Working for the public health: politics, localism and epistemologies of practice

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Abstract   The recent move of public health back to English local government has reignited debates about the role of a medicalised public health profession. The explicit policy rationale for the move was that local government is the arena in which the social determinants of health can be addressed, and that public health specialists could provide neutral evidence to support action on these. However, if a discourse of 'evidence-based' policy is in principle (if not practice) relatively unproblematic within the health arena, within the more overtly politicised local government space, rather different policy imperatives come to the fore. Responding to calls for research on evidence in practice, this article draws on ethnographic data of local authorities in the first year of the reorganised public health function. Focusing on alcohol policy, we explore how decisions that affect public health are rationalised and enacted through discourses of localism, empiricism and holism. These frame policy outcomes as inevitably plural and contingent: a framing which sits uneasily with normative discourses of evidence-based policy. We argue that locating public health in local government necessitates a refocusing of how evidence for public health is conceptualised, to incorporate multiple, and political, understandings of health and wellbeing.

Keywords: local government, social determinants of health, evidence, alcohol policy

Introduction

The recent relocation of public health back into English local government, after 40 years as part of the National Health Service (NHS) is, at one level, a rational outcome of the policy shifts associated with the 'new public health' (Baum 2008, Campbell 2012) and its focus on upstream determinants of health such as housing, local economic development and the built environment (Marmot 2010). As these domains fall largely within the remit of the local authorities in the UK, the stated policy rationale for this move was that the public health function should be located where it could be fully articulated with service planning and provision. Alcohol use is one example of a domain where public health gain has been mooted as a potential benefit from the relocation of public health policy (Martineau *et al.* 2013) and indeed, the example chosen by Dame Sally Davies, the Chief Medical Officer for England, in an interview about the potential of the relocation:

> You can't sort [excessive drinking] out from Whitehall, and you can't sort it out through a sickness service, but you can begin to think about it in communities. Do they have too many off-licenses? Do they have bars and pubs that are open too late? (Ross 2013)

However, as Hunter *et al.* (2010), in their overview of public health in England, note, the relationship between local government and the health sector has historically been problematic, and at times antagonistic. One area of tension reflects the long-running debate about a medicalised public health profession (Evans 2004, Hunter 2011, Scott-Samuel 1986). As local government has, arguably, been delivering health gains in the social determinants of health for the last 40 years on core areas of health protection such as environmental hygiene, and improving health by intervening in areas such as transport, urban planning and housing, questions have been raised about the specific role of medical professionals such as the directors of public health in local authorities (Vize 2013). The potential threat of marginalisation of the medicalised public health profession was raised by a number of commentators on public health (see for instance Jolley 2011, McKee *et al.* 2011, Middleton 2011), with a particular concern for what would happen to the health agenda within the politicised spaces of local government. In light of these concerns, a repeated justification for the continued need for a specialist public health function was suggested by Public Health England, a body created in 2012: that of providing neutral and scientific evidence as a defence against both political decision-making and inefficiency (Public Health England 2013). This call has been echoed by public health professionals positioning their role as what we might call 'evidence guardians' in the new political space of local government, and as a necessary bulwark against ideologically driven decision-making. One public health consultant, for instance, argued that 'the practice of evidence based public health (EBPH) needs to become universal and routine to ensure that scarce resources are directed at the efficient roll-out of evidence-based interventions' (Conrad 2014).

Such appeals to a neutral evidence base as a potential arbiter of political decisions are rooted in the well-documented creep of normative discourses of evidence-based medicine to broader and more uncertain areas such as public health and policy (Bell 2012, Black 2001, Dobrow *et al.* 2004). This creep has attracted critique from a number of perspectives. Early concerns related to the inappropriateness of assuming that evidence has a linear influence on policy (Black 2001), with later studies delineating the rather more contingent role that evidence does play in practice. Stevens (2011), for example, describes how civil servants make policy by selecting from an overwhelming mass of largely inconclusive information to tell particular stories to support a policy, and Qureshi (2013) delineates the silencing of certain types of evidence in policy-making on inequalities.

