Chapter 16
Local Health Planning and Governance

Evelyne de Leeuw and Vivian Lin

Introduction

Municipal health planning has increasingly adopted a whole-of-society approach in its embrace of Healthy Cities principles and strategies. The political science literature shows that policy and planning considered too complex or controversial to deal with at state or national levels seems more easily developed at a local level (De Leeuw and Polman 1995), as Corburn et al. (2014) have found in the United States development of Health in All Policies. Givel (2006) describes how the policy momentum in US tobacco control has shifted from the federal to the state level, and Bulkeley and Kern (2006) show how local governments in the UK and Germany, despite statutory and governance differences, take leading roles in the formulation, adoption and implementation of climate change policies. An important aspect for the greater commitment—and possibly success—of local governments in developing policy responsive to community needs is that spatial and cognitive conditions for engagement in planning processes at the local level allow more immediate and relevant feedback between stakeholders.

Planning is an important participatory process as well as a way for translating vision into action (Laverack and Labonte 2000). It is a technocratic exercise and a policy and management tool, but also a core component of governance and stewardship at all levels. Echoing the Greek poet Cavafis' work 'Ithaka', we argue that planning is more about the journey (the participatory process) than about arrival (the plan).

E. de Leeuw (✉)
Centre for Health Equity Training, Research & Evaluation (CHETRE),
University of New South Wales, South Western Sydney Local Health District,
Ingham Institute, Locked Bag 7103, Liverpool, BC NSW 1871, Australia
e-mail: e.deleeuw@unsw.edu.au

V. Lin
College of Science, Health and Engineering, School of Psychology and Public Health,
Department of Public Health, La Trobe University, Victoria, Australia

© Springer Science+Business Media LLC 2017
E. de Leeuw, J. Simos (eds.), *Healthy Cities*,
DOI 10.1007/978-1-4939-6694-3_16

Ithaka
As you set out for Ithaka
hope the voyage is a long one,
full of adventure, full of discovery.
Laistrygonians and Cyclops,
angry Poseidon—don't be afraid of them:
you'll never find things like that on your way
as long as you keep your thoughts raised high,
as long as a rare excitement
stirs your spirit and your body.
Laistrygonians and Cyclops,
wild Poseidon—you won't encounter them
unless you bring them along inside your soul,
unless your soul sets them up in front of you.

Hope the voyage is a long one.
May there be many a summer morning when,
with what pleasure, what joy,
you come into harbors seen for the first time;
may you stop at Phoenician trading stations
to buy fine things,
mother of pearl and coral, amber and ebony,
sensual perfume of every kind—
as many sensual perfumes as you can;
and may you visit many Egyptian cities
to gather stores of knowledge from their scholars.

Keep Ithaka always in your mind.
Arriving there is what you are destined for.
But do not hurry the journey at all.
Better if it lasts for years,
so you are old by the time you reach the island,
wealthy with all you have gained on the way,
not expecting Ithaka to make you rich.

Ithaka gave you the marvelous journey.
Without her you would not have set out.
She has nothing left to give you now.

And if you find her poor, Ithaka won't have fooled you.
Wise as you will have become, so full of experience,
you will have understood by then what these Ithakas mean.

C.P. Cavafy Collected Poems. Translated by Edmund Keeley and Philip Sherrard. Edited by George Savidis. Revised Edition. Princeton University Press, 1992

This chapter considers the challenges of urban health governance by a review of the municipal public health planning experience. In particular, the experience of an early innovator, Victoria, Australia in legislating for health planning at the local governance, is assessed.

Planning and Governance

Planning as a policy instrument was adopted widely in post-World War II reconstruction, although the history of urban planning extends to a much earlier time in western civilizations (see Chap. 2). In its classic incarnation, planning was a top-down blueprint for resource allocation, often driven by technical possibilities and limitations. With the success of those forms of planning (for instance, the dramatic innovation of assembly-line production of automobiles by the Ford Motor Company in 1913), the notion of planning started to pervade wider society. Friedmann (1998) recounts how around the middle of the twentieth century steps were made toward theorizing planning, and how pioneers straddled fields such as philosophy, economy, political science, engineering and urban studies. No wonder that a single definition of the idea has been hard to settle on. In the arena of health and well-being, planning may become a process for articulating preferred approaches to problem-solving for health service delivery agencies or public health services; but ‘planning’ is embraced, too, as a credentialed process in more complex social systems like urban development, and in the marketplace when it comes to product development and placement.

