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Rhetoric, evidence and policymaking: a case study of priority setting in primary care

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and Enquiry**

**Jill Russell and Trisha Greenhalgh
Open Learning Unit
Research Department of Primary Care and Population Health
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1. Introduction and background

1.1 Aims of the study

The focus of this study is the representation and meaning of evidence in healthcare policymaking. Our aim is to contribute to scholarly inquiry about how policymakers talk about and reason with evidence by exploring the micro-processes of deliberation and specifically the meaning-making practices of a group of people charged with prioritising health care within an NHS Primary Care Trust in the UK. The research connects with a substantial 'evidence into practice' literature concerned with how healthcare policymaking might be improved by greater use of more and better research evidence (Dopson & Fitzgerald, 2005; Innvaer et al., 2002; Nutley et al., 2002; Walshe & Rundall, 2001). However, in contrast to the hortatory stance of much of this literature, the starting point for our study has been a concern to study policymaking 'as is', rather than addressing the question of how we might get decision makers to behave more evidentially (policymaking as 'ought to be'). In other words, the orientation of the study is on the 'real life' enactment of evidence, rather than on any idealised or prescriptive model of how evidence should be used in practice (Braithwaite, 2004).

The research was undertaken as part of a three year interdisciplinary programme of research at UCL on 'Evidence, Inference and Enquiry'. As sponsors of the overall programme, the Leverhulme Trust and the Economics and Social Research Council (ESRC), together with academic colleagues from other disciplines at UCL who participated in the programme, form one audience for this final project report. Additionally, the practitioners with whom we worked and whose practices provided the research focus comprise a significant audience. Our hope is that for these practitioners the research process and report support reflection and stimulate debate about the complex nature and demands of policymaking in practice. Our study was not an evaluation (which would have focused on quite different utility-oriented questions), and we did not seek to pass judgement on particular practices of policymaking. Our interest was more abstract: we sought to gain an understanding of *what goes on* in the policymaking process. Nevertheless, we are aware that in-depth analyses of practice can easily be interpreted as critical of those practices. That is not our intention. We seek not to criticise but to *critically examine the process of policymaking*.

Beyond these specific audiences, we hope that this report will be of interest more broadly to those inspired by the 'argumentative turn' in policy research, and that it contributes to a small but growing body of empirical work using discourse methods to explore health care policy and practice. Given the diversity of our audience it is likely that some parts of the report will be of more interest to some readers than others. An overview of each chapter is given in section 1.3.

1.2 Themes of this study

The research relates to a number of contemporary themes in current health policy debate. Firstly, it addresses what has become perhaps *the* defining feature of present-day government – the modernisation of the policymaking process through the implementation of evidence-based policy (Parsons, 2002; Sanderson, 2003; Wells, 2007; Young et al., 2002). Evidence has come to play an increasingly prominent role in the process of policymaking in the UK, with the norm now being for decisions to be justified in pragmatic terms rather than any overarching philosophical goals or ideologies (Parsons, 2002). Modern government has come to mean collecting high quality evidence and finding out ‘what works’ (Bullock et al., 2001). We see reference to evidence-based health care, evidence-based nursing, evidence-based public health, evidence-based education, evidence-based childcare, and so on. Sanderson suggests that ‘what works’ has become the new holy grail of policymaking (Sanderson, 2003). This report takes a critical look at the concept of evidence-based policymaking and explores its inherent problems and paradoxes.

Secondly, our research is focussed on one of the most politically sensitive and complex issues facing healthcare policymakers - the rationing of resources, or ‘priority setting’. The debate about what constitutes fair and reasonable allocation of resources has become a predominant one in modern day discourses about health care, informed by a range of disciplinary perspectives from political science, health economics, moral philosophy, and sociology. In this report we draw on Ham and Robert’s analysis of priority setting over the past three decades to summarise the key phases of debate (Ham & Robert, 2003), and present a brief overview of empirical studies as context for our analysis of priority setting in one NHS Primary Care Trust.

Thirdly, with its focus on the deliberations of a Priorities Forum, our study relates to broader issues concerning the micro-politics of deliberation and the role of deliberative processes in contemporary policymaking. As Barnes and colleagues among others have noted, greater involvement of stakeholders in arenas within which decisions are made about public policies is part of a broad shift of emphasis in political discourses in western societies from representative to participative forms of democracy (Barnes et al., 2004). Opening up decision-making systems to wider influence is seen as one important way of improving the legitimacy and quality of decisions and thus the services about which decisions are being made. In this report we take a critical look at the notion of a ‘deliberative ideal’ and explore how evidence actually gets talked into practice at a micro-level of social interaction, and how problems and evidence are socially constituted and represented through deliberation.

A great deal has already been researched and written about each of these important areas of inquiry and debate, which begs the question of what yet

another study might add to our knowledge and understanding of the representation and meaning of evidence in health policy decision-making arenas? In this report we hope to show how, by drawing on rhetorical theory (an under-utilised and rather unfashionable political theory in recent times) and discourse analysis (a theoretically informed approach for studying language and practice that is rising in popularity in health and social care research), our research offers fresh insights into the nature of policymaking and how evidence is enacted in this process. The power of a rhetorical perspective and discourse methods is that they encourage us to address the language, arguments and discourses through which policy is constructed and enacted, and provide a conceptual framework for linking decision-making to processes of practical reasoning and human judgement.

1.3 Structure of the report

There are two overall parts to this report – in the early chapters (Chapters 2, 3, and 4) we present our literature review and theoretical research on evidence-based policy, the priority setting/rationing debate in health care, and rhetorical theory. These chapters set the scene for an account of our empirical research, with a description of the overall methodology and our research methods (Chapter 5) and a detailed exploration of our data forming the second part of the report (Chapter 6).

In Chapter 2 we briefly explore the different ways of conceptualising the relationship between evidence and policy, identifying the scientific rational approach to policymaking, the political rationalist approach, and a third, radically different, ‘policy-as-discourse’ approach. We argue that positivist, rationalist approaches to policymaking fail to address key elements of the policymaking process, and that to explore the ‘black box’ of policymaking (i.e. what actually happens as policymakers engage in social interaction and enact the practice of policymaking) we need research approaches situated within interpretivist and constructivist paradigms (Schwandt, 2000b) that offer opportunities for illuminating the agency of policymakers, the ‘meaning-making’ practices of those actors and the situated nature of evidence. Furthermore, we draw on the work of commentators who raise fundamental questions about the desirability of the ‘evidence-based policy’ agenda, arguing that it serves to devalue democratic debate about the ethical and moral issues faced in policy choices, and erodes practitioners’ confidence in their ability to make judgements by marginalising professional experience and practical knowledge.

In Chapter 3 we show how the chosen focus of our empirical study – the deliberations of a Priorities Forum of an NHS Primary Care Trust – offers an opportune case study of the enactment of ‘evidence-based policymaking’ in practice. We briefly review theoretical and research literature on priority setting and rationing in health care and extend the critique introduced in Chapter 2 of naïve rationalist conceptualisations of policymaking. We show how as the debate about fair and reasonable approaches to priority setting in health care has progressed, so there has been increasing recognition of the

value of deliberative processes alongside an emphasis on evidence and technical 'solutions' to priority setting.

In Chapter 4 we come to the essence of the theoretical ideas informing our research. We draw on the work of key rhetorical theorists to argue that rhetoric, so often seen as something negative that detracts from the reasoning process, in fact can be considered a positive force that helps to invoke particular and personal forms of knowledge and emotion and thus enables rather than corrupts our capacity for judgement. Rhetorical theory, we argue, provides us with a very different conceptualisation of human rationality to that created by the scientific rationalism of the evidence-based policy movement. It requires us to shift from equating rationality with procedure, as emphasised by the current approaches to priority setting outlined in Chapter 3, to a consideration of rationality as a situated, contingent human construction.

In Chapter 5 we introduce discourse analysis as a theoretically informed approach to studying language and practice, and justify the appropriateness of this methodology for our area of study. We outline the design of our study, the key research questions, data collection methods, and our approach to analysis. We also report on a preliminary supplementary study of 'value based argumentation frameworks' undertaken by our colleague, Emma Bryne, utilising a sub-set of our data, and reported in full in Appendix 3.

Chapter 6 presents an in-depth account of our research findings. We begin our analysis by teasing out aspects of how the Forum collectively constructs its role and attempts to make sense of its work. We identify a number of critical tensions in conceptualisations of what the Priorities Forum is and its role in resource allocation - between prioritising and cost-cutting, between a 'systematic' and 'muddling through' approach to decision-making, between local prioritising and central control of resource allocation, and between conceptualisations of the Priorities Forum as both a deliberative and technocratic 'speech event'.

Identification of these tensions sets the scene for an exploration of how the Priorities Forum members talk about and reason with evidence. We show how a particular type of evidence becomes privileged over other forms of evidence and how a predominantly numerical and measurement-oriented framing of policy issues is created. We then explore the powerful potential of rhetorical deliberation to reframe policy problems and give examples to illustrate ways in which Forum members attempt to bring a different type of evidential knowledge to the policymaking table. Drawing on the ideas of Bakhtin (Maybin, 2001) we consider the Priorities Forum discussions as a discursive struggle between a dominant, technocratic rationality and an alternative one based on practical reasoning and human judgement. Finally, we explore the discourse of 'principalism', and the way in which this discourse constructs not only a particular view of what constitutes a robust 'evidence-based' process but also a particular view of what constitutes a robust ethical process.

The concluding chapter presents a synthesis of the key themes raised in the report, and suggests the contribution our study can make to reflection and debate about the complex nature and demands of policymaking in practice.

2. Evidence-based policymaking: a review and critique

2.1 Conceptualising policymaking

The idea of evidence-based policymaking is a simple one. As Klein suggests:

'The notion is as seductive as it is simple: if evidence-based medicine is desirable then so, by definition, is evidence-based policy. Just as no one would argue that clinicians should practise medicine without regard to evidence, so it would seem an incontestable, self-evident proposition that policymakers should base their decisions on evidence.' (Klein, 2000)

However, the relationship between evidence and policymaking is far from unproblematic, as a body of work by political scientists and health care analysts has highlighted. It is possible to group the different ways of conceptualising the relationship between evidence and policy into three broad categories. Firstly, there is the scientific rational approach to policymaking, or what we have elsewhere referred to as 'naïve rationalism' (Russell et al., 2008). Elliott and Popay call this the 'problem solving' model and political theorists refer to as 'comprehensive' or 'instrumental' rationality (Dryzek, 1987; Lindblom, 1959). Within this model a policy problem is defined and research evidence is used to fill an identified knowledge gap and solve the problem. The relation between research evidence and policy is assumed to be essentially a linear one (Black, 2001). The model embraces a positivist epistemology, with its belief in a value-free science. It assumes a 'hierarchy of evidence', in which the gold standard of research is defined in terms of a particular method (for example, the randomised controlled trial for questions of therapy). Decision-making is seen as a technical, logical process comprising the selection, synthesis and evaluation of evidence, from which the preferred answer to a particular policy problem will emerge (Miller, 1990). Lefstein summarises the basic logic of instrumental rationality in terms of certainty (knowledge should be based on secure foundations); objectivity (as opposed to personal subjectivity); method (as the primary means by which objectivity is secured); measurement and calculability, efficiency, and control (the ability to isolate and control objects of inquiry and manipulation (Lefstein, 2005). In this report we argue that despite substantial and sustained critiques by political scientists over several decades (Dryzek, 1987; Fischer, 2003; Lindblom, 1959; Stone, 1988), the hegemony of instrumental rationality persists in the dominant discourse of evidence-based policymaking within the NHS.

A second approach to conceptualising policymaking implies a more diffuse influence of evidence on policy and considers research evidence as one of a range of possible influences on policymaking decisions. Weiss referred to this

as the 'interactive' or 'enlightenment' model of policymaking (Weiss, 1977), also referred to as 'political rationalism'. Bacchi describes how:

'Theorists in this category object to the impression conveyed by technical rationalists that policy is a straightforward matter of finding technical answers to readily identifiable problems. They are much more sensitive to the give and take of politics, to the shifting of positions and perspectives, and to the role played by politics... in decision making. Importantly, they address the need to talk about the role of values in policymaking...' (Bacchi, 1999)

From this perspective, the role of evidence is considered within the context of dynamic patterns of interaction and adaptation among policymakers. Shaw suggests that:

'whereas comprehensive rationalists dismiss political issues as troublesome, political rationalists see policy problems as constructed through the varied perceptions and social interpretations of the political actors involved' (Shaw, forthcoming).

A third and more recent approach to conceptualising the relationship between evidence and policymaking can loosely be labelled 'policy-as-discourse'. This is a radically different approach to thinking about policymaking and evidence, as its starting point is not to consider policy as being essentially about decision-making or finding solutions to problems. Rather, policy as discourse is concerned with *'revealing the assumptions about the nature of the problem in any postulated solution. It is concerned with problem representation'* (Bacchi, 1999). Policymakers are not simply responding to 'problems' that 'exist' in the community, but are actively framing problems and thereby shaping what can be thought about and acted upon. Stone argues that:

'The essence of policymaking in political communities [is] the struggle over ideas. Ideas are at the centre of all political conflict... Each idea is an argument, or more accurately, a collection of arguments in favour of different ways of seeing the world.' (Stone, 1988)

Within this conceptualisation of policymaking, the understanding of what evidence is takes on a very different meaning. Evidence can no longer be considered as abstract, disembodied knowledge separate from its social context. Wood et al argue that:

'There is no such entity as the body of evidence'. There are simply (more or less) competing (re)constructions of evidence able to support almost any position. Much of what is called evidence is, in fact, a contested domain, constituted in the debates and controversies of opposing viewpoints in search of ever more compelling arguments.' (Wood et al., 1998)

A critical limitation of rationalist approaches to policymaking, suggest policy-as-discourse theorists, is the implicit assumption that policymakers and analysts are somehow able to stand 'outside' the policy process from a disinterested standpoint. To the extent that values and interests are taken into account, they are considered as fixed entities brought to bear on the policy process, rather than as emergent within policy discourse, and an inevitable and immanent aspect of what policymakers are themselves engaged in doing (Stone, 1988).