The challenges of the use of evidence for public health are also seen as residing in the rather different cultures of evidence in non-health sectors, with one systematic review of qualitative studies identifying issues such as the practical applicability and provenance of evidence as more pressing for those in the non-health sectors than in public health (Lorenc *et al.* 2014), echoing calls for a more nuanced appreciation of what counts as evidence in terms of influencing policy (Nutley *et al.* 2007). However, research on policy-making in public health suggests that precisely the same imperatives shape the views and utilisation of evidence in these fields (Bunn and Sworn 2011, Green 2000, Innvaer *et al.* 2002, Orton *et al.* 2011, Roberts *et al.* 2004). Public health practice has long entailed working across institutional boundaries, where different professional and organisational cultures have to be negotiated in the messy business of actually developing and implementing policy. Finally, critics of creep also point to the ideological effects of prioritising particular kinds of evidence within the discourse of 'neutrality' (Marston and Watts 2003, Muntaner *et al.* 2012). As Bell (2012) argues, evidence drawn from systematic reviews elides context, social structure and practice, emphasising behavioural rather

than structural approaches to public health problems. On the social determinants of health, the evidence base to date is largely more oriented towards downstream, behavioural interventions that are amenable to experimental evaluation (Petticrew *et al.* 2004, Whitehead *et al.* 2004, Ogilvie *et al.* 2005), with a corresponding lack of evidence on those more structural interventions that might be within the purview of a local authority.

Over 10 years ago, Mykhalovskiy and Weir (2004) called for a greater range of empirical work on precisely how evidence-based medicine has been enacted. There has been relatively little research on evidence-based public health in practice, and even less on local government as a site of health policy-making. As English local government is a field which is currently being brought under the evidence-based policy lens through the incorporation of the public health specialists, it is timely to explore how policy that impacts on the public health is enacted in practice.

This article aims to make a contribution to the empirical literature on evidence in practice, not by examining the uptake of evidence or views of evidence, but rather by looking in detail at how decisions that impact on the determinants of health are currently taken by the officers in local government responsible for making and implementing them. Taking alcohol policy as a timely focus, we therefore explore how local government officers provide rationales for their action, the knowledge resources they draw on, and how these are orientated (or not) to health. After unpacking the ways in which decisions are currently undertaken, we return to the debates on evidence-based public health to explore the tensions between different conceptualisations of evidence, and draw out the implications for public health research and practice.

The setting: local government

Local government in England has been described as a creature of statute. It has no constitutional basis or general autonomy (Gains 2004). It exists as a complex web of legislation created through individual Acts of national parliament. Firstly, legislation provides a framework for certain provisions that the local authority must undertake, such as parks, libraries, refuse collection and housing, all of which are mandated (Wilson and Game 2006). Secondly, legislation is a tool with which the local authority can shape and control the local commercial, physical and social environment. In statutory work, officers have a degree of discretionary autonomy in how they apply these tools, enabling them to shape health determinants (if in often marginal ways) through, for instance, the control of licences for alcohol sales. Outside the core legislated duties, non-statutory work is developed in line with the policies and priorities of the incumbent local political administration, and their historical commitments and ethos. Much of this non-statutory work relies on external funding from national government schemes and initiatives, from private industry partnerships or from charity and third-sector organisations tendering for work related to the aims and priorities of their own agendas. Local government has, then, a far-reaching influence on the health of the local population, both in terms of providing a safe and healthy environment and in delivering goods and services that are fundamental determinants of health. These functions are undertaken by town planners, environmental health officers, transport planners, housing officers and a range of other professionals. These officers are part of what Hunter *et al.* (2010: 9) describe as the 'large and diverse' broader public health workforce, given that they have a role in health protection or health improvement, but they are not generally part of the Faculty of Public Health-trained specialist public health workforce, which has been employed until recently largely by the NHS.

Methods

To explore how professionals in local government make decisions that are likely to impact on the public health, we utilised an ethnographic approach. This article draws on fieldwork conducted across six local authorities in England; three in London and three drawn from across the rest of the country, selected purposively to include a range of metropolitan and district or county authorities. The fieldwork focused on local government service areas and projects that have an intersection with the social determinants of health agenda: alcohol licensing, trading standards, commercial environmental health, community safety, transport, town planning, economic development, energy and leisure services.

