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The Potential Value of Priority-Setting Methods in Public Health Investment Decisions: qualitative findings from three English Local Authorities

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Abstract

This paper reports on an action-oriented research study providing decision support to three local authorities in England on the prioritisation of public health investment and disinvestment decisions. We adopted a political science perspective, and used Kingdon's (1995) multiple streams framework to investigate the use of prioritisation tools in public health spending decisions at a time of severe financial constraints. The challenges and implications of their potential use in everyday practice were explored.

Twenty-nine interviews were conducted before the targeted decision support occurred and nineteen interviews after the decision support had been delivered. Interviews were held with locally elected politicians, officers and public health professionals based within local government, the NHS, and the local independent consumer watchdog for health and social care. Targeted workshops with local stakeholders were facilitated in each site by health economist members of the project team. Structured observational notes were recorded during these workshops and integrated with the interview data.

Many respondents expressed an interest in prioritisation tools although some scepticism was expressed about their value and impact on decision-making. This paper analyses the enablers and barriers to adopting priority-setting tools in a local government environment that by definition is political. The findings suggest that the adoption of priority-setting tools in decision-making processes in public health poses some significant challenges within local government and that certain enabling factors have to be present.

Keywords

Public health; priority-setting methods; local government; health economics

Introduction

Following the passage of the Health and Social Care Act 2012 in England, public health responsibilities were relocated from the NHS to local government (Gorsky, Lock, & Hogarth, 2014; South, Hunter, & Gamsu, 2014; Marks et al 2015; Hunter, 2016). Implementation of the Act has meant that public health investment decisions are shaped by different actors, including locally elected politicians, within a local government setting. How prioritisation decisions would be reached within this new context was unclear, including the criteria decision-makers would view as important, how these might be weighted, and which enablers and barriers would emerge in relation to adopting health economics approaches to priority-setting.

Decision-makers are faced with numerous options about how to use the budgets they control. With respect to interventions to improve health and wellbeing the evidence base is often incomplete and contested and ‘evidence’ is in any case only one factor amongst many that local authority (LA) decision-makers may consider and include in their decision-making (Lorenz et al, 2014). Prioritising investment in public health is especially salient at a time of austerity and severe financial constraints when local government is facing deep cuts in public spending (Levitas, 2012), and where longer-term public health priorities may suffer (Local Government Association, 2016). Under such circumstances, it is particularly crucial to make the economic case for investment and disinvestment. Thus, the processes through which these decisions are made are a suitable topic for academic inquiry.

A political science perspective (de Leeuw et al, 2014; Hunter, 2015a; 2015b) that recognises the complexity of local policy processes in the light of the variety of stakeholders involved, where multiple and sometimes competing interests are embedded within distinct professional cultures, is adopted in order to shed light on the complex of factors and power plays influencing decision-making processes. Kingdon’s (1995) multiple streams framework is employed to further an understanding of the ambiguous and complex contexts in which stakeholders shape policy and seek to prioritise public health spending decisions.

Kingdon’s first stream – the *problem stream* – comprises research and evidence that establishes the existence of an issue. The second stream – the *policy stream* – is the process whereby stakeholders involved discuss ideas and solutions about the issue concerned. The third stream – the *political stream* – considers the political aspects that may shape agendas, including the influencing role of key stakeholders. Where the three streams are aligned, they create, or open up, a ‘window of opportunity’ so that policy change can be activated. This may occur with the assistance of policy entrepreneurs who seek to create policy windows and then successfully exploit them. Kingdon was concerned with ‘big windows’ in regard to national level policy-making but ‘little windows’ at local level are equally important to bring about policy change (Exworthy and Powell, 2004). Our focus in this paper is on such ‘little windows’ in a local government context.

With respect to the focus of our study, Kingdon's approach is useful in examining whether issues related to prioritisation of public health investment/disinvestment are recognised (problem stream); in exploring whether and how far developing a policy in regard to what to invest and/or disinvest in can be aided and strengthened through the use of health economics decision support tools (policy stream); and whether plans or solutions for policy change, informed by such decision support tools, can be developed which secure a wide measure of support to enable successful implementation to occur (political stream). By framing prioritisation through a political science perspective, we are able to demonstrate how politics influence approaches to priority-setting. Acknowledging the existence and role of politics, and the play of power in which relevant stakeholders are engaged, allows us to understand better how political strategies shape investment and disinvestment decisions in public health. The issues are principally political rather than technical or managerial and awareness of this is critical in regard to developing and sustaining a receptive context for the application of prioritisation tools.

