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Public health interventions in English local authorities: constructing the facts, (re)imagining the future

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Abstract

Purpose – This paper examines the contested value of healthy life and wellbeing in a context of severe austerity, exploring how the value of "Public Health" is constructed through and with material-discursive practices and accounting representations. It seeks to explore the political and ethical implications of constructing the valuable through a shared consensus over the "facts" when addressing complex, multi-agency problems with long time horizons and outcomes that are not always easily quantifiable.

Design/methodology/approach – The theorisation, drawing on science and technology studies (STS) scholars and Karen Barad's (2007) agential realism, opens up the analysis to the performativity of both material and discursive practices in the period following a major re-organisation of activity. The study investigates two case authorities in England and the national regulator through interviews, observations and documentary analysis.

Findings – The paper demonstrates the deeply ethical and political entanglements of accounting representations as objectivity, consensus and collective action are constructed and resisted in practice. It goes on to demonstrate the practical challenges of constructing "alternative accounts" and "intelligent accountabilities" through times of austerity towards a shared sense of public value and suggests austerity measures make such aims both more challenging and all the more essential.

Originality/value – Few studies in the accounting literature have explored the full complexity of valuation practices in non-market settings, particularly in a public sector context; this paper, therefore, extends familiar conceptual vocabulary of STS inspired research to further explore how value(s), ethics and identity all play a crucial role in making things valuable.

Keywords Public health, Performativity, STS, Value, Publicness, Public interest

Paper type Research Paper

1. Introduction

Accounting practices of naming, measuring and reporting across organisations and society play a crucial role in the articulation and reproduction of concepts such as "financial sustainability", "value for money", "costliness" and "accountability" at the core of what is made valuable. In so doing, such practices are far from politically or ethically neutral, and should, this paper argues, be understood as socio-material practices that produce and reproduce important organisational and societal knowledge frameworks. Constructing

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and contesting what is made valuable through these frameworks is a dynamic, iterative and entangled process of everyday "intra-action" in which we all hold a stake, and in which accounting practices, of naming and representing, act to mediate, legitimise and disrupt. Following this approach, this paper follows the contested value(s) of healthy life and wellbeing as public health professionals "make the case" for public health activities in the years after a major restructure of local government and the National Health Service (NHS) in England.

In critical accounting research the construction of economic value, and the role of accounting devices and practices in such constructs, has come under renewed focus (Kornberger *et al.*, 2015). In particular, there is a rich and developing discussion of the role of accounting in the making of markets and the performativity of accounting instruments on the back of a renewed interest in the social studies of finance and economics (Miller, 2008; Vollmer *et al.*, 2009; Justesen and Mouritsen, 2011; Kornberger *et al.*, 2015). However, to take the "performativity" of accounting devices to be their effect(s), in cause-and-effect relationships, with the "performativity thesis" to be proven or disproven is problematic (Butler, 2010; Callon, 2010; Vosselman, 2014). Just as crucially, despite the hegemony of exchange values in both the discourses and materialities of advanced capitalist economies – monetary values, via constructed market exchange mechanisms, do not represent the only means through which the value of objects and practices are contested in organisational life. What is valued in the public interest can and does extend beyond reductive measures of economic utility and is not always confined by traditional organisational boundaries. Publicness (Bozeman, 2007; pp. 7-10) and a renewed interest in the inter-organisational construction of public value (Steccolini, 2019), therefore, present fertile ground for the study of how pluralistic valuation practices are operationalised through accounting practices of naming and counting (Bassnett *et al.*, 2019) and "intelligent accountabilities" (Roberts, 2009), and how alternative accounts (Bracci *et al.*, 2015) can come to establish what counts and for whom.

Towards this end, this paper examines the reforms of the Health and Social Care Act 2012 in England, under which "Public Health" activities underwent a historically significant reorganisation. From April 2013, local public health teams were transferred from the NHS, along with the abolition of 152 primary care trusts (PCTs), to local authorities (LAs) across England. An initial £2.7 billion ring fenced grant fund was set up and distributed to LAs via a newly created statutory body, Public Health England (PHE). Teams of public health professionals across the country were physically transferred to offices in LA estates and were required to rebuild, almost from scratch, previously taken for granted legitimacy, professional identity and working vocabularies in a context itself being redefined by austerity. Challenges that finally crystallised in 2020 as the underfunded national response to the COVID-19 pandemic was widely criticised, with the government responding by announcing the abolition of PHE, the body they had created just seven years earlier.

Public health activities, particularly since 2013, have become wide-ranging multi-agency and cross-profession activities that address "wicked problems" through "preventative" action (Pedersen *et al.*, 2017). They represent huge potential for improved quality of life and the financial sustainability of health care systems and local government (King's Fund, 2014; Davies, 2015; Buck, 2017). They typically have long time horizons, needing to be strategically planned along the "entire life course" (Marmot, 2010) and are enmeshed with localised issues of health and economic inequality. Public health professionals meanwhile pursue the dual role of the "scientist", who analyses the evidence and "advocate" of public health interventions and of the profession itself. This study therefore follows the socio-material assemblages that (re) construct the "Public Health agenda" in a local government context in which LAs and other agencies have lost a major part of their budgets through successive rounds of austerity cuts. Two urban case study LAs were selected, "Metro Town" and "Midland City", both with significant health, wealth and educational deprivation, together with the newly created national agency PHE, private sector consultants, charitable organisations, and current and former

public health professionals. The empirical focus throws into sharp contradistinction conflicting processes of valuation: those based on hard to measure pluralistic valuations and "intelligent accountability" practices, against increasingly short-term, monetised or "cashable" outcome measures as austerity cuts take hold. In exploring the valuation practices employed by practitioners in making the case for public health, the paper exposes serious dysfunctionalities in the implementation of short-term austerity measures and the challenges of building collaborative ethical accounts in a context of cuts to budgets and existing services.

The paper therefore contributes to the growing discussion in the public sector accounting literature on how and to what extent we can move "beyond" New Public Management (NPM) in our characterisation of recent austerity reforms (Bracci *et al.*, 2015; Hyndman and Lapsley, 2016; Steccolini, 2019) both empirically, by following contested discourses and practices encountered by public sector experts and theoretically by drawing greater emphasis on the role of the knowledge production process itself. In particular, we show how "public value" and "publicness" arise from accounting practices that establish and reproduce what is counted and the contested ethics of intelligent accountabilities as they play out in practice. Following this approach, the study concludes that the accounting inscriptions and practices that operationalise economic values in organisational life must be understood as inherently and ontologically political (Vosselman, 2014), entangled, as they are, in unfolding knowledge making processes in which we all hold a stake. In framing this knowledge construction processes as *ethical* and *ontological*, the paper draws on Barad (2003, 2007 and 2012) and Haraway (1978, 1991) to explore how such a processes emerge from everyday iterative performative interventions, across organisational boundaries.

The first section of the paper introduces the conceptual vocabulary of science and technology studies (STS) and demonstrates how it can be mobilised to understand processes of value construction (2); current issues in the public sector accounting literature (3); and then a review of the recent reforms to public health activities in England and the emerging empirical literature in this area (3). The paper then summarises the methods and data collection (4) before presenting the analysis in two parts: the impact of austerity following the transfer of public health activities (5) and the (re)construction of public health interventions (6).

2. Performativity, the "facts" and (re)imagining the future

In questioning "what counts" in organisational life and in addressing valuation practices beyond the construction of explicit markets for exchange, this study draws on Barad's (2007) "agential realist" framework. Barad's framework develops well-known currents in STS (for example, Hacking, 1985 and Latour, 1987) as they attempt to theorise the epistemological and ontological basis of scientific knowledge, as well as drawing on the work of Butler (1990) and Foucault (1978) in their "performative" account of scientific understanding. Unlike many other STS scholars, however, the "material" is not presented in contradistinction to, or in the absence of, the human, the discursive, or the subjective, but is instead understood as entangled with, and constructed through, them. One important example of this is in how we understand the concept of "translation", and how we, therefore, follow the "sociology of translation" (Latour, 2005, p. 106) when investigating how things are *made valuable* in this paper.

In the accounting literature, Miller and Rose (1990) discuss "translation" as the reproduction of power relations, in the Foucauldian sense, through the proliferation of "inscription devices" that fix language and detach it from the speaker for ready reinterpretation by subjects under discursive and calculative regimes of control. Miller and Rose (1990) draw on the emerging actor-network theory (ANT) literature to introduce a second discussion of translation as the mobilisation of networks who may variously come to

share a common interest, particularly through material conditions, and referencing Callon (1986) and Latour (1987), the agency of non-human actors. Latour (2005, p. 179) later clarifies this point in his discussion of the sociology of translation by emphasising the openness of such processes through "displacement, drift, invention, mediation, the creation of a link that did not exist before", but also in his emphasis on the importance of objects, devices and technologies in solidifying and making permanent such social links.

In drawing on both of these angles through and with one another: translation through the reproduction of power relations and subjectifying practices (for example Miller, 1992) and the realisation of agency through mediating material devices in later ANT studies (Justesen and Mouritsen, 2011), this study turns to Barad's (2007, pp. 134-137) posthuman conception of *performativity*. In particular, this is to resist polemical understandings of material-discursive contradictions; processes of translation are neither exclusively or primarily "material" processes, on the one hand, nor exclusively or primarily "discursive" or linguistic processes on the other. Following Barad, processes of understanding are necessarily "intra-active" [1] agential processes that work through and with material-discursive "entanglements". The "performative", in this context, is mobilised to express that which simultaneously represents reality and changes reality; it is not simply the "performance", nor is it solely the quality of display or representation, rather it is the mutual unfolding or becoming of objects, bodies and discourses as they encounter a complex and dynamic material world (Barad, 2003, 2007, pp. 132-133 and 2012).

Barad's (2003, 2007, pp. 46-47) introduction to material-discursive frameworks is an extension of Butler's (1990) humanist conception of gender performativity and the iterative, agential and political inflections of the concept in their work. And it is Butler, strongly influenced by Foucault in coining the phrase "gender performativity" (Butler, 1990), who plays a significant role in the rise of a more generalised concept of performativity in the STS literature through the 1990s (see for example Callon, 2007, 2010; and Licoppe, 2010). Barad (2007, 2012), like Callon (2007), sees the importance of Butler's work in an extended socio-material conception of performativity as the process through which we interact with, and construct, the world around us. This has implications for our critical analysis in several important ways: firstly, it requires a rejection of positivistic approaches to "objectivity" that are independent of the framework, or apparatus, used to produce such objectivity in practice. Second, the concept of performativity, following Barad (2007, p. 134), draws attention to the ways in which participants actively engage with their subject matter through reports, strategies and open meetings to produce objectivity through iteration and negotiation; noting that such processes are mutually dependent on discursive and material practices. Third, the phenomena subject to analysis under this framework are, necessarily, entangled (Barad, 2007, p. 394); that is, impossible to understand in isolation or abstraction from the system in which they are produced. For example, in the context of public health: ethics and identity, budget practices and key performance indicators, informal professional networks and formal accountabilities and so on, should be analysed through and with one another where they intersect to produce specific knowledge claims or value statements. Finally, knowledge frameworks cannot be ethically neutral; ethics and politics are instead foregrounded in processes of knowledge production that can be either emancipatory or exclusionary (Haraway, 1978, 1991).