The data, generated by the first author, include 8 weeks of participant observation, working daily in the local authority offices. This focused on work related to alcohol as a topical case study, and involved a mixture of overt participant observation at internal meetings and informal conversation in the offices, accompanying officers on work visits and activities, as well as non-participant observation at public meetings and more formal in-depth interviews with officers. After a period of data analysis, subsequent fieldwork focused on semi-structured interviews and brief periods of participant observation to include a range of service areas across the other local authorities.

This was, then, a study in organisational ethnography (Nicolini 2009, Van Hulst 2008) in that we were focusing on the work of officers in their organisations in areas that impact on public health, rather than following evidence or policy through the various fields within which they move. The aim was to generate a grounded understanding of the rationales for decisions from the perspective of those responsible for making and enacting them. From early observations and interviews we built up, inductively, an understanding and representation of the actors and activities that constitute the work of local government. This was followed up in later data collection and analysis with a focus on the use of different forms of knowledge used in everyday working life to make sense of events, justify responses and to account for successes in practice.

To protect confidentiality in what are relatively small fields, we have included tags with generic job titles only, and removed all local identifying detail from quoted extracts.

Findings

Negotiating health outcomes

For local authority officers in transport, housing, trading standards and other sectors, public health outcomes are rarely a primary goal. Indeed, some health outcomes may be marginalised in achieving other goals: advocacy of free parking in town centres to support local businesses, for instance, is contrary to encouraging active transport and reducing the impact of car emissions on air quality. Further, different health outcomes may be prioritised by different constituencies. Funding for cycle path development is contingent on the selection of segregated cycle paths, but officers interpret evidence to indicate that these might increase cycle casualties in their specific locality. If health outcomes were rarely the sole aim of policy enactments, they were recognised as potentially privileged outcomes. Evocations of health impact could therefore be useful as strategic resources. They provide legitimacy to other goals, particularly in statutory enforcement work and in leveraging external funding, and can justify preventive work that is under threat from constrained budgets. Health was available as an alternative, and in some ways incontestable, framing:

A lot of our services have been cut back quite severely ... I think because we work a lot with Public Health it's been really good for us because we're, there's a good, um, strength around understanding the, the kind of things that we deliver, probably the basic principles for people's lives, you know, that you've got somewhere that's OK to live in and then you can eat and drink safely. (Service director)

Air pollution is easier to sell than climate change because there is a direct and immediate impact of air pollution (businesses can smell and taste it) and there is increased awareness of the health impacts of air pollution. (Transport planner)

However, this framing was not one that could be utilised often. In practice, the work of local authority officers entailed managing multiple stakeholders across a complex set of accountabilities, within which the broader wellbeing of a geographical 'public' may well not align neatly with public health priorities.

Managing multiple stakeholders
Given that local government sits at the nexus of national government and the local population to whom the council is accountable, local government officers are inevitably balancing the agendas of a number of different actors: national government represented in legislation, local politicians, the financial concerns of their executive directors, the priorities of external funders, their own human resources and the interests of the local community and businesses. At a more senior officer level, this is typically work negotiating with and managing the expectations of elected councillors, particularly the executive members in the cabinet, who lead the political side of the local authority and form the joint management team with the senior directors.

At a more operational level, in their work of controlling the environment and providing resources, officers find themselves as arbitrators, having to balance and adjudicate the interests of different local publics, who are often in direct conflict with one another. Providing park benches is lauded by residents who enjoy sitting on them, but others want them removed because they may attract street drinkers. In deciding on a cumulative impact licensing policy, officers must balance the development of the night-time economy, which contributes to local economic wellbeing, with the costs of emergency services to deal with alcohol-related crime and accidents, and the needs of local residents for a safe and supportive environment in which to live.

