



This is a repository copy of *The return of public health to local government in England: changing the parameters of the public health prioritization debate?*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/89296/>

Version: Accepted Version

Article:

Marks, L., Hunter, D.J., Scalabrini, S. et al. (6 more authors) (2015) The return of public health to local government in England: changing the parameters of the public health prioritization debate? *Public Health*, 129 (9). pp. 1194-1203. ISSN 0033-3506

<https://doi.org/10.1016/j.puhe.2015.07.028>

Article available under the terms of the CC-BY-NC-ND licence
(<https://creativecommons.org/licenses/by-nc-nd/4.0/>)

Reuse

Unless indicated otherwise, fulltext items are protected by copyright with all rights reserved. The copyright exception in section 29 of the Copyright, Designs and Patents Act 1988 allows the making of a single copy solely for the purpose of non-commercial research or private study within the limits of fair dealing. The publisher or other rights-holder may allow further reproduction and re-use of this version - refer to the White Rose Research Online record for this item. Where records identify the publisher as the copyright holder, users can verify any specific terms of use on the publisher's website.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

The return of public health to local government in England: changing the parameters of the public health prioritisation debate?

L. Marks ^a BA, MSc

^a Centre for Public Policy and Health, Durham University, School of Medicine, Pharmacy and Health, Wolfson Research Institute for Health and Wellbeing, Durham University Queen's Campus, University Boulevard, Thornaby, Stockton on Tees, TS17 6BH, UK
linda.marks@durham.ac.uk

D.J. Hunter ^a MA, PhD

d.j.hunter@durham.ac.uk

S. Scalabrini^a BA, PhD

silvia.scalabrini@durham.ac.uk

J. Gray ^b BA, MSc

^b Faculty of Health & Life Sciences, Northumbria University Coach Lane Campus, Benton, Newcastle-Upon-Tyne, NE7 7XA, UK
Joanne3.gray@northumbria.ac.uk

S. McCafferty ^c MSc, PhD

^c Institute of Health and Society, Newcastle University, The Baddiley-Clark Building Richardson Road, Newcastle upon Tyne, NE2 4AX, UK
sara.mccafferty@ncl.ac.uk

N. Payne ^d PhD, FFPHM

^d Section of Public Health School of Health and Related Research (ScHARR), The University of Sheffield, Regent Court, 30 Regent Street, Sheffield, S1 4DA, UK
n.payne@sheffield.ac.uk

S. Peckham ^e BSc, MA

^e Centre for Health Services Studies, George Allen Wing, Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF, UK
S.Peckham@kent.ac.uk

S. Salway ^d MSc, PhD

s.salway@sheffield.ac.uk

P. Thokala ^d MAsc, PhD

p.thokala@sheffield.ac.uk

Corresponding author: Linda Marks, Senior Research Fellow, Centre for Public Policy and Health, School of Medicine, Pharmacy and Health, Wolfson Research Institute for Health and Wellbeing, Durham University Queen's Campus, University Boulevard, Thornaby, Stockton on Tees, TS17 6BH

Tel: +44(0)191 334 0703

Fax: +44(0)191 334 0361

The return of public health to local government in England: changing the parameters of the public health prioritisation debate?

Abstract

Objectives

To explore the influence of values and context in public health priority-setting in local government in England.

Study design

Qualitative interview study.

Methods

Decision-makers' views were identified through semi-structured interviews and prioritisation tools relevant for public health were reviewed. Interviews (29) were carried out with Health and Wellbeing Board members and other key stakeholders across three local authorities in England, following an introductory workshop.

Results

There were four main influences on priorities for public health investment in our case study sites: an organisational context where health was less likely to be associated with health care and where accountability was to a local electorate; a commissioning and priority-setting context (plan, do, study, act) located within broader local authority priority-setting processes; different views of what counts as evidence and, in particular, the role of local knowledge; and debates over what constitutes a public health intervention, triggered by the transfer of a public health budget from the NHS to local authorities in England.

Conclusions

The relocation of public health into local authorities exposes questions over prioritising public health investment, including the balance across lifestyle interventions and broader action on social determinants of health and the extent to which the public health evidence base influences local democratic decision-making. Action on wider social determinants reinforces not only the art and science but also the values and politics of public health.