It is this third approach to understanding the relationship between evidence and policymaking that has underpinned our research project. In drawing on this theoretical tradition, we aim to build on innovative empirical studies that have begun to demonstrate the value of adopting a more discursive, constructivist approach in illuminating the practices of policymakers. We briefly describe three examples of such empirical work. Each of these studies highlights the agency of policymakers, the 'meaning-making' practices of those actors and the situated nature of evidence.

2.2 Evidence, policymaking and discourse: examples from empirical studies

Gabbay and colleagues undertook an in-depth case study of the use of evidence by two multi-agency groups working on service development improvements for older people (Gabbay et al., 2003). They found that despite the efforts of group facilitators to promote 'evidence-based' decision-making, there was a strong bias towards experiential evidence, much of which was in the form of anecdotes or generalisations based on a person's accumulated wisdom about the topic. An especially significant finding was how certain individuals appeared able to influence the accepted currency of evidence and persuade others of its experiential relevance, depending on the power and influence they held within the group. Through such subtle persuasive tactics, research evidence was often 'transformed' as issues were debated. Also important were the skills that individuals had – interpersonal skills, critical appraisal skills, storytelling skills, skill in appraising the values and norms of the group, and group leadership skills. As the authors comment: *"Depending on the group dynamics, interventions using such skills could result in a radical shift in the way in which the group made sense of new information, and incorporated it into their thinking, or could lead to a 'stand-off' in which the new information was simply ignored"*.

Judith Green's exploration of local decision-making by multi-professional Accident Alliances came to similar conclusions about the critical role of individuals in the construction and utilisation of evidence by policymaking groups (Green, 2000). She found that the personalised, practical knowledge of key people was frequently more significant than citations of published research evidence about 'what works'. These individuals used two tactics to recruit others to specific courses of action – accounts of personal experience (often a 'trump card') and appeals to common sense. She describes a discussion about a systematic literature review on falls in the elderly that had

apparently demonstrated the efficacy of soft hip protectors (which staff poignantly referred to as ‘padded knickers’) in reducing hip fractures. But however good the evidence (and, incidentally, this ‘robust evidence-based recommendation’ has latterly been overturned (Parker et al., 2006), the idea of asking elderly clients in residential settings to wear ‘padded knickers’ was completely alien to the values of respect and dignity that many of the front-line staff held strongly. She concludes that:

‘The citation of research evidence is one of a set of strategic resources which can be deployed not only to ‘make policy’, but also to establish expertise in a professional role, or to construct the problem in a particular light. Evidence does not speak for itself, but must be spoken for, and the skilled use of devices, such as personal experience and appeals to common sense, is needed to establish its relevance and credibility.’

Steve Maguire describes a longitudinal case study of the development and introduction of drugs for the treatment of AIDS in the USA from 1981 to 1994 (Maguire, 2002). Detailed analysis of extensive field notes and narrative interviews with people with AIDS, activists, researchers, industry executives and policymakers led his team to challenge three assumptions in the evidence-into-policy literature: (a) that there is a clear distinction between the ‘evidence producing’ system and the ‘evidence adopting’ system; (b) that the structure and operation of these systems are given, stable and determinant of, rather than affected by, the adoption process; and (c) that the production of evidence precedes its adoption. Maguire’s study found the opposite – that there was a fluid, dynamic and reciprocal relationship between the different systems involved, and that activists “*successfully opened up the black box of science*” via a vibrant social movement which, over the course of the study, profoundly influenced the research agenda and the process and speed of gaining official approval for new drugs. For example, whereas the scientific community had traditionally set the gold standard as placebo controlled trials with hard outcome measures (i.e. death), the AIDS activists successfully persuaded them that placebo arms and ‘body count’ trials were unethical in AIDS research, spurring a shift towards what is now standard practice in drug research – a new drug is compared with best conventional treatment, not placebo, and ‘surrogate outcomes’ are generally preferred when researching potentially lethal conditions. As in the two previous examples, the role of key individuals in reframing the issue (‘hard outcomes’ or ‘body counts’) was crucial in determining what counted as best evidence and how this evidence was used in policymaking.

Importantly, Maguire’s fieldwork showed that AIDS activists did not simply ‘talk their way in’ to key decision-making circles by some claim to an inherent version of what was true or right. Rather, they captured, and skilfully built upon, existing discourses within society such as the emerging patients’ rights movement and the epistemological debates already being held within the academic community that questioned the value of ‘clean’ research trials (which only included ‘typical’ and ‘compliant’ patients without co-morbidity). They also collaborated strategically with a range of other stakeholders to

achieve a common goal (*“strange bedfellows...pharmaceutical companies along with the libertarian, conservative right wing allied themselves with people with AIDS and gays”*). Once key individuals in the AIDS movement had established themselves as credible with press, public and scientists, they could exploit this credibility very powerfully: *“their public comments on which trials made sense or which medications were promising could sink research projects”*.

2.3 Critiquing evidence-based policy

Alongside the rich picture of policymaking shown by such empirical work, political theorists have raised critical questions concerning the *desirability* of evidence-based policy. A number of arguments have been put forward. It is suggested that the very idea of evidence-based policy unduly elevates the role that ‘science’ can ever play in solving socio-political problems. Thomas Schwandt argues that *‘as we increasingly look to science for guidance in overcoming the quotidian problems of social life, there emerges the expectation of the mastery of society by scientific reason’*. (Schwandt, 2000a) And Elliott and Popay (Elliott & Popay, 2000) quote William Gorham:

‘No amount of analysis is going to tell us whether the nation benefits more from sending a slum child to preschool, providing healthcare for an old man or enabling a disabled housewife to resume her normal activities. The grand decisions – how much health; how much education; how much welfare and which groups of the population shall benefit – are questions of value judgements and politics.’

Furthermore, it is argued that the overriding emphasis in evidence-based policy on ‘what works’ eclipses equally important questions about desirable ‘ends’ and appropriate ‘means’. Sanderson, for example, suggests that what matters is not just what works, but what is *appropriate* in the circumstances, and what is agreed to be the overall desirable *goal* (Sanderson, 2003). The problem, as critics of the evidence-based policy project see it, is that political problems are turned into technical ones, with the concomitant danger that ‘political programmes are disguised as science’ (Saarni & Gylling, 2004).

At a more subtle but pervasive level, it is argued that the effect of the dominant culture of evidence-based policy is to devalue democratic debate about the ethical and moral issues faced by policy choices (Hammersley, 2001) and erode practitioners’ confidence in their ability to make judgements by marginalising professional experience and tacit knowledge. In Schwandt’s view, the application of scientific method to contemporary life has led to the deformation of praxis: *‘the ailment is the growing inability to engage in decision making according to one’s own responsibility as we continue to concede that task to experts in all social institutions’* (Schwandt, 1997).

3. Priority setting in primary care

Over the past decades rationing, or the less emotive but essentially equivalent term 'priority setting', has become a taken for granted part of the NHS landscape. Historically, the processes of resource allocation in health care have remained largely *implicit* (i.e. integrated into routine decision-making through mechanisms such as non-availability, primary care gate-keeping and waiting lists (Heginbotham quoted in Robert) rather than explicit (Coast, 1997). However, since the 1980s the development of the purchaser/provider split in health care (requiring purchasers to be explicit about what services to commission), together with the trend towards more open and accountable forms of government, has prompted the development of more explicit systems of priority setting (Joyce, 2001; Light & Hughes, 2001). And, despite a popular perception of the National Institute for Health and Clinical Excellence (NICE) as the main 'rationing arm' of the NHS, it is local Primary Care Trusts, in their role as NHS budget-holders, that have become the principal site of resource allocation decisions (McMillan et al., 2006).

In this chapter we suggest that the particular focus of our study – the deliberations of a Priorities Forum of an NHS Primary Care Trust – offers a fruitful case study of the enactment of 'evidence-based policymaking' in practice. We briefly review the theoretical and empirical literature on priority setting and rationing in health care and extend the critique introduced in Chapter 2 of naïve rationalist conceptualisations of policymaking. We show how as the debate about fair and reasonable approaches to priority setting in health care has progressed, increasing recognition has been given to the value of deliberative processes alongside an emphasis on evidence and technical 'solutions' to priority setting.

3.1 *The debate about approaches to priority setting*

In their review of international experience of priority setting in health care, Ham and Robert identify three phases of development in approaches to priority setting (Ham & Robert, 2003).

Box 1: Phases in the debate about priority setting in health care

Phase 1

There is a principled way of making priority decisions, and it is possible to devise a rational priority setting system.

Decisions made by applying the correct technical and ethical priority setting system are thereby legitimate.

Phase 2

There is no principled way of making priority decisions.

Decisions made through 'good' priority setting processes are thereby legitimate.

Good priority setting processes are characterised by transparency, accountability and broad stakeholder involvement.

Phase 3

Attempts to combine elements of the first two phases, recognising that decisions need to be based on sound techniques (evidence, ethical principles) AND on rigorous processes.

Adapted from (Holm, 1998)

Ham and Robert describe how in the first phase, attention focused on the use of scientific, technical approaches to set priorities. These approaches include a range of epidemiological and economic methods, for example health technology assessments, and cost-utility analyses such as QALYs; the emphasis being on the application of cost-effectiveness and clinical-effectiveness data. This phase can be characterised as evidence-based policymaking writ large - faith in clinical and economic evidence providing the 'correct' answers to questions of what to do when faced with complex rationing decisions (Holm, 1998).

In parallel with the broader critique of the naïve rationalist model of policymaking referred to in the previous chapter, a range of limitations of such approaches has been identified. It is not the intention here to give a detailed critique of these technical approaches to priority setting, but in brief the following shortcomings have been identified:

- Even the 'best evidence' is rarely unambiguous and conclusive. Available clinical evidence is frequently contestable and may be contradictory. Upshur suggests that medical evidence is inherently provisional, defeasible (revisable in the light of new information), emergent and incomplete (Upshur, 2000).
- The range of complex problems faced by decision makers means that the specific evidence sought may be unavailable – the evidence base for complex combinations of problems is never going to be comprehensive (Coast et al., 1996).
- Despite researchers' frequent claims to the contrary, clinical trial evidence may not be considered generalisable or applicable to a given local context by those wanting to use it.
- In reality decision makers draw on a diverse range of evidence ('scientific', 'contextual' and 'colloquial' evidence (Lomas et al., 2005)) and yet, despite recent advances in academic work, a single, agreed framework for combining and synthesizing these different forms of evidence in the practice of policymaking remains elusive (Mays et al., 2005; Rycroft-Malone et al., 2004).
- Cost and clinical effectiveness are merely two of a range of possible criteria by which to establish priorities. Technical approaches to priority setting tend to naively assume there is already agreement about the goal of health care. In cost-utility analysis, for example, the goal is

assumed to be the maximisation of health care – it is essentially a utilitarian approach, in which collective benefit for the majority has a higher priority than, say, individual need (as in the ‘rule of rescue’) or entitlement, or the goal of addressing inequalities among specific population groups (Harrison & Dowsell, 2001).

- Cost-utility analyses such as QALYs are based on a range of assumptions about the value of different health states, and indeed the overall value of health in society. They are criticised for generating a ‘pseudoscientific aura’ and offering an ‘illusion of objectivity’ by implying that it is possible to identify valid and reliable utility values, and funnel a complexity of health outcomes into a single measure (Coast, 2004; Harris, 1987; Loughlin, 1996).

Alongside this rationalist belief in the role of evidence in providing answers for priority setting, has been an accompanying belief in the possibility of applying a set of ethical principles that will give decision makers the rules by which decisions about priorities can be made. Although the introduction of ethical principles can be seen as addressing some of the limitations of a ‘value-blind’ use of evidence, the idea that ethical principles can be applied in a logico-deductive way to reach a ‘rational’ decision about what is right still fits broadly within Holm’s description of the first phase of priority setting: *‘a search for priority setting systems which, through a complete and non-contradictory set of rational decision rules, could tell the decision maker precisely how a given service should be prioritized in relation to other services.’* (Holm, 1998)

Principlism (as represented by Beauchamp and Childress’ classic four principles of biomedical ethics - autonomy, justice, beneficence and non-maleficence) has received its share of criticism from moral philosophers, highlighting its limitations as an approach for supporting decision-making. One problem, it is argued, is that in real life people do not proceed deductively from moral principles to judgement but rather justify their moral judgements in the opposite direction (Murray, 1987). Moreover, there is the problem that various ethical principles lack any systematic relationship to each other, and may conflict with each other. The attraction of a set of ethical principles for decision makers, according to Evans, is that they offer the false allure of commensuration: *‘Commensuration is essentially a method for discarding information in order to make decision making easier by ignoring aspects of the problem that cannot be translated to the common metric’*. Evans argues that the four principles of biomedical ethics, for example, are a *‘method that takes the complexity of actually lived moral life and translates this information into four scales by discarding information that resists translation’* (Evans, 2000).

The second phase in the development of approaches to priority setting, according to Ham and Robert, focuses less on techniques and more on decision-making processes. It acknowledges that there is no principled way of making priority decisions (Holm, 1998) and that evidence cannot ‘speak for itself’ (Green, 2000).