In accounts of their work in interviews, officers reflected this broad conceptualisation of their role, seeing it as their responsibility both to navigate the legal frameworks within which the work of the joint executive of senior officers and local politicians (councillors) must be determined, and to act as the first point of call in the development and maintenance of the local economic, physical and social environment. Their accounts emphasise their role as custodians, of both the local environment and the legislation that constitutes English local government:

It's our job to sort of work with members and devise policy, implement it and then in my case, because I do a lot of statutory work, it's around making sure that we comply with all the kind of legislative requirements that are on us. And, you know, that we apply the way that we do that to a kind of level that's responsive to our population. (Service director)

The practical challenges of negotiating the agendas of different stakeholders in line with both statutory obligations and political goals is illustrated in a closed meeting between officers from a licensing team and local residents about temporary event notices (used to regulate the sale of alcohol at specific one-off events not in already licensed premises such as pubs or bars).

The discussion illustrates the mix of bureaucratic contingencies and statutory obligations that frame the negotiations:

Resident 1:	You said you're not allowed to write to residents?
Service Director:	If we had written to residents we aren't allowed to use what you say in the licence committee decision.
Resident 2:	But what about writing to us to inform us about it?
Service Director:	The problem is we get hundreds of them, so it would be impossible for us to do it.
Resident 3:	Can you find them anywhere on the website to look at?
Licensing Officer:	We aren't required to make them public but they are on the website, but they're filed by address, so you've got to really want to find it.
Service Director:	In [another local authority area] they've been sued by the Information Commissioner for making them available because they're not public documents. So we have some constraints there.(Field notes, 6 February 2013)

These negotiations take place in an ever-changing environment, with new laws or initiatives being passed down from national government and changes of local political administration, shifting the agendas to which officers have to persuade the local actors. Managing in this environment therefore requires good relations with a range of actors. At a strategic level, it requires being good at talking politicians round to their way of seeing things:

[O]ne of the parties at one point at election time said that they wanted to give free school meals to every child in the borough. And so with something like that the officers can work before the election . . . so that if they do get in, they can present them with some options. But it's all the other policies that are more complicated . . . we have to say to them, 'Well you can't really change these things, because of x, y and z reason'. And so we have to work with them to find the bits around the edge that they can tweak. (Service manager)

At an operational level, it entails an ability to demonstrate fairness without being unduly bureaucratic or obstructive while delivering services or enforcing legislation. At street level, officers typically stressed their approach as one of 'helping' rather than 'policing' and described themselves as being very much 'in the firing line' of public discontent:

I like being helpful – I think I'm good at it . . . I'd rather be helpful, I'd rather see you before we got to court, before I have to dry-clean my suit. (Licensing officer, on training licensees to avoid under-age alcohol sales)

[Our approach] is trying to also like foster a culture where a meeting is about trying to work together and move forward rather than being a place to kind of air grievances and get very grumpy. But you know, we've got a role to play on both of those. I don't mind: people can shout at me as much as they want like; it's part of my, it's what I'm paid for. (Community safety officer)

Interpersonal relationships are therefore of paramount importance and this everyday politics of influencing, persuading and negotiating is far more prominent in officers' accounts than the party political 'Politics with a big P'. It is through the use of these interpersonal relationships that officers not only appease the conflicting needs of different local publics, but also contain and counter the 'Politics' of local government when they do arise.

Hard data, seeing problems and the locality

In addition to political skills, officers also require an intimate and detailed knowledge of the local environment and the local population: what they need, what will be accepted, and how well interventions are likely to work. Officers described the importance of empirical evidence: being able to 'see' a problem through the collation and analysis of numerical data, and using them to tell a story about what is going on. Numerical data, for instance, are cited as providing supporting 'evidence' for a cumulative impact zone in alcohol sales licensing and for legitimating decisions about areas for crime prevention work:

> [T]he police have been on a real drive um in terms of trying to reduce the number of crimes ... they've got this really lovely graph which shows you like the number of crimes in 2004 by time of the day, compared to 2011, and as you can imagine, you know, in 2004 we have loads of places closing at sort of like 11 or 12 o'clock, you know, it went quiet after sort of pub kicking out time. Whereas 2011 it, it's, it is well and truly peaking beyond midnight through till 6 o'clock in the morning. (Service manager)

> [P]art of our job is trying to get that good quality information that then helps us actually be able to tackle the problem properly ... [to]see where the main problems are because, obviously, resources are quite tight so we've got to find a way to prioritise and divvy them up. (Community safety officer)