Following this approach, this paper argues that as public health professionals reconstruct the facts, they are reimagining their own local activities and identity through reassembled understandings of collective action. This outline follows the constructivist emphasis in critical accounting research on understanding both *how* accounting contributes to the formation of organisational life and to what extent we as researchers can offer up meaningful advice and guidance towards the better functioning of that life (Quattrone, 2015). Across this broad body of work are a range of studies inspired by ANT, referencing particularly Latour's

(1987) Science in Action (Justesen and Mouritsen, 2011), followed more recently by a number of studies that draw on the work of Michel Callon, 1998, 2007, 2010 and Donald MacKenzie (MacKenzie, 2006, 2009; Hardie and MacKenzie, 2007) in economic sociology and their particular conceptual use of "performativity". A number of empirical examples follow this latter approach, inspired to varying degrees by Vollmer *et al.* (2009) and Justesen and Mouritsen's (2011) calls for greater focus on the role of accounting in the making of markets (for example, Cushen, 2013; Williams, 2013; Vesty *et al.*, 2015). In taking up these calls, there have been many recent empirical studies noting the active performative consequences of accounting practices as knowledge-producing, framing, representing, or boundary-drawing activities (Skærbæk and Tryggestad, 2010; Dambrin and Robson, 2011; Cushen, 2013; Williams, 2013; Boll, 2014b; Vesty *et al.*, 2015; Revellino and Mouritsen, 2015; Corvellec *et al.*, 2016) and in some studies evidence of performativity "failing" to produce action at a distance (Asdal, 2011) or producing what MacKenzie terms "counter-performative" consequences in studies of management accounting devices (Cushen, 2013).

Across these studies it is notable that few have drawn on examples of knowledge or value construction processes specifically in the public sector, and that there has been an overall emphasis on performative intervention as "material" and "active" over and in contradistinction to "discursive" and "subjectifying". Scott and Orlikowski (2012) and Boll (2014a, b), present two counter examples to this characterisation, exploring instead iterative, material-discursive conceptualisations of performativity that draw on both post-Foucauldian sensitivities to processes of subjectification and sophisticated conceptualisations of agency. Scott and Orlikowski (2012) apply Barad's (2007) notion of intra-action and entanglement to demonstrate the unfolding performative drift as users become aware of web 2.0 technologies to engage with ranking systems of regional hotel businesses, and how, in turn, business owners and the hotel staff are iteratively transformed through and with both their customers and technological developments. Boll (2014a) applies the performative understanding they outline in Boll (2014b) to give a theorisation of the structure-agency dialectic as it plays out in Danish Tax Administration inspections of small businesses; juxtaposing the concepts of the Panopticon (Foucault, 1977) and the Oligopticon (Latour, 2005, p. 175) to demonstrate that structures of surveillance, discipline and internalisation, iteratively play out through and with active processes of inspection, translation and interpretation (Latour, 2005).

Drawing on this unfolding conversation this study looks to apply the tools made available by STS scholars, particularly drawing on Barad (2003, 2007, 2012), in the process of knowledge construction implied in "making Public Health count". As will be seen, the contested valuation practices in this context are predicated on establishing knowledge claims and building consensus through and with identities and a shared concern for the public interest. This theoretical framework, therefore, is *methodological* as opposed to ostensive (Mouritsen, 2006) in the sense that it guides and sensitises the data collection and analysis towards both the material and discursive practices as public health professionals seek to make their case and re-establish their own identity. This approach demonstrates that the empirical question of how the "facts" are constructed, and how public health activities are made valuable, turns on the ethical-ontological question of what possible futures the contested objectivities can or should seek to establish and for whom, in a context dominated by deep austerity.

3. New Public Management and austerity: the new public health arrangements

There has been considerable debate over the continued relevance of NPM as a general characterisation of reforms and practices in an austerity climate (Bracci *et al.*, 2015; Hyndman

and Lapsley, 2016) and on the increasingly complex and pluralistic relationship between budgetary activities involving complex non-financial outcomes (Julnes and Steccolini, 2015). The fragmentation of the public sector under regimes of NPM has, arguably, promulgated a "paradigm shift" from NPM to "New Public Governance", under which there is greater emphasis on horizontal collaboration, hybridisation and inter-organisational working (Almquist *et al.*, 2013). Others, however, argue that while practices develop and change over time, much of the traditional thrust of NPM, particularly the focus on "business like" practices, remain deeply entrenched in the UK context (Hyndman and Lapsley, 2016). As will be seen, the Health and Social Care Act 2012 (HSCA, 2012) reforms to public health activities in England are ambivalent to easy characterisation, but pluralistic approaches to providing alternative accounts (Bracci *et al.*, 2015) through "intelligent accountabilities" (Roberts, 2009) are evident in attempts to embed the value of a public health "ethos" across local government activity.

Extending this ambiguity, Bracci *et al.* (2015) suggest that austerity measures now present a context that alters the role and implications of accounting practices fundamentally, where once the NPM advocates were "promoting the principles of the market, encouraging competition, results-oriented behaviour, the quantification of performance and an emphasis on value-for-money" policy is now focused instead on national debt reduction, supranational institutions and localised fiscal tightening Bracci *et al.* (2015). In this environment, short-term budgetary cycles in LAs in England, in particular, become hugely influential and, indeed, overpowering for many who would seek to resist (Ahrens and Ferry, 2015). Others argue that social impacts and inequality are left out of the discussion in favour of financial savings in the context of austerity through new and distinct accountability arrangements (Olson *et al.*, 2001, cited by Bracci *et al.*, 2015). Hyndman and Lapsley (2016), however, point out that increased decentralisation and "localism" under recent austerity reforms are strikingly similar to early stage NPM reforms implemented by the Thatcher government of the 1980s so may not be indicative of an alternative paradigm.

3.1 "Intelligent accountabilities" and alternative accounts

One central difficulty in tracing value construction in a public sector context is precisely the complex and multiple accountability arrangements that NPM reforms seek to measure, rationalise and control. This is especially true in local government settings. "Accountability", in such contexts, has come to prominence in recent times over traditional concepts of "representation" and "responsibility" (Mulgan, 2003, p. 6) and implies a process, or at least the possibility, of "holding to account". While growing calls for "accountability" may have been concurrent with the growth in NPM through the 1980s and 1990s (Hood, 1991, 1995; Power, 1997, p. 42; Lapsley, 2009), there is an ambivalent relationship between the two. Direct "political" accountability, for example, is replaced under NPM with arm's length organisations and independent "experts" operating at a distance from political centres (Mulgan, 2003, p. 151). Following this outline, NPM could be at least partially characterised as a process of transfer from political accountabilities to managerial accountabilities and an increased reliance on arm's length agency relationships.

In introducing the critical accounting audience to the concept of "intelligent accountabilities", Roberts (2009) proposes an alternative to the "fantasy" of accountability as transparency. Accountability as transparency seeks snapshots of truth in an untrusting world in which "what counts" is uncritically and "violently" imposed, while intelligent accountability is a more compassionate exchange over time that affords the opportunity to listen, test commitments and develop reports in conversation between the giver and receiver of account. Such accounts are ultimately more productive and provide an antidote to the well-

documented failures of corporate governance, financial accounting and performance management (Roberts, 2009).

Relatively few studies have explored the construction of intelligent accountabilities in practice, and none have explored in detail how ethics are embedded in and reproduced through, measurement and accounting practices themselves. Empirical examples of intelligent accountability emphasise the contested and difficult nature of maintaining more forgiving and collaborative alternatives to hierarchal regimes of transparency (English, 2013; Yates *et al.*, 2019), with English (2013), in particular, providing a convincing account of how more intelligent governance founded on intelligent accountability can improve performance of large public interest institutions. Intelligent accountability is also, arguably, an extension of a number of similar concurrent themes in the critical accounting literature; for example, reflecting on the social and environmental accounting literature Bebbington *et al.* (2017) envision alternative accounts and accountability relationships that are transformative and emancipatory in answer to grudging partial disclosures of big corporations and governments. Similarly, Bracci *et al.* (2015) call for public sector accounting scholars to explore the performativity of accounting technologies in relation to austerity narratives and to consider alternative accounts that break down myths, stereotypes and bias on which such supposedly value neutral economic arguments rest.

In conceptualising accountability relations and following them through our data, we consider both structural principle-agent relationships (Bryer, 2006), together with the personal and subjective experience of accountability relations in practice (Roberts, 2009). Roberts (2009), in particular, draws on Butler (1997) and on Freudian analysis to suggest that accountability is both an interpersonal process (how we relate to others) and an intrapersonal one (how we relate to ourselves). In this analysis, accountability is presented as deeply socially and psychologically constructed as accountability becomes largely a fantasy used to legitimise decisions, construct a certain kind of transparency with a "self-fulfilling life of its own" based on ideals that can never quite be lived up (Butler, 1997). To explore accountability relationships, therefore, is to explore particular forms of *power relations* in which what is named and counted through particular statement types matters (Bassnett *et al.*, 2019), and through which subjects are constructed as subjects both materially and discursively (Roberts, 2009; Foucault, 1982) in a manner that is often punitive and yet holds the potential for more forgiving, collaborative and "intelligent" alternatives.

Moreover, it has long been recognised in public sector accounting research that budgetary cycles represent important means of allocation, control and accountability (Jones and Pendlebury, 2010, p. 62). Prior to the implementation of post-crisis austerity in the UK, Goddard (2004) conducted a detailed study of four UK LAs to find that budgetary cycles were already a key source of tension; centralising power in overall resource allocation while providing limited freedom to manage within directorates once allocations were made. Austerity, one would expect, may increase such pressures and tensions. Bracci *et al.* (2015), for example, note that LAs in England lost an average of 37% of their budgets between 2010 and 2016 while experiencing strict limits on their ability to increase revenues through local taxation. Ahrens and Ferry (2015) cite the statutory arrangements in LA that require them to make savings on a short-term annualised basis, forcing a short-term "temporal politics" (McGivern *et al.*, 2017) into LA decision making processes.

Public health arrangements speak to this latter interest structurally; as they provide local public health teams with a ring fenced grant that provides a level of autonomy to manage their own activities and commissioned services; discursively, as they then have to "justify"

why they are "different" or "special" by constructing a language of "spend to save" in Health and Wellbeing Boards (HWBs) where they are confronted by other budget holders facing major cuts; and, finally, as a cite of resistance.

3.2 Public health in local authorities: from health in all policies to austerity

Following the HSCA 2012, the Department of Health (2011), the Local Government Association (2014a, b), and the newly established PHE (2013) issued various fact sheets that laid out the details of the statutory arrangements on public health intended for LAs. These statutory arrangements described the duties and responsibilities of Directors of Public Health (DsPH), HWBs, PHE and the new reporting and accountability arrangements associated with the ring fenced public health grant. Drawing on the initial government White Paper entitled "Healthy lives, healthy people" (HM Government, 2010), the Department of Health (2011) outline the vision for public health in local government, which was described variously as bringing public health "home", "democratising Public Health" and providing local government with the "freedom to innovate" using the newly provided local funding. Increased aspects of democracy were welcomed as public health commentators described the reforms as an opportunity to bring "health into all policies" (Buck and Gregory, 2013; LGA, 2014a, b; Peckham *et al.*, 2017) and the emphasis on the full "life course approach" (Nuffield Trust, 2011).