The paper draws on qualitative data from a National Institute for Health Research (NIHR) School for Public Health Research (SPHR) study aimed at developing support for local government based decision-makers and other stakeholders in prioritising investment/disinvestment decisions in public health. The decision support tools (see Marks et al., 2013 for an overview of decision support methods relevant for local authorities in prioritising public health investment and in making decisions over disinvestment) are primarily based upon core economic principles that resources are finite, choices have to be made, and that the optimal choice is the one that minimises the benefits that could have been obtained from the next best alternative deployment. These same approaches also show who reaps the benefits and who bears the costs. The relevance of these tools for decision-making in public health and other policy arenas has been widely explored (Urquhart, Mitton, & Peacock, 2008; Morgan et al., 2011; Marsh, Dolan, Kempster, & Lugon, 2012; Tudor Edwards, Charles, & Lloyd-Williams, 2013; Marks, Weatherly, & Mason, 2013; Public Health England, 2014).

Although previous studies have explored decision-making processes and how evidence may be understood and used by the various actors involved (Lorenc et al., 2014; Tyner et al., 2013) there is an absence of detailed understanding about how public health priorities are determined in local government and how priority-setting tools might support decision-making. Such understanding requires a fine-grained analysis of the various and multiple practical issues and challenges associated with complex decision-making processes. Priority-setting tools arguably support explicit and transparent decision-making processes and provide opportunities for formal deliberation whereby actors involved can explore in-depth information that may be used to inform their decisions. They can also be used as a management tool to assess whether the level of spending is consistent with the areas of concern identified.

An earlier paper arising from this study (Marks et al. 2015) explored values and context in priority-setting for public health investment. This paper explores the likely acceptability and

utility of priority-setting tools and the perceived barriers and enablers for decision-making relating to prioritising investment in public health. In addition to interview data, it draws upon participants' experiences of the targeted workshops offered in three LA sites, as these illustrate many of the practical aspects of adopting these tools within the real-world settings of LA decision-making. The paper is structured as follows. First, we describe the methods adopted to collect data. Second, we present our findings in regard to participants' thinking on priority-setting methods and their perceived value in making decisions about public health investment/disinvestment. The findings are presented under sub-headings concerned with the level of engagement with, and the influence and application of, priority-setting tools on public health investment and disinvestment. Finally, in the discussion section, we consider how our analysis contributes to, and can inform, approaches to priority-setting and the selection of specific decision tools to assist with public health investment decisions that are undertaken in a political context.

Methods

Three LA sites were recruited for the study: one falling within the 20% of the most disadvantaged areas, one from the 20% of the most advantaged group, and one from near the average for England. The selected sites also comprised a mix of two-tier (county and district) authorities, urban and rural characteristics, and a North-South spread. An introductory workshop was held in each of the three LA sites outlining a range of decision-support methods. Priority-setting forms one part of a decision-making process, which involves: agreeing objectives and options for achieving them; identifying resources; selecting criteria for comparing options; and deciding on how to weight and score multiple criteria (where these are considered important) in order to reach a judgement. Economic approaches (e.g. score cards, programme budgeting and marginal analysis, multi-criteria decision analysis, return on investment) vary in their complexity, the extent to which different stakeholders are involved and also how weighting and scoring of criteria is performed.

We conducted semi-structured face-to-face first-phase interviews (n=29) with Directors of Public Health (DsPH) (3), locally elected members (7), other LA officers (6), participants from public health teams (4), a representative from a private local provider (1), representatives from the NHS (5) and from the local independent consumer watchdog for health and social care (3), an organisation that promotes collaborative working amongst local stakeholders in order to improve health and social care services. Overall, 8 interviews were carried out in Site 1, 10 in Site 2 and 11 in Site 3 between July and August 2013. Interviewees were mainly members of Health and Wellbeing Boards (HWBs), new forums established in 2013 to promote the health and wellbeing of people in local areas. They were identified during the introductory workshops and subsequently approached by team members. We sought to sample a wide variety of roles across local organisations in order to obtain a spectrum of views.