Such hard data, as in many other arenas, therefore have a social function in providing justification or aiding the making of claims (Stevens 2011). However, in practice, other more concrete, tangible, detailed and locally situated types of knowledge are prized for deciding on specific responses and courses of action; for instance on granting or revoking alcohol licences. This type of information is only obtained through visiting, inspecting and witnessing, interacting with the objects and actors that make up the physical and social environment. Moreover, decisions and activities are widely presented as only being possible in the light of this empirical and experiential knowledge: officers described needing to 'see it to believe it':

> We're not supposed to be doing any inspections of the [lower] risk businesses ... unless we get a serious complaint or a serious accident ... what we find is that we, you, you don't actually know what's there until you're there. And so it's not always as simple as, 'Oh, they're an A, they'll be really bad and they're a C ... they'll be really good'. (Environmental health officer)

In compiling evidence to support enforcement, witnessing breaches of the law, such as undercover officers purchasing alcohol outside licensed hours of sale or the seizure of illicit alcohol from an off-licence, officers see this type of tangible and personal evidence as conclusive and indisputable. However, the same fact can have different salience in different contexts. The facts of non-compliance or the data demonstrating the existence of a problem are put into conversation with officers' experience and intuition about the individuals with whom they are dealing or the data they use to see problems. Indeed, this ability to draw on intuitive judgement was cited as an indicator of expertise:

> I see so many different off-licences, I can give an authoritative comparison between what might be a well-run business and the one that we're reviewing, which is not likely to be a well-run business ... [I'm] not necessarily too worried about consistency or apparent consistency ... it may be [that] on apparently similar facts [we] come to a different decision, but

there will always be a bit of delving, there will always be some sort of explanation for that. (Trading Standards officer)

The logic of balancing hard data with experiential knowledge did not apply just to operational decisions; it also framed more strategic decisions. One example was the introduction of cumulative impact zones for alcohol sales licensing:

Interviewer: So the, did you consider other areas in the borough for the saturation zone that you didn't select, or . . . ?

Service manager: Um in reality, no, because we very much, we use the um, the alcohol crime data to sort of give us a framework. And then we did look at what we, our sort of local knowledge on, on areas. So say, for example, you'll probably find between here and up to the High Road, probably doesn't feature hugely on um any hotspot map, but we know that there are a number of premises in the area and we wouldn't want the, any more new premises in the area might just tip the balance.

Crucially, experiential knowledge is built up over time and in specific geographic localities. Many of the senior managers in local authorities had worked their way up through the officer ranks and, because many services are still internally delivered, they work directly with their subordinate officers who are still out on the streets engaging with the local population, businesses and other organisations. Working with local councillors, who are likewise typically connected to their constituents, adds to this geographically bounded and locally embedded expertise.

Beyond the local patch, professional expertise was described as socially networked, with officers doing similar roles through a number of formal and informal activities of sharing best practice. Formal activities include sharing experiences through professional publications or networking events or, in service areas subject to external auditing, through reciprocal peer reviewing with other local authorities. However, while many officers recalled getting interesting ideas from such exchanges, few could provide examples of actually having implemented programmes or techniques that they had heard about. In general terms, they cited the difficulties of implementing ideas presented through these formal routes as the lack of time, resources or managerial support. However, a more fundamental disincentive to utilising best practice from elsewhere lay in the privileging of local experiential knowledge. If local populations and issues are unique, and uniquely known to those working within them, they warrant locally developed solutions:

I mean best practice is, sometimes you think, oh that'll be great but we haven't got time to do it, so it's like, it isn't a priority for us so it's going to take, you know, it might be good practice but it is a priority for you, or have you got the resources to do it, really? Does it fit in with what you're doing really? (Trading standards officer)

One facet of this stress on localness was the importance of constructing a unique organisational identity in relation to other (English) local authorities. For many, there was an eponymous 'local authority way of doing things' that was a source of pride. In both interviews and informal talk, officers emphasised the unique, rather than the typical, features of their area or population. For example, the authorities were described as having the 'poorest' health in the region and therefore standard practice guidance on smoking cessation was unlikely to be appropriate; being the 'first' to implement a certain piece of legislation; or as having unusually narrow

pavements and a large cycling population, making generic road engineering solutions inappropriate.