Since the establishment of these reforms, research on the organisational, professional and practical implications of the transfer of public health into LAs has been published across several journals. In the public health literature studies have investigated questions of leadership (Day *et al.*, 2014), public health advocacy and evidence (Brown *et al.*, 2014; Phillips and Green, 2015; Smith and Stewart, 2017; Sanders *et al.*, 2017; Reynolds *et al.*, 2018) and strategic delivery and partnership working in the new context (Caron *et al.*, 2014; Van Der Graaf *et al.*, 2017; Chantler *et al.*, 2019), with some studies in the local government literature having taken up similar questions (Peckham *et al.*, 2017; McGivern *et al.*, 2017). Several studies note that the new system introduces a complex mix of stakeholders, with a range of sometimes competing accountabilities to the local population, to management and to politicians with increasingly "fragmented" structures of performance measurement and reporting (Brown *et al.*, 2014; Phillips and Green, 2015; Chantler *et al.*, 2019). The NAO (2014), in particular, cited this as a concern, criticising the lack of standardisation and the likely national variability they expect to result from PHE's limited statutory control. Weakened links between PHE and the NHS, with a loss of links between clinical commissioning groups (CCGs) and the new public health teams, in particular, were reported by Brown *et al.* (2014), while Chantler *et al.* (2019) report a lack of clarity in the allocation of roles between LA public health and NHS England in commissioned services. Similarly, there is also evidence of contrasting "epistemologies of practice" between "experiential" and qualitative forms of knowledge traditional in LA and the more scientific "evidence based" forms of knowledge that were observed among public health professionals, particularly those at PHE (Phillips and Green, 2015; Brown *et al.*, 2014).

Despite the complexity, however, the dedicated public health grant and the proximity to LA services were seen as a "freedom" to embed public health activities and, initially, to use the new found evidence base to resist austerity cuts (Brown *et al.*, 2014). In bringing public health professionals closer to the "wider determinants of health" they were able to work more closely with existing local services such as alcohol licencing (Reynolds *et al.*, 2018) and local commissioning (Sanders *et al.*, 2017). In making the transfer a "success' public health professionals needed to proactively build new working relationships and learn to present

their evidence base to new audiences, while taking on new roles as budget holders and commissioners (Milton *et al.*, 2014). HWBs were found to act as both a traditional accountability mechanism in which public health professionals present their work, and crucially, as a forum for collaborative working towards a new "Public health agenda" (Phillips and Greene, 2015). The reforms therefore placed particular focus on the role of the DPH as a key advocate and powerful actor in an increasingly politicised context (Day *et al.*, 2014; Hunter *et al.*, 2016; Peckham *et al.*, 2017).

A major challenge to public health professionals was developing a culture of "evidence based decision making" in an environment where evidence had previously been relatively peripheral (Hunter *et al.*, 2016; Sanders *et al.*, 2017) and within a political context of negotiation and often *post hoc* justification. Brown *et al.* (2014) describe the resulting two-way dynamic as public health professionals learn to "tell the story" of public health interventions, particularly when dealing with elected members and short-term political cycles, while also defending their own professional identity. The "value" of public health extends to their ability to make use of evidence and their formal scientific training to direct strategic decision making around investment and intervention, and increasingly, around disinvestment decisions (Marks *et al.*, 2015).

Hunter *et al.* (2016) describe successful public health interventions as a coincidence of evidence, policy opportunity and political support, so that the "evidence" of what works underlying valuation practices becomes contingent on organisational, professional and political networks. Similarly, McGill *et al.* (2015) cite the trade-off between relevance and quality of public health evidence while other studies cite the crucial importance of not only establishing the facts but being able to mobilise actors in the new organisational context (Reynolds *et al.*, 2018; Sanders *et al.*, 2017). In an analysis of a social return on investment based commissioning tool, Sanders *et al.* (2017) note both the political subjectivity inherent in calculative practices and, at the same time, the need for measures to have sufficient rigour that they could convince a questioning audience. Public health commissioners were found to be skilled in finding the evidence to support their case, but they also note that the majority of academic literature professionals draw upon fails to recognise the "messy" reality of constructing evidence in practice and in context (Sanders *et al.*, 2017). Interventions must enrol key actors both inside and outside of the organisation and align with what they note as a "transactional" business ethic focused on cost effectiveness and value for money not only to be effective but also to be possible (Sanders *et al.*, 2017).

More recent findings and industry commentary increasingly emphasises that funding cuts to the central public health grant are beginning to impact on delivery and are leading to reductions across a range of core public health activities (Peckham *et al.*, 2017; Buck, 2017, 2018). Government announcements in 2017 amounted to real terms cuts in the region of 4–5% in the public health grant nationally for a population that has increased by 3% (Buck, 2018), resulting in strong criticism from the Local Government Association (LGA, 2017) who had previously expressed support for the public health reforms (LGA, 2014a, b). The consequences of these budgetary cuts were highly variable across the different areas of public health spend nationally, with all areas besides childhood obesity spending showing varying levels of cuts. There was little evidence that these changes were coordinated at the national level so that the impact of the grant reductions is highly depended upon local strategic priorities and the ability of public health professionals to make their case. This variation in the reduction in activity is demonstrated in the Health Foundation's (2018) analysis in which all areas of spend, besides childhood obesity, see significant cuts between 2014/15 and 2019/20 (see Figure 1):

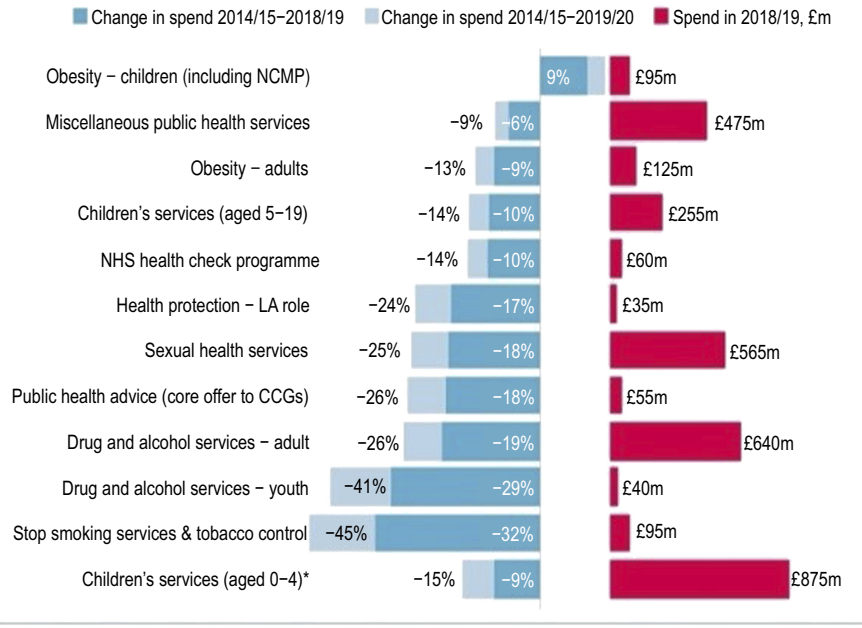

Figure 1.
Public health grant change in net expenditure since 2014/15 by element of provision

4. Methods and data analysis

In exploring the emerging knowledge frameworks in the new public health system, initial pilot interviews were conducted at "Metro Town", a mid-sized city authority in the midlands area of England, which quickly highlighted a range of interesting tensions around scientific or "evidence based" vs experiential knowledge; "culture" and "language" differences; budgets and the initial ring fencing of the public health grant; and the extent to which public health networks extended beyond any one organisation. To follow these networks in more depth, a second case study, "Midland City", was selected. This was a considerably larger city authority in terms of total revenue and expenditure, within the same geographical region. Both Midland City and Metro Town shared many of the same regional networking spaces, particularly those facilitated by the regional PHE office such as regional workshops and monthly DsPH meetings.

The specific focus on two urban authorities with increased levels of deprivation emphasised the challenges posed by austerity conditions as practitioners sought to make the case for public health in this new context. LA budgets were reduced nationally by 37% between 2010 and 2016 (Bracci *et al.*, 2015), but this reduction disproportionately affected deprived authority areas with greater health, wealth and educational inequalities (Hastings *et al.*, 2015). Both authorities selected in this study reflect this. Both were highly populated urban authorities, and analysis of PHE's outcomes shows that for 2015/16 both Metro Town and Midland City were rated as "red" for all 8 benchmarked overarching indicators on a green-amber-red system. In terms of budget cuts Midland City identified in their 2014/15 budget consultation that they would lose more than 66% of their managed expenditure by 2017/18, while Metro Town identified that they had already lost 52% of their central block grant by 2015/16 (£126m).

Following Latour (2005), this study places emphasis on "following the actors", which led us outside and beyond the immediate organisational environment. Detailed notes on the physical locations contextualising the various interactions were made, and a questioning of the physical and material nature of agency alongside interview and documentary analysis was included throughout. The interview questions explored how public health consultants made their case in their new context, what calculative and discursive devices worked for them and how these differed to the NHS context, and how they mobilised networks both within and beyond the local authority. Particular focus was given to the range of calculative practices, and several of the interviews at both case authorities and with PHE staff were with specialists in drug and alcohol interventions. These findings were then triangulated with the observations and with the documentary analysis.

In both cases, public health professionals were physically transferred to new premises following the abolition of PCTs in April 2013. The public health professionals who transferred into Metro Town, described as a relatively small team after several of consultants left, were placed in the authority's main post war civic centre located in the city centre. Meanwhile, Midland City's public health team moved to a large newly built building on the edge of the city University with an expansive open plan layout, but separate from the main LA building in which the HWBs and other Authority meetings took place. The decision to pick two LAs in the same region was primarily in order to follow the networks across organisational boundaries more fully; the intention was not to construct a full comparative case analysis, but to follow *how* the case was made for the public's health and wellbeing across these settings.

Documentary analysis of both primary and secondary case documents, reports and calculative devices was then conducted. Detailed field notes were taken at meetings of the regional DsPH, a PHE workshop introducing their calculative tools on drug and alcohol interventions, and at an unstructured focus group of public health consultants in the region in 2016 at which one of the researchers presented the initial findings. The documentary analysis was focused on knowledge production practices that ranged from locally produced surveys, public health annual reports and document packs, commissioning documents, interpretations of knowledge tools constructed at the national level, social return on investment calculations, to PHE's national outcomes framework. Due to the breadth of the public health remit, covering 7 prescribed areas of public health as a condition of grant, and a further 13 non-prescribed areas of discretionary spend (Department of Health, 2016), the particular attention given to drug and alcohol interventions allowed for greater depth of analysis and cross referencing to interviews with drug and alcohol specialists and specific commissioning processes.