Keywords

Priority-setting; public health investment; local commissioners; democratic decision-making

Introduction

Despite widespread agreement over political and social determinants of health and health inequity¹⁻⁴ and an evidence base for achieving health equity across the life course,⁵ policy and practice internationally have drifted towards individual lifestyle change.⁶ The relocation of many public health responsibilities (and a ring-fenced budget) from the National Health Service (NHS) to local government in England in 2013, following implementation of the 2012 Health and Social Care Act, suggested a shift towards a social model of health. It aligned responsibility for public health with organisations more able to influence the social determinants of health and put the ‘public’ back into public health⁷ through local democratic accountability.

Health and Wellbeing Boards (HWBs) were formally established in 2013 as statutory committees of local government to promote collaboration and provide strategic leadership for commissioning. Core membership includes elected representatives; local authority Directors (Adult Social Care, Children’s Services, Public Health); NHS representatives (Clinical Commissioning Groups (CCGs)); and local Healthwatch, a public involvement organisation. Public health priorities are informed by Joint Health and Wellbeing Strategies of HWBs, intended to reflect Joint Strategic Needs Assessments, although they do so in a highly variable and uneven fashion.⁸

The return to local government resulted in a new organisational and governance context for prioritising public health investment. This major re-structuring raises important questions regarding factors that will shape public health investment in the future as well as processes through which potential investments will be assessed and prioritised. A burgeoning literature supports local government in its new public health role,⁹⁻¹² including support for prioritisation, such as return on investment¹³ and spend and outcome tools.¹⁴

Drawing on Acheson’s definition of public health,¹⁵ public health economics has been described as ‘the science and art of supporting decision-making as to how society can use its available resources to best meet these [public health] objectives and minimise opportunity cost’.¹⁶ However, reviews of decision-support for public health priority-setting question the relevance of methods of economic evaluation adopted for prioritising clinical interventions¹⁶⁻²¹ because of the need to consider equity, effects across different sectors, cost-impact and the lengthy timescales involved. While the National Institute for Health and Care Excellence (NICE) uses cost-utility analysis, a form of cost-effectiveness analysis, to make consistent recommendations for investment, the process of option appraisal, which draws on a range of methods for assessing value, is better suited to policy evaluation across central and local government.²² Social return on investment, where social value is estimated through considering

social, economic and environmental costs and benefits, also better reflects the broader remit of local authorities.

A research study (2012-2016), funded by the National Institute for Health Research, School for Public Health Research aimed to identify enablers and barriers for decision-making related to prioritising investment in public health, through developing targeted health economics support in conjunction with decision-makers. This article presents findings from first phase interviews with key stakeholders, designed to explore the new context for public health priority-setting including, but not limited to prioritisation of the ring-fenced budget. Interviews followed introductory workshops in each site, but predated health economics support.

Methods

A scoping review described prioritisation methods relevant for public health decision-making.²⁰ Table 1 summarises decision-support methods and Table 2 summarises the decision-making process, which involves relevant stakeholders in identifying criteria and assessing their relative importance. A purposive sample of three local authorities in England was offered introductory workshops, incorporating an overview of prioritisation methods for key decision-makers, including HWB members (45 participants). Subsequently, face-to-face, semi-structured interviews (29) of about one hour in length were carried out (in late 2013) with 22 out of 26 invited HWB members; members of public health teams (4); an additional elected member (1); and voluntary sector representatives (2). Interviews were recorded and transcribed: an inductive thematic analysis was carried out by two members of the project team.

Results

Four influences on prioritising public health investment are described: organisational context; commissioning and priority-setting context; views of evidence; and understandings of public health.

Organisational context for decision-making

Local government plays a key role in shaping local determinants of health and in promoting wellbeing. Public health investment was considered in the context of the breadth of relevant local authority activities, as in the following example from a Director of Children's Services (DCS) (site 1):

... a council's role is to create a habitat or an environment in which the individuals who live in the borough can flourish, and that's about health and wellbeing. So everything we do in a council is about that. How we plan the streets, how we keep the environment clean, how we provide services for children, the education that we provide, the adult learning

that we provide, everything we do is about creating that habitat in which the health and wellbeing of residents can flourish.