Interviews were digitally recorded and transcribed verbatim by an external transcription company. Transcripts were fully anonymised; both participants and study sites were then identified through individual coding. Data analysis was informed by Braun and Clarke's

(2008) thematic analysis framework, which combines deductive approaches involving some key issues and themes derived from the interview guide and the conceptual framework with other themes and patterns emerging inductively from participants' accounts. We used Kingdon's multiple streams framework, comprising problem, policy and political streams, alongside the inductive thematic analysis in order to make sense of and interpret the findings. Notes of all introductory health economics workshops carried out in the three sites were also analysed and differences between sites identified. For the interview data, sentences, statements and key words that seemed relevant to the research questions were extracted from the text and grouped into individual tables for each informant. In addition, recurrent ideas and statements (or 'themes') that captured the meaning of the quotes were added in a separate column of the table. The purpose of this action was to provide insights from the whole data set by constructing a narrative for each interviewee. We also compared sites and roles to explore differences and similarities of participants' experiences. The final step was to make sense of all the ideas, or themes, and patterns of action and thinking emerging from the data set.

Following the interviews, targeted prioritisation support was offered through health economics workshops that involved key informants in each of the study sites. Site 1 received three sessions of support whereas Sites 2 and 3 received one session each. These differences were due to varying organisational dynamics and contextual issues that affected the development of the support in each site and determined what ultimately was possible in each location. The primary goal of the targeted workshops was to practise using selected tool(s) by prioritising interventions for a particular topic or across a specific budget chosen by participants.

Key topics explored in the first-phase interviews included: the relocation of public health to local government; the allocation of the ring-fenced public health budget transferred from the NHS; the decision-making role of HWBs; the identification of public health priorities; informants' experiences of priority-setting tools and views on their application in support of decision-making processes. Participants were also invited to comment on the targeted support on offer and the degree to which, if any, stakeholders concerned could benefit from it.

Second-phase interviews (19) took place with DsPH (2), locally elected members (5), other LA officers (6), participants from public health teams (1), representatives from the NHS (3) and from the local independent consumer watchdog for health and social care (2). Overall, six interviews were carried out in Site 1, eight in Site 2 and five in Site 3 between September 2014 and March 2015. Ten of the interviewees had participated in one or more health economics targeted workshops and were invited to comment on the support provided and whether, and how, stakeholders could benefit from it. In the second-phase interviews participants were asked to comment on the support received, the extent it was found to be useful and of value, and whether there were particular aspects in employing them which required attention. Other topics included the development of HWBs; and changes in public health commissioning and participants' understandings of how public health priorities were generated in their LA.

Ethics approval for the study was obtained from Durham University's School of Medicine, Pharmacy and Health Ethics Committee. Our study has some limitations. In particular, working with only three LAs out of 152 means that the study sites are not representative of all English local authorities. Arguably no sample would have captured the full range of variation. However, although the findings may not be strictly generalizable, they are of significance in that they help enrich our understanding of the complex and intensely political settings in question and of participants' views and experiences of the practical relevance of priority-setting methods in public health decision-making.

Findings

In this section, we present findings from the first- and second-phase interviews, considering informants' understanding of the prioritisation/decision-support tools, their perceived practical relevance and barriers and enablers to their uptake. We report also on the process and outputs of the health economics workshops and the reflections of the second-phase interviewees who used the tool in practice.

Understanding priority-setting methods

Most participants showed a general understanding of some of the principles underlying the tools and their practical adoption. Across the three sites, local government elected members appeared to be the least knowledgeable about the tools. Local government based participants were mainly familiar with option appraisal, which is required for the evaluation of public works, and described a process consistent with this approach (The Green Book, 2011).

One local politician in Site 3 felt strongly that in-depth knowledge of priority-setting methods was not part of politicians' day-to-day work. This person drew a clear distinction between their role and that of local government officers, where the former were largely involved in setting a policy direction for the organisation.

If you want politicians to be playing with that tool, we actually are becoming managers, which is what politicians are not supposed to be. We can say that we are a member-led authority, which is fine, but to actually say we are getting down to day-to-day management, I think that is where the line between elected politician and the professional could get very blurred.

Engagement in local prioritisation workshops

The development of the limited health economics support in the workshops depended on close collaboration with decision-makers and there were many very clear differences between the sites in terms of their focus, their ways of working, and the roles and relationships of the participants.