Through the first round of data collection in 2015 one of the authors attended these public meetings, collected key documents and arranged interviews with public health professionals and their partners, including interviews with public health professionals in the regional PHE team and 4 interviews with financial advisors in the public sector practice of a large mid-tier accountancy firm. Follow-up interviews were then conducted through 2016 and 2017 to broaden out and triangulate the themes coming out of the initial round of interviews. These continued the central questioning of the knowledge construction process, skill sets, ethics and perceived expertise of public health professionals, but this time were extended to include members of the finance and strategy teams in the LAs, a local charity, public health professionals delivering the vocational public health master's program in a local University and health economists working for PHE at the national level. In total, we conducted 27 semi-structured interviews with 25 participants (Kvale, 2007, p. 10), including a total of 16 interviews with public health professionals and a follow-up interview with the DPH in each of the case study locations, which were then fully transcribed and coded in Nvivo (Kvale, 2007, p. 105). In total, 5 observations of HWBs were conducted using field notes cross referenced to supporting committee document packs, 2 of which were fully recorded, transcribed and

coded. 2 full sessions of the 2016 parliamentary enquiry, with contributions from a total of 14 senior professionals and policy advisors including an interview with the DPH of Metro Town, were similarly coded in Nvivo using the parliamentary transcriptions.

For the interviews, recorded observations and transcripts obtained from the parliamentary enquiry, the decision was made to systematically code using Nvivo as far as possible. We note that some STS inspired methodologies, particularly those drawing on Actor-network Theory, tend not to follow this approach. Following the principle of "general symmetry" between the researcher and the researched (see McLean and Hassard, 2004), it could be argued that representational accounts constructed via coding are inherently problematic; that to ensure that practice precedes reality (Law, 2004) or that researchers are not obfuscating their own data by replacing the language of our participants with our own (Latour, 2005, p. 49) it may be better not to code at all. While this study has chosen to code its qualitative data, it tries to resist these critiques. In particular, essentialised or separable codes that reveal underlying social mechanisms under a Grounded Theory style approach (Glaser and Strauss, 1967) were resisted. Instead, following Barad (2012), coding is seen as a material engagement through which angles of analysis are entangled, and through which conclusions are drawn that are themselves ethical-political (re)engagements in ongoing processes of knowledge construction.

The codes were thus constructed on three levels: the first produced the two-way analysis of accountability relations; top-down hierarchal accountabilities on the one hand and accountabilities that generated agency, mobilisation, translation and drift on the other. Within these two primary codes specific material, discursive and calculative devices were drawn out of the data through two further rounds of analysis exploring budgetary, professional and statutory accountabilities, spaces in which actors came together, and then the key recurrent themes that were noted. Wherever possible themes from the interviews, observations and the parliamentary enquiry were triangulated against the primary and secondary documents obtained. The breadth of this data analysis across multiple organisations created a necessarily messy picture, but one that allowed us to follow the role of accounting devices through complex networked processes of knowledge construction.

5. Austerity and the ring fenced public health budget

Following the initial transfer of public health activities into LAs there was an initial increase on the base line PCT level funding of 5.5% for 2013/14 (NAO, 2014) to £2.7bn nationally. Additionally, following the transfer, both LAs generated savings through large scale re-commissioning as the full public health budgets came under their direct control. However, by 2014 the funding had been restricted, and in the Autumn statement of that year, the UK Chancellor announced a £200m cut from the following year's public health grant, which was to be followed by further reductions nationally of 3.9% per year through to 2020/21 (King's Fund, 2017a). Between 2013/14 and 2017/18 the King's Fund (2017b) identify that the like-for-like public health grant to LAs had fallen by 5.2%.

In the early phase of the project, participants talked about the "opportunity" to more closely integrate public health across the LAs and cited the DPH's statutory duty in signing of the public health grant declaration as protecting against abuse of the grant. Examples of existing services being brought into the new public health remit were seen as helping to embed public health and bring the new budgetary department closer to the wider determinants of health. But by 2016 and the second round of data collection, the negative impact of the cuts to public health began to come through strongly in the data. The Chancellor's 2014 announcement impacted Metro Town more immediately as it resulted in the loss of allocated reserves that had been rolled over from 2013/14 into 2014/15, and which had been generated by initial re-commissioning of contracts and closer scrutiny of service level activity. The DPH at Metro Town expressed their frustration at the lack of notice:

> We got huge savings out of certain contracts, but huge savings and with a view to being able to reinvest that money for services that we needed to do because of our health needs. And this is where I'm uber disappointed because the government then turns around and penalises us for what I think is sound financial management and actually with an ambition to invest in preventative services in the areas that we needed to for [Metro Town]. And of course, what the government's done now is taken away £1.3 million out of our budget in-year. . .
>
> So I had earmarked all our underspend against future projects against our priorities for obesity, for infant mortality, for smoking cessation, for alcohol harm reduction. "We'll invest in this. We'll do a pilot in this. 'It was energising. . . and no'. Local authorities, you've got underspend in your Public Health budget, i.e. you do not need it, so we're going to take it away from you." Joanna, DPH Metro Town, Dec 2015.

Here we see "localism" and the "freedom to manage" the local public health budget being directly undermined as earmarked reserves were retrospectively removed. The Strategic Finance officer at Metro Town commented on the impact this had on the medium term financial plans as they had to be re-written, leading to "very tricky" variation to tender negotiations. For many existing contracts, however, the authority was simply "locked-in" to commitments they could no longer afford. This was described as being the situation the "length and breadth of the country" (Gerry, Strategic Finance Metro Town, Dec 2016).

In the follow-up interview, the DPH at Midland City was also expressing his frustration at being faced with conversations "every single day" requesting money from his budget. The impact of austerity within public health and across the authorities was acute, with similar examples of long term planning being undermined by ad hoc budget cuts, loss of links and the breakdown of established networks. In 2016, the CEO of a local charity was interviewed shortly after hearing that two of their commissioned services, funded from the public health grant, were to be cut:

> We knew that things were really bad in terms of the council's budget, and we knew that they were going to have a significant cut, but we had not had any discussion with them. We were invited to a meeting, and then following that meeting in February, we got a letter to say that two of our services were going to be decommissioned.
>
> At that point, that was just enormous. Three quarters of our income [from Midland City]. They informed us that two of our services for them would be decommissioned, which was about half of our income as an organisation, which was devastating. My response to that had to be a practical one, and I put all my staff at risk [of redundancy], because I knew that if those two services went half of our workforce had to go, and we'd have to look at our viability as an organisation. [That] was something I was very angry about having to do, to stand and explain to my staff that I was putting them all at risk of redundancy. [. . .] A couple of members of staff burst into tears. Barbara, Charity CEO, Oct 2016.

The KPIs on these commissioned contracts showed that the charity had exceeded their agreed performance, and that the discussions with Midland City's public health commissioners and DPH had not raised any performance issues. It was simply a matter of their services having become "unaffordable" in light of the HWB's newly narrowed health and wellbeing strategy. This cut appeared to contradict both the government's "big society" vision, which saw a greater role for the third sector and Midland City's own initial focus on Childhood Obesity outlined in their 2013/14 Health and Wellbeing Strategy. The CEO concluded this point with reference to the cut as a "business decision", linking the rhetoric of NPM (Hyndman and Lapsley, 2016) to the austerity measures being imposed:

> They've been very clear with us that it was nothing to do with our performance. It was nothing to do with our reputation. It's nothing to do with what they felt about us. It was purely a business decision. Barbara, Charity CEO, Oct 2016.

Interviewing a joint public health and Environmental Health officer at Midland City, it was noted that cuts across the rest of the authority (outside of the public health ring-fence) were similarly creating inefficiencies as working relationships were disrupted; information flows were broken, and staff became increasingly demoralised:

> A lot of our work is working with other agencies and what's happened is we've reduced and everyone else has and so people have completely disappeared. What's been quite difficult is they've disappeared and we did not even know. Physical people and then physical agencies have just gone. One day they're there and the next minute they're gone and you do not even know. It's the inefficiency [. . .] we just do not know what is happening to every other agency. It just feels very, very scary. Jane, Public Health / Environment Health, Midland City, Nov 2015.

This demonstrated the tension, noted across the data, between the short-term need to balance the books of the authority in an austerity context and the longer term multi-agency collaborations valued by public health practitioners. Particularly across the larger Midland City budget consultation documents, what was considered *valuable* had become conflated with what was considered *viable* within a newly taken for granted context of resource reduction, which in turn influenced how public health professionals sought to make their case. The underlying, and even shocking, politics and ethics of such a position were expressed by one private sector financial advisor, describing the futile resistance to such practices in the first round of data collection in 2015:

> So, the one part right now which is a very expensive part to maintain, nearly 10 or 20 per cent of the demographics of the UK is consuming 70 per cent of the entire budget, that 10 per cent is shortly going to become 20 per cent, which would be a doubling of the health service and we've got no way that we can cope with it. We're just getting older and we cost more. It's like an MOT on a car, at some point you've got to say, "No more." But you cannot politically say, "We believe in euthanizing anyone over 85 who has got cancer." No we throw 10 grand at you to fix it, even though you're not *economically viable*. [emphasis added] Mike, Senior Consultant in national Accountancy firm, Aug 2015.

The emphasis added to the closing phrase draws attention to the association of the ethical value of a human life with a purportedly de-politicised economic valuation, in which a human life is comparable to any other commodity value. While rarely so openly expressed this exposes the morally laden and sinister logic underpinning an uncritical acceptance of austerity practices and the potential consequence of narrow economic modes of valuing in an austerity context.

In the case authorities analysed, there had been a significant cumulative effect of austerity over many years with deep cuts to front line services. Each year in which new cuts were announced without comprehensive long term planning existing services were further stretched, with a number of participants highlighting the danger of a "salami slicing" approach to disinvestment. When public health professionals were questioned about how they coped in this context, participants responded by discussing their ethical commitment to a "Public Health ethos", to their professional identity and their accountability to local populations. In answer to this question, the DPH at Metro Town put it as follows:

> From professional accountability, I've absolutely got a duty to improve the health of the residents of the city of [Metro Town]: to protect them from harm. And I also need to be reducing health inequalities. And that is absolutely my driving principle. I come and remind myself of this every day. So whether I have flak and worries around that money, flak and worries around doing politically the right thing, ultimately, my main accountability is to those 252,000 people out there in terms of me continually striving professionally to do my best. And that is absolutely what I hold most dear. Joanna, DPH Metro Town, Dec 2015.

Public health professionals were found to be resisting narrow economic valuations of health and wellbeing by attempting to integrate social values into economic models and by drawing attention back to pluralistic public health outcome measures. Although it was decreasing, the ring fenced nature of the public health budget and the statutory accountability of the DPH gave some strength and leverage in negotiations across the authority. These attempts are further explored in the following section of the analysis, focussing on *how* calculative practices were employed by public health professionals, before concluding with a discussion of the consequences for public health professional accountability and identity and the implications for an ethics of intelligent accountability.

6. (Re)constructing public health interventions

Across the two case authorities, and PHE, public health professionals stress their commitment to detailed construction of facts, objectivity and scientific methods. A number of tensions were noted through this construction, which became increasingly pronounced as budgets became restricted. There were conflicts between nationally aggregated data and locally produced analysis; between upstream preventative interventions that were potentially more difficult to evaluate on an individual basis and acute service based interventions that generated more robust short-term data; and, finally, whether interventions released cash savings and where such savings would fall across organisational and budgetary boundaries.