Friedmann (1998) sees six kinds of planning: (1) applied rationality, (2) societal guidance, (3) a behavioural (positivist) approach, (4) a communicative practice, (5) social learning or (6) radical planning or emancipatory practice. An underlying assumption about planning, regardless of these perspectives, is that it is core to the governance of institutions and governments and a means for managing the path from the present to the future. The core can be mainstream and aligned with political priorities at government level, but can also take the shape of countervailing or radical pronouncements from, or on behalf of, populations on the fringe of political or social life—and anything in between, and in widely different forms. For instance, participatory budgeting and policymaking and deliberative democracy (Abers 2003) may be fully integrated in the institutional structures of a government, but also be found in social movements engaging with or opposing official policies.

Planning for health emerged in the 1960s as part of community moves to shift the focus in health sector planning to a concern for health outcomes, community participation and the voices of the disadvantaged. The major proponents of this approach were Laframboise in Canada (1973), Blum in the USA (1974) and Van der Werff in the Netherlands (1976). They contributed to major shifts in planning paradigms through their input on national policy documents (the Lalonde report in Canada), development of a public health profession strongly grounded in local health planning (spreading from California across the United States), and ‘futuring’

for health in the context of broad social targets for WHO/EURO member states (Brouwer and Schreuder 1988; Van Herten and Gunning-Schepers 2000). These approaches share a conviction that by collecting sufficient knowledge patterns of action may be determined and controlled.

Even before these important moves to community health there was a strong connection between community health planning and urban planning. Many participatory planning models found in public health and health promotion demonstrate this joint development: Arnstein's (1969) 'ladder of participation' and Davidson's (1998) 'wheel of participation' both connect community development, health and well-being, and urban planning processes and outcomes, and current practice in local health planning is built on these models.

Governance

Geoff Green (1998) was the first to analyse comprehensively patterns of local governance for health in WHO/EURO. To our knowledge there have been no similar attempts elsewhere or in other policy domains. He mapped responsibilities for health care delivery, public health and health promotion, and management of the social determinants of health at all levels of government in member states of the European Region of WHO. He did so for good reason. There is a profound connection between governance and health (e.g. Marmot et al. 2008; Plochg et al. 2006; Vlahov et al. 2007). In a foundation report for WHO/EURO Health 2020, Kickbusch and Gleicher (2012) build on Green's evidence to argue that there is a difference between health governance and governance for health: health governance is the administration and strengthening of a health system, while governance for health is any action by health or non-health sectors, public or private sectors, and community groups or individual citizens, for a common health cause. Kickbusch and Gleicher define governance for health as 'the attempts of governments or other actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches'.

Cairney (2012) explains why the idea of governance has replaced the imperative of government, essentially seeing the starting point for this development in the Thatcherism and Reaganism of the 1980s. With the assumption that market mechanisms would deliver 'value for money' more than government bureaucracies, public policy authority devolved from (supra)national to local government levels, and from government to quasi-government (QUANGO) and private sectors. This led to what some called a 'hollow state' (Milward and Provan 2000): 'a metaphor for the increasing use of third parties, often non-profits, to deliver social services and generally act in the name of the state'. With its multitude of state and non-state, individual and institutional actors, the health arena is a particular case of hollow state governance.

Kickbusch and Gleicher (2012) assert that

> many of the current health challenges could be better resolved through whole-of-society approaches, which include civil society and the private sector as well as the media.

> Health 2020 can support health ministries and public health agencies in reaching out to people within and outside government to find joint solutions. It can propose new programmes, networks and initiatives to engage many different stakeholders and, above all, citizens throughout Europe and explore new incentive mechanisms. Stakeholders could jointly identify and implement new means for assessing accountability and health impact, such as the contribution to a European health footprint. The WHO European Healthy Cities Network would be an excellent laboratory for such an innovation.