Site 1 decided to focus on the historical allocation of the whole public health budget as it transferred from the NHS into local government, and a set of criteria was developed against which various interventions included in the public health budget were scored (see Table 1,

Supplementary Web Appendix); on the other hand, Site 2 was concerned with the LA as a public health organisation and was therefore interested in looking at the whole council budget. By contrast, Site 3 used the criteria already included in the Joint Strategic Needs Assessment (JSNA) as a starting point for their prioritisation exercise (see Table 2, Supplementary Web Appendix); the same site also identified some priorities taken from the abridged version of the JSNA (i.e. children, personal responsibility, long-term conditions, mental health and dementia). Similarly, both Sites 1 and 3 developed in-depth discussions about the importance of policy mandates in the form of national and local documents that had to be considered when reflecting on public health priorities. In both these sites, whilst in the process of developing the criteria to be adopted in the scorecard approach, participants realised that the discussion about criteria and priorities relied heavily upon their level of information, and the data and evidence available. Site 3 in particular agreed that qualitative data could complement a poor data set in order to obtain a powerful narrative around the area(s) concerned.

Importantly, due to limited time and participants' baseline knowledge, a scorecard approach was favoured in Sites 1 and 3 as it was perceived to be simple, accessible and meeting stakeholders' needs to remain in control of the whole process. By contrast, Site 2 increasingly focused on a wide cross-directorate approach to public health spending, which reduced the feasibility of scorecard approaches adopted for the public health budget. In this site, participants in second-phase interviews reported that facilitators with in-depth knowledge of the local context, the council's key strategic documents and frameworks were of critical importance given the approach adopted by the council.

The extent to which people engaged with the exercise was influenced by the role of the DsPH and their respective relations with officers and elected members. In Site 1, for instance, the DPH proved vital in arranging the workshops and promoting a positive framing of the tools as a necessary way to ensure a transparent and systematic approach to priority-setting. In this site the targeted workshops were particularly successful and participants were positive about the whole learning experience. Conversely, in Site 2 the DPH struggled to establish working relationships with elected members and officers in the light of a clash of cultures. This related to contrasting conceptions and sources of evidence informing decisions, and the difficulties encountered in identifying decision-making structures. These factors affected progress in establishing sustained engagement between the project and the site. It was clear that public health consultants were expected to learn the political etiquette and respect the power relationships in operation within local government, which translated into an expectation of complying with local politicians' requests.

Furthermore, a lack of continuity of participants from the earlier meetings in which the project plan and purpose was explained and prioritisation methods introduced was an obstacle to establishing long-term working relationships amongst participants and a sense of collective memory in relation to the decisions made. There was also a lack of clarity about the overall objectives of the targeted workshops, and, in particular how they fitted into council activities and the existing decision-making structures. For instance, the workshops notes highlighted

that an elected member in Site 3 believed that the workshop would generate data that the council could use instead of the health profiles, which are produced by Public Health England and aimed at providing information about the health of local populations. Participants in Sites 1 and 3 were also concerned as to how they could reconcile a locally based prioritisation exercise with national policies and mandated services. Particularly in Site 2, observational data showed that some attendees had to be reassured that the prioritisation exercise was complementary and not intended to replace, conflict with or undermine the processes already in operation within the LA.

Post-workshop application of priority-setting tools

Broadly, there did not appear to be significant changes arising from the application of the tools within our LA sites as a result of the health economics input provided. However, participants in Site 1, as well as public health professionals in Site 3, were very positive about their respective learning experiences. By highlighting the practical limitations in adopting the tools, particularly in relation to the supremacy of political strategies and beliefs within local government, participants emphasised the connection between the council's underlying values and the selection of criteria for prioritisation. This is further discussed in the following sections.

Public health professionals across the three sites were particularly enthusiastic about the tools and their potential role in providing robust support to the prioritisation of public health investments and disinvestments. Across the three sites, participants generally emphasised the need for flexibility and responsiveness in the prioritisation process so that the approach selected could be adapted to the specific characteristics of the local contexts, ensuring that stakeholders involved could build a strong sense of ownership of the priorities. Local politicians were said to consider local knowledge and information gathered from the communities to be very important in informing their decisions.

Attendees highlighted the importance of adopting simple tools, which could give ample opportunities for deliberation to the participants involved rather than using a method mechanically with the risk of omitting or overlooking all the nuances and complexities involved. What counted as a useful decision-making tool was thus shaped by participants' perceptions of how it fitted into the political values and contingencies of the work of a LA. As an NHS representative in Site 3 explained:

“it is about setting values rather than rules. And it's about identifying the questions you need to ask [...] It is almost a value judgment rather than an arithmetic one”. A public health consultant from the same site reiterated that “[these workshops] are useful in terms of bringing the sort of structure, but obviously the quality of what comes out at the end depends very much on the people in the room and their contributions, not just on the sort of tools that we were offered to use there”.