To quote Rudolph Klein:

'... there is no technological fix, scientific method, or method of philosophical inquiry for determining priorities. Of course, the three Es – economists, ethicists and epidemiologists – all have valuable insights to contribute to the debate about resource allocation and rationing, though none of them can resolve our dilemmas for us. But what really matters is how that debate is structured: how far it promotes reasoned, informed, and open argument, drawing on a variety of perspectives and involving a plurality of interests. The debate about priorities will never be finally resolved.... Our aim must therefore be to build up, over time, our capacity to engage in continuous, collective argument.' (Klein, 1993)

And so this phase of the priority setting debate is characterised by policymakers seeking to strengthen the *institutional processes* of decision-making, and involving not only experts and professionals in decision-making but also the public. Daniels' work on processes that 'account for reasonableness' has been highly influential here in making the case for the development of deliberative processes to support priority setting in health care. Daniels argues that:

'In pluralist societies, we are likely to find reasonable disagreement about principles that should govern priority setting... In the absence of consensus on principles, a fair process allows us to agree on what is legitimate and fair. Key elements of fair process will involve transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly, and procedures for revising decisions in light of challenges to them. Together these elements assure "accountability for reasonableness" (Daniels, 2000).

And similarly, Klein and Williams stress the importance of getting the institutional setting for debate right, suggesting that *'the right process will produce socially acceptable answers – and this is the best we can hope for'*. (Klein & Williams, 2000)

The third phase in the development of priority setting approaches identified by Ham and Robert combines elements of the first two phases, *'recognising that decisions [need] to be based on sound techniques **and** on rigorous processes'* (our emphasis).

'Our own assessment is that there remains considerable scope for strengthening both the information base to support decision making and the institutions charged with responsibility for setting priorities.... To be more concrete, there is a need for greater openness in decision making, a stronger commitment to giving reasons for decisions, the development of formal appeal mechanisms, and regulation of the decision making process. In parallel, there is scope for involving patients' organisations and the public in priority setting in recognition of the role that values play in decision making and the need for decision makers to demonstrate legitimacy to different stakeholders. More

broadly, by involving these organisations, there is an opportunity to enhance democratic deliberation in priority setting and in the process open up the ethical dilemmas that underpin choices in health care.' (Ham & Robert, 2003)

Lomas and colleagues' position is similar to that expressed by Ham and Robert; they see the deliberative process as a critical mechanism for combining different types of evidence (both 'scientific' and 'colloquial' evidence), as well as offering a way of achieving 'sound and acceptable decisions' and improving democratic governance. Drawing on a systematic review of literature, they summarise arguments in support of deliberative processes for priority setting (Box 1). However, as we show in Chapter 4, some deliberative theorists have begun to problematise this essentially consensual model of deliberation.

Box 2: Arguments for deliberative processes (Lomas et al., 2005)

Eliciting and combining evidence

- To bring evidence together and weigh it all up
- To determine what risks are acceptable
- Exposing and/or resolving conflict over evidence (and/or over values)
- To facilitate interdisciplinary dialogue between 'experts'
- To reveal 'evidence' not otherwise available
- To be seen to be taking care over evidence
- To enable quality to be addressed

Facilitating democratic governance

- Democracy
- Involvement of people in their own governance
- Accountability
- Transparency
- A check on the partiality of 'experts'
- To create a learning public
- To embody the public's values

Creating acceptable guidance

- To get potential opposition inside the tent
- To let all stakeholders have their say
- To be plausible to the public and professionals
- To maintain public and professional commitment and confidence
- To embody implementation issues of specific contexts

The thinking behind the setting up of the local Priorities Forum that provided the focus of our empirical study (and priorities fora established by other NHS Primary Care Trusts) encapsulated both these characteristics of the third phase of the priority setting debate, with a concern about strengthening

institutional processes and the use of evidence in policymaking (Hope et al., 1998).

3.2 Research studies of priority setting in health care

The findings of empirical studies of priority setting lend support to the picture of priority setting and policymaking more generally presented in this and the previous chapter. A number of studies highlight the limitations of the technical, scientific model of decision-making. Coast, for example, describes studies that have shown how decision makers find technical data on cost-effectiveness of limited use in practice (Coast, 2004), Williams and Bryan found that it was rare for cost-effectiveness analyses to inform technology coverage decisions of local formulary committees (Williams & Bryan, 2007), and Jenkins and Barber similarly report from their ethnographic study of decision-making in a drugs and therapeutics committee that cost-effectiveness data was either inadequate or insufficient for a locally implementable decision (Jenkins & Barber, 2004).

Other studies of priority setting describe how decision makers do not in practice adhere to the hierarchy of evidence promoted by the evidence-based medicine movement, rather they draw pragmatically on multiple sources or a 'mixed economy' of evidence, including 'lower-level' and 'softer' forms of evidence (Mitton & Patten, 2004; Rosen, 2000), and take account of a range of local knowledge or 'colloquial evidence'. Jenkins and Barber identify a wide range of factors that influence decision-making alongside the scientific evidence, including 'patient demand, clinician excitement, and personality of the applicant'. They conclude from their study of drug therapeutic committees that:

'Together as a committee [members] succeed, often in the face of very limited scientific evidence, in making rational decisions on whether to accept or reject drug application in a way that is accountable to both 'good' EBM and the local contingencies that are the everyday reality of practical healthcare. This is a highly skilled and sensitive practice with various negotiated agreements to be achieved. In doing so they are sensitive to both the scientific rationality and the local rationality of the workplace.' (Jenkins & Barber, 2004)

Empirical research also points to the limitations of a principalist model of decision-making. Martin, Pater and Singer undertook a qualitative case study of a priority setting committee in Ontario and concluded that the

'conception of priority setting as trade-off (e.g. equity vs efficiency) was too simplistic and abstract to describe actual priority setting reasoning. Priority setting decisions involve clusters of factors that vary according to the decision. Rationales are assembled by combining these factor-clusters in support of a particular decision' (Martin et al., 2001).

In other words, decisions are situated and contingent and are more likely to follow a casuistry (concern with individual cases) than deductivist (proceeding from general theory to judgements about cases) model of reasoning (Murray, 1987).

In a qualitative research study of priority setting committees in Ontario involving analysing documents, interviewing committee members, and observing meetings, Singer and Martin and colleagues report strong support for Daniels' model of fair processes. Decision makers identified factors such as representation of multiple perspectives, opportunities for everyone to express views, transparency, and an explicit appeals process as key elements of fair decision-making (Singer et al., 2000).

The above studies highlight the significant amount now known about priority setting and the use of evidence in practice. However, the studies also suggest gaps in our knowledge and indicate an agenda for further research into the social practices of priority setting. A paradox of the body of existing research on priority setting and rationing in health care is that whilst it describes the dynamic and complex reality of policymaking, the wide range of influences, the locally contingent nature of evidence use, and the requirement to get inside 'the black box' of priority setting through 'fine-grained' analysis of the factors that shape not only 'decisions' but what can be thought and acted upon (Light & Hughes, 2001; Tensebel, 2000), in the main the methodologies being drawn upon fail to provide the analytic frameworks to support this. If we wish to understand better the deliberative processes of priority setting, and how evidence actually gets talked into practice at a micro-level of social interaction, how problems and evidence are socially constituted and represented through deliberation, then we require a framework of ideas and research methods that address the role of language, argument and discourse.

4. The value of rhetoric

In this chapter we present a case for rhetorical theory providing a useful analytic lens through which to study the processes of priority setting and the use of evidence in health care policymaking.

Rhetoric has received a poor press in modern times. In general, when an argument or a piece of speech or text is described as 'rhetorical', it is being either described as manipulative or dismissed as superficial. Both in everyday language and in much academic debate it is seen as something undesirable, a disruptive force and a threat to democratic deliberation (Garsten, 2006). Iris Young notes the common distinction drawn between 'rational speech' and 'mere rhetoric'.

'Rational speech, on this view, the speech to which deliberative democracy should be confined, consists of universalistic, dispassionate, culturally and stylistically neutral arguments that focus the mind on their evidence and logical connections, rather than move the heart or engage the imagination.... Rhetorical speech, on the other hand, aims not to reach understanding with others, but only to manipulate their thought and feeling in directions that serve the speaker's own ends'. (Young, 2000)

However, there is an alternative, affirmative conceptualisation of rhetoric, which has its roots in classical scholarship, and which is our interest in this report. Aristotle defined three dimensions of scholarship – analytic (logical argument using premises based on certain knowledge), dialectic (debating moves to argue for and against a standpoint), and rhetoric (the use of persuasion to influence the thought and behaviour of one's audience) (Aristotle, 2004). To Aristotle, the art of persuading an audience comprised three elements: *logos* – the argument itself, *pathos* – appeals to emotions (which might include beliefs, values, knowledge and imagination); and *ethos* – the credibility, legitimacy and authority that a speaker brings and develops over the course of the argument (Van de Ven & Schomaker, 2002). Prior to the Enlightenment, the study of persuasion, or rhetoric, was considered a fundamental part of a democratic citizen's education. But with the rise of modern science, 'demonstration' (formal logic) superseded other methods of inquiry as a way of explaining the world and dialectic and rhetoric were pushed to the background. Rhetoric in particular was consigned to the margins of legitimate scholarship and seen as a disruptive force in democratic life.

In recent years, there has been a resurgence of interest in the study of rhetoric. In part, this 'rhetorical turn' (Simons, 1990) reflects the broader trend in philosophy and the political and social sciences towards the study of discourse and language; a recognition that language is not simply the neutral medium through which facts and meanings are transparently conveyed, as the dominant positivist paradigm of science has tried to suggest. Moreover, through its close attention to language and discourse, the rhetorical turn

draws our gaze to the nature of deliberative processes, the role of judgement within those processes and our conceptions of human rationality. In the paragraphs that follow we draw upon the work of Bryan Garsten, among others, to explore these aspects of rhetorical theory, and suggest they provide a helpful framework for illuminating and developing our understanding of priority setting processes and the use of evidence in policymaking.

Garsten describes his project as being to 'save persuasion' from its modernist critics who have denigrated it to a form of manipulation. He acknowledges the inherent risk of rhetoric as a form of manipulation but nevertheless makes a strong case for persuasion being considered a positive force:

'...a politics of persuasion – in which people try to change one another's minds by appealing not only to reason but also to passions and sometimes even to prejudices – is a mode of politics that is worth defending. Persuasion is worthwhile because it requires us to pay attention to our fellow citizens and to display a certain respect for their points of view and their judgments. The effort to persuade requires us to engage with others wherever they stand and to begin our argument there, as opposed to simply asserting that they would adopt our opinion if they were more reasonable. (Garsten, 2006)

The notion of deliberation is central to rhetoric, as Booth's definition of rhetoric highlights: *'Rhetoric is the art of discovering warrantable beliefs and improving those beliefs in shared discourse'* (Booth, 1974). But Garsten draws a critical distinction between the commonly held view of deliberation as a process underpinned by and aiming to elicit some common concept of public reason and 'rhetorical deliberation'. The former view of deliberation is derived from the work of Rawls and Habermas, and widely seen as the 'deliberative ideal'. Implicit within this model is the requirement that dialogue be 'free from domination, coercion, manipulation and strategizing' so that 'the only power remaining is that of better argument' (Davies et al., 2006). In this sense, Young argues that Habermasian notions of deliberative democracy based on the communicative ideal 'aims to purify rational argument from rhetoric' and imply that ideal deliberation is 'coolly and purely argumentative' (Young, 2000). From this perspective, then, deliberation equates to rational argumentation (Widdershoven, 2001). It can be noted here that there are obvious parallels between Habermas' conditions for this ideal form of communication and those for 'accountability for reasonableness' in priority setting decision-making outlined by Daniels in the previous chapter.

In arguing for a different, rhetorical view of deliberation, Garsten contrasts persuasion with justification. The problem with justification, he argues, is that it treats different audiences similarly, and assumes that every citizen is equally capable of giving and receiving 'public reasons' – *'the modern liberal tradition of justification assumes that people can find some shared point of agreement ('public reason') and asks how they can engage in deliberation within the boundaries set by that underlying agreement'* (Garsten, 2006). In contrast, persuasion does not rest upon a commitment to any underlying agreement. Garsten explains that:

'Rhetorical appeals need not and, in fact, must not take the intention to think reasonably for granted. They frequently start from premises or attitudes shared only by members of the present audience. Often they rely on premises that are not even made explicit; these premises are supplied by the audience itself. In trying to bring an audience from the conventional wisdom to thoughts or intentions they might not otherwise have adopted, rhetoric intends to wield influence over them'. (Garsten, 2006)

Garsten argues that this influence is distinctive from manipulation. *'The speaker who manipulates his audience so as to bring them to a belief or action without their consent... has not persuaded but coerced'*. To persuade someone is to induce them to change their own beliefs in light of what has been said. *'Though we speak of 'being persuaded' in the passive voice, we recognise the difference between being persuaded and being indoctrinated or brainwashed; the difference lies in the active independence that is preserved when we are persuaded'*. (Garsten, 2006)

The critical component of 'active independence' is of course judgement. Here Garsten explains: *'By judgement I mean the mental activity of responding to particular situations in a way that draws upon our sensations, beliefs, and emotions without being dictated by them in any way reducible to a simple rule.'* This is what Aristotle called practical wisdom, or 'phronesis'. Crucially, the role of deliberation from a rhetorical perspective becomes one of drawing out good judgement. Garsten argues that speech that invokes particular and personal forms of knowledge and emotion can draw citizens into exercising their capacity for judgement.

The problem with modern life, according to Garsten and other commentators such as Schwandt is that the rules and methods of the modernist discourse of rationality have shrunk our capacity for judgement.