The responsibilities of local governments in governance for health are determined by statutory pronouncements and legal codes, and as Green (1998) shows for WHO/EURO, these are widely—and wildly—diverse. In Table 16.1 we present a selective (and perhaps biased) sample of statutory statements on local government responsibilities and commitments to health development. Some local governments are directly responsible for running health services (including their financing from local revenue), including public health and health promotion. Others are directed in

Table 16.1 Local government responsibilities for health in four jurisdictions

Nation	Local government responsibilities
United Kingdom	UK responsibilities follow the legal principle of *ultra vires*: local councils are able to do only what they are statutorily permitted to do. Their rights and competences are not general but specific (Wilson and Game 2011)
Germany	The right of 'self-government': local authorities have responsibility for all matters relevant to the local community (örtliche Gemeinschaft), but within existing legislation (Grundgesetz, article 28, section 2)
Victoria, Australia	(1) The primary objective of a Council is to endeavour to achieve the best outcomes for the local community having regard to the long term and cumulative effects of decisions
	(2) In seeking to achieve its primary objective, a Council must have regard to the following facilitating objectives:
	(a) to promote the social, economic and environmental viability and sustainability of the municipal district
	(b) to ensure that resources are used efficiently and effectively and services are provided in accordance with the Best Value Principles to best meet the needs of the local community
	(c) to improve the overall quality of life of people in the local community
	(d) to promote appropriate business and employment opportunities
	(e) to ensure that services and facilities provided by the Council are accessible and equitable
	(f) to ensure the equitable imposition of rates and charges
	(g) to ensure transparency and accountability in Council decision making (Local Government Act, 1989)
The Netherlands	Public Health Law: municipalities have the administrative responsibility to create, sustain and coordinate efforts in public health. Their task is to prevent, protect and promote the health of their populations. Apart from core responsibilities in public health, infectious disease control and the health of young people, municipalities need to enable intersectoral collaboration and the establishment of coherence between public health and cure. A Health care Inspectorate monitors compliance and has the authority to direct change (Steenbakkers 2012).

such responsibilities through national legislation that requires strict compliance and reporting, often without direct control over the flow of resources or of priorities. Some local governments do not have—or do not feel they have—any say over the health of their populations, including the provision of, and control over, the quality of housing, sanitation, public transport, roads and social support mechanisms.

Municipal Public Health Planning in Victoria: A Case Study

We now turn to a local case study, looking at municipal public health planning in Victoria, Australia. Australia has a federalist system, and the constitution designates the state as the level with primary responsibility for service delivery. Local governments are created by state legislation and their roles, therefore, vary widely across the country. More than any other state, Victoria has delegated responsibilities for health and other services to local government.

The responsibility for local government to develop a municipal public health plan (MPHP) was legislated in 1987 amendments to the Health Act of the State of Victoria, at a time when there were some 220 local governments. The implementation of this legal requirement was initially under the direction of one officer in the State's health department, working with the Municipal Association of Victoria. Councils were mandated to prepare a new plan every 3 years and review them annually. The plans had to identify and assess actual and potential public health dangers, and outline the programs and strategies the council would pursue to minimize these and enable people to achieve maximum well-being.

The initial response from local councils was one of caution (Wills 2001). There was the question of cost and capacity, the scope of the task, and a sense of a top-down imposition by the state government. There was confusion about this idea of a public health plan with its core in local government authority: was it a corporate (or 'business') plan for those environmental health officers working locally already, or was it to be a corporate plan for all local government services which had some influence on health? Or was it supposed to be a plan for the health of the local population? These initial doubts and questions were grounded in the fuzziness of the idea of 'public health': Is it 'the public's health', or 'public sector health', or 'rats and drains'?

As with anything newly mandated, there was some suspicion about the government's intent. Was the responsibility to formulate a municipal public health plan simply a devolution and decentralization of tasks, lip service to the emerging idea of 'government close to the people'? How would local governments without much experience or professional expertise be supported in framing and implementing their plans for social model of health?

Despite such initial concerns, political momentum for 'the new public health' built. Also in 1987, the Victorian Tobacco Act was passed, enabling the establishment of the Victorian Health Promotion Foundation (VicHealth), a world first: using revenues from tobacco taxation. VicHealth began to support development of 'healthy localities' and this helped local communities and governments understand what a health plan could entail. However, there were challenges in implementing

planning priorities which touched the core of local political economies, as when a local community wanted to address pollution from the main local employer.