Perceived practical relevance and limitations of priority-setting tools

Priority-setting methods were often viewed as reductionist in their approach by elected members, LA officers and NHS professionals. It was evident that most participants favoured a pragmatic approach to prioritisation that considered specific contextual features, and the overarching values and vision for the locality concerned. Indeed, interview participants felt that the tools were almost unable to capture fully the complexities and the constraining aspects that shaped local investment and disinvestment decisions. Many informants also believed that the tools could get “*horrendously complicated*”, as one NHS representative put it.

However, several respondents expressed an interest in the tools and in the various approaches presented by the researchers in the workshops. Participants discussed the usefulness of tools designed to identify a return on investment (both social and economic) and the benefits of ‘fast and frugal’ techniques such as scorecards. Public health practitioners were broadly very supportive of scorecard techniques.

Some significant tensions (and uncertainties) also emerged in relation to how respondents reflected on the rationales and the practical implications of priority-setting processes and tools. For instance, a local politician in Site 2 was aware of the tension between investments that benefit the greatest number of people and those that “*only affect a minority of people*”. A NHS representative from Site 3 emphasised the importance of considering the overall timescale of the interventions when making decisions about investment:

I think there are some things that deliver really significant benefit but they take quite a bit of time for the results to be seen. And there are other things that deliver lower ultimate benefit but actually it comes through quicker.

The potential influence of priority-setting tools on public health investment and disinvestment

There was scepticism amongst the majority of participants about the actual impact of the tools on decisions and the extent to which they would influence expenditure decisions given other potentially more powerful influences, such as the political orientation of local government councillors, their values and their commitment to local accountability. The Director of Commissioning from Site 2 explained:

Well, to be honest, what we constantly end up doing is balancing the political environment, the legislative environment, the policy environment and the financial environment in terms of evaluating the right way of designing or specifying or letting a service or a contract.

Across all three sites, it was very clear that political priorities and values should represent the starting point of any prioritisation process and discussion around decision-making. The Chief Executive in Site 2 pointed out that:

“our major discussion is not so much about what our priorities are, because that’s a given, but what’s the best way of achieving them, that’s where the discussion takes place”.

An elected member in Site 2 identified clearly the main arena for decision-making by stating that *“a lot of the time the decision-making mechanism is between the officer and the cabinet member”*. Similarly, the Deputy Chief Executive in Site 1 noted:

I’ve worked for three elected mayors now, three cabinets, all the rest of it. They will usually have a very clear policy direction. I have a grasp of the resources at my disposal on their behalf, and I can quite quickly say “If that’s your priority, here’s what you might do. Here’s what I have available, would you like me to do that and get on with it?”

It was acknowledged that a political influence could outweigh the evidence base for certain interventions or programmes. A public health practitioner in Site 3 captured the essence of this tension by stating that:

“you could do the evidence base that shows that there’s no evidence for doing a particular intervention, and yet politicians want to do it”.

A public health professional from Site 1 was especially negative about the possibility of priority-setting tools being adopted within local government, a key reason being its political nature. They also suggested that prioritisation processes as introduced by the research team did not seem to take into account the broader organisational context in which they were to be applied:

This very exercise, this sanitised academic process of prioritisation [...] this pseudo-scientific rigorous prioritisation process is completely inappropriate for a local authority. And just because it is public health, public health won’t trump the way the public are, the way the local authority works. We have to embed ourselves into the culture of the council [local government], which is all about politics. It’s all about aligning politicians, of selling them, what you need to sell them.

This respondent doubted whether the political context of local government might positively encourage change and the adoption of health economics approaches to prioritisation. Introducing priority-setting tools through the academic route might not be the best way to ensure that they are seen as a topic requiring attention from decision-makers.

Discussion

This paper has explored local actors’ views, thinking and experiences around priority-setting tools in public health investment/disinvestment decisions, emphasising their highly contextual nature. The analysis informs an understanding of how the adoption of priority-

setting tools could be promoted in local government, i.e. how priority-setting tools could be seen as an aid to managing difficult decisions in regard to public health investment and disinvestment (the ‘problem stream’ in Kingdon’s framework); how adoption of such tools may facilitate the development of plans for investment and disinvestment (‘policy stream’); and how this can occur in a receptive political context (‘politics stream’). When aligned, all three streams create a ‘window of opportunity’ whereby priority-setting tools can be viewed as offering a useful means to prioritising public health spending in highly political settings such as those prevailing in local authorities. A ‘policy window’ facilitating the adoption of the tools might open if local government stakeholders recognise the need for them, a policy proposal becomes available to promote their adoption and, simultaneously, the political context is conducive to, and supportive of, the active adoption of the tools. Where any of these elements is missing or out of alignment then the value of the decision support tools is likely to be negligible.