'Today we are more than ever governed by rules that eliminate space for even the smallest exercises of judgment. These rules are created by both private and public authorities, by legislators, bureaucrats, and corporate managers, all interested in minimizing the uncertainty associated with judgment... Today's culture of rules and codes not only eliminates the risk of imprudence but also the responsibility that breeds prudence'. (Garsten, 2006)

Schwandt makes a similar point in his argument for a 'substantive' rather than 'procedural' conceptualisation of dialogue (whilst acknowledging that these overlap). A 'substantive' view of dialogue encourages us to view dialogue as 'an event of understanding' and 'helps us again understand that there are no determinate rules or methods that allow us to escape from the responsibility that we have as citizens to exercise wise judgement':

'...efforts to recover substantive conceptions of dialogue as an event of understanding in which we participate (and through which we are

transformed) provide one avenue for revitalizing praxis.’... ‘To resist the ‘colonization’ of social and political life by expert knowledge based on method and to restore a sense of ‘praxis’ (in both public and civil society), many believe that we must recover the understanding that praxis involves judgement (phronesis), it requires moral wisdom, engagement and practical application to oneself’. (Schwandt, 2001)

To summarise, the above analysis suggests that the value of rhetorical theory is that it brings to the fore the human capacity for judgement in our understanding of the process of deliberation. This, we suggest, offers a framework that enables us to conceptualise the social practice of deliberation as an essentially human activity of judgement-making. This is in stark contrast to the image created by the rationalism of the evidence-based policy movement. The modernist project has been concerned with replacing human agency with impartial uniformity, whereas the value of rhetoric (but also the reason why it has perhaps been treated so suspiciously in modern times) is that it reminds us that there are alternative ways of understanding knowledge, reason and judgment (Garsten, 2006; White & Stancombe, 2003).

Rhetorical theory thus provides us with a very different conceptualisation of human rationality, and requires us to shift from equating rationality with procedure (which can be seen as the basis of both the first and second phase of the priority setting debate described in the previous chapter). Rather, rationality becomes a situated, contingent human construction: *‘The constructive activity of rationality occurs through the discovery and articulation of good reasons for belief and action, activities that are fundamental to deliberation. Rationality concerns a process or activity (not a procedure) that guarantees criticism and change (not correctness)’* (Miller, 1990).

Miller expands on how a rhetorical perspective redefines what we understand as rationality:

‘Scientific rationality emphasizes substance when it assumes that objectively correct decisions are achievable. It emphasizes procedure when... it assumes that they are not; what procedure can guarantee, rather than correct results, is optimal results from any given starting point. Rhetorical rationality, on the other hand, must emphasise the interdependence of substance and process. As a process, deliberation both requires and creates substance, that is, systems of meaning. The deliberative processes of reason-giving, inducement, and change can yield at least temporary agreements, the substance of which depends upon the substance of previous of previous beliefs and the effects of rhetorical art upon them. History, convention, insight, emotion, and value all become rational, this is, possible ‘good reasons’. And the process of deliberation, or argumentation, as Perelman and Olbrechts-Tyteca note, ‘alone allows us to understand our decisions’...’ (Miller, 1990).

In this sense rhetoric can claim to offer *‘a theory of choice in human affairs’* (Miller, 1990):

'Only the existence of an argumentation that is neither compelling nor arbitrary can give meaning to human freedom, a state in which a reasonable choice can be exercised. If freedom was no more than adherence to a previously given natural order, it would exclude all possibility of choice; and if the exercise of freedom were not based on reasons, every choice would be irrational and would be reduced to an arbitrary decision operating in an intellectual void' (Perelman & Olbrechts-Tyteca, 1971).

Thus rhetorical theory redefines rationality in terms of what a group engaged in rhetorical deliberation come to agree as 'reasonable'. It also shifts our understanding of what it might mean to engage in ethical decision-making. Whereas a conventional definition of ethical decisions are those that have followed certain ethical principles, a rhetorical ethics defines as ethical what is thought to be the good and right thing to do through shared inquiry and deliberation. *'Shared moral inquiry is moral... because it attempts to determine what is the right thing to do in contingent cases; where such judgments are not made deterministically'* (Tallmon).

Sanderson reminds us what all this theorising about judgement and rationality has to do with evidence and policymaking:

'...we need to work within a broader conception of rationality to recognise the validity of the range of forms of intelligence that underpin 'practical wisdom', to acknowledge the essential role of fallible processes of craft judgement in assembling what is to be accepted as 'evidence', and to incorporate deliberation, debate and argumentation in relation to the ends of policy and the ethical and moral implications of alternative courses of action. From this perspective, the challenge faced by policy makers is seen not as a technical task of reducing uncertainty through the application of robust, objective evidence in the pursuit of more effective policies, but rather as a practical quest to resolve ambiguity through the application of what John Dewey calls 'creative intelligence' in the pursuit of more appropriate policies and practice.' (Sanderson, 2004)

5. Methodological considerations and methods

5.1 Discourse analysis

Our interest in policy as discourse and the exploration of evidence and policymaking through a rhetorical lens suggests discourse analysis as a particularly appropriate research methodology for our study of the micro-processes of deliberation and specifically the meaning-making practices of a group of people charged with prioritising health care. Although data in the social sciences is predominantly discursive (interviews, surveys etc.), language is often treated as a transparent medium: a direct pathway to what the researcher is interested in finding out about (Potter, 2003; Rapley, 2001). By contrast, discourse analysis treats language as its central focus and offers methods and techniques for the researcher interested in exploring social interaction.

Discourse analysis has developed within many different academic disciplines, each with its own perspective on what discourse actually is, and hence what kind of activity the analysis of this discourse involves. There is no unitary discourse 'method', however there are certain shared assumptions across the traditions of discourse analysis that serve to distinguish it from other qualitative research methods. Phillips and Hardy suggest:

'Discourse analysis shares the concern of all qualitative approaches with the meaningfulness of social life, but it attempts to provide a more profound interrogation of the precarious status of meaning. Traditional qualitative approaches often assume a social world and then seek to understand the meaning of this world for participants. Discourse analysis, on the other hand, tries to explore how the socially produced ideas and objects that populate the world were created in the first place and how they are maintained and held in place over time. Whereas other qualitative methodologies work to understand or interpret social reality as it exists, discourse analysis endeavours to uncover the way in which it is produced. This is the most important contribution of discourse analysis: it examines how language constructs phenomena, not how it reflects and reveals it.' (Phillips & Hardy, 2002)

A simple definition of discourse analysis is the study of 'language in use' (Wetherell et al., 2001). A focus on 'language in use' immediately conveys the importance of the social in discourse research – the sense of language doing work' and the role of language in producing human meaning. From this position, language is not a neutral transparent medium through which a person simply conveys thoughts, but is *constitutive* of social life. As the quote above implies, it does not just reflect, but actively *constructs* social worlds. Discourse analysts are interested in the process of this construction, in how 'truths' or social realities are built.

What counts as discourse varies enormously between different traditions of discourse analysis. Some discourse researchers focus on utterances within communications at the micro linguistic level (i.e. on the study of language in situ, emphasising how social realities are built from the 'bottom-up') and other discourse traditions focus more on the macro level of analysis, exploring how broad socio-cultural discourses in society define and shape the reality-constructing activities of everyday life. Commonly, there is an attempt to synthesise micro-linguistic analysis with the analysis of wider social structures, combining fine-grained analysis of communication with ethnographic and other social research methods to explore socio-cultural contexts.

In this study, following writers such as MacLure, who adopts an 'intentionally impure' and 'promiscuous' approach to discourse analysis in her investigation of discourse in educational and social research, we draw pragmatically on various discourse theories to help explore and illuminate our specific questions of interest (MacLure, 2003). For example, we draw on analytic ideas from the discourse traditions of interactional sociolinguistics and the ethnography of communication to explore how language is used to construct particular framings of policy issues and what norms of interaction and 'rules of speaking' are discernible within speech communities (Goffman, 1974; Hymes, 1972). We are also interested more broadly in discourses as systems of representation, drawing on Foucauldian ideas about the ways in which particular discourses in society facilitate transmission of basic values at a cultural level and have the capacity to shape the way we think, feel and do particular things (White & Stancombe, 2003). We are interested in the ideological role of language and the politics of representation, and gain insight from the work of Bakhtin on language as a site of social struggle. Within the Bakhtinian tradition, language is conceptualised as a constant struggle between *centripetal forces* (the wider authoritative discourses of science and religion, for example) and *centrifugal forces* (the diversification of language associated with different genres, professions and historical periods for example). This tension can be observed at all levels of language use, from individual conversations to wider cultural discourses. Bakhtin suggests that different social languages and 'speech genres' cohabit, '*supplementing and contradicting each other, and intersecting or becoming hybridized in various ways*', producing a 'heteroglossia' – a multiplicity of languages within speech (Maybin, 2001).

Gee draws a useful distinction between 'big D' and 'little d' discourses (Gee, 1999), the former referring to broad discourses in society '*which are the ways of acting, thinking and valuing to enact identities and practices which privilege certain groups and ways of knowing over others*' (Roberts & Bailey, 2008). Little d discourses, on the other hand, are examples of language in use at the micro-level of social interaction. Our approach to discourse analysis was concerned with exploring both 'big D' and 'little d' discourses in health care policymaking and the ways in which they co-construct one another. Specifically, we are interested in exploring how 'big D' discourses in UK health policy such as 'evidence-based policy' and health care rationing, are represented, reinterpreted, shaped and constituted at the micro-level of the

policymaking table. This sort of analysis, as Sarangi and Roberts suggest, *'attends to the smallness of things and aims to understand them in all their interpretive complexity. It also acknowledges the overarching social order in which they interact and which binds and regulates as it re-invents itself'* (Sarangi & Roberts, 1999).

A simple illustration of discourse analysis, for the benefit of readers less familiar with its approach, comes from an example used by MacLure. The example illustrates well how discourse analysis can attend to both the micro-level of language in use and explore the meanings of 'big D' discourses. Rather than taking an example from academic research, MacLure uses a more accessible extract from a journalist reporting on a speech by Tony Blair to highlight how the writer has tuned in to (and parodied) the way in which language is used to invoke political and moral virtues, and in the process conveys something about the meanings of New Labour discourse.

'New Labour, Real words. No verbs

As so often in a Blair speech, as it progressed it began to shed verbs. Sentences were reduced to a cluster. Nouns and pronouns. Sentences, verbless. "Fairness at work. Practical proposals. In crime, tough on crime, tough on the causes of crime. In Europe, leadership not isolation.... [...] Smaller classes. Shorter waiting lists. A turning point in British politics. New Labour. New life for Britain." For too long the party's energy wasted. On verbs. For the British people, now, no more verbs. Tough on verbs. Tough on the causes of verbs. New Labour. New nouns, adjectives. Real words. Words for a new Britain. There is a purpose to this. Verbless sentences sound as if they are firm promises [...] Yet nothing concrete has been proposed.' Simon Hoggart, *The Guardian* 5th July 1996, quoted in (MacLure, 2003)

Discourse analysis is sometimes characterised as being academically indulgent and of limited practical use. We distance ourselves from 'indulgent' applications of discourse analysis, and instead seek to use this complex and powerful approach to stimulate reflection and debate about what policymaking is. The advantage of discourse analysis is the way in which it helps illuminate and develop understanding of the practice of professional work as it unfolds by enabling a 'slowing down' of the activity being researched. When shared with practitioners in an accessible way, this detailed unpacking of what is going on can, we hope, provide a new lens for looking at practice and inspire new understandings of work activity (Roberts & Sarangi, 2004).

5.2 A description of our methods

The specific case study of our research was a Priorities Forum of an NHS Primary Care Trust (PCT). Through preliminary discussions with colleagues at a local Primary Care Trust, we chose this particular case for the opportunity it gave us to:

- Observe and record an aspect of policymaking (specifically priority setting) in practice. The stated aim of the Priorities Forum is to provide a mechanism within the PCT to ensure a robust ethical and evidence-based process for identifying treatment priorities. The Forum therefore provided a chance to study the concrete actuality of the use of evidence in practice through an exploration of the deliberations of this Forum.
- Explore the context of these deliberations through access to background papers, a range of documents about PCT policy and practice, and one-to-one interviews.
- Share emerging findings from the research with those we were researching. Whilst the research design did not follow an explicit action research model, the nature of our working relationship with the PCT (one of the authors is an academic consultant in primary care for the Trust) enabled us to exploit whatever opportunities arose to engage in discussion with potential users of our research.

The key research questions that guided our case study of the Priorities Forum were:

- How are policy problems ‘named and framed’?
- How do Forum members talk about and reason with evidence?
- How do they legitimate their knowledge claims, values and opinions?
- How do they seek to persuade one another through deliberation?

We gained ethical approval for our research study from the local research ethics committee (reference no. 04/Q0509/39, Nov 2004). We held a series of preliminary meetings with key stakeholders in the Primary Care Trust to establish access and negotiate the details of fieldwork. We undertook five context-setting interviews with members of the PCT to better understand the Priorities Forum and its role within the work of the PCT. Over a two and a half year period we attended nine meetings of the Priorities Forum (which in total comprised approximately 25 hours of discussion), and recorded and transcribed discussions of 20 substantive agenda items. A full list of agenda items during the study period is contained in Appendix 1. During the research period we engaged in regular ongoing discussions with the Chair of the Priorities Forum and responded to requests to facilitate two training sessions for members of the Forum, which provided further contextual data for our analysis of Forum deliberations.