Local authorities are democratically accountable to the local population: this was identified by interviewees as a key factor in decision-making and underlined how priority-setting differed from a centralised NHS. A Director of Social Services (site 2) commented:

...local authorities are different from many public institutions, because we are autonomous, we are legally accountable to the people of (the city), *but we're not part of a government departmental structure or NHS structure, whatever it might be.*

Moreover, following the 2012 Local Government Finance Act, local government was subject to less central control of local spending decisions. A Director of Commissioning (site 2) commented:

Because what you previously had basically is services were specified by government according to the indicators that they measured us on, and *even if they weren't the right indicators they're the ones that people slavishly drove for, and even though we've had self-determination in reality probably for at least three/four years, we've still yet to really determine what success looks like ourselves and prioritise accordingly.*

This increase in local autonomy for local government provided greater scope for setting priorities in line with the corporate values of the organisation.

Commissioning and priority-setting context

Decision-support methods needed to be considered in the context of local government priority-setting and commissioning processes, where the latter was largely understood as purchasing services to meet policy priorities. In the NHS, purchasing was one phase of a commissioning cycle, which began with needs assessment. Differences between local government and the NHS were noted by an Assistant Director of Public Health (site 3):

And it was quite interesting that the people that worked in the county that wanted to come and work in public health, their idea of a commissioning cycle was basically a PDSA cycle, so plan, do, study, act. Rather than a commissioning cycle that we might recognise coming from the health service ... *so they didn't recognise that at all.*

Priority-setting was part of an iterative decision-making process, subject to review and amendment in the process of policy implementation. This

developmental approach involved the public and other stakeholders, as described by a DCS (site 1):

We have big forums where we debate things and try and harness the collective intelligence of the group, and then out of that will come a set of priorities.

Directors of Public Health (DsPH) had some familiarity with prioritisation methods, such as Programme Budgeting and Marginal Analysis, from their NHS experience, while local authority commissioners were more familiar with option appraisal. However, prioritisation methods could be seen as complex and ‘technocratic’, forming a barrier to the influence of local knowledge on decision-making. A Director of Social Services (site 2) described the HWB, as follows:

The Health and Wellbeing Board is a bunch of people, not a bunch of computers. *And the reason that they are there is that they’ve got intelligence in both senses of the word.* They have the ability to behave intelligently, but they have knowledge as well.

It was recognised that the transfer of public health practitioners from the NHS, combined with a ring-fenced public health budget which largely reflected ‘downstream’ public health spending, could lead to conflicts over the choice of criteria for priority-setting. How, for example, were decisions to be reached between interventions that were effective for the few over the shorter term and those more likely to be effective for the many, but over the longer term? Some interviewees considered that changes in priorities could lead to gaps in service provision and across pathways of care. A DPH (site 2) noted:

...we had conversations about the weight management programme for people who are overweight and obese in ..., which is something that we currently commission, but elected members say that it looks like clinical intervention for people that have already got problems and actually what you ought to be doing is spending the money on more money on food work to help people eat more healthily and physical activity and so on, which is a completely understandable philosophy.

Crucially, most participants drew attention to the impact of austerity on local government priorities. A CCG chair of a HWB (site 2) noted:

I think that whatever we try to do with any investment, public health and other things, will be like a drop in the ocean compared with the impacts of austerity.

Austerity would have repercussions on the use of public health budget, given flexibility in how it could be used; reduce services which promoted wellbeing,

such as leisure centres; and restrict the capacity of local authorities to carry out anything other than statutory duties. Identifying return on investment and prioritising disinvestment became correspondingly more important.

What counts as evidence?

Interviewees reflected tensions over definitions of evidence, the emphasis to be accorded to the evidence base for public health interventions and the influence of local knowledge in determining priorities. Commenting on the public health role, the Chair of a HWB (site 3) noted:

Inevitably the cultures are different and I think you will inevitably see a tension between a culture that likes to see itself as very evidence based in a possibly sometimes purist way and the political process which by its very nature is rather different.