HWBs were found to be important sites of translation and mobilisation between the public health team and their key contacts among CCGs, elected councillors and other budget holders and service directors. One important example of mobilising local data came from Metro Town, as the DPH introduced their childhood obesity strategy at the first presentation of the second public health annual report to their HWB in 2015.

> Obesity, I've already given you those killer stats [. . .] for obese reception class it's 26.4%, if you bring in overweight and obese. That's 12.5% obese and 26.4% obese or overweight. So that's over a quarter of our four year olds who are already starting school. That is why we're constantly talking about this life course approach, that we are starting right at the beginning and getting them with prevention work right from the start.

> You can see there, that scary statistic – over 40% of our 10 and 11 year olds are overweight or obese. 26.2% of those children are obese. That's really robust data, because our school nurses take the height and weight measurements of our reception classes and year 6 classes and we get about 91% uptake. That's really, really accurate data. Joanna, DPH Metro Town, HWB July 2015.

We noted here that the associated slides gave a highly visual representation of the data through charts and graphs that were cross referenced to the annual report document itself. We also noted the emphasis on the robustness of the data around an issue that was perceived to be emotionally important. In this case, the Director was able to mobilise the relatively strong descriptive statistics based on a combination of primary local data and secondary national data to drive a detailed list of recommendations. In the analysis of the 2015/16 public health annual report referred to in the above, it was noted that the evidence was presented and constructed around health and wellbeing outcomes, with the economic argument only briefly introduced in broad terms in the introduction rather than by each recommended intervention.

Evidence of tension between the localised approached exemplified in the above, with a clear emphasis on enrolment of actors in areas of stark emotive need, and engaging more explicitly with economic arguments were noted in the evidence from the health economists in PHE's national head office. Following the DPH's presentation, the childhood obesity situation in Metro Town was described by the elected member for Health and Well as a "ticking time

bomb" and she called for the stakeholders around the table to come together to "do something about it". However, the PHE health economists problematised the "political" influence on public health interventions as follows:

> Politics has a massive influence; there are certain things that you have in your public health grant that you'd want to cut but you can't – so some things are mandatory. There are certain ones that you don't think in your area that this is a priority, but for political reasons you can'|t cut it. Childhood obesity is an area where we have very little evidence – very little evidence of anything being effective, yet it's a massive priority to change it. And public opinion, public sensitivity and political influences are that we need to invest in it. So that's fair enough, because, in some places, there are whatever, 50, 60% of children who are obese – overweight or obese. But if there are no effective interventions. . .. Suzanna, Health Economist, Nov 2016.

This tension also appeared to play out nationally, with the "category of spend" data from the Health Foundation (2018) (Figure 1) showing that childhood obesity was the only area of the public health budget to see increased investment. Across several such examples, recurrent difficulties in how the "objective" analysis was constructed included: the choice of time horizons; whether outcomes were constructed as "health" or "health and wellbeing"; whether they were measured in qualitative or quantitative terms; whether such quantifications commensurate a variety of measures into concepts of "social value" calculated in economic terms, and if so whether such values were constructed across the wider economy, or whether they were constructed within specific organisational or budgetary boundaries.

6.1 The case example of drug and alcohol interventions

Drug and alcohol interventions are a major area of public health LA spend, both through commissioned services and direct provision. They represent one of the six mandated areas of the ring-fenced grant and nationally accounted for £716m of the total spend in England (King's Fund, 2017b). Both case locations underwent major re-tendering of their various drug and alcohol programs following the transfer of public health activities in 2013, after the public health budgets fell under the direct control of the DsPH in the new arrangements. Participants commented on the number of previous contracts and the lack of scrutiny of activity prior to the transfer to LAs. In Midland City the lead commissioner described saving £16m over 5 years while at the same time delivering better outcomes through closer scrutiny, bringing together 28 separate commissioned contracts. Similarly, in Metro Town, significant re-tending activity took place across drug, alcohol and sexual health services, resulting in significant savings. These reviews allowed public health professionals to re-draw the service level key performance indicators, through discussion with users, volunteers and providers and align them against PHE's new outcomes framework.

Following this initial re-tendering activity after the transfer, PHE developed several nationwide tools to assess the "social value" added by different types of interventions in the newly recommissioned drug and alcohol contracts. This was through the development of a Drug and Alcohol "Cost Calculator" and "Commissioning Tool", and later, a Drug and Alcohol "Social Return on Investment tool". The first two were related to cost identification to facilitate more accurate information returns to central government, the latter tool was then rolled out in 2016 to help articulate the "social return" on commissioned services based on national data sets and academic research adjusted for local variables. To facilitate the development of these tools, a member of PHE's health economics team organised knowledge sharing workshops in each of PHE's regional offices. During a follow-up interview, after observing one of these workshops, the health economists described the "tricky" balance of developing the tools based on accurate standardised data whilst getting the input of those who would ultimately be using the tools. After explaining the importance of establishing

activity through the "cost calculator", one health economist went on to emphasise the iterative nature of the construction of the subsequent tools and the engagement with practitioners:

> We've also got another tool called the commissioning tool, which has a cost calculator embedded into it, [that] looks at the different types of treatment pathways that different types of clients can be accessing and what the cost effectiveness is. So, by cost effectiveness, we are defining it as spend over successful completions of treatment. [. . .] that was out last year and we've received a lot of feedback and made amendments to try and improve, make it more user-friendly. Vicky, Health Economist, Dec 2016.

The calculative tools were not delivered in a top-down fashion to drive commissioning strategies, but instead developed through a two-way process of negotiation in order to develop tools that would be useful and relevant in practice. These iterations allowed tensions between different knowledge practices to play out and for the models to be continually updated.

One of the results of this project was the "Families Drug and Alcohol tool", a tool for "estimating the benefits of treating substance misusing parents". This tool contained a detailed set of calculations combining locality with known output data across social care, education, employment, housing and crime. It then allowed the user to adjust for their preferred time horizons and length of service across each of the outputs. These are then converted into pound-sterling figures by via three categories: "fiscal" defined as cost savings to the public sector; "economic" defined as wider benefit to the local economy, and "social" defined as wider gains to society.

The Families Drug and Alcohol tool was an extensive piece of work that took PHE's health economists many months to develop, refine and review. Within the document detailed methodologies are explained to the user, enrolling them in the nature and relative robustness of the calculations. There is an emphasis throughout the tool on "fiscal" savings, although also an emphasis in the introductory page that even these savings may not be "cash releasing" or "cashable", giving examples of how some savings listed may release cash in other areas of the public sector outside of the local authority. One of the few measures where all three elements of the model come together (fiscal, economic and social) was in domestic violence interventions. Here the calculation draws on a range of academic and governmental research to estimate the various costs and qualities associated with issues of domestic violence and draws on "QUALYs" (quality adjusted life years) in its conversion to social values.

The social element in the domestic violence interventions example considerably increases the overall cost of an incident of domestic violence, so that investment in prevention appears as considerably more attractive. However, this also introduces more estimation and variation from case to case, which in turn made it more difficult to enrol key actors in the "true" value of the activity. Included in the underlying calculations in the above example were use of QUALYs, which were discussed with one of the chief health economists at PHE, who described how the use of QUALYs, and in turn the construction of the evidence base, had changed over time:

> We're operating in a completely different environment now, where what the local authority needs is to balance the books, every year. And they need to understand what they're going to benefit from investing in Public Health. And what we find hardest is that all of the literature is based around cost per QUALY – because we used to be NHS; in the NHS where that was the outcome – the outcome measure was health.
>
> Now the outcome measure is less and less health, which is quite depressing really because Public Health literature has been around to do that. So taking alcohol[. . .] we used to say alcohol treatment is cost effective, you'll get lots of health outcomes. Now we're changing the argument to say, "The impact on families is X, therefore in a local authority you'll need to spend less on your children's

> social service. And the impact on crime is Y, and therefore the criminal and justice system, and the police in your area will have to spend less on Y." Suzanna, Health Economist, Nov 2016.

This was supported by the analysis of the Families tool where the vast majority of returns were calculated in "fiscal" and/or economic terms, with only 1 of the 17 elements drawing on "social' values, and this with the option that it could be left out by the user. The reconstruction of this calculation reflected, therefore, not just the changing communication of public health outcomes, but the relative value of the outcomes themselves when making the case for the investment of limited funds.

Through the reconstruction of such measures, it was noticeable that there was a clear commitment to "evidence" and "objectivity" among the professionals involved, but equally, that part of the purpose of such calculations was to "make the case" for public health by determining what ought to matter within the calculations themselves. One of the lead commissioners in Midland City, however, when asked about the Drug and Alcohol SROI tool and the changing nature of public health evaluations problematized this move, returning to the core ethical argument in making the case for public health on its own non-monetary terms:

> My approach is that I recognise that these are potential savings you could make. And I'm not sure that actually putting a pound sign on it, a cost, is what you really ought to be arguing. It is about what is the *value* of what you are investing. So if people don't commit as much crime, or don't need specialist residential care, but can live at home, it is not the difference in the costs, but actually the *value* to the person that actually ought to be what we're trying to work a because that's a good in itself. Adam, Public Health Commissioner, Midland City, Dec 2015.

This cuts directly to the contestation of processes of *economisation* (Çalışkan and Callon, 2010) at play in the commensuration of *values*, plural, to *value*, singular, defined in economic terms. This contestation remained unresolved, but it was clear that a number of local public health professionals asked about PHE's SROI tools around Drug and Alcohol questioned the narrow focus on service level activity rather than "upstream" prevention and qualitative as well as quantitative evidence. They were resistant to their valuation techniques being opportunistically redefined to address short-term austerity concerns. While more acute short-term activities were potentially easier to measure, and therefore economise, they also ran against a developing public health "ethos" that sought to integrate health and wellbeing across all activities and across all policies rather than provide a public health "service".

7. Discussion and concluding remarks

This paper has explored how public health activities, and more broadly "the public's health and wellbeing", were made valuable in the context of two deprived LAs in England in the aftermath of the HSCA, 2012. In so doing, the paper has sought to shed light on how ethics and politics are produced and reproduced through material-discursive exchange and intra-action, and in particular, through calculative and discursive devices that are continually contested, amended and mobilised across organisational boundaries. Throughout this analysis, an understanding of knowledge construction as a messy, heterogeneous and *performative* process was central (Barad, 2003, 2007, pp. 134-137). Inscription devices were observed "in action" in HWBs; for example, the construction of a joint health and wellbeing strategy at Midland City, or the presentation of the public health annual report at Metro Town, which led to translation and mobilisation through highly visual power point presentations, handouts and discussion. While the difficult and contested construction of valuation techniques, such as social return on investment tools and KPIs, were followed between PHE, local authority practitioners and service providers.

