and the findings disseminated widely within the public health and local government sectors.

An exemplary model for partnering with local government to improve health is the World Health Organization's Healthy Cities movement, which public health practitioners can be involved in leading or advocating for in their urban area. In Europe, the movement was based on "the recognition of the importance of the local and urban dimension in health development, and of the key role of local government in health policy and partnership building for health and sustainable development" (WHO Europe 2003). The model has been adopted in Christchurch, and there are 211 signatories, from the Ministry of Health, to local government and District Health Boards (DHBs), to multiple community organisations, all committed to working together to "promote, protect and improve the health and wellbeing of the people of Christchurch" (Healthy Christchurch 2013).

Another option to create sustainable partnership is to develop joint health plans between local government and public health units/District Health Boards. In

Box 1: MARCO, Waikato

MARCO (Monitoring and Reporting of Community Outcomes) is a Waikato inter-agency group led by Waikato Regional Council whose partners include local councils, Waikato District Health Board, and central government. Its purpose is to "develop joint approaches to measuring and reporting progress toward community outcomes in the Waikato Region as a basis for more evidence-informed decision-making" (MARCO 2012/13).

In monitoring the community outcomes through indicators on sustainable economy, sustainable environment, culture and identity, quality of life, and participation and equity, the work from MARCO provides invaluable information for the development of long-term plans and strategic directions (Huser 2013).

Box 2: Jointly employed staff

Since 2006, Christchurch City Council and Canterbury DHB have jointly employed a staff member who works across the agencies, shares relevant information, and assists with training on and conducts health impact assessments. The position has helped forge partnerships for public health matters and it has been noted that “the council has found valuable synergies, understandings and relationships resulted from appointing staff who have a health sector background, particularly in management roles where they can share information, skills and experience” (MoH 2009). The role has also facilitated capacity building and a richer understanding of the determinants of health (Gawith 2012).

Box 3: Canterbury Health in All Policies Project (CHIAPP)

This initiative evolved from the Canterbury Health Impact Assessment Partnership Project which began in 2009. In its current form, CHIAPP is an arrangement between Community and Public Health (CDHB), Christchurch City Council, Environment Canterbury (Regional Council), and Partnership Health Canterbury (Primary Health Organisation) in which members champion health in all policies within their own organisations’ activities (CHIAPP 2012). In addition to the effectiveness of the shared public health specialist role between the council and public health unit an evaluation of CHIAPP found that Environment Canterbury has been increasing their capacity to include health in all policies within their planning, and that Christchurch City Council is incorporating a social determinants of health approach into their strategic planning and policies (Gawith 2012).

Victoria, Australia, development of state and municipal Public Health and Wellbeing Plans are required by the *Public Health and Wellbeing Act 2008*. Municipal plans reflect the functions of local councils set out in this Act which include, amongst others:

- a) creating an environment which supports the health of members of the local community and strengthens the capacity of the community and individuals to achieve better health
- b) initiating, supporting and managing public health planning processes at the local government level
- c) developing and implementing public health policies and programmes within the municipal district

(Section 24, *Public Health and Wellbeing Act 2008*
Victoria, Australia)

Under this Act, plans must include an examination of data on health status and determinants within the municipal district, in addition to “identifying goals and strategies based on available evidence for creating a local community in which people can achieve maximum health and wellbeing” (Section 26 (2)). *Significantly*, the plan must also specify “how the Council will work in partnership with the Department [of Health] and other agencies undertaking public health initiatives, projects and programmes to accomplish the goals and strategies identified in the public health and wellbeing plan” (Section 26 (2d)).

Although such partnerships for joint planning are not required under legislation in New Zealand, our framework would not prevent such partnerships and would be an example of joined-up processes that are encouraged by government. Initiatives that set out shared public health objectives between local government and the public health sector, and plans to implement them, are able to be undertaken without a specific legislative mandate, and would be appropriate and effective in improving population health in New Zealand.

Perhaps the ultimate form of partnership which would fully realise the synergistic potential of a joint local government and public health approach, would be for public health to shift from the domain of District Health Boards into local government. This very transition is occurring in the United Kingdom this year. In explaining the rationale behind it, the Department of Health UK, states:

“The Government is returning responsibility for improving public health to local government for several reasons, namely their: population focus, ability to shape services to meet local needs, ability to influence wider social determinants of health, ability to tackle health inequalities.”

(Department of Health 2011)

Acknowledging the factors that determine health in its broadest sense, and local government’s role as place shapers, it is difficult to disagree with this logic.