The value attached to accountability to local communities, combined with direct knowledge of local community organisations and of living and working conditions, provided an influential counterpoint to the evidence base, as expressed by an elected member (site 2).

We had a discussion about smoking and drugs, and it was pointed out that lots more people die of smoking related conditions than they do of drug related conditions, alcohol and drug related conditions, but nobody complains to me about the next door neighbour smoking. But they will complain about the drug dealers on the corner and the alcohol, noise and abuse and all that stuff, which *has a big effect on peoples' lives. It ripples out on the community. But they've got a point, but we've got a point as well.*

In a context where final decisions are made by democratically elected members of the local authority, public health practitioners raised questions of independence, professional judgment and degree of influence over priority-setting:

I don't know to what extent I as Director of Public Health can legitimately say, I think these should be the priorities. These are my priorities as Director of Public Health. Because if I say that and they say, actually we think it's something different, what happens then? (DPH, site 2)

This underlined tensions over what counts as evidence as well as pointing to the limitations of the public health evidence base.

Understandings of public health

Debates over what constituted a legitimate use of the ring-fenced budget and over responsibility for services originally funded through it revealed differences in how public health and public health interventions were understood. It was argued that local authorities were less familiar with a population-based approach, as expressed by one DPH (site 1):

...sometimes there's a bit of confusion around the fact that public health is all health somehow and that we would fund therapeutic services for children with disabilities or things like that but we don't, so we have to work through all that.

There was also concern that aspects of public health were being neglected:

There's a risk that the, what I call the heavy duty end of public health, health protection which I know is a national/local issue and the immunisation programme, somehow don't get the attention they deserve because they are moving into a bigger organisation that doesn't specialise at the top in that. (DPH, site 2)

Whereas in the NHS, funding for population-based preventive services was under threat from health care demands, in local authorities the ring-fenced budget could be 'top sliced' and used to supplement funds for local authority services which could have an impact on health. DPH influence over these decisions varied across sites. In one site, the DPH had been overruled; in another, negotiations had led to a significant part of the budget being lost; and in a third there was more evidence of a public health team successfully applying criteria for allocating the budget. For many interviewees, the priority was to push public health funding upstream, as expressed by a DCS (site 2).

However, I would like to see the public health budget used more flexibly across things like we said earlier about, you know, the families that live in poverty, the poor housing and the effects that that can have.

The point was repeatedly made that the ring-fenced public health budget was a small proportion of a local authority budget and that impact would be maximised by public health being reflected in corporate values and in decision-making across the local authority. This would involve a shift from a more regulatory and process-driven approach to planning to the adoption of health impact assessment, for example. A DCS (site 1) commented:

...the size of the public health grant is miniscule compared to... the children's services budget and the adult social care budget, and then if you put some of our environmental health budgets into the context, the major programme, this notion

that we'll only fund public health from the x million of public health funding that's coming into the council is bizarre.

In one site, it was argued that promoting health involved making changes for which public health funds could act as a catalyst, kick-starting initiatives with public health benefits over the longer term, or as seed-corn funding for promoting public health initiatives across local authority directorates. This approach to fostering innovation across the local authority contrasted with an approach based on a 'shopping list' of public health interventions. A CCG Chair (site 2) noted:

It's more conceptual really than just a shopping list with numbers written by the side of each item. It needs almost to be, entrepreneurial is not the right word really, but it needs a bit more of a feeling of a can-do sort of feel.... you're thinking instead of investing into the future for the benefit of the people of the City.

This reflected tensions between a focus on effective public health interventions, as reflected in the evidence base for public health on the one hand, and broader notions of wellbeing across a local area on the other.