Given this emphasis on innovation and uniqueness, neither standardised solutions nor best practice from elsewhere were likely to be prioritised. The few examples provided of the deliberate adoption of programmes or policies from elsewhere were therefore largely presented as either somewhat embarrassing or as evidence of the authority being particularly innovative in its reach beyond the UK:

> I can't even remember where we got the idea from ... I think it might actually be that probably I was looking to see what [neighbouring authority] had done in their policy ... So then it made sense to see if we could incorporate that into the licensing policy in some way ... so we basically [laughs] copied what they're doing, which makes sense [laughs]. (Service manager)

> We compare ourselves to a lot of European cities and, and they tend to be the most progressive and, you know, innovative as well, so we're always looking abroad ... we've probably got more in common with other metropolitan cities around the world than we have say, you know, parts of Devon or Cornwall. (Transport planner)

Evaluating outcomes: for whom?

Officers must justify their practice variously in relation to frameworks of legality, in the context of enforcement activity; social acceptability, in arbitrating between different publics; the obligations of new public management (Hood 1991) to cost-efficiency and performance monitoring; and relevance and necessity, in the eyes of their senior managers enforcing budget cuts. When reflecting on how they judge the success of their actions after the event, the officers talked explicitly about performance management and evaluation. Much has been written in the field of public administration on the different aims and time frame of performance management compared to evaluation in government settings (Davies 1999b) and about the dominance of auditing in recent UK political history as a way of monitoring progress and success on timescales compatible with the (short-term) policy cycle (Martin and Sanderson 1999). Performance management is built into the fabric of local government. Work is organised around service plans and performance indicators, which may be internal or be imposed by external agencies, particularly in the statutory enforcement service areas, such as reporting numbers of inspections and prosecutions to central agencies such as the Food Standards Agency:

> We've got sort of national performance targets, the food ones are good examples of that. Sometimes they might just be local targets that we set ourselves ... every team has a set of targets. And every officer knows how they contribute and what they've got to do (Service director)

Particularly in service areas that focus on control activities, where non-compliance is geographically confined and identifiable, such as illicit alcohol in an off-licence or drug dealing in a particular housing estate, routine activities of inspection and visiting in themselves provide an assessment of the effect of officers' work. If you can see where the problem is located, using direct observation or data, then these same sources of information can be used to demonstrate that a problem has gone, for example, comparing the number of failed under-age test purchases and firework-related antisocial behaviour offences observed before and after a

trading standards campaign to improve age verification practices in shops licensed to sell fireworks.

In areas of work that are more developmental or externally funded, talk of evaluation is more common. Of all their work, officers most readily label their efforts to assess success or progress as evaluation in relation to externally funded projects, although a focus on processes rather than outcomes, echoing the paradigm of performance management, still seems to be prominent:

> When you er apply for [Home Office] funding you'll be expected to kind of you know set out what your objectives are and your milestones and your key, they're called KPIs, key performance indicators. So how you're going to measure the success of the project basically . . . it's just to make sure that we're accountable. (Community safety officer)

Where external funders provide money to evaluate a particular project, this frequently involves input from external researchers in the form of advice or undertaking the evaluation. Where officers carry out their own internal evaluations, these can focus on anything from outcomes to public opinion as they feel appropriate to the main aim of the activity. There was a commonality across officers' accounts in placing great importance on the reception of a project or event by the local residents, coupled with an intuitive sense of when something has been a success, based on interpersonal interaction and feedback. This parallels the importance that officers place on their local expertise and knowledge in developing services and to the centrality of contact with residents and business owners for these activities:

> I think things like the literacy festival we tried to do a little in-house evaluation of that, what worked and what didn't. And sometimes it might be quite crude, just sort of feedback sessions or, you know, giving out questionnaires and collating that. Um, and sometimes it'll just be around the sort of reception it gets, so, you know, if it got, if something worked really well and we got good feedback from the community members then, you know, we'll repeat it. (Service director)