Plans and the planning experienced proved to be highly variable across the state, reflecting differing organizational capacity and culture (Bagley et al. 2007). There was agreement that the legislatively mandated process had improved local planning, but often the focus remained on the development of a plan rather than on implementing the identified priorities and strategies. Nonetheless, there now was a minimum standard for public health planning. For some councils, municipal public health planning was the testing ground for developing strategic planning and alliances, and the beginning of a whole-of-community approach to health (Wills 2001). It became evident in the early years that local government's role in public health could shift from hazard surveillance to active agents in the development of healthy communities.

In 2001, after more than a decade of experimentation, the government of Victoria adopted its Environments for Health (E4H) policy framework (Department of Human Services 2001). E4H provides evidence-based guidance for the development of local policies that address the social and environmental determinants of health in the overlapping domains of the social, built, economic and natural environments. E4H explicitly embraces a social model of health, and the policy package provides local governments with a comprehensive evidence base, assistance in building capacity in local health bureaucrats and communities, and exemplars of policy action. Five years after its adoption an evaluation of E4H assessed the extent to which it had

- been incorporated by local governments in their policies and practices.
- contributed to greater consistency and quality in the scope and approach of municipal public health planning across the state.
- led to the integration of municipal public health plans with other council plans.
- increased the level of understanding among appropriate local government staff of the impact of the social, economic, natural and built environments on health and well-being.
- created additional opportunities for health gain through strengthened intersectoral partnerships to address the social determinants of health.
- been supported effectively by the Department of Human Services and other stakeholders (De Leeuw et al. 2006).

The evaluation objectives were the outcome of negotiations between a range of stakeholders, including the Department of Human Services, local governments and research sector representatives. A number of political theories were hybridized in the evaluation framework (Pawson and Tilley 1997), notably policy diffusion theory (Lindblom 1959), implementation theory (Mazmanian and Sabatier 1983) and multiple streams theory (Kingdon 1984). It also drew on a range of data collection strategies:

- Analysis of local government authorities' municipal public health plans (62 plans).
- 73 individual and group interviews with key stakeholders in municipal public health planning.
- An online survey of relevant individuals, including councillors, council staff, non-council organizations and community members (108 respondents).

- Five community forums to present preliminary findings and obtain input from other stakeholders and groups.

The evaluation (Department of Health 2014a) found that E4H had substantially changed the way local governments thought about health, improved the way local governments planned for health, and had led to the start of sectoral integration. However, developing a plan was still frequently seen as a means in itself, and implementation often lagged. The Department of Health consequently launched programmes for implementation, knowledge co-creation, capacity-building and networking at the local level, case models for environments for health development, and political skills with stress on economic environments. These aligned closely with an update in 2008, the *Victoria Health and Wellbeing Act*, which mandated the fuller integration of an approach based on social determinants of health with local governments' daily practices and policies, setting the stage for the 'Healthy Together Victoria' prevention system, which acknowledges more fully the responsibilities and opportunities of a broad range of institutions and actors (Sylvan 2013; Department of Health 2014b). The 2008 Act represents a securing of intersectoral action as mainstream practice. The journey from the initial legislative requirement to undertake municipal public health plans to the present is a successful evolutionary pathway from creating an initial authorizing environment to creating a sustainable enabling environment for intersectoral action on local health (Lin 2013).

Lessons and Governance Challenges

From Victoria municipal public health planning diffused to other states. Queensland is now another exemplar in Australia. Interestingly, this diffusion contrasts with the expansion of Healthy Cities in Australia, which began in the late 1980s. While Victoria legislated municipal public health plans, Healthy Cities projects were initiated in New South Wales (Illawara/Kiama), ACT/Canberra and South Australia (Noarlunga) largely on the initiative of the novel health promotion sector, and on the back of the second WHO Global Conference on Health Promotion, held in Adelaide in 1988 with the theme of 'healthy public policy'. While a number of Australian cities have joined the Alliance of Healthy Cities, there is not the same widespread acceptance of the 'brand' as for municipal public health plans. This may be because planning has always been a core function for local government, and public health planning is not a completely foreign concept, and because a legislated mandate will be carried out, enabling public health planning to become an internalized function of local government. Moreover, a health promotion initiative may still be seen as a health sector project rather than as a core function of urban governance. In other words, municipal public health plans may be seen as an instrument of local governance and more readily accepted than Healthy Cities.