Discussion

Perhaps ironically, given that local government is often perceived as the natural home for public health,²³ the study exposed differences between NHS-based public health and local authority-based public health in views over evidence, priority- setting processes and the role of local democratic decision-making. Generalisability of findings is limited by the small number of case study sites and by public health still being in transition in late 2013, with the public health budget largely 'rolled over' with few changes to previous contracts. Local authorities show great variation, and even in the three case studies studied, marked differences of emphasis were evident: one site was keen to refocus the budget on community engagement and community assets; a second focused on corporate values and how they reflected the local authority as a public health organisation, with part of the public health budget being used as a catalyst; while a third was particularly concerned to improve collaboration with CCGs in developing preventive services and integrated care. This diversity demonstrates that local authorities are likely to adopt different solutions to prioritisation tensions described in this study. It is also the case that the political composition of a local council, and views over the role of individual responsibility, may lead to a focus on lifestyle choices rather than on wider policy interventions. If this were to happen on a significant scale, it might call into question one of the key purposes of putting public health back into local government since a key driver for the move was to address the wider determinants of health and wellbeing in a setting that was perceived to be more sympathetic to such a structural approach than the NHS had been.²⁴

Evidence is one of many influences on policy; ²⁵ there are differences in how evidence is understood; and it has been argued that the shift to local government will require a reconceptualisation ²⁶ of public health evidence. A review of ‘cultures of evidence’²⁷ showed, for example, that decisions in non-health sectors are more likely to be framed by political or legal constraints. Limitations of a public health evidence base, skewed towards cost-effective lifestyle interventions ²⁸ become increasingly evident given the ‘healthy placemaking’²⁹ role of local government. Policies were developed following a process of option appraisal for achieving agreed policy priorities, which was iterative and developmental and it was not clear how decision-support methods developed for prioritising between different interventions fitted into the wider decision-making processes of the local authority or the role of elected members. When public health was the responsibility of the NHS, funding was threatened by health care demands.¹⁷ With the relocation of public health responsibilities to local authorities, the nature of the debate is already changing,^{30, 31} as public health investment is interpreted within wider local authority responsibilities for health and wellbeing.

How these issues are addressed also affects the location and role of public health practitioners in local government and perceptions of the ‘added value’ of public health skills or whether new skills are required. A recent study of experiences of DsPH in local government³² also showed different degrees of control over the public health budget and the importance of normative arguments and persuasive narratives for public health investment.

Prioritisation inevitably involves political and social value judgments,^{33,34} reflected both in ‘process’ values (such as accountability and participation) and in ‘content’ values (including criteria for making decisions, such as cost-effectiveness and how criteria are weighted).³³ While priority-setting methods allow for improved transparency and accountability and encourage discussion of values underlying decision-making, their use is made more complex for public health investment where notions of evidence conflict and different definitions of public health coincide. Assessing options for social return on investment over the longer term reflects not just the art and science but also the values and politics of public health. This article shows how the transfer of public health responsibilities into local government throws into relief the pivotal influence of context and values in public health priority-setting.

Author statements

Acknowledgements

The authors wish to thank the local authorities involved for agreeing to participate in this project, the many interviewees who generously gave up their time and Dr

Christianne Ormston who carried out first phase interviews. We would also like to thank Professor Luke Vale for helpful comments.

Ethical approval

The project was approved by the ethics committee of the School of Medicine Pharmacy and Health, Durham University (ESC2/2012/12).

Funding

The study is funded by the National Institute for Health Research (NIHR), School for Public Health Research (SPHR) (SPHR-FUS-PH1-SGS). The views and opinions expressed are those of the authors and do not necessarily express those of the NIHR SPHR or the Department of Health.

Competing interests

None declared

References

1. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organisation; 2008.
2. Marmot M. (Chair) UCL Institute of Health Equity. Review of social determinants and the health divide in the WHO European region: final report. Copenhagen: WHO Regional Office for Europe; 2013.
3. Whitehead M. (Chair) Due North. Report of the inquiry on health equity for the North. Liverpool: University of Liverpool and Centre for Local Economic Strategies; 2014.
4. Ottersen OP, Dasgupta J, Blouin C, Buss P, Virasakdi C, Frenk J et al. The political origins of health inequity: prospects for change. *The Lancet-University of Oslo Commission on Global Governance for Health*. *The Lancet* 2014; 383:63-7.
5. Marmot Review. Fair society, healthy lives. Strategic review of health inequalities in England post-2010. London: The Marmot Review; 2010.
6. Popay J, Whitehead M, Hunter DJ. Injustice is killing people on a large scale: but what is to be done about it? *Journal of Public Health* 2010; 32(2): 148-9.
7. South J, White J, Gamsu M. People centred public health. Bristol: Policy Press; 2012.
8. Beenstock J, Sowden S, Hunter DJ and White M. Are health and well-being strategies in England fit for purpose? A thematic content analysis. *Journal of Public Health* 2014 doi: 10.1093/pubmed/fdu073.
9. Public Health England and Institute of Health Equity. Local action on health inequalities: Introduction to a series of evidence papers; 2014.