The ‘problem stream’ – the need for prioritisation of public health spending in the local authority setting – appears to be recognised across all sites. Agreement to be involved in the priority-setting workshops and the contributions offered at these suggest that participants at all three sites wanted to find ways to address the problem. With increasing pressure on squeezed budgets, prioritising spending decisions is likely to become more acute.

There is also some evidence that the ‘policy stream’ is in place. In part, this evidence shows again in the willingness of the sites to participate in the workshops and related discussions. Descriptions of relationships among the different professional groups also suggest that processes and channels for discussions do exist. The crucial role of relationships (both formal and informal) amongst stakeholders concerned with decision-making processes emerged as a key theme throughout the study, and the differences in how various professions were viewed also influenced the extent to which the tools were seen to be useful.

A recurrent theme, emerging in both sets of interviews and in the workshops themselves, was that participants’ practices (and thinking) were heavily shaped by, and embedded in, complex organisational, political and relational contexts. This is part of Kingdon’s ‘political stream’. In the second-phase interviews particularly, LA officers and public health professionals emphasised the need to persuade elected members of the value of the tools in supporting their decision-making. Indeed, the interview data demonstrate that the tools need to be seen to make a real difference to the day-to-day work of decision-makers and local government politicians rather than constituting an additional layer of complexity or being regarded as an academic exercise of little practical value. How these tools are presented to elected members and others is therefore of critical importance.

In two of the three LA sites there was little or no evidence of alignment between the problem, policy and politics streams. The misalignment encountered in these sites did not allow for the emergence of a ‘window of opportunity’ through which priority-setting tools could be put on LAs’ agenda with the full support of local politicians and officers. In our third LA site, there was a commitment at all levels of the organisation to employ priority-setting tools to inform

the decisions about where to invest and disinvest in public health. In this authority it was possible to discern an alignment between Kingdon's three streams. In particular, the elected members charged with leading on health and wellbeing were fully committed to an approach to prioritisation which utilised decision support tools. In this regard there were, to use Kingdon's term, 'policy entrepreneurs' in evidence to promote the use of priority-setting tools and ensure they remained on the local authority's agenda.

We suggest that with regard to the problem stream, the issue of public health prioritisation is already on the agenda within the LAs possibly aided by the growing demands on shrinking budgets. Some effort might be needed to improve progress on the policy stream, as there are still significant differences in understanding between professional groups. More attention needs to be paid to the narrative around the purpose and value of adopting the tools and the types and/or level of decision-making where they might be useful. For example, where local authorities view themselves as public health organisations prioritisation is concerned with decisions made within and across the budgets of different local authority directorates. However, it is the political stream that could benefit from much greater development. Further research is needed in order to identify how best to support relevant decision support tools within a LA's working practices, particularly working within the strong culture of ensuring that it is local political priorities and values that predominantly inform and shape complex decisions rather than some detached notion of what comprises appropriate evidence to steer investment and/or disinvestment decisions. Above all, our study shows that a local government context, which embraces and validates multiple sources of evidence (Lorenc et al., 2014; Phillips & Green, 2015; Tyner et al., 2013) and especially highlights the importance of tacit, experiential knowledge of a type acquired by elected members, is certainly central in relation to priority-setting processes in public health that are intensely political in nature.

Conclusions

By drawing attention to stakeholders' understanding of, attitudes towards, and practical experience of, priority-setting tools, we have sought to highlight how they relate to a local government context where elected members are the key actors playing a central role in decision-making following the relocation of public health responsibilities from the NHS to local government in England. Adopting a political science perspective, drawing on Kingdon's multiple streams framework, the key factors shaping the likely acceptability and utility of prioritisation methods in English local authority settings appear to be: the importance of the wider organisational and cultural context of local government; and the role of LA officers and elected members in identifying public health priorities as important and building accompanying political strategies to realise them.

Through a more thorough comprehension of these factors it might be possible to adopt tools that are appropriate to address the difficult questions being considered about where to invest resources to improve health and wellbeing and maximise the return on investment. In the absence of such understanding, and lacking sufficient appreciation and awareness of the political context and processes governing adoption of decision support tools, it seems

unlikely that merely advocating the adoption of such tools and/or approaches, even with access to appropriate technical support, will in and of themselves be sufficient.

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