The challenge for local government is to remember that public health planning is not about producing a blueprint, in the way that land use or transportation or other

statutory plans might be produced. Bagley et al. (2007) find that the Victorian councils who found the planning framework beneficial were those who took a strategic approach to public health plans, who made reference to the social model of health, who had high levels of community involvement and who had formal processes in place for implementation and evaluation. In a sense, these councils practised planning in a way consistent with Burris et al. (2005) of governance, 'the management of the course of events in a social system'.

Future of Local Health Governance and Environments for Health

Municipal public health planning is an illustration of what good governance and intersectoral action for health could be. Good governance is typically characterized as participatory, fair, accountable, transparent and sustainable (UN-Habitat 2002). At any level of governance in a complex social system the problems are how to mobilize dispersed knowledge, capacity and resources for the public good, and how to leverage local knowledge and capacity to influence policy outcomes. In a local urban setting where the scale is smaller and the social networks pervasive, poor governance may be more transparent while good governance may deliver desired outcomes; thus, municipal public health planning is a device for promoting good governance as well as improving health in the community.

Local councils around the world have widely varying responsibilities for and involvement with health. Depending on the political agendas of leaders and the capacities of local civil society, there is an opportunity for innovative approaches to address local health concerns, and particularly to tackle social determinants of health with a health-in-all-policies approach at the local level. Healthy Cities exemplifies both the potential and the uncertainties of governance strategies for health (Burris et al. 2007), given the diversity of contexts and leadership capabilities. However, municipal public health planning can also be a mechanism of intersectoral governance, with the prioritizing of problems to be addressed, the involvement of community interests and the tools chosen to implement solutions.

Cities across the world share many challenges. There are few, if any, places not experiencing global economic integration and climate change, and with them some degree of increased social division and social inequality. These forces ultimately produce a myriad of health challenges, including infectious and emerging diseases, risk factors for non-communicable diseases, violence, and other social dysfunction. Good urban governance for health can link governmental and civil society institutions, link local with regional and global communities of interest, create safe or trusting spaces for diverse interests to interact, and integrate solutions for health problems with solutions for other urban concerns.

For municipal public health plans to be successful, a variety of good urban governance practices appear to be important. These include building institutions to increase participation and network governance to strengthen connections across

interests and sectors, ensuring technical competence, providing forums for creativity and ensuring responsive government (Burris et al. 2007). By recognizing local health issues as the manifestation of complex social interactions, and situating local health governance within an understanding of global forces, tools such as municipal public health plans can bring together diverse knowledge and practices through citizen engagement and intersectoral governance.

References

Abers, R. (2003). *Deepening democracy: Institutional innovations in empowered participatory governance* (Vol. 4). Verso.

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners, 35*(4), 216–224.

Bagley, P., Lin, V., Sainsbury, P., Wise, M., Keating, T., & Roger, K. (2007). In what ways does the mandatory nature of Victorian's municipal public health planning framework impact on the planning process and outcomes? *Australia and New Zealand Health Policy, 4*, 4.

Blum, H. L. (1974). *Planning for health: Development and application of social change theory*.

Brouwer, J. J., & Schreuder, R. F. (Eds.). (1988). Scenarios and other methods to support long term health planning: Theory and practice. *Steering committee on future HealthScenarios*. Leidschendam: Ministry of Welfare, Health and Culture.

Bulkeley, H., & Kern, K. (2006). Local government and the governing of climate change in Germany and the UK. *Urban Studies, 43*(12), 2237–2259.

Burris, S., Drahos, P., & Shearing, C. (2005). Nodal governance. *Australian Journal of Legal Philosophy, 30*, 30–58.

Burris, S., Hancock, T., Lin, V., & Herzog, A. (2007). Emerging strategies for healthy urban governance. *Journal of Urban Health, 84*(1), 154–163.

Cairney, P. (2012). *Understanding public policy: Theories and issues*. Palgrave Macmillan.

Corburn, J., Curl, S., Arredondo, G., & Malagon, J. (2014). Health in all urban policy: City services through the prism of health. *Journal of Urban Health, 91*(4), 623–636. doi:10.1007/s11524-014-9886-3.