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357406/Local_action_health_inequalities_series_introduction.pdf

10. Buck D. and Gregory S. *Improving the public's health. A resource guide for local authorities*. London: King's Fund; 2013.
11. Greig G, Garthwaite K. and Bambra C. Addressing health inequalities: five practical approaches for local authorities. *Perspectives in Public Health* 2014; 134 (3), 132-4.
12. South J, Hunter DJ, and Gamsu M. What Local Government Needs to Know About Public Health. A Local Government Knowledge Navigator Evidence Review. Need to Know Review Number Two. London: Local Government Association; 2014.
13. NICE Return on Investment Tools. Available at:
<http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools>
14. Public Health England. Spend and Outcomes tool for local authorities. Available at:
<http://www.yhpho.org.uk/resource/view.aspx?RID=203757>
15. Acheson D. Public health in England. The report of the committee of inquiry into the future development of the public health function. London: HMSO; 1988.
16. Tudor Edwards R, Charles JM and Lloyd-Williams H. Public health economics: a systematic review of guidance for the economic evaluation of public health interventions and discussion of key methodological issues. *BMC Public Health* 2013; 13:1001.
17. Marks L, Weatherly H, and Mason A. Prioritising investment in public health and health equity: what can commissioners do? *Public Health* 2013; 127 (5): 410-418.
18. Morgan A, Ellis S, Field J, Owen L, Jones D, Minchin M et al. Supporting investment in public health: Review of methods for assessing cost effectiveness, cost impact and return on investment. Proof of concept report. London; NICE: 2011.
19. Public Health England. Project CPB 6: investing in prevention. Approaches to prioritisation in local authorities and the NHS. London: Public Health England; 2014. Available at:
<http://www.yhpho.org.uk/resource/item.aspx?RID=195885>
20. Marks L, Ormston C, Hunter DJ, Thokala P, Payne N, Salway S, et al. Prioritising public health intervention in local authorities: a scoping study of approaches for decision-support. 2013. Available at:
<https://www.dur.ac.uk/public.health/projects/shiftingthegravity/researchoutputs>
21. Williams I, Robinson S and Dickinson H. Rationing in health care; the theory and practice of priority-setting. Bristol: The Policy Press; 2012.

22. HM Treasury. *The Green Book – Appraisal and Evaluation in Central Government*. London; TSO: 2010.
23. Gorsky M, Lock K, Hogarth S. Public health and English local government: historical perspectives on the impact of 'returning home'. *J. Public Health* 2014; 36 (4): 546-51.
24. Department of Health. *Public Health in Local Government Factsheets*. London; Department of Health: 2011.
25. Davies HTO, Nutley SM, Smith PC (eds). *What Works? Evidence-Based Policy and Practice in Public Services*. Bristol: The Policy Press, 2000.
26. Phillips G and Green J. Working for the public health: politics, localism and epistemologies of practice *Sociology of Health & Illness* 2015; doi: 10.1111/1467-9566.12214
27. Lorenc T, Tyner EF, Petticrew M, Duffy S, Martineau FP, Phillips G, Lock K. Cultures of evidence across policy sectors: systematic review of qualitative evidence. *European Journal of Public Health* 2014; 24 (6):
28. Owen L, Morgan A, Fischer A, Ellis S, Hoy A, Kelly MP. The cost-effectiveness of public health interventions. *J. Public Health* 2012; 34 (1): 37-45.
29. Royal Town Planning Institute. *Promoting healthy cities: Why planning is critical to a healthy urban future*. Planning Horizons No. 3, London; RTPI: 2014.
30. Local Government Association and Public Health England. *Public health transformation nine months on: bedding in and reaching out*. London: Local Government Association; 2014.
31. Local Government Association. *Public health transformation twenty months on: adding value to tackle local health needs*. London: Local Government Association; 2015.
32. Willmott M, Womack J, Hollingworth W and Campbell R. Making the case for investment in public health: experiences of Directors of Public Health in English Local Government. *Journal of Public Health* 2015, doi: 10.1093/pubmed/fdv035 First published online: March 15, 2015
33. Clark S, and Weale A. Social values in health priority setting: a conceptual framework. *Journal of Health Organisation and Management* 2012; 26 (3); 293-316.
34. Smith N, Mitton C, Davidson A and Williams I. A politics of priority-setting: ideas, interests and institutions. *Public Policy and Administration* 2014; 29 (4); 331-47.