Although officers acknowledge a hierarchy of data sources and the difficulty of capturing these more social effects, the empirical and experiential orientation, outlined above, also shaped their assessments of impact:

> I know what people really like is figures . . . 'I want my statistics.'. . . that's constantly something we're up against because we just don't have it . . . the beauty of what we do is that it's really holistic but . . . how can you say for sure, 'OK well clearly going to that public meeting last night has had this impact'? And I'm bloody sure that it does have an impact but there's no way to measure [it]. (Community safety officer)

In assessing success, whether framed as performance management or evaluation, officers are, then, primarily concerned with accountability: to the public, to senior managers and to external funders or central regulating agencies, to defend their chosen course of action and their professional or organisational credibility. Evaluation activities are used to manage some of the reputational risks that arise from developmental work or from particular sources of funding, in that they can demonstrate that a project was effective in the face of potential criticism. Evaluation results can also be used to solicit further funding internally or externally, providing proof of principle. Evaluation is therefore both an incremental and political affair: it is about improving and evolving practice, being responsive and adaptable to the local public and not about

selecting between discrete policy options. In this sense, there is little room for any activities to be wholly unsuccessful, or a complete failure: there is always something to be learned:

> Well I mean, I think the key benefits for . . . us in Trading Standards was . . . the positive aspect of working with businesses . . . that was of real value to us . . . the problem with the statistics because they're quite small areas, was that . . . there was a reduction in ASB [anti-social behaviour orders] but not a huge reduction. (Trading standards officer)

Discussion

We have shown how, in their work of controlling the environment and providing resources, local authority officers emphasise their accountability to a number of stakeholders: their local population, new public management and elected councillors. They must arbitrate between the needs of different publics and integrate their needs with the financial and legislative constraints from higher tiers of government. At different times the same course of action may be more or less palatable depending on the particular constellation of local and national politics, public opinion and funding. It is in this ever-changing context that the possibilities and options for action on the social determinants of health are determined. Local authority officers require the respect and cooperation of the different businesses and publics between whom they must mediate and with whose agendas they must integrate the requirements of legislation and resource constraints. This public relations work requires officers to demonstrate understanding and responsiveness and to present proof of their successes. It is in this everyday sense that politics is inescapable in local government.

The inevitably local focus in officers' practice, framed by discourse of uniqueness and innovation, supports the privileging of local knowledge and expertise as a way of understanding problems, designing actions and understanding their value. Officers put local evidence in the form of various data and information into conversation with their experiential expertise to create the knowledge that is used to reassure the public before a decision is made and justify those actions afterwards. In this framing, officers are constantly evolving their work in response to the fluid agendas of national and local actors and sources of internal and external funding, developing ideas and actions in an organic way. There is a sense in which any course of action will never be allowed to be a complete failure. Knowledge generated through evaluative activities is embedded in practice and used to develop and adapt their approach in the future, rather than to judge an approach as universally valid or invalid. This ongoing monitoring and evolution of work sits very much within the dominant performance management and auditing discourse in UK government (Davies 1999a). Given that officers are concerned with demonstrating the appropriateness of their actions and their professional capabilities locally, the very paradigm of a generalisable evidence base is therefore largely lacking in salience.

The successes of the evidence-based healthcare movement have been much trumpeted. Broom and Adams (2012: 3) comment that 'Evidence based paradigms now fundamentally shape the way health service providers, health funding bodies, governments and policy makers view "effectiveness"'. Strikingly, local government work on the determinants of health appears to be one arena in which this paradigm was largely absent. Rather than citing a neutral discourse of evidence-based practice to justify decisions, officers drew on rather different epistemologies of practice. These were rooted in localism, empiricism and a holistic approach that arose from the need to defend decisions from the scrutiny of diverse potential stakeholders. At one level, these findings resonate with those in many other fields, where the messy contingen-

cies of policy-making undermine any naive faith in a linear process of putting evidence into practice. However, our research suggests not that there were barriers, or contingencies that shaped the utilisation of evidence, but rather that decisions that impacted on the social determinants of health were taken within an entirely different framework, and one which had at its heart a messy, contingent and plural vision of 'wellbeing'.