Given the different and new health challenges facing communities in the UK (compared to before 1974, the year when the National Health Service took over public health), the full impact of this return will take time to become apparent. The question to ask is whether New Zealand should follow suit. Understandably, such evolution will only occur in New Zealand if and when the political environment is supportive. It would be valuable, however, for public health practitioners to be future and forward thinking, to start considering this possibility now, discuss and consult widely as to whether it would be appropriate and advantageous for New Zealand, and if so, start preparing for such a change and even helping it to eventuate.

In each phase of the partnering continuum, public health practitioners must be vigilant and watch for proposals to further modify local government's role, responsibilities, and structure. This includes the changes proposed to the RMA, which, in affecting decisions on land and water, have exceptional importance for Māori communities. Also in the pipeline recently, as part of local government reform, is the discussion started by the New Zealand Productivity Commission in its report *Towards Better Local Regulation*. This seeks to review the regulatory performance of local government.

Changes to the roles, responsibilities, structure, and representativeness of councils, and their governing legislation may affect local democracy and democratic practices, in addition to social, cultural, physical, and environmental wellbeing. It is in the interest of the public health sector, and that of their communities, to identify such present and future challenges. Responding to such challenges involves taking appropriate action as best and as timely as possible with those levers and tools available, and establishing formal mechanisms to evaluate the impact of legislative changes on public health to guide actions in the future.

Framing

Over the course of public health's history, the political environment has changed immensely. This is an inevitability; it will continue to change. At present the focus is on value for money – cost-effectiveness and financial “prudence”. It is therefore pertinent for public health practitioners to increasingly frame arguments for public health action with these imperatives in mind. This will require data on communities' health status, the impact of the provision of services on different groups, analysis of the costs and savings of action and inaction, and modelling of future health status and outcomes.

Public health practitioners may also advocate for the social and environmental value of actions to be incorporated into such an analysis to better inform decision making. A Social Return on Investment Analysis measures and accounts for the full impact of actions which includes not only the economic, but

also and importantly, environmental and social costs and benefits. This tool can be used to evaluate actions, but also to help forecast the social value created if the intended outcomes are achieved (Cabinet Office 2009).

Reframing public health may be challenging, but can be accomplished through joint action between DHBs, public health units, academia and nongovernmental organisations (NGOs), and a commitment to translate research into policy. It is a course worth pursuing as speaking in the same language as the government of the day may secure a place at the policy table.

Stakeholders

At the heart of this discussion is the belief that public health must prioritise local government as a key stakeholder. Knowing local government's influence on the social determinants of health, the public health sector must ask itself if it can realise its full potential if it does not work closely with local government. Working effectively with local government will require a commitment at all levels of public health, particularly management, to secure the necessary time and human resources.

In addition to prioritising local government as a key stakeholder, public health organisations can also partner with those groups that have vested interests in the work of local government, augmenting the volume of the public health voice. In particular, this includes District Health Boards, who are able to articulate the health problems facing their populations. Iwi, Māori health providers, Pacific and Asian community groups, refugee organisations, NGO health service providers and advocacy groups – all those with a mandate from their respective communities – are potential partners whose contributions are invaluable to the wellbeing of New Zealand's diverse communities.

Communities are the number one stakeholders. Fulfilling the Ottawa Charter, public health practitioners must be connected to communities to strengthen community action, particularly enabling those who may be most marginalised and bear a disproportionate burden of ill-health, to be empowered and heard, and for their aspirations to be realised as well. Community connection and empowerment should be the standard mode of operating, not the exception but the rule.

Raising profiles of public health and local government

A significant commonality between public health and local government is that the effectiveness and impact of both often goes unnoticed – until something goes wrong. Both public health and local government make invaluable contributions to the health and vitality of communities and societies. This contribution may often be perceived as under-recognised and undervalued.

Redressing this for public health may require an image makeover, one which increases the understanding within communities and populations of what public health actually is and aims to achieve – that it focuses on the conditions in which people live, rather than just ill-health, medical treatment and health services. Furthermore, in prioritising local government as a key stakeholder, the public health sector has an important role to play in enhancing public appreciation of local government and encouraging communities to be engaged with their councillors and councils.

Outside the public health box, into the ballot box

With local government elections approaching in October 2013, there is no time like the present to ask what the public health sector can do to ensure candidates and the public are more informed about public health issues and how local government policies affect them.

Several opportunities and options exist, the first of which is encouraging public health colleagues to stand for council. How better to have a seat at the table, learn from, and share ideologies with local government? The time commitments of councillors vary from region to region, but if there are those for whom this could be a viable opportunity, public health practitioners can suggest this option, stand beside them and offer their encouragement and support. In addition, or alternatively, if public health workers are not running for council then they can run alongside. Individuals or associations might consider endorsing candidates and incumbents who would act in the interest of public health and even campaign for them if possible. Public health practitioners can also work with candidates to increase knowledge and awareness of the health needs of their communities and the solutions to address them; it cannot be assumed that public health knowledge is common knowledge.