Table 1**Methods for decision-support**

Method	Key characteristics	Advantages	Disadvantages	Stakeholder input	Complexity/skills required
Cost-effectiveness analysis (CEA)	Compares costs and outcomes. Aims to achieve maximum gain, within available resources	Maximises 'effectiveness' and provides a consistent framework to evaluate a number of interventions (over a period of time)	Needs to have a monetary value of effectiveness. Has limited consideration of equity and does not permit cross-sectoral considerations	Medium	Medium/High
Cost-benefit analysis (CBA)	A method of economic evaluation that compares costs and benefits in commensurate units (often monetary)	Considered a useful tool for considering return on investment and an important method for option appraisal Encourages a strategic approach and makes hidden costs and benefits explicit Should include all costs and benefits, no matter on whom they fall Allows for a multi-sectoral approach and is advocated for complex public health interventions	Over-reliance on quantitative data and not enough recognition of qualitative data May involve assumptions over how non-monetary factors are to be valued Allows consideration of who bears the costs and who reaps the benefits, so can provide strong information on equity	Medium/High	Very High

Table 2

Decision-making and decision-support

Stages of decision-making	Relevant information	Decision-support methods	Comments
1) Agree public health objectives	National context; Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy; performance on public health outcomes; public health intelligence including modelling	Broad stakeholder involvement, including interest groups	Key objectives are likely to have been identified through the JSNA. Need to understand the decision context i.e. macro, micro or meso levels
2) Identify options for reaching objectives	Evidence on effective public health interventions; economic evaluation; effectiveness of current services	Modelling tools; programme budgets and benchmarking; spend and outcome tool (SPOT) analysis; stakeholder involvement	Identify intervention options to maximise value (i.e. benefits) in a specific budget (such as the new ring-fenced public health budget) or intervention options in a single topic area (such as smoking)
3) Identify resources	Council plan; directorate budgets		Council's financial plan will indicate where the public health budget has been allocated
4) Identify measureable criteria for comparing options/ interventions and assess costs and benefits of different options (e.g. option appraisal) exploring a full	Data and evidence depends on choice of criteria and may include equity data, estimates of return on investment (ROI), effectiveness,	Stakeholder involvement; health impact assessment; business cases; cost impact assessment; metrics for calculating ROI; Cost consequence	Criteria can include (cost)-effectiveness; affordability; impact on health inequalities; burden of disease; quality of evidence; cost of intervention; population eligible; cost saving within/beyond 5 years; feasibility; acceptability; certainty; and non-health effects.

range of options	cost-impact, impact on other sectors	analysis; cost benefit analysis; evidence synthesis	Comparing options in relation to the criteria listed above
5) Deciding on preferences	Evidence relevant to scoring and weighting criteria; stakeholder judgements	Deliberative discussions; scoring and weighting through decision-conferencing; discrete choice experiments; paired comparison analysis	Identify the relative importance of the different criteria. Consider feasibility of using tools in relation to time, costs, skills and complexity
6) Making choices	Combine the evidence with stakeholder priorities to evaluate the options	Economic evaluation, multi-criteria decision analysis (MCDA)	Economic evaluation is used if cost-effectiveness is the sole criterion. MCDA methods can be used if there are multiple criteria and MCDA variants include option appraisal, and programme budgeting and marginal analysis (PBMA), among others
7) Evaluating impact			