Throughout, participants were seen to constantly be re-working what Barad (2007, p. 206) describes as the material-discursive apparatus. Akin to a series of scientific experiments, public health practitioners reconstructed both their material apparatus (for example, by circulating new local surveys and data collection) and their theoretical apparatus (for example, by shifting the focus from "health outcomes" in terms of QUALYs to broader health and wellbeing outcomes, and increasingly, towards financial outcomes) to produce objective arguments to fit their circumstances. Drawing on both Barad (2003, 2007) and Haraway (1978) it is no surprise to discover that such a process does not produce abstract "truth" about the state of the public's health, but instead inscribes and reproduces an ethical and political "Public Health agenda", which was itself always in flux. public health practitioners were found to be highly reflexive agents in this network, and from the PHE national outcomes framework, which created a dashboard for each authority, down to the service level agreements on commissioned contracts they sought to embed their ethics through measurement and reporting arrangements within the newly ring-fenced public health grant.

What this tells us about a "post"-NPM, and future directions for the theorisation of measurement practices in the public sector in times of deep austerity are discussed below with a view to deepening our understanding of "making things valuable" (Kornberger *et al.*, 2015) in the public interest. The extent to which the accountabilities that emerged in this new system can be described as "intelligent accountabilities" (Roberts, 2009), and the implications for producing such accounts are then presented.

7.1 Towards a "post"-New Public Management?

The focus on two case authorities and the newly formed national body, PHE, in this study demonstrated that both the mobilisation of evidence and enrolment in the value of public health interventions were central to the reconstruction of new knowledge networks. In this setting, short-term annualised budgetary practices and austerity were found to play an increasingly negative and dysfunctional role in this reconstruction. Public health practitioners were divided as they sought to resist the "opportunism" of embedding an increasingly short-term measureable focus into their evidence base, while, on the other hand and particularly through PHE, they sought to demonstrate the social, financial, and increasingly, "cashable" value of their interventions. Participants across the project spoke of their frustration as systems fragmented under "salami-slicing" cuts to national budgets, and of the counterproductive consequences for health, wellbeing and longer-term financial viability of the health and social care system.

The story of public health activities in England during this period provides good ground for critical accounting scholars looking to investigate accounting under austerity and the possibility of counter or "alternative" accounts in a post-NPM environment (Bracci *et al.*, 2015; Steccolini, 2019), but also presents a note of caution against easy characterisations. Many elements of the initial government White Paper (HM Government, 2010), preceding the HSCA, 2012, could be said to "fit" a NPM story – public health activities were "disaggregated" from wider primary care budgets and a national outcomes framework was developed through an arm's length body, PHE, to ensure the system provided value for money (Hood, 1991; Power, 1997, p. 44). Similarly, the emphasis in the reforms on the "freedom to innovate", and the political rhetoric of "localism" and the "big society", together with subsequent cuts to funding were, arguably, consistent with early stage NPM reforms designed to shrink the state (Ferlie *et al.*, 1996; Hyndman and Lapsley, 2016). However, the shift from investment in a "well resourced" ring-fenced public health grant (HM Government, 2010; Department of Health, 2011), with an initial uplift in funding, to annualised cuts from 2014 onwards began to directly undermine the initial ambitions of the

HSCA, 2012 and led to the cutting of services whose value for money was never contested. This ironic twist in the NPM logic was illustrated in the case of the local charity in Midland City, who lost half of their income in the 2016 budget, when they were told that the cut "was nothing to do with [their] performance[. . .] it was purely a business decision". This irony has perhaps come full circle, at the time of writing, as the fragmentation of the public health system is strongly criticised in the context of the COVID-19 pandemic (BMJ, 2020; The Lancet, 2020), and as a result, the government announces the dissolution of PHE, the body they had created just 7 years earlier.

As articulated in previous literature (Bracci *et al.*, 2015; Julnes and Steccolini, 2015; Steccolini, 2019) the austerity context of recent years is opening new avenues for critical public sector accounting research, particularly the growth of budgeting and performance measurement across complex inter-organisational collaborations. Public health activities were a good example of this developing dynamic as they sought to embed longer time horizons and a broadening out of "what counts" in decision making across increasingly multi-agency networks. In response to the fragmentation of services under the HSCA 2012 and progressive rounds of budget cuts, regional collaborations between the NHS and Local Government in England emerged. During the second round of data collection practitioners in both case authorities had established public health working groups within the newly formed regional Sustainability and Transformation Plans (STPs); joint-commissioning roles within the case authorities; and in the case of Midland City had been working closely with the regional combined authority to ensure public health objectives were central to wider regional planning. Similarly, budgetary collaboration with the NHS developed through HWBs under the Better Care Fund (HM Government, 2019). Perhaps counter intuitively, while annualised budget cuts increased pressures to deliver short-term and "cashable" savings they also created a climate in which remaining services such as public health saw integration and collaboration as increasingly vital to their future viability.

Multi-agency and cross-profession collaboration were prominent in a "Public Health ethos" that sought to embed what Marmot (2010) described as the "health in all policies" approach, so that they were well placed to engage with newly emerging networked governance practices (Almquist *et al.*, 2013). However, as one public health consultant observed in their feedback on this project "it was the right reform, but at the wrong time", emphasising the double edge of better collaboration in times of austerity. This was similarly observed in the STPs that sought, essentially, to reduce demand in the NHS while also seeking to reduce investment in the very activities that might achieve those ends. The strategy of public health professionals was therefore increasingly one of influence outside of a reducing public health budget – to steer ongoing strategic planning across transport, adult social care and local economic development. In some senses this could be described as evidence of a "post'-NPM (Julnes and Steccolini, 2015; Steccolini, 2019), but it might better be understood as a continuation of an underlying business ethic in a context that forced practitioners towards collaboration over dwindling funds in the face of increasingly contradictory, short-term and economised (Çalışkan and Callon, 2010) measurement practices. To what extent practitioners were able to develop intelligent and alternative accounts as this process unfolded is discussed in Table 1.

7.2 Intelligent accountability and austerity

Intelligent accountabilities were introduced with reference to Roberts (2009) as possible alternatives to the fantasy of accountancy as transparency, through which public health practitioners reconstructed both their identity and the collective value of their activities.

Evidence of "classic" NPM (Hood, 1991, 1995) in HSCA 2012	"Early stage" or "Thatcherite" NPM and austerity (see Ferlie *et al.*, 1996; Hyndman and Lapsley, 2016)	"post"-NPM (Julnes and Steccolini, 2015; Steccolini, 2019) strategies to address contradiction between classic NPM and austerity
"Disaggregation": Budgets disaggregated from wider PCTs "Free to manage": autonomy over new ring-fenced Public health grant "Corporitised" or quasi-autonomous governmental body created in public health England "Standardised performance measurement": via the PHE national outcomes framework	Fragmentation and the "localism" agenda "Big society": De-emphasis on state provision in favour of third sector provision and competitive tender Annualised cuts to budgets and focus on inputs rather than outputs or outcomes Range of outcomes narrowed and aligned with local authority's corporate strategy Contradiction with classic NPM as services demonstrating measureable value for money are cut away	Emergence of new "public policy networks": Regional collaborations via STPs and the Better Care fund to address financial deficits in the NHS. New regional Combined authority "Hybridity" and "co-production": public health professionals learn to speak a "different language" to embed "health in all policies" across hybrid spaces. Increasing use of job shares, joint-commissioning and multi-agency work PHE outcomes embedded outside of core public health function in new hybrid settings

Table 1.
NPM, austerity and "post"-NPM following HSCA 2012

Instead of the "violent" imposition of measures, intelligent accountabilities ought to offer a more compassionate exchange between the giver and receiver of account that would be capable of incorporating a reflexive ethics. It was suggested that this rejection of transparency and the call for ethical (and more effective) alternatives, mirrors similar calls across the accounting literature for "emancipatory" "alternative" or "counter" accounts that challenge corporate greed and politicised austerity narratives in which harmful cuts to services are argued as necessity (Bracci *et al.*, 2015; Bebbington *et al.*, 2017). This study contributes to the limited empirical literature on intelligent accountability in practice (English, 2013; Yates *et al.*, 2019) by demonstrating that attempts towards intelligent accountabilities gradually came under pressure as short-term austerity measures that sought to "balance the books" (Bracci *et al.*, 2015) shifted calculative and discursive practices, fragmented existing services and re-imposed short-term hierarchal control.

In the early years, following the HSCA 2012 reforms, public health teams were found to be mobilising their expertise and identity as applied medical scientists to enrol city planners, politicians, charities, CCGs and others in an increasingly broad understanding of "health and wellbeing". This involved a necessary shift as the "rigorous" scientific terms of reference, so familiar in the NHS, no longer carried the same weight. To enrol and mobilise in this new context public health professionals instead needed to learn to "speak a different language" (Brown *et al.*, 2014; Phillips and Green, 2015), linking their data on population wide health and wellbeing to the personal and individual. Faced with this new environment, public health professionals sought to adapt their calculative techniques to include *emotive* localised information on need, deprivation and health inequality in order to influence the authority towards more evidence based policy decisions. The emphasis on more pluralistic health and wellbeing outcomes, following the HSCA 2012, was also seen by participants as a move away from a "service" culture in the NHS. All of this reshaped the giving and receiving of account through the newly formed HWBs and through newly re-commissioned contracts. The move from the NHS environment therefore not only involved reforming the budgetary, accountability and reporting arrangements, it began to change the very idea of public health itself as a discipline.

To some extent, therefore, we can see public health professionals as embedding themselves in their new local authority context through a network of *intelligent accountabilities*, negotiating their ethical agenda with colleagues, service providers and politicians towards collective action on a shared problem. The process of compromise and iteration was evident throughout the data and was exemplified in the new calculative drug and alcohol tools as PHE health economists sought to work with local practitioners to develop a system of measuring SROI that built consensus on "what worked" and "what mattered" in their new context. It was also clear that these outcomes, in turn, (re)shaped the ethical commitment and motivations of professionals who worked towards these ends.

In coming to these conclusions, we have noted that public health professionals were acutely aware of the limitations of traditional accountability as transparency, which in turn had crucial methodological implications as accountability ceased to be a top-down form of control and instead was revealed as a two-way process of *translation* (Latour, 2005, p. 106). Public health professionals were not simply "held to account", but used established mechanisms of calculating, communicating and reporting to influence and engage. They were skilled and largely successful in mobilising public health annual reports; joint strategic needs assessments; and the forum of the HWB to convince various professional stakeholders of their objectives and interventions. In actively mobilising forums of accountability they not only transformed themselves through new calculative and discursive practices, they successfully convinced others of the importance of "spending to save", "bringing Public Health into all policies" and the "whole life course approach". The relative *value* of the public's health and wellbeing had therefore been iteratively (re)articulated and (re)defined through intelligent accountabilities.

However, this does not tell the full story. As described above, the disaggregation and fragmentation of public health activities under the HSCA 2012 subsequently led to reductions in the scope of direct interventions as budgets were reduced from 2014 onwards, which coincided with increased multi-agency and cross-profession collaborations. The holistic, mixed-method, "Public Health agenda" came into increasing conflict with the language of "financial" and "economic" "security" and "sustainability", often referenced specifically to annualised budget processes, which were found to be pushing some calculations towards "fiscal" or even specifically "cashable" outcomes. While this continued to be contested and resisted, the fiscal and budgetary "reality" of cuts from central government broke up pre-existing contracts and re-imposed the hierarchal "violence" of austerity. This was seen in two of the examples presented in section 5. as one charity CEO described how her staff "burst into tears" as they lost half of their budget while another financial advisor coldly talked of euthanizing those no long "economically viable". This speaks profoundly to not only the continually contested nature of intelligent accountabilities in practice, but also of the highly ethical-political consequences intelligent accountability in times of austerity.