The potential constraints on the ability for public health practitioners to undertake these options are important to acknowledge. Specifically, those practitioners working in government agencies will be operating under a code of conduct which states employees must “maintain the political neutrality required to enable [them] to work with current and future governments” (State Services Commission 2007).

Public health practitioners can lead by example and vote. If local government is undervalued, however, it may be difficult to obtain information on candidates and exercise an informed decision. Often, those candidates whose names are known or recognised may seem to be the easiest, and perceived as the safest, people to vote for. To redress this, practitioners or associations can know who candidates are, attend public events where they are speaking, facilitate such forums which establish the positions of candidates on key public health issues

in the community, publish these positions, and then, finally, vote.

Ask not what they can do for public health...

...but what public health, can do for them.

Finally, it is a worthwhile exercise to take a step back. Good health and wellbeing are not only ends in themselves, but means by which individuals and communities may fulfil their potential. The social determinants of health provide the freedoms people need to lead the lives they value (Sen, 1999, Marmot, 2004 in CSDH 2008). Is the present health centric approach, which seeks to encourage other sectors of society to take account of their impact on health, the best way of achieving public health’s goal of wellbeing and health for all?

Perhaps it is time to consider emphasising another aspect of the public health paradigm – how good health and wellbeing result in achievement and excellence in other sectors, and how public health practitioners may serve and support them.

Summary

The amendments to the local government legislation have the potential to impact public health, though the extent to which they do so will only be realised with time. While this becomes apparent, there is much that the public health sector is doing, can continue to do, and can do differently, to work towards improving health and reducing disparities within New Zealand. These include prioritising local government as a key stakeholder, establishing partnerships with colleagues in local government, partnering with the community and community organisations, and framing arguments in the language of today’s government. Achieving change, however, takes time, and public health practitioners will need to remain cognisant of the incremental nature of their work and endeavour to maintain a positive outlook. Raising the profile of public health and the value of local government are investments which have the power to significantly change the context in which we work. In doing so, it may be time to focus on how health is not just an ends within itself but also the means through which all members of society can fulfil their aspirations.

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Conclusion

Public health practitioners work in a constantly changing environment. Most recently the political environment has altered with the amendments to the *Local Government Act 2002*.

While the full impact of these amendments becomes apparent, the context within which public health operates will continue to change, especially as Government continues to work through the phases outlined in its *Better Local Government* programme.

Operating in an environment which may not be compatible with public health values, or that presents a risk to the health and wellbeing of the population and the achievement of public health goals, is perhaps one

of the greatest challenges the workforce is facing. It is essential for public health practitioners to be able to adapt quickly, maintain drive, prepare for the future, and continue to advocate, more vocally than before, with and on behalf of local communities for actions that will improve wellbeing.

Throughout this process, public health practitioners must recognise and prioritise local government as a key partner on the path to improving population health and reducing inequalities within New Zealand.

In order to achieve this goal, now is the time to set the agenda for sustainable collaboration and partnership between local government and public health.



It is essential for public health practitioners to be able to adapt quickly, maintain drive, prepare for the future, and continue to advocate, more vocally than before, with and on behalf of local communities for actions that will improve wellbeing.

How this thinkpiece was developed

This thinkpiece was developed in response to the recognition of the significant changes to local government legislation and concern within the public health sector regarding how these changes could impact the provision of services and activities by local government which affect population health. The intent of the thinkpiece was to bring together the range of perspectives and experiences of those working in the local government and public health interface, to help inform present and future action of the public health sector as a whole.

The thinkpiece was developed through a series of key informant interviews and exchanges with those acknowledged earlier. A small group of specialists, known to the Public Health Association team were initially selected for their expertise in public health and/or local government. Through subsequent snowball sampling, further specialists were identified, contacted and interviewed.

The key informants represented a cross-section of specialists working in academia, local government, and public health at the local and national level. Semi-structured interviews focused on the present and potential impact to public health of the recent local government legislative changes, honouring of the Treaty of Waitangi within local government, and the options available to public health practitioners to work with local government within the changing context. Thematic analysis of the informants' responses was conducted with the recurring motifs and points of difference identified and presented here.

A search of the grey literature, a review of several submissions made on the *Local Government Act 2002 Amendment Bill 2012*, and a review of the Public Health Association's reports and resources on local government and public health were conducted to provide the context for the interactions between local government and public health.