Davidson, S. (1998). Spinning the wheel of empowerment. *Planning, 1262*(3), 14–15.

de Leeuw, E., Butterworth, I., Garrard, J., Palermo, J., Godbold, T., & Tacticos, T. (2006). *Evaluation of the environments for health framework*. Melbourne, VIC: Deakin University and the University of Melbourne.

de Leeuw, E., & Polman, L. (1995). Health policy making: The Dutch experience. *Social Science and Medicine, 40*(3), 331–338.

Department of Health. (2014a). *Local government planning for health and wellbeing—Resources*. Melbourne: Department of Health. Retrieved February 4, 2014, from http://www.health.vic.gov.au/localgov/resources.htm.

Department of Health. (2014b). *Healthy together. Prevention and population health*. Melbourne: Department of Health. Retrieved August 15, 2014, from http://www.health.vic.gov.au/prevention/healthytogether.htm.

Department of Human Services (2001). *Environments for health: Promoting health and wellbeing through built, social, economic and natural environments*. Municipal Public Health Planning Framework. Melbourne, VIC: Department of Human Services.

Friedmann, J. (1998). Planning theory revisited. *European Planning Studies, 6*(3), 245–253.

Givel, M. (2006). Punctuated equilibrium in limbo: The tobacco lobby and US state policymaking from 1990 to 2003. *Policy Studies Journal, 34*(3), 405–418.

Green, G. (1998) Health and governance in European cities: A compendium of trends and responsibilities for public health in 46 member states of the WHO European Region. *European Hospital Management Journal*.

Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. Copenhagen: World Health Organization Regional Office for Europe.

Kingdon, J. W. (1984). *Agendas, alternatives and public policies*. Boston: Little, Brown and Co.

Laframboise, H. L. (1973). Health policy: Breaking the problem down into more manageable segments. *Canadian Medical Association Journal, 108*(3), 388.

Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning, 15*(3), 255–262.

Lin, V. (2013). Conclusions. In Lin, V. (Ed.), *Australian social determinants of health casebook*.

Lindblom, C. E. (1959). The science of 'Muddling Through'. *Public Administration Review, 19*, 79–88.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet, 372*(9650), 1661–1669.

Mazmanian, D. A., & Sabatier, P. A. (1983). *Implementation and public policy*. Glenview, IL: Scott Foresman.

Milward, H. B., & Provan, K. G. (2000). Governing the hollow state. *Journal of Public Administration Research and Theory, 10*(2), 359–380.

Pawson, R., & Tilley, N. (1997). *Realist evaluation*. Thousand Oaks: Sage.

Plochg, T., Delnoij, D. M. J., Hogervorst, W. V. G., Van Dijk, P., Belleman, S., & Klazinga, N. S. (2006). Local health systems in 21st century: Who cares?—An exploratory study on health system governance in Amsterdam. *The European Journal of Public Health, 16*(5), 559–564.

Steenbakkers, M. (2012). *Lokaal integraal gezondheidsbeleid: Realistische uitdaging of utopie. Een onderzoek binnen gemeenten naar mogelijkheden tot intersectorale samenwerking*. PhD thesis. Maastricht University, Academic Collaborative Centre of Public Health Zuid Limburg.

Sylvan, L. (2013). Chapter 5: The challenges ahead. In *'State of Preventive Health 2013'*. Canberra: Australian National Preventive Health Agency.

UN-Habitat. (2002). *The global campaign on urban governance: Concept paper*. Nairobi: UN-Habitat.

Van Der Werff, A. (1976). *Organizing health care systems: A developmental approach*. Eindhoven, Greve Offset.

Van Herten, L. M., & Gunning-Schepers, L. J. (2000). Targets as a tool in health policy: Part I: Lessons learned. *Health Policy, 53*(1), 1–11.

Vlahov, D., Freudenberg, N., Proietti, F., Ompad, D., Quinn, A., Nandi, V., & Galea, S. (2007). Urban as a determinant of health. *Journal of Urban Health, 84*(1), 16–26.

Wills, J. (2001). Case study: Municipal public health planning. In P. Garrett, K. Eagar, & V. Lin (Eds.), *Health planning: Australian perspectives*. Allen and Unwin: Sydney.

Wilson, D., & Game, C. (2011). *Local government in the United Kingdom*. Palgrave Macmillan.