7.3 (Re)constructing the valuable

It was argued in sections 1 and 2 of this paper that there was a need to explore empirical examples of how activities are made valuable in organisational life beyond the special case of monetary value via constructed market exchange mechanisms, and that few studies had considered such concerns in public sector settings. In addressing this gap, this paper has sought to follow the performativity of accounting and budgetary techniques through and with the material-discursive regulatory regimes they encounter, moving beyond the "special case' of the "performativity thesis" (Vosselman, 2014) towards performativity understood as translation and iteration through which knowledge networks are continually (re)constructed. Karen Barad's agential realism (2007) provided the methodology for doing just that; following the translations in organisational activity through the subjective and discursive, together

with the material and the calculative, in investigating the physical-theoretical apparatus for truth claims about the public's health that were deeply ethical and political in nature.

Valuation was found to be a two-way process that played out through performative intra-actions (Barad, 2007, p. 184) and "intelligent accountabilities" (Roberts, 2009) in the day to day back-and-forth of organisational truth making in which what counts is always contested. The story of how public health activities were valued and revalued over time demonstrates that the construction of the "facts" is always entangled with what "ought" to be accounted for in terms of time horizons, outcomes and economisation, which consequently affected crucial investment and disinvestment decisions. It is in this sense that this paper provides empirical support to the claim made by Vosselman (2014) that the politics of accounting exists in the (re) production of knowledge claims. Similarly, by drawing reference to feminist science studies, in particular, among the broader concerns of the STS field, we see that the radical decentering of the human can form the basis for an analysis of the posthuman ethical subject through and with matter, discourse, bodies and practices across assumed organisational boundaries. Thus, making things valuable in the public interest, across the traditional public sector and beyond, is always a shared but pluralistic and hybrid endeavour in which human subjects and public perceptions are constantly reconstructed through social and material relations that are always in flux and in which we all hold a stake.

Note

1. Barad (2007, p. 139) uses this term, as opposed to the more obvious "inter-action", to emphasise their relational ontology. There is no "inter"-action between discrete objects or independent variables, only "intra"-action through which objects and practices (re)constitute and (re)define one another within entangled systems.

References

Ahrens, T. and Ferry, L. (2015), "Newcastle City Council and the grassroots: accountability and budgeting under austerity", *Accounting, Auditing and Accountability Journal*, Vol. 28 No. 6, pp. 909-933.

Almquist, R., Grossi, G., van Helden, J.G. and Reichard, C. (2013), "Public sector governance and accountability", *Critical Perspectives on Accounting*, Vol. 24 Nos 7-8, pp. 479-487.

Asdal, K. (2011), "The office: the weakness of numbers and the production of non-authority", *Accounting, Organizations and Society*, Vol. 36 No. 1, pp. 1-9.

Barad, K. (2003), "Posthumanist performativity: toward an understanding of how matter comes to matter", *Signs: Journal of Women in Culture and Society*, Vol. 28 No. 3, pp. 801-831.

Barad, K. (2007), *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*, Duke University Press, Durham.

Barad, K. (2012), "On touching – the inhuman that therefore I am", *Differences*, Vol. 23 No. 3, pp. 206-223.

Bassnett, S., Frandsen, A.C. and Hoskin, K. (2019), "The unspeakable truth of accounting on the genesis and consequences of the first 'non-glottographic' statement form", *Accounting, Auditing and Accountability Journal*, Vol. 31 No. 7, pp. 2083-2107.

Bebbington, J., Russell, S. and Thomson, I. (2017), "Accounting and sustainable development: reflections and propositions", *Critical Perspectives on Accounting*, Vol. 48 No. 1, pp. 21-34.

BMJ (2020), "The UK's public health response to covid-19", *The BMJ Website*, 15 May 2020, available at: https://www.bmj.com/content/369/bmj.m1932 (accessed 22 October 2020).

Boll, K. (2014a), "Shady car dealings and taxing work practices: an ethnography of a tax audit process", *Accounting, Organizations and Society*, Vol. 39 No. 1, pp. 1-20.

Boll, K. (2014b), "Representing and Performing Businesses: a segmentation model in action", *Journal of Cultural Economy*, Vol. 7 No. 2, pp. 226-244.

Bozeman, B. (2007), *Public Values and Public Interest: Counterbalancing Economic Individualism*, Georgetown University Press, Washington, DC.

Bracci, E., Humphrey, C., Moll, J. and Steccolini, I. (2015), "'Public sector accounting, accountability and austerity: more than balancing the books?", *Accounting, Auditing and Accountability Journal*, Vol. 28 No. 6, pp. 878-908.

Brown, H., Ellins, J., Kearney, J., Singh, K., Jackson, O., Krelle, H. and Snelling, I. (2014), "Measuring up? The health of NHS cancer services", A report for Cancer Research UK by the Health Services Management Centre at the University of Birmingham and ICF International.

Bryer, R.A. (2006), "Accounting and control of the labour process", *Critical Perspectives on Accounting*, Vol. 17 No. 5, pp. 551-598.

Buck, D. (2017), "Chickens coming home to roost: local government Public Health budgets for 2017/18", *The King's Fund Website*, 12 July 2017, available at: https://www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18 (accessed 11 April 2018).

Buck, D. (2018), "Local government spending on Public Health: death by a thousand cuts", *The King's Fund Website*, 3 January 2018, available at: https://www.kingsfund.org.uk/blog/2018/01/local-government-spending-public-health-cuts (accessed 13 April 2018).

Buck, D. and Gregory, S. (2013), "'Improving the public's health: a resource for local authorities", *The King's Fund*, available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf (accessed 12 January 2018).

Butler, J. (1990), *Gender Trouble*, Routledge, London.

Butler, J. (1997), *The Psychic Life of Power; Theories in Subjection*, Stamford University Press, Stamford.

Butler, J. (2010), "Performative agency", *Journal of Cultural Economy*, Vol. 3 No. 2, pp. 147-161.

Çalışkan and Callon (2010), "Economization, part 2: a research programme for the study of markets", *Economy and Society*, Vol. 39 No. 1, pp. 1-32.

Callon, M. (1986), "Some elements of a sociology of translation: domestication of the scallops and fishermen of st. Brieuc bay", in Law, J. (Ed.), *Power, Action and Belief: A New Sociology of Knowledge?*, Routledge, London, pp. 196-233.

Callon, M. (1998), "An essay on framing and overflowing: economic externalities revisited by sociology", *The Sociological Review*, Vol. 46 No. 1, pp. 244-269.

Callon, M. (2007), "What does it mean to say that economics is performative?", in MacKenzie, D., Muniesa, F. and Siu, L. (Eds), *Do Economists Make Markets? on the Performativity of Economics*, Princeton University Press, Princeton, pp. 225-244.

Callon, M. (2010), "Performativity, misfires and politics", *Journal of Cultural Economy*, Vol. 3 No. 2, pp. 163-169.

Caron, R., Hiller, M. and Wyman, W. (2014), "Public health system partnerships: role for local boards of health in preparing the future public health workforce", *Journal of Community Health*, Vol. 39, pp. 29-34.

Chantler, T., Bell, S., Saliba, V., Heffernan, C., Ramsay, M. and Mounier-Jack, S. (2019), "Is partnership the answer? Delivering the national immunisation programme in the new English health system: a mixed methods study", *BMC Public Health*, Vol. 19 No. 1, pp. 1-12.

Corvellec, H., Ek, R., Zapata, P. and Zapata Campos, M.J. (2016), "Acting on distances: a topology of accounting inscriptions", *Accounting, Organizations and Society*, Vol. 67, pp. 56-65.

Cushen, J. (2013), "Financialization in the workplace: hegemonic narratives, performative interventions and the angry knowledge worker", *Accounting, Organizations and Society*, Vol. 38 No. 4, pp. 314-331.

Dambrin, C. and Robson, K. (2011), "Tracing performance in the pharmaceutical industry: ambivalence, opacity and the performativity of flawed measures", *Accounting, Organizations and Society*, Vol. 36 No. 7, pp. 428-455.

Davies, A. (2015), "£200m cuts to Public Health: the situation is getting serious", *The Nuffield Trust Website*, 16 June 2015, available at: https://www.nuffieldtrust.org.uk/news-item/200m-cuts-to-public-health-the-situation-is-getting-serious (accessed 21 April 2018).

Day, M., Shickle, D., Smith, K., Zakariasen, K., Moskol, J. and Oliver, T. (2014), "Training public health superheroes: five talents for public health leadership", *Journal of Public Health*, Vol. 36 No. 4, pp. 552-561.

Department of Health (2011), *Public Health in Local Government*, Department of Health, December 2011, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216708/dh_131904.pdf (accessed 11 December 2017).

Department of Health (2016), *Public Health Ring-Fenced Grant 2017/18*, Department of Health, 15 December 2016, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/578906/LAC_DH__2016_3_v2.pdf (accessed 16 December 2017).

English, L. (2013), "The impact of an independent inspectorate on penal governance, performance and accountability: pressure points and conflict 'in the pursuit of an ideal of perfection'", *Critical Perspectives on Accounting*, Vol. 24 Nos 7-8, pp. 532-549.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996), *The New Public Management in Action*, Oxford University Press, Oxford.

Foucault, M. (1977), *Discipline and Punish*, Allen Lane, London.

Foucault, M. (1978), *The History of Sexuality*, 1st ed., Pantheon Books, New York.

Foucault, M. (1982), "The subject and power", *Critical Inquiry*, Vol. 8 No. 4, pp. 777-795.

Goddard, A. (2004), "Budgetary practices and accountability habitus A grounded theory", *Accounting, Auditing and Accountability Journal*, Vol. 17 No. 4, pp. 543-577.

Hacking, I. (1985), "Making up people", in Heller, T.L., Sosna, M. and Wellbery, D.E. (Eds), *Reconstructing Individualism*, Stanford University Press, Stanford.

Haraway, D.J. (1978), "Animal sociology and a natural economy of the body politic, Part I", *A Political Physiology of Dominance', Signs*, Vol. 4 No. 1, pp. 21-36.

Haraway, D.J. (1991), *Simians, Cyborgs and Women: The Reinvention of Nature*, Free Association, London.

Hardie, I. and Mackenzie, D. (2007), "Assembling an economic actor: the agencement of a hedge fund", *The Sociological Review*, Vol. 55 No. 1, pp. 57-80.

Hastings, A., Bailey, N., Bramley, G., Gannon, M. and Watkins, D. (2015), *The Cost of the Cuts: The Impact on Local Government and Poorer Communities*, Joseph Rowntree Foundation, York.

Health Foundation (2018), "Health investment needs long-term thinking", available at: https://www.health.org.uk/blogs/health-investment-needs-long-term-thinking (accessed 28 November 2019).

Health and Social Care Act (2012), available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 10 July 2021).

HM Government (2010), "Healthy lives, healthy people: our strategy for public health in England", 30 November 2010, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf (accessed 28 November 2019).