5.2.1 Methods of analysis

Analysis of our data involved an iterative process of sense-making. Our initial impressions from observing Forum meetings provided the basis for early discussion of ideas between us. One researcher (JR) listened to the recordings of each of the Priorities Forum meetings we had attended, and followed this with careful reading and re-reading of transcripts, alongside the

field notes we had taken from observation at the meetings. Bailey points out that although transcribing is often presented as a straightforward technical task, it in fact involves all sorts of judgements about what level of detail to choose and how to interpret and represent data (Bailey, 2008). In this study, given the focus of our research questions and the size and breadth of our data set, a decision was taken to produce a record of what was said by whom, rather than any more detailed transcription of how things were said (in terms of emphasis, speed, tone of voice, timing and pauses etc.) However, returning to the recordings provided a helpful adjunct to the transcribed texts, and enabled some of these features of talk to inform the analysis.

Gee identifies seven broad 'building tasks' of language and uses these to identify generic questions a discourse analyst might address in any discourse-oriented research study (Gee, 1999). We used these questions as exploratory devices to facilitate the interrogation of our research data and its analysis:

- Building significance – how is language used to make certain things significant or not and in what ways? How is language used to give things particular meaning or value? For example, what meaning and significance are terms such as 'priority setting' and 'rationing' given in Forum discussions?
- Building activities – what activity or set of activities is language being used to enact? For example, what styles of communication and deliberation are discernible in Forum discussions? What sort of 'speech events' are members engaging in?
- Building identities – what identities and roles/positions is language being used to enact? For example, what identities (roles and positions) with their concomitant personal, social and cultural knowledge and beliefs, feelings and values, seem to be relevant to, taken for granted, or under construction in discussions?
- Building relationships – what sort of relationships is language seeking to enact with others? For example, how is the relationship between the National Institute for Health and Clinical Excellence (NICE) and the PCT constructed and enacted in deliberation?
- Building politics – what perspective on social goods is language communicating (i.e. what is being communicated about what is taken to be 'normal', 'right', 'good' etc.) For example, how are resource constraints made significant in discussions? How is the concept of 'affordability' made relevant or not? How do the boundaries of NHS care get drawn?
- Building connections – How does language connect or disconnect things; how does it make one thing relevant or irrelevant to another? For example, what sorts of connections are made to broader 'big D' discourses in health care?
- Building sign systems and knowledge – How does language privilege or disprivilege specific sign systems or different ways of knowing and believing or claims to knowledge and belief? For example, what 'framings' of 'problems' and 'solutions' are discernible in Forum discussions?

Our initial readings and analysis led to the construction of case studies of selected agenda items. As indicated in Appendix 1, the range of agenda items broadly divide into the following categories, and these guided the selection of case-studies:

- Should the PCT invest more money in an existing service?
- Should the PCT start funding a new innovative service?
- Should the PCT stop funding an existing service?
- Should the PCT shift funding from one form of service provision to another for a particular patient group?
- Discussion of the process by which the Priorities Forum makes decisions
- Consideration of general ethical issues in PCT work

Analysis of case studies developed through discussions between the two main researchers (JR and TG) and also through discussion with colleagues with a specific interest in discourse analysis and our project (SS, DS, EB). Additional dimensions of analysis included searching the transcripts to explore contributions from specific members in order to identify salient characteristics of their contributions, and searching for and exploring the use of key linguistic terms (such as 'evidence', 'judgement', 'rational', NICE, etc.).

We recognise that our analysis is inevitably selective and reflects our interest in exploring critical tensions in conceptualisations of the Priorities Forum and its role, representations of evidence, and the processes of rhetorical deliberation. Throughout the presentation of our findings in the next chapter we discuss and analyse our data in the context of the theoretical ideas introduced in previous chapters, attempting to bring together our empirical and theoretical research on rhetoric, evidence and policymaking.

The original plan for this study was that it would be a joint initiative with colleagues in Computer Science at UCL with expertise in the study of argumentation; however they did not receive funding of their application from the Leverhulme programme. Nevertheless, our shared interests and commitment to interdisciplinary working meant that we continued throughout the project to collaborate on an ad-hoc basis with Janet McDonnell (previously at UCL and now at Central Saint Martins University) and Emma Byrne. In July 2006, as a result of discussions about the significance of exploring values within the Priorities Forum discussions, we submitted an application to the Leverhulme programme at UCL for additional funding to enable Emma Byrne to undertake an analysis of a sub-set of our data utilising value-based argumentation frameworks (VAFs). (Bench-Capon, 2003) This enabled a supplementary study of how VAFs may be used in an inferential way to deduce the hierarchy of values articulated by participants in observed discussions from an analysis of the arguments that are accepted and rejected. Preliminary findings from this study are presented in Appendix 3.

6. Findings

6.1 Introduction

A data extract from a Priorities Forum discussion about services for in vitro fertilisation (IVF) treatment:

Chair: Shall I just quickly summarise what I think I've heard to be the main points? We've got NICE guidance, which is not compulsory, but is recommended for the management of infertility where people need assisted conception.

Patient representative: How many cycles do they recommend?

Chair: Three. Shortly after that was published, the then Secretary of State for Health said he expected all PCTs to fund at least one cycle for eligible couples from the first of April, and to move towards the NICE recommended three cycles for couples. The number of couples that we've got in [the local area], partly as a result of previous policy funding, originally three and then two cycles per couple, and because of the fixed budgets that we've got, resulted in us having a very large number of women waiting to be treated. The main effect of that is, because they have to wait so long, almost inevitably we are only treating women aged 38 and 39, irrespective of their age when they go on the waiting list, you are going to be 38 or 39 by the time you're treated, which is almost the most inefficient and ineffective time to be treated. So our policy is actually creating cost ineffectiveness and clinical ineffectiveness. And it's also become apparent from published success rates, that the unit that we are with, has a lower success rate than anywhere else. So I think the two key questions that I would suggest that we need to look at are, should we look to change our provider, and do we consider that IVF, in view of what John Reid, the former Secretary of State for Health said, do we consider that IVF is of sufficient importance, sufficient priority, that we should actively look for places where we can reduce expenditure elsewhere, in order to fund IVF? We do not have a proposal at the moment that we should reduce funding of service X in order to fund IVF. But if we think that IVF has to be given more priority than it is now, because of the circumstances that we find ourselves in, we are going to have to create a mechanism to look for where that money should come from. I think those are the key points.

GP: I agree with the principle that we look at everything and we look at all providers and looking at what the cost is and what the effectiveness is. I'm not clear, however, from the paper, and in the discussion, the weight of the evidence of which units are more effective and which units are less effective. Now, I grant the fact that you had to resort to

... [inaudible], for some of the figure work. But unfortunately, a lot of questions pop up rather than get answered here, and that is, which unit looks after more patients? What are the average ages of the patients in each of the units? How long have they been established, how well staffed they are? I don't know any of these things to be able to give you a considered judgement on the figures. I accept that the figures on face value show one is bad, and one is good. But I'm finding it very hard to really grasp exactly, are we comparing like with like here? [...]

Chair: ... what we've done is quite deliberately simplified the figures which are available. HFEA [Human Fertilisation and Embryology Authority] data does give success rates at different ages. I expect we could drill down and get the number of patients and length of time they've been established as well. And this is an important point to make. [...]

Patient representative: Can I just ask – this is only two years' data here. So if you look at [another hospital provider of IVF services] – the jump from 20.6 to 29.6 – well the question is, can they sustain that level of improvement and what are the component elements in terms of ages of the women and success – so that if they had mostly younger people, then their successes would be greater and they may not have that. Another issue is, whether they have the capacity, the one that we are moving in to?

Chair: Capacity isn't referred to here but from the work that [a public health specialist] did 12 months ago, then there is very substantial capacity in London for this. But I think the point has been made by [the non-executive member and the patient representative] that we have insufficient information in this paper, understandably, to make a definite decision about which unit we should go to. But we perhaps have enough information to say, 'we should look at this in more detail with a view to changing.'

Non-executive member: I think in any case, I would be very hesitant about an arrangement that was entered into four or five years – well at least four years ago, on a basis which nobody knows and yet we're continuing. I think, at the very least, I think we ought to re-tender or equivalent.... But if we do that, what assumptions are we going to make? And the first one, I think, is that we want to, as far as possible, to reduce the waiting list. Secondly, I don't believe that there's any possibility of an increased budget in this area. I personally fail to understand how this is higher priority than other medical priorities. And I think, at the very least, we should assume that there's no increase in the budget. There may well be a reduction. So I think what we need to do is, at least go to the possible providers on this basis and say, 'Here is our population, this is how we expect it to develop in this area, what can you offer?' And when I say, 'This is our population' – kind of age ranges, etc. And how many cycles they've had if they've already had

one. I think it's actually not justifiable to carry on as we are, because we've always done it that way.

Chair: So we have to review the provider, but you're also making the suggestion that IVF is not a priority?

Non-executive member: I'm saying that I find it personally difficult to place it above other priorities which I know we have. I would find it impossible to go to the [PCT] Board and say, 'We actually need to put more resources into it.' I could be persuaded that we need to put less in. But I certainly feel that we should assume this is the maximum, that's purely personal.

GP: I agree with the first part of what you said, but I'm sorry I just completely disagree about the priority of it. I think it's difficult sitting here, for me, like this, to be divorced from the real front line of general practice, and community medicine. It is a very important area of women's health and health of couples, that actually plays on the practice every day. The results of providing a successful outcome are extremely important and helpful to the couple and the individuals involved. So what I'm saying is, that the debate about the priority, whether or not – when somebody talks about a priority and when you say, 'against other priorities' – that's the issue. What are the other priorities? Because it's very hard to make a decision and compare it in a vacuum, and I grant you, there will come a time, there may be a time, when our hand is forced and I would have to accept that the priorities elsewhere are better. But it's very hard to make that decision about different priorities unless we know exactly what else is demanding that priority.' (Priorities Forum transcript no. 2)

In the above extract we see one specific example of what happens in a Primary Care Trust Priorities Forum when a group of people come together to discuss priority setting. The extract comprises a few minutes of a lengthy discussion that took place over two Priorities Forum meetings in June and October 2005. The purpose of beginning this chapter with a 'raw' example of our data is to highlight to readers the richness of deliberations, and to give an immediate sense of the multitude and complexity of questions and possible interpretations prompted by the data. For example, how are external factors considered to shape and constrain the Forum's work? How are boundaries drawn around what information is required to inform decision-making? What assumptions are made in coming to judgements? What sorts of arguments are put forward to challenge assumptions? How is the task of prioritisation conceptualised? In subsequent sections of this chapter, we return to parts of the above data extract and address such questions.

We begin the presentation of our findings by exploring how the Forum collectively constructs its role and attempts to make sense of its work. We identify four critical tensions in conceptualisations of what the Priorities Forum is and its role in resource allocation - a tension between prioritising and cost-cutting, between a 'systematic' and 'muddling through' approach to decision-

making, between local prioritising and central control of resource allocation, and lastly between conceptualisations of the Priorities Forum as a deliberative and a technocratic ‘speech event’. Identification of these tensions sets the background for the main focus of this chapter - an exploration of how the Priorities Forum members talk about and reason with evidence.

6.2 Inherent tensions within the Priorities Forum

6.2.1 The tension between prioritising and cost-cutting

The formal definition of the Priorities Forum is that it provides ‘a mechanism to ensure a robust ethical and evidence-based process for identifying treatment priorities in [the Primary Care Trust]’. Our micro-linguistic analysis of Priorities Forum discussions highlights the work that the term ‘identifying treatment priorities’ or ‘priority setting’ performs. As Hunter notes in his analysis of the use of the terms ‘priority setting’ and ‘rationing’ in health care policy debates, ‘words are important because the terms used to define phenomena reveal much about the processes and activities they seek to describe or conversely, obscure or conceal’ (Hunter, 1997). Within the PCT in our study, priority setting is presented as a task that is subtly set apart from rationing or cost-cutting:

‘In simple terms, and importantly, the role of the [...] Priorities Forum will be to determine whether [the] PCT should support ‘x’ or ‘y’ – not ‘x’ or ‘nothing’’. (Appendix 2 of Dec 05 Priorities Forum papers).

According to this formal account, frequently repeated within Priorities Forum discussions, prioritising is about deciding which services have higher priority, rather than about saving money by ‘supporting nothing’ rather than ‘x’.

‘...what the Forum agreed when it was founded and that the Board endorsed, was that we would make judgements on priorities – that we wouldn’t say that we can save X pounds here and to put that in the bank so that the option is X or nothing. It will be, this is the founding principle – X or Y. If we can save money here, we will spend it here, because Y is a greater priority.’ (Chair, Priorities Forum transcript 2)

And in introducing an agenda item concerned with a proposal to shift resources from a local exercise referral scheme to cardiac rehabilitation services, the Chair of the Forum says:

‘The argument of this paper is that there is a lack of evidence for what we are spending our money on, therefore we should be spending money where there is strong evidence for benefit and also there is evidence of an unmet need. We’re not suggesting that we cut spending here in order to support the deficit that the PCT has got. We’re actually suggesting here that this is a straight shift of money from one area of treatment, where there is a paucity of evidence, to another area of

*treatment where there is a body of evidence and unmet needs'.
(Priorities Forum transcript 6)*

The Chair makes a similar point in an agenda item concerned with a proposal to withdraw the PCT contract for complementary treatments from a London hospital:

'I think we're fundamentally saying that there is only weak evidence that some of these treatments work for some people in certain circumstances, therefore if we can't fund other stuff through a lack of money, when there is a very good evidence base where it really works, it would be crackers to be funding this stuff, we ought to be putting it in to the stuff that really works. And that's not so much cutting a service as shifting our priorities, hence 'priorities.'" (Priorities Forum transcript 7)

This sort of linguistic work serves to mark out priority setting as something distinct from cost cutting, and invokes a more positive sense of the activity in which the Forum is engaged. As Loughlin suggests, *'instead of deciding which services have to be cut, we think about which to provide'* (Loughlin, 1996). A similar distinction is made in a number of formal accounts of resource allocation – the British Medical Association, for example, suggests that priority setting is about deciding what the NHS should provide while rationing is about deciding what the NHS should not provide, or to whom treatment should be denied (BMA, 1995).

The formal definition of the Priorities Forum (*'a mechanism to ensure a robust ethical and evidence-based process for identifying treatment priorities'*) does not contain any reference to an economic dimension of the Forum's role. Rather, the terms 'ethical' and 'evidence-based' serve to stress the moral and scientific nature of the process. However, running alongside this construction of the term 'priority setting' is a parallel discourse about the financial state of this and other PCTs in the NHS. A recurring theme of Priorities Forum discussions is the large deficit the PCT has (along with a significant proportion of other PCTs in the country) and consequently the need to identify significant financial savings. Members are regularly reminded by PCT managers that the NHS is in financial crisis, and of the need to reduce the deficit. For example, in a discussion about whether to withdraw funding from a primary prevention exercise referral scheme to free up additional funds for cardiac rehabilitation, the Chair of the Forum asks the assistant director of finance (ADoF) to remind the group of the size of the PCT's financial deficit:

'Chair:[ADoF], can you just remind us about the projected deficit for this year? Is it, I know it changes per day, but you know, at the last calculation.

ADoF: Apparently it's £8.4 million.

Chair: So we are looking to have commitments to spend on treating people who are sick of £8.4 million more than we've actually got in the

bank. And this is because we've been top sliced and that budget's reduced and whatever, in year by £19 million. And we've instituted savings, but we are still, at the moment, about £8.5 million short, so there are people who are sick already and can't be treated because we literally don't have the money. Is that right?

ADoF: Yes.' (Priorities Forum transcript 6)

The context of Priorities Forum discussions is thus one of manifest financial crisis, and this institutional narrative gives strong support and legitimacy to the economic framing of discussions. Members are reminded that their role is to *'be tough'* and *'brave'* in having to make *'unpalatable'* decisions. Within the context of such financial pressures, framing a discussion about, for example, hospital discharge of elderly people in terms of how to save money (rather than in terms of elderly people's health care needs or health outcomes) becomes the obvious, and moreover, the apparently most rational thing to do.

Overall, we see the development of a narrative that creates an ambiguity about the Priorities Forum's relationship to rationing resources. This ambiguity is particularly apparent in the following exchange, which forms part of a discussion in which the Forum approves the principle of *'affordability'* as an additional principle in the Forum's agreed framework for decision-making (see section 6.3.3):

Director of Nursing: 'Because I'm supposing in my head, that feels, am I right, it's one step further on than what we've been doing, in the line we've been using.... I think we haven't sort of come out and said, 'We just can't afford to do it.' We've always managed to balance it out with, 'We can't afford to do X because it might not be clinically that good,' or whatever. But also we have to be mindful if we do do X, we will not be able to do Y. That's how we've sort of sold it a bit.'

Chair: 'I think we've fudged it up to now by saying that'. (Priorities Forum transcript 5)

In summary, the work of the Priorities Forum is constructed as being about prioritising, which is something different and separate from cost-cutting or rationing. Priority setting is constructed as a robust ethical and evidence-based process. But at the same time the work of the Forum is constructed as being about saving money and addressing the financial pressures of the PCT. This ambiguity is explored from an ideological perspective by Joyce in his macro-level analysis of priority setting. He suggests that bodies such as the Priorities Forum can be seen as discursive spaces within which *'neo-liberal forms of health governance re-code and re-problematise the function of the health care system, predominantly in terms of an economic discourse'*. But he argues, the particular nature of this health economics discourse is such that it simultaneously *'presents a form of explicit rationing as a reasoned and ethical response to the contemporary problem of maximising the benefits of health care within a state-funded and predominantly state-provided health care system'*. (Joyce, 2001) Joyce's analysis points to the inherent tension

between economic and welfare models of health care and how PCTs are positioned trying to serve the duality of market-oriented values of the NHS and its original aims and values relating services to needs and ensuring universal access.

6.2.2 A 'mechanism' for priority setting or 'muddling through'?

A second significant strand of narrative about the Priorities Forum is the aspiration for some sort of overarching 'mechanism' (meaning strategy or framework) that will address the problem of how a given service should be prioritised in relation to other services. One meeting of the Forum during the study period was devoted to discussing how the Forum might guide the PCT Board '*over the next few months about how it prioritises its use of resources and its use of its time and management effort.*' During the discussion the search appears to be for some kind of mechanism that members can apply to problems and will help identify solutions, a sort of calculus of priority setting:

Chair: 'Okay, can I just remind us that [the PCT Chief Executive] said what he'd like us to have at the end of the afternoon? It is to advise the Board on the use of resources including time and management efforts. My feeling is that that's got to be coming up with the suggestion for the mechanism to approach the problem rather than a list of things that we should and shouldn't fund'. (Priorities Forum transcript 3)

The search for this 'mechanism' is one that takes up a considerable amount of the Forum's time and energies. There is frequent reference to the formal list of principles that the Forum has developed and adopted as a framework for its decision-making (see section 6.3.3), and as indicated above, the Forum itself is defined as a mechanism. But, over and above the existence of these mechanisms, discussion regularly returns to the search for some sort of overarching mechanism that will help the Forum further in addressing the dilemmas it is facing. Sometimes the search seems to be for a mechanism that will help the Forum choose between x and y when x and y are different sets of services or patient groups – mental illness or IVF, hip replacements or coronary care, etc. Sometimes the search seems to be for a mechanism or formula that will produce a systematic approach for what gets on the agenda at Priorities Forum meetings. The Chair of the Forum comments: '*I like the mechanisms we've got but I don't actually know how we choose what we talk about.*' And sometimes it is made more or less explicit that the search for a mechanism is fundamentally about finding a way of making more radical cuts than hitherto in service provision:

'I suggest we've fundamentally got the framework [of principles] but what's unclear to me at the moment is how we apply it at a sufficiently big scale to address the financial problem that we've got.... I can't work out for the moment what I'm going to ask the Health Improvement Team to do in terms of spending their own time efficiently to identify how we can provide care more clinically and cost effectively such that

we can free up several million pounds a year of current expenditure.... What concerns me is that, at the moment, we don't actually have the mechanism to identify what we should target our efforts on'. (Chair, Priorities Forum transcript 3)

However, a parallel narrative, running alongside the apparent searching for something more systematic and mechanistic, is an acknowledgement that 'muddling through' is perhaps the best that can be hoped for. A number of members of the Forum allude to this in their contributions to discussions, as does the PCT Chief Executive in summarising his introductory comments during the agenda item about how the PCT might take a more strategic approach to prioritisation:

'So, how do we try and balance this all together? In some ways, you may come to the conclusion that it is just not possible, and somehow we should have to continue just muddling through, I suppose, in the way we do at the moment. But, I suppose, ideally, there will be a way that we can try and say, you know, based on what we think is best for [our local PCT], these are the areas we should be concentrating our time and efforts on, these are the areas we should be concentrating our resources on and these are the areas which we should not. And somehow be able to do that and keep the public and the media happy at the same time'. (PCT Chief Executive, Priorities Forum transcript 3)

This underlying tension between different constructions of the priority setting process – on the one hand, the aspiration that priority setting can somehow be 'mechanised', or at least become more systematic than hitherto, and on the other hand, that perhaps inevitably it is more a case of 'muddling through', conveys an ambiguity about members' relationship to the process in which they are engaged. Metaphors such as 'mechanism' and 'muddling through', as Lakoff and Johnson (quoted in (Yanow, 2000)) point out, are more than innocuous exercises in naming. The use of metaphor '*... is one of the principal means by which we understand our experience and reason on the basis of that understanding. To the extent that we act on our reasoning, metaphor plays a role in the creation of reality.*' The repeated use of the term 'mechanism' serves to suggest a systematic, scientific process, somehow external to and separated from the members themselves, and something that can be applied to '*make our decisions for us*'. This is contrasted with the '*ultimately subjective*' process of '*muddling through*', which suggests an emergent process in which members are actively engaged. Crucially, we suggest that reference to and searching for a more systematic mechanism serves to downgrade the process that Forum members ARE engaged in – muddling through (the data extract presented at the beginning of this chapter can, we would argue, be read as one example of muddling through). Muddling through is portrayed as something second best to the more desirable, albeit elusive, process of a 'mechanism' for decision-making.

It is pertinent to note here that the term 'muddling through', used in the quote from the PCT chief executive above, is a term employed by commentators on the priority setting debate (and can be traced back to Lindblom's classic 1959

paper on policymaking as the 'science of muddling through' (Lindblom, 1959). For writers such as Mechanic (Mechanic, 1997) and Hunter, muddling through, far from being second best, is promoted as holding appeal, in that it acknowledges that *'rationing is a priori, an unavoidably messy affair and always will be'*. The attractions of a muddling through approach for Hunter are that it:

'acknowledges the dynamic nature of rationing, its complexities and its subtleties. The approach is well suited to situations of extreme uncertainty, paradox and complexity (even multiplexity) where information is poor, incomplete and often contested' (Hunter, 1997).

6.2.3 Local prioritising and central control of resource allocation

A third key tension evident within Priorities Forum discussions concerns the power that the Forum has to make decisions and the external constraints within which it is operating. At various times in discussions the Priorities Forum is constructed both as a decision-making group with considerable power and control over the allocation of resources locally and, at the same time, as a body heavily constrained by the national and local context within which it is positioned, with little room for manoeuvre. In this sense the Priorities Forum can be seen as embodying broader tensions evident in the NHS, between central prescription and local prioritising. Peckham et al point out that the ambiguity over central control of the NHS and localisation of health care decision making is a long-standing theme in government policy, and refer to a speech by Sir Nigel Crisp, NHS Chief Executive in June 2004 in which he comments on the decentralizing direction of NHS policy. Crisp suggests that instead of the old days of 80% of initiatives being dictated nationally, with 20% set locally, we are moving towards an NHS where 80% of NHS priorities are determined locally. But he warned:

'The journey will not be a straight line. There will be times when the centre seems to be too interfering and too controlling, and other times when everything will seem too decentralised, with accusations not just of postcode prescribing, but of 'postcode health care'. (Peckham et al., 2005)

This quote captures well the tension embodied within the Priorities Forum. On the one hand the Forum sees itself as responsible for controlling expenditure and managing local resources in a way that best meets the needs of the local population. Nowhere is this perceived responsibility more apparent than when the group discuss individual patient treatment requests – in these discussions there is a palpable sense of the enormity of the power and responsibility they have and the potential life/death implications of the group's deliberations. This strong sense of agency and control over resource allocation is fuelled by government and media framings of PCT finances as being largely the result of 'good' or 'poor' management at the individual institutional level, rather than affected by a more complicated set of factors and circumstances (Kings Fund, 2006).

Paradoxically, alongside this sense of agency and control, a recurring theme in Priorities Forum discussions is how little power and control the PCT ultimately has over resources, in the sense that it is seen as trapped between the clinical autonomy of GPs to 'do as they like' on the ground, and the central 'dictats' that come from 'above' – from the Department of Health, NICE and political interference from ministers. The result is a feeling of powerlessness in the face of external pressures, and a feeling of constantly being 'ambushed' in their efforts to control local expenditure, as the following extract from a Priorities Forum discussion indicates:

Chief Executive: Now, under Payment By Results, if that happens, if the GP refers to the Trust and that procedure takes place, we have to pay. So the idea that we can sit here in [the PCT office] or wherever and say, 'Well we don't like, we don't really want to commission varicose veins,' is all very well, but if the GP in the surgery refers for varicose veins to the [local hospital], and the [local hospital] do it, we will get a bill we have to pay. So I think we have to understand also where the actual power lies in the system. It doesn't necessarily mean the PCT can make priorities and make statements and necessarily have the ability to carry those out. They can in certain areas, but it does reflect, and what Practice Based Commissioning tries to say, is, actually that is the nature, that is what happens, it's the GP who makes the decision in practice rather than the PCT. Let's give them the budget and let's see if they can try and use it in a different way, if only just to see the effects of it and to see actually how much money they are committing on behalf of the NHS. But I think it is important, because we need to understand when we're setting our priorities, actually what power we have and what limitations there are in our power to make those decisions.

[.....]

Director of Nursing: How much power do we think we have in our PCT to be able to perhaps make certain things unavailable to our residents that perhaps are available in [another PCT] or in Scotland or anywhere else for that matter?

Chief Executive: Well part of the problem is that the Department of Health and the politicians have never really come off the fence between local commissioning, here's the power to PCTs, here's the power to GPs, and postcode prescribing. The two are two sides of one coin really. You know, if you're going to devolve things locally, if you're going to devolve decision-making, then inevitably decisions will be different. And the politicians always – once there's a case of postcode prescribing, then they're not happy with that. But in terms of a clear line on that, there's never been one. They try to have it both ways, and it's not possible to have it both ways. But in terms of how much power we have, I think it depends.

[....]

GP: The dilemmas that we're sort of discussing, and this is really what we've had many times over in this forum, looked at in many ways, that some of them are, I mean the difficulties is the control that you try and exercise – there are so many pressures that come from different directions that it is quite difficult, because you can make as much of an assessment on the criteria that we have, that we devised for ourselves, that will work within the bounds of ethics, or the bounds of clinical effectiveness and cost effectiveness and all that. The difficulty is that the pressures that arrive, arrive out of nowhere as they do often. And it's how we're going to be able to contend with them, and these are the ones that, as you said, quite rightly, about having to deal with them on a case-by-case basis at the moment.

[...]

Chair: ...the Secretary of State has decided that [Herceptin] is such an important medical breakthrough, that on an individual patient basis, it is clinically appropriate according to the clinician looking after the patient with breast cancer, that it should be given. And that PCTs, whilst making a decision about whether it may be given may not refuse to support it purely on financial grounds. I think this is a political decision and certainly flies in the face of all the mechanisms which are in place to assess the clinical and cost effectiveness of the interventions. But we're stuck with that situation at the moment. (Priorities Forum Dec 05)

6.2.4 The Priorities Forum as a deliberative or technocratic speech event?

An important concept underpinning bodies such as the Priorities Forum is the notion that a significant way of increasing the legitimacy of decisions reached by public bodies is through group discussion by stakeholders. This concept links both to the idea of participative democracy (the democratisation of policymaking through the active engagement of the public and professionals as stakeholders in debate about policy dilemmas of societal concern such as the allocation of health resources) and that of transparency (suggesting that fair due process will be achieved by rationales for decisions being open and accessible). These ideas are illustrated in the following quote from an interview with the Chair:

'...if we're going to make a decision about X and withdraw a significant amount of treatment then we have to have I believe a pretty firm basis for making that decision. And you know [the Director of Commissioning] and me and a couple of other people having a chat over a cup of coffee I don't think is enough, but to have to put a formal case, to have discussed it in the Priorities Forum where you've got several people from different backgrounds, to come to a conclusion and make a recommendation and then take that to ANOTHER

committee which is what's going to happen next week, I think demonstrates and genuinely provides a much more robust decision about whether this is fair or not.' (Interview with Priorities Forum Chair)

The work of discourse analysts with an interest in the ethnography of communication suggests a consideration of the Priorities Forum as a 'speech event'. In differing contexts we use language differently, following particular 'rules of speaking' (Cameron, 2001), and to contribute successfully to speech situations and events we need to know how to use language in a contextually appropriate way. In the Priorities Forum we see an ambiguity about the nature of the speech event. On the one hand, the Forum can be conceptualised as a deliberative forum. It brings together patient representatives with professionals and public officials (see Table 1 below), providing an opportunity for debate between stakeholders. It is named a 'forum', suggesting a deliberative space for discussion of topics of public concern (although it has recently been re-named the Priorities Working Group). At times, as evident in some of the data extracts in this chapter, exchange between members can be characterised as deliberative, the interactional dynamics giving a sense of debate and challenge between members of the Forum, and in-depth discussion of issues.

Table 1: Membership of the Priorities Forum

Member	'Specialist' perspective
Chair (consultant in public health medicine)	Oversight of appropriateness of epidemiology, evidence-base and statistical and other analyses
Two patient/public representatives	Patient/public view and potential need for more detailed review by the Patient and Public Involvement Forum
Three executive directors (health improvement, commissioning, finance, primary care)	Practical implications of implementation; leading on implementation
Four general medical practitioners	Generalist medical expertise, practice based commissioning perspective, patient advocacy
Ad hoc attendance by specialists	Specialist expertise on subject being considered

However, at other times, the norms of interaction and 'rules of speaking' suggest that the Forum is conceptualised as a committee meeting, with its formal agenda and background papers, and interaction through the Chair; in other words, more as a 'technocratic' speech event. This style of interaction is reinforced by the normal procedure of the Forum, which is for the Chair to invite a public health specialist from his department to introduce an agenda item by summarising the background paper they have prepared on the item (for an example of such a summary, see Appendix 2), and then for the Chair to summarise the summary (as in the data extract presented at the beginning

of this chapter) before inviting Forum members to give their views and comments. Members tend to make their comments back to the Chair, who typically responds with a comment such as *'OK, are there any other points that people want to raise'?* as a way of inviting further discussion. Sometimes the Chair or another member engages with the substance of what has been said, but more typically the next person takes their turn at offering their comment on an aspect of the background paper. In this sense then, the norms of interaction are ones of members giving comments back to the Chair, rather than of deliberation between members.

If one interpretation of the Forum is as a sounding board or 'stage' (Degeling, 1996) on which PCT managers can air their proposals, receive comments from a stakeholder group and, they hope, receive support for the difficult dilemmas they face in their daily work, then this more technocratic and directive style of interaction serves well. However, the purpose of shared moral inquiry and deliberation is served less well. In advocating an emphasis on strengthening the institutional processes of decision-making, political theorists give particular emphasis to the role of collective argument. Klein for example, as we saw in Chapter 3, argues that in the debate about resource allocation and rationing in health care *'what really matters is how that debate is structured: how far it promotes reasoned, informed, and open argument, drawing on a variety of perspectives and involving a plurality of interests'*. The aim must be, he suggests, *'to build up, over time, our capacity to engage in continuous, collective argument'* (Klein, 1993). Recent empirical studies of deliberative fora have highlighted the difficulties and complexities of promoting 'collective argument' – Barnes et al for example conclude from their study of the micro-politics of deliberation that *'creating the opportunity for officials and citizens to meet and discuss policy and service issues does not automatically mean that deliberation will ensue – it has to be nurtured by an awareness of the conditions necessary to enable argumentation and challenge'* (Barnes et al., 2004). They suggest that such conditions include the recognition and legitimation of different types and sources of knowledge, attention to both the substance and process of exchange, and to the different discourses through which the meanings of events and circumstances are constructed.

6.3 The use of evidence in practice

We now turn to a focused exploration of the central research question addressed by this project - how a group of people around a policymaking table talk about and reason with evidence. We apply the concept of 'framing' to explore the representation and meaning of evidence within Priorities Forum discussions. The metaphor of the frame, like metaphors generally, conveys the idea of some parts of reality being represented at the expense of others (Fischer, 2003). In a policy context, Rein and Schon define framing as *'a way of selecting, organizing, interpreting and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading and acting. A frame is a perspective from which an amorphous, ill-defined, problematic situation can be made sense of and acted on'* (Rein & Schon, 1993). Lewis describes framing of policy issues in the following way:

'Naming and framing a problem puts a boundary around the rest of the discussion about what might be done in terms of policy change. It influences what is seen in relation to a particular policy problem. Once an area has been labelled and a boundary has been drawn around what will and will not be discussed, this influences what is visible and what is invisible, and creates beliefs about what policy can change and what it cannot touch. It also structures the discourse of a particular area, limiting what can be talked about, and defines who has a right to be involved in this discussion, who can claim an interest, and what kind of power they will have'. (Lewis, 2003)

6.3.1 Framing by numbers

In the Priorities Forum, framing begins with the background paper that accompanies each agenda item. This is typically a 10 – 15 page document produced by a public health specialist within the health improvement directorate that gives an overview of the problem to be discussed and summarises a range of research evidence, local and national policy documents and financial information, ending with recommendations to the Priorities Forum. More recently the background papers have also included a checklist of the ethical principles that the Forum considers as part of its agreed framework of principles (see section 6.3.3). As already described above, at the beginning of each agenda item the author of the background paper takes the Forum members through the paper, summarising the key points, which are then re-summarised by the Chair, before the agenda item is opened for discussion.

A striking characteristic of the background papers and oral summary is the way in which policy problems are constructed in terms of quantitative information, with an emphasis on numerical patterns, quantities, and levels. The starting point for exploring a particular policy problem is typically 'looking at the data'. So in the case of an agenda item about hospital discharge of elderly people (an agenda item titled 'hospital bed cost savings proposal: enhanced planning of the whole systems approach') the starting point of the background paper is an analysis of health resource group 'trim points' (the point at which additional costs per day are incurred if a patient exceeds the average anticipated stay for a particular condition or procedure). The following extract, reported in full to convey this emphasis on numerical information, is taken from the author's summary of the background paper, introducing the item to the Priorities Forum:

'So what we did was, was to go back and have a look at the data. And basically, what we did, was to run off – erm, the information, is now stored on our Information Systems, related to the number of patients who exceed their length of stay in hospital. Now this information is now monitorable. And what we call this, we call this the HRG – and the HRG is linked to the length of stay, and each length of stay is, in some respects, set to the diagnosis and the procedure that each

patient undergoes.... Hospital length of stay is linked to the Health Resource Group and, in practice, this means the length of stay is linked to a number of factors and this could be the patient's diagnosis and the procedures, whether admitted through A&E or through elective admission, where the patient has had a booked admission. And linked to that HRG is set a number of days that you would expect the patient to be in hospital. And linked to that also is the cost, so the cost to the PCT of say, a patient going into hospital for an appendectomy for 10 days, is paid. If the patient exceeds their 10 day length of stay, then the PCT pays for every day that the patient exceeds that standard length of stay. Okay? So, obviously not all patients can be discharged at that exact point. Some people need to stay in. All we did was to look at the excess costs incurred by the PCT for a number of specialties and treatments. And particularly those where you would expect a high proportion or a higher proportion of people to be in the older age group. So, in other words, it definitely missed out things like paediatrics and some of the other services that would be particularly accessed by the younger patient group. Now, the first figure that came out was that we could potentially reduce the cost to the PCT of excess length of stay by £2.7 million. Now, to achieve that 100% is probably asking the impossible. But what I have done is to look at it by different areas, particularly, say, by reducing it 10% or just reducing the length of stay in geriatrics. This is the excess length of stay. By reducing it in general surgery and general medicine. So there are a number of options that we could examine. And certainly, even a 10% reduction across the board, which, in theory should not be unachievable, would release a potential reinvestment sum of nearly £300,000. Now that's significant. So the next step really was to think about, 'Well how can we release this money, how can we improve services so that we can enable people to be discharged and to have the appropriate discharge?' And what the paper suggests is that we appoint a consultant physician who can offer us, not only clinical time, but particularly clinical time going in to developing the community support services particularly for older people, such as the ... rehabilitation care, intermediate care services, continuing care, primary care and perhaps even palliative care, so that we can get a good continuum of care. But also to be able to build a balanced network of services, so people have a smooth transition from one care to the other. But this person could also offer clinical time and training time to, particularly to discharge coordinators and other commissioners, and the important aspect of the role of this person, who would be PCT appointed and representing the interests of the PCT as well as the patients', he or she could link with the clinicians, because the success of the project would be winning the hearts and minds of the clinicians. The benefits coming out of this, if we can reduce, particularly, even 10%, although I think we can probably achieve higher than that over the years, is obviously a significant year on year cost savings'. (Public health specialist, Priorities Forum transcript 2)

The argument being constructed here is that there are potential savings of £2.7 million to be made from earlier discharge of elderly people from hospital, although it is acknowledged that to achieve this full level of savings is *'probably asking the impossible'*. Nevertheless, the general point that there are considerable savings to be made is established by presenting 'trim point' data showing how much money the PCT spends on patients whose length of stay exceeded the trim point and defining this as 'excess costs' and thus potentially reducible.

In the above extract, and in the ensuing discussion, we can see how PCT members of the Forum use various linguistic strategies to help construct a particular framing of the problem. Firstly, as indicated above, the description of the policy problem is primarily through numbers. Numbers, in the form of excess trim point costs, are invoked to authenticate a specific story about hospital discharge. As Stone has pointed out, numbers have come to have such a pre-eminent status in our scientific culture that their pervasiveness as a mode of describing society in policy discussions tends to be taken for granted rather than interpreted as just one of many ways of describing and understanding the world. Second, the numbers being put forward have been 'run off' from the computer: *'the first figure that came out was £2.7 million'*. The suggestion is that numbers are the result of an impersonal, mechanical routine and thus the figures are presented as computational fact rather than a social construction, subject to human influence and interpretation. Thirdly, the numbers are supported by other pieces of evidence explicitly labelled as 'facts' – in the background paper there is a short section headed 'facts that demonstrate differences in hospital lengths of stay' that quotes figures from Dr Foster's case notes on differences between US and English hospitals (but without further contextual information). These facts, the background paper suggests, *'demonstrate that there is considerable scope for reducing hospital length of stay'*. Fourthly, the various numbers are presented in such a way that they roughly tally, with the suggestion that the equation neatly adds up, thus invoking the idea that the proposal offers a conveniently tidy way of dealing with a complex problem. This is a commonly used technique in Forum discussions – in this particular agenda item, the number of delayed discharges from acute hospitals is presented as approximately the same number of unfilled beds in the community hospitals:

There are a number of beds. This number varies slightly on a day to day basis. But there are a number of beds which are unoccupied at [the local community hospitals]. Just concentrating on [the local acute hospital], which is where we've looked at ... but I'm sure a similar principle applies at [another nearby acute hospital]. There are a number of people who are defined as being, with having delayed discharges. Very, very roughly, the number of delayed discharges at [the local acute hospital] is the same as the number of unfilled beds in [the local community hospitals]. Now that is not saying it's exactly the same number every day. It is not to say that on clinical grounds, it would be appropriate for all those people to be discharged from [the local acute hospital] into [the local community hospitals]. But there is clearly a capacity issue. (Chair, Priorities Forum transcript 2)

The significance of ‘tallying’ is discernible in several of the Priorities Forum discussions. The following example is repeated on more than one occasion by the Chair, and seems to be used as an ideal model of prioritisation to which the group might aspire:

‘And what the Forum agreed when it was founded and that the Board endorsed, was that we would make judgements on priorities – that we wouldn’t say that we can save X pounds here and to put that in the bank so that the option is X or nothing. It will be, this is the founding principle – X or Y. If we can save money here, we will spend it here, because Y is a greater priority. And a real example of that, which... I’ll just go through very quickly – is when we looked at acute, management of Acute Coronary Syndrome, where, to cut a long story short, it was clear on modern practice, that we weren’t spending enough money on Coronary Angiograms, we weren’t spending enough money on percutaneous interventions. If it doesn’t sound too silly, we were spending too much money on Coronary Artery Bypass Grafts, by modern treatment standards. And by sheer luck, the excess money that we were spending on Coronary Artery Bypass Grafts was enough to balance up what we should be spending on Angiography and Percutaneous procedures. That therefore was quite simple and a beautiful real example of ‘we’ll shift X to Y’. (Chair, Priorities Forum transcript 2)

Equally, if the numbers do not add up, this creates an argument for not supporting a particular proposal. This is evident in the discussion about whether to commit resources to cardiac rehabilitation:

‘I’m going to suggest that what the [public health specialist’s] work has done is to show how clinically effective it is to provide cardiac rehabilitation, that we are meeting the minimum standards of cardiac rehabilitation in [the PCT], that there would be health benefits and a contribution to our targets of reducing deaths from CHD by investing more in cardiac rehabilitation. But... there is not potentially sufficient saving in terms of excess hospital costs to pay for the additional cost of cardiac rehabilitation, and therefore if we were to pay for it, we would need to take some money from somewhere else. And that’s not something that we’re in the position to do today’. (Chair, Priorities Forum transcript 2)

In fact, in a later Priorities Forum meeting, a proposal is considered to stop funding a local primary prevention exercise referral scheme and to shift that money to fund the additional cardiac rehabilitation services (the argument put forward is that the money saved from one ‘balances out’ the extra costs of the new service). However, although the majority of members agree that ‘the evidence’ does not seem to support continued funding of the exercise referral scheme, the Assistant Director of Finance suggests that this decision should be ‘uncoupled’ from the funding of cardiac rehabilitation, challenging the tallying argument:

'I mean you can make a decision that putting the £50,000 into the walking scheme is not a good use of money, then it's a separate decision about where then you apply that £50,000. Do you put it towards the deficit, do you put it to the cardiac programme or do you, in fact, use it for something different?.... I mean although they are related areas, to me there isn't a direct link because of what ... there isn't a direct way across. I mean ... I would say the evidence suggests we shouldn't be investing money in the walking scheme and if we didn't have a deficit, a good use would be to pay for the cardiac rehab scheme. However, we do have a deficit, so I would suppose say, I would say that given that, how does that investing in the cardiac rehab scheme match up to all the other things that we might have to do with a huge range of resources'. (ADoF, Priorities Forum transcript 6)

We see similar examples of 'framing by numbers' with other agenda items. In the case of an item about prioritising funds to establish a fracture liaison service (see extract in Appendix 2), for example, the policy issue of elderly people suffering from osteoporosis is constructed primarily in terms of quantitative measures. On a number of occasions there is reference to the difficulties of interpreting the data and of understanding what actually is happening in practice; however, at no point in the verbal summary or the background paper are other types of evidence, such as qualitative interpretive data, introduced.

We suggest that discernible within the PCT's framing of policy problems is what Tsoukas refers to as 'information reductionism'. Tsoukas' argument is that there is a danger that information becomes a surrogate for the world – 'what is going on tends to be equated with what the relevant indicators say is going on':

'In the information society, the abundance of information tends to overshadow the phenomena to which information refers: the discussion about crime easily slips to debating crime rates and spending on police; the debate about quality in education more often than not leads to arguing about league tables; the concern with the performance of hospitals leads to debating readmission rates and other indicators. In short, the more information we have about the world, the more we distance ourselves from what is going on and the less able we become in comprehending its full complexity.' (Tsoukas, 1997)

In Priorities Forum discussions we see the way in which evidence is drawn upon so that the discussion about improving hospital discharge for elderly people slips into a discussion about HRG trim points, a discussion about the value of establishing a fracture liaison service leads to debating local prescribing rates of bisphosphonates and other indicators, and a discussion about the management of mental illness leads to a debate about episodes of care statistics. In the latter case, focused on a discussion about talking therapies, a GP member of the Forum indicates that he finds the information in the background paper 'very difficult' because all the evidence in it is based

on the assumption that mental illness can be defined as episodes of care, *'when in fact in the real world it is clear that mental illness is a dynamic condition and can't be easily categorised and expressed as episodes of care.... the science and research base will give very precise definitions and use these to measure interventions but in real life this preciseness does not exist'* (GP Jan 08 Priorities Forum).

The suggestion is not that these sorts of statistical indicators are unimportant, but that the privileging of them results in other types of knowledge being marginalised or left unidentified as relevant to discussion. For example, although the background papers for discussions about hospital discharge make brief reference to a literature review and to a consultation with local staff with responsibility for discharge planning, this evidence is given only a cursory mention in the discussion and the knowledge from these potentially rich data sources are not drawn upon in discussion. In a paper on making evidence fit for purpose in decision-making in the case of hospital discharge of older people, Glasby et al argue that 'theoretical evidence' and 'experiential evidence' (see Table 2) be considered equally important sorts of evidence for decision makers to seek and act on (Glasby et al., 2007). Surprisingly, although the main thrust of the proposal in the hospital discharge discussion is for the PCT to employ a consultant physician *'to give strong leadership to the management of hospital discharge procedure'* no evidence is given or asked for to help the Forum members understand how this intervention might work in practice, nor how it might compare with other models of service provision for improving hospital discharge of elderly people. And in a discussion about cardiac rehabilitation, despite a lengthy background paper and discussion, one of the main conclusions of the group is that they don't have an understanding of how the service is being provided locally, and have numerous unanswered questions about the inherent practices of the service.

Table 2: A typology of evidence for decision-making (Glasby et al., 2007)

Type of evidence	Description	How it contributes to knowledge
Theoretical evidence	Ideas, concepts and models used to describe the intervention, to explain how and why it works, and to connect it to a wider knowledge base and framework	Helps to understand the programme theories that lie behind the intervention, and to use theories of human or organisational behaviour to outline and explore its intended working in ways that can then be used to construct and test meaningful hypotheses and transfer learning about the intervention to other settings
Empirical evidence	Information about the actual use of the intervention, and about its effectiveness and outcomes in use	Helps to understand how the intervention plays out in practice, and to establish and measure its real effects and the causality of relationships between the

		intervention and the desired outcomes
Experiential evidence	Information about people's experiences of the service or intervention, and the interaction between them	Helps to understand how people (users, practitioners and other stakeholders) experience, view and respond to the intervention, and how this contributes to our understanding of the intervention and shapes its use

Espeland and Stevens suggest that information reductionism can be understood as a form of 'commensuration' (Espeland & Stevens, 1998). Commensuration, they argue, is the process by which qualities are transformed into quantities, and has become so much taken for granted as a natural feature of social life that it is largely invisible to us as an 'instrument of social thought'. Commensuration, as with Tsoukas' information reductionism, creates a particular understanding of the world:

'In abstracting and reducing information, the link between what is represented and the empirical world is obscured and uncertainty is absorbed. Everyday experience, practical reasoning, and empathetic identification become increasingly irrelevant bases for judgment as context is stripped away and relationships become more abstractly represented by numbers' (Espeland & Stevens, 1998).

At an ideological level, 'framing by numbers' reflects and helps to create a view of priority setting as a science, as a technocratic endeavour. As others have pointed out, the discursive device of quantification is vital to the representation of information as 'fact' and serves to achieve specific persuasive and argumentative ends (Petersen & Lupton, 1996; Porter, 1996; Potter et al., 1991). Furthermore, through skilful use of data from both evidence-based medicine literature and from local financial and activity data, we see a *'double discursive alliance of scientism and managerialism'* (Webb, 2001) that creates a context within which the main concerns come to be data about economic performance, efficiency and effectiveness. In the process, as Espeland and Stevens suggest in the quote above, everyday experience, practical reasoning and empathetic identification become increasingly irrelevant bases for judgement. Our findings concur with other studies of how health authorities talk about their priority setting role (Greener & Powell, 2003), suggesting an increasing 'economization' of discourse. Greener and Powell suggest that their respondents consciously used *'the language of management, finance and economics to present a rational picture of their decision-making processes, making sure that they correspond with national agendas in health care. They are trying to demonstrate they are 'talking the talk', or using the prevailing acceptable discourse'*.

6.3.2 The role of rhetorical deliberation

Alongside a 'framing by numbers', however, our data highlight the potential of rhetorical deliberation to reframe policy problems. We use the term rhetorical deliberation here to convey a style of speech that moves beyond the 'coolly and purely argumentative' mode of deliberation implied by the communicative ideal advocated by deliberative theorists and exemplified in the accountability for reasonableness framework. As indicated in Chapter 4, rhetorical deliberation is an exchange of speech that invokes particular and personal forms of knowledge, drawing an audience into exercising its capacity for judgement (Garsten, 2006). Whereas the deliberative ideal (an ideal which has gained increasing acceptance in recent health policy debate and has directly informed the setting up of bodies such as the Priorities Forum) defines rational speech as that which is purified from rhetoric (a background paper circulated to Priorities Forum members, for example, states that '*focusing on the logical structure of argument can help ensure that rhetorical devices are not used to make an invalid argument persuasive*' (Parker & Hope, 2000)), a model of communication as rhetorical deliberation both acknowledges it as a necessary part of any communication, and emphasises its positive contribution in the practice of deliberative democracy. Carolyn Miller puts forward this constructive view of rhetorical deliberation in her powerful critique of 'decision science':

'...decision science... ignores the best capacities of human beings – to reason with and learn from each other; it encourages our submission to technical, knowledge-based solutions for what are social, value-based problems. The 'rhetorical turn' in recent scholarship challenges the assumption that intellectual and social progress demand the certainty sought by the instrumental reason of scientism. As an art, not a science, rhetoric reaffirms the value of that which cannot be wholly systematized, that which is subject to human influence. A humane and honest theory of choice, therefore, should be based on rhetorical art, not on scientism – or technicism. Decision science, which resists the fundamental uncertainty of human life, should not replace rhetorical deliberation, which helps us to live with it.' (Miller, 1990)

In the Priorities Forum discussions we see instances of Forum members, in particular GPs, invoking particular and personal forms of knowledge, talking with powerful rhetorical effect from 'the frontline of general practice' for example, and in this way putting forward different framings of a problem to the dominant one on the table. One illustration of this comes towards the end of a lengthy discussion about hospital discharge and consideration of the proposal to employ a consultant physician to expedite the discharge of elderly people from acute hospitals, when a GP member challenges the view put forward by PCT staff that, in addition to the not aggressive enough discharge procedures of some clinicians, the payment system between acute trusts and PCTs creates perverse incentives for the acute trusts to keep patients in hospital:

'I just think, I'm just trying to clarify one thing. I think we're in danger of making a great big supposition, and that is, this has been mentioned twice about the perverse incentive to keep patients in beds. I don't know where the evidence comes from. You probably are better informed than I am. But I would have thought it's quite unlikely, certainly from where I'm looking from as a GP.... I get the impression that they certainly want them off the beds.... So I think we're in danger of making a supposition that there is a perverse incentive. I'm not that convinced that it's being exercised. I don't think it's really that'. (GP, Priorities Forum transcript 2)

This comment prompts the following response from the Chair:

'I actually get the impression that may be we do need to do some more work around that. And I just wondered if the outcome of that work ought to come back here before moving on'. (Chair, Priorities Forum transcript 2)

This action point is followed up by staff in the health improvement directorate, and a second paper on the subject of hospital discharge is brought back to the Priorities Forum the following year. Interestingly, in contrast to the earlier discussion, the follow-up paper suggests that in fact very few patients exceed the 'trim point' and that in fact *'there was no evidence of a culture or expectation that patients should not be mobilised and that the appropriate discharge arrangements should be made'*. The author of the paper concludes in her presentation to the Forum: *'this study has been quite useful, because it's blown away some of the myths and some of the sort of conjectures that people were making as to what was going on.'*

Whilst this is a particularly clear example of how a persuasive contribution seems to prompt a significant re-framing of a policy problem, our data contains other isolated examples where members appear to draw on the combined effects of ethos and pathos (as defined in Chapter 4) to persuade the audience of a different framing of an issue. These contributions to discussion can be characterised as being less about engaging with 'the evidence' as constituted in the dominant discourse outlined above, and more about offering particular and personal knowledge situated in practice and experience and often involving the expression of a personal judgement. Although there are one or two examples where patient representatives on the Forum make these sorts of contributions, most examples in our data come from GPs, who make more contributions in general to discussion, and we argue, appear to draw on their dual role as professional clinician and patient advocate to particularly powerful rhetorical effect.

In the following example, taken from the data extract presented at the beginning of this chapter, a GP member of the Forum makes a fairly forceful response to a comment by a non-executive PCT member who is arguing that IVF treatment should not be afforded any higher priority than that given at present by the PCT:

Non-executive member: 'I'm saying that I find it personally difficult to place it above other priorities which I know we have. I would find it impossible to go to the Board and say, 'We actually need to put more resources into it.' I could be persuaded that we need to put less in. But I certainly feel that we should assume this is the maximum, that's purely personal'.

GP: 'I agree with the first part of what you said, but I'm sorry I just completely disagree about the priority of it. I think it's difficult sitting here, for me, like this, to be divorced from the real front line of general practice, and community medicine. It is a very important area of women's health and health of couples, that actually plays on the practice every day. The results of providing a successful outcome are extremely important and helpful to the couple and the individuals involved'. (Priorities Forum transcript 1)

And the same GP, during a discussion about an individual patient whose care costs are considered so excessive as to warrant them coming to the Forum for consideration of a proposal to make changes in her care arrangements, makes the following quite dramatic contribution to discussion:

GP: 'You know, we've got some information, but I'm afraid we haven't