In this vision, in which some valued outcomes (the reduction of pollution, alcohol harm and road injury) overlap with those of public health, the different 'healths' of diverse publics are also brought explicitly into the arena of decision-making. As we have shown, this is a deeply political process in that in entails taking seriously different values across many constituencies. In the terms within which Public Health England, and many commentators, have framed the obligations of public health specialists, this is problematic. A public health profession is not only deeply wedded to the normative obligations of evidence-based public health but also to professing these as its unique contribution is unlikely to articulate easily with everyday policy-making as we have described it; playing a likely role as simply one more interest group or as a marginal influence on decisions. If the rationale for public health specialists is primarily one of evidence guardians, it is guardians of an evidence base that relates largely to the evaluations of discrete health outcomes, not the holistic and multiple goals typical of local authority practitioners.

However, if the role of evidence guardian is one that has been prioritised in professional discourse, it is not the only one that public health has traditionally espoused. Unlike clinical medicine, public health as a medical speciality has historically had a perhaps ambiguous relationship to the doctrine of scientific neutrality: it is 'both a science and a means of intervention or advocacy' (Dew 2012: 109). The stories it tells of its own origins, with heroes like John Snow and Rudolf Virchow idolised for their political activism as well as their scientific approach (Dew 2012, Green and Labonte 2008) suggest a profession at ease with a political or advocacy role. This is, though, a politics wedded to a largely medicalised paradigm of health. Despite the widening of access to specialist training to non-medical graduates in 1998 (Evans 2004) the curriculum remains dominated by a medical model, with epidemiology as a core discipline, and a commitment to a hierarchy of evidence that favours evidence from randomised controlled trials. As the public health profession is reintegrated into local government in England, it brings with it a largely depoliticised and individualised model of health, reflected in the creation and utilisation of a generalisable research evidence base which can be ideologically positioned as objective and neutral (Marston and Watts 2003). From this position it has been possible to critique local government actors as privileging politics and experiential expertise over evidence in decision-making (Jolley 2011, McKee *et al.* 2011). This critique may underplay the politics of public health decision-making (Innvaer *et al.* 2002, Katikireddi *et al.* 2011, Qureshi 2013, Smith and Joyce 2012) but it does set up apolitical neutrality as a normative goal. However, as we have shown, everyday politics, for local authority officers, entails the privileging of local (empirical) expertise and experience. This both necessitates and reproduces a holistic and plural conceptualisation of wellbeing, and one that is contingent on the particularities of geographically bounded communities.

The local authority is connected to and answerable to its local population in a way that public health professionals have not been within the NHS. Directly interacting with the social and physical environment is intrinsic to officers' work and a substantial amount of local authority work is still carried out by in-house officers. This is in contrast to public health specialists in the health sector, whose training involves rotations around different settings and accreditation by the Faculty of Public Health, which fosters an orientation to the profession, not to the local community.

The weaknesses of the current evidence base for action on the determinants of health have been well documented (Bambra *et al.* 2010, Petticrew 2007). The National Institute for Health and Care Excellence, in developing its guidance on public health issues, has had to grapple with not only the lack of evidence on upstream determinants but the methodological challenges of incorporating the diverse kinds of evidence needed to understand what works for public health and equity gain (Kelly *et al.* 2010). In advocating the use of evidence across local government services, and using it as a defence against political decision making, Public Health England is perhaps underutilising the opportunity that a relocation to local government provides. Instead of decrying the politics of local government, it may be timely to explore what local government officers have achieved over the last 40 years without the organisational incorporation of medical public health specialists. Over fields as diverse as food risks, refuse collection, transport safety and the provision of green space, local government in England has been protecting and, at times, improving the health of its citizens. It has been doing this within a broader framing of wellbeing that both incorporates public views (however imperfectly) and negotiates between competing interest groups. This is an opportunity to develop an evidence base on what works and what does not on the determinants of health from case studies of practice in context (Woolcock 2013). Starting with an exploration of what is working, rather than a presumption that the politicised field of local government is inherently inimical to health projects, would be a useful first step.

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Acknowledgements

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