HM Government (2019), "2019-20 better care fund: policy framework", 10 April 2019, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/821676/Better_Care_Fund_2019-20_Policy_Framework.pdf (accessed 30 September 2019).

Hood, C. (1991), "A public management for all seasons?", *Public Administration*, Vol. 69 No. 1, pp. 3-19.

Hood, C. (1995), "The 'new public management' in the 1980s: variations on a theme", *Accounting, Organizations and Society*, Vol. 20 Nos 2-3, pp. 93-109.

Hunter, D., Marks, L., Brown, J., Scalabrini, S., Salway, S., Vale, L., Gray, J. and Payne, N. (2016), "The potential value of priority-setting methods in public health investment decisions: qualitative findings from three English local authorities", *Critical Public Health*, Vol. 26, pp. 578-587.

Hyndman, N. and Lapsley, I. (2016), "New public management: the story continues", *Financial Accountability and Management*, Vol. 32 No. 4, pp. 385-408.

Jones, R. and Pendlebury, M. (2010), *Public Sector Accounting*, Pearson, London.

Julnes, P. and Steccolini, I. (2015), "Introduction to Symposium: performance and accountability in complex settings–metrics, methods, and politics", *Public Administration*, Vol. 20 No. 4, pp. 329-334.

Justesen, L. and Mouritsen, J. (2011), "Effects of actor network theory in accounting research", *Accounting, Auditing and Accountability Journal*, Vol. 24 No. 2, pp. 161-193.

King's Fund (2014), "Making better decisions on Public Health spending: getting to grips with value for money", *The King's Fund Website*, 18 September 2014, available at: https://www.kingsfund.org.uk/events/making-better-decisions-public-health-spending (accessed 11 April 2018).

King's Fund (2017a), "Spending on public health", *The King's Fund Website*, 18 May 2017, available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health (accessed 14 January 2018).

King's Fund (2017b), "Big cuts planned to Public Health budgets", *The King's Fund Website*, 12 July 2017, available at: https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets (accessed 14 January 2018).

Kornberger, M., Jusesen, L., Moursitsen, J. and Madsen, A.K. (Eds) (2015), *Making Things Valuable*, Oxford University Press, Oxford.

Kvale, S. (2007), *Doing Interviews*, Sage, London.

Lapsley, I. (2009), "New public management: the cruellest invention of the human spirit?", *ABACUS*, Vol. 45 No. 1, pp. 1-21.

Latour, B. (1987), *Science in Action: How to Follow Scientists and Engineers through Society*, Harvard University Press, Cambridge.

Latour, B. (2005), *Reassembling the Social: An Introduction to Actor-Network Theory*, Oxford University Press, New York.

Law, J. (2004), *After Method: Mess in Social Science Research*, Routledge, London.

Licoppe, C. (2010), "The 'performative turn' in science and technology studies: towards a linguistic anthropology of 'technology in action", *Journal of Cultural Economy*, Vol. 3 No. 2, pp. 181-188.

Local Government Association (2014a), "Public Health transformation nine months on: bedding in and reaching out", *Local Government Association*, January 2014, available at: https://www.local.gov.uk/sites/default/files/documents/public-health-transformat-88b.pdf (accessed 11 December 2017).

Local Government Association (2014b), "Public Health in local government – one year on", *Local Government Association*, April 2014, available at: https://www.local.gov.uk/sites/default/files/documents/public-health-local-gover-ad1.pdf (accessed 11 December 2017).

Local Government Association (2017), "Councils respond to cuts in Public Health grants allocation", *Local Government Association Website*, 21 December 2017, available at: https://www.local.gov.uk/about/news/councils-respond-cuts-public-health-grants-allocation (accessed 18 June 2021).

MacKenzie, D. (2006), *An Engine, Not a Camera: How Financial Models Shape Markets*, MIT Press, Cambridge.

MacKenzie, D. (2009), *Material Markets: How Economic Agents Are Constructed*, Oxford University Press, Oxford.

Marks, L., Hunter, D., Scalabrini, S., Gray, J., McCafferty, S. and Payne, N. (2015), "The return of public health to local government in England: changing the parameters of the public health prioritization debate?", *Public Health*, Vol. 129 No. 9, pp. 1194-1203.

Marmot, M. (Chair) (2010), "Fair society, healthy lives: the Marmot review", available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (accessed 18 June 2021).

McGill, E., Egan, M., Petticrew, M., Mountford, L., Milton, S., Whitehead, M. and Lock, K. (2015), "Trading quality for relevance: non-health decision-makers' use of evidence on the social determinants of health", *BMJ*, 2015-04, Vol. 5 No. 4, pp. 1-8.

McGivern, G., Dopson, S., Ferlie, E., Fischer, M., Fitzgerald, L., Ledger, J. and Bennett, C. (2017), "The silent politics of temporal work: a case study of a management consultancy project to redesign public health care", *Organisational Studies*, Vol. 39 No. 8, pp. 1007-1030.

McLean, C. and Hassard, J. (2004), "Symmetrical absence/symmetrical absurdity: critical notes on the production of actor-network accounts", *Journal of Management Studies*, Vol. 41 No. 3, pp. 493-519.

Miller, P. (1992), "Accounting and objectivity: the invention of calculating selves and calculable spaces", *Annals of Scholarship*, Vol. 9, pp. 61-86.

Miller, P. (2008), "Calculating economic life", *Journal of Cultural Economy*, Vol. 1 No. 1, pp. 51-64.

Miller, P. and Rose, N. (1990), "Governing economic life", *Economy and Society*, Vol. 19, pp. 1-31.

Milton, S., Petticrew, M. and Green, J. (2014), "Why do local authorities undertake controlled evaluations of health impact? A qualitative case study of interventions in housing", *Public Health*, Vol. 128 No. 12, pp. 1112-1117.

Mouritsen, J. (2006), "Problematising intellectual capital research: ostensive versus performative IC", *Accounting, Organizations and Society*, Vol. 49, pp. 21-31.

Mulgan, R. (2003), *Holding Power to Account – Accountability in Modern Democracies*, Palgrave Macmillan, Basingstoke.

NAO (2014), *Public Health England's Grant to Local Authorities*, National Audit Office, 17 December 2014, available at: https://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england's-grant-to-local-authorities.pdf (accessed 11 December 2017).

Nuffield Trust (2011), *Public Health White Paper 'Healthy Lives, Healthy People': Our Consultation Response*, available at: https://www.nuffieldtrust.org.uk/resource/public-health-white-paper-healthy-lives-healthy-people-our-consultation-response (accessed 24 April 2020).

Olson, O., Humphrey, C. and Guthrie, J. (2001), "Caught in an evaluatory trap: a dilemma for public services under NPFM", *European Accounting Review*, Vol. 10 No. 3, pp. 505-522.

Peckham, S., Gadsby, E., Jenkins, L., Coleman, A., Bramwell, D. and Perkins, N. (2017), "Views of public health leaders in English local authorities – changing perspectives following the transfer of responsibilities from the National Health Service to local government", *Local Government Studies*, Vol. 43 No. 5, pp. 842-863.

Pedersen, P., Hjelmar, U., Høybye, M. and Rod, M. (2017), "Can inequality be tamed through boundary work? A qualitative study of health promotion aimed at reducing health inequalities", *Social Science and Medicine*, Vol. 185, pp. 1-8.

PHE (2013), *Directors of Public Health in Local Government*, available at: https://www.fph.org.uk/media/1706/dsph_in_lg_guidance_on_appointments-2013.pdf (accessed 13 June 2021).

Phillips, G. and Green, J. (2015), "Working for the Public Health: politics, localism, and epistemologies of practice", *Sociology of Health and Illness*, Vol. 37 No. 4, pp. 491-505.

Power, M. (1997), *The Audit Society: Rituals of Verification*, Oxford University Press, Oxford.

Quattrone, P. (2015), "Value in the age of doubt: accounting as a maieutic machine", in Kornberger, M., Jusesen, L., Moursitsen, J. and Madsen, A.K. (Eds), *Making Things Valuable*, Oxford University Press, Oxford.

Revellino, S. and Mouritsen, J. (2015), "Accounting as an engine: the performativity of calculative practices and the dynamics of innovation", *Management Accounting Research*, Vol. 28, pp. 31-49.

Reynolds, J., McGrath, M., Engen, J., Pashmi, G., Andrews, M., Lim, J. and Lock, K. (2018), "Processes, practices and influence: a mixed methods study of public health contributions to alcohol licensing in local government", *BMC Public Health*, Vol. 18 No. 1, pp. 1-13.

Roberts, J. (2009), "No one is perfect: the limits of transparency and an ethic for 'intelligent' accountability", *Accounting, Organizations and Society*, Vol. 34 No. 8, pp. 957-980.

Sanders, T., Grove, A., Salway, S., Hampshaw, S. and Goyder, E. (2017), "Incorporation of a health economic modelling tool into public health commissioning: evidence use in a politicised context", *Social Science and Medicine*, Vol. 186 No. 1, pp. 122-129.

Scott, S. and Orlikowski, W. (2012), "Reconfiguring relations of accountability: materialization of social media in the travel sector", *Accounting, Organizations and Society*, Vol. 37 No. 1, pp. 26-41.

Skærbæk, P. and Tryggestad, K. (2010), "The role of accounting devices in performing corporate strategy", *Accounting, Organizations and Society*, Vol. 35 No. 1, pp. 108-124.

Smith, K.E. and Stewart, E.A. (2017), "Academic advocacy in public health: disciplinary 'duty' or political 'propaganda'?", *Social Science and Medicine*, Vol. 189, pp. 35-43.

Steccolini, I. (2019), "Accounting and the post-new public management", *Accounting, Auditing and Accountability Journal*, Vol. 32 No. 1, pp. 255-279.

The Lancet (2020), "Building a resilient NHS, for COVID-19 and beyond", *The Lancet*, 3 October 2020, available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32035-3/fulltext (accessed 22 October 2020).

Van Der Graaf, P., Forrest, L.F., Adams, J., Shucksmith, J. and White, M. (2017), "How do public health professionals view and engage with research? A qualitative interview study and stakeholder workshop engaging public health professionals and researchers", *BMC Public Health*, Vol. 17 No. 1, pp. 1-10.

Vesty, G.M., Telgenkamp, A. and Roscoe, P.J. (2015), "Creating numbers: carbon and capital investment", *Accounting, Auditing and Accountability Journal*, Vol. 28 No. 3, pp. 302-324.

Vollmer, H., Mennicken, A. and Preda, A. (2009), "Tracking the numbers: across accounting and finance, organizations and markets", *Accounting, Organizations and Society*, Vol. 34 No. 5, pp. 619-637.

Vosselman, E. (2014), "The 'performativity thesis' and its critics: towards a relational ontology of management accounting", *Accounting and Business Research*, Vol. 44 No. 2, p. 181.

Williams, J. (2013), "Regulatory technologies, risky subjects, and financial boundaries: governing 'fraud' in the financial markets", *Accounting, Organizations and Society*, Vol. 38 Nos 6-7, pp. 544-558.

Yates, D., Gebreiter, F. and Lowe, A. (2019), "The internal accountability dynamic of UK service clubs: towards (more) intelligent accountability?", *Accounting Forum*, Vol. 43 No. 1, pp. 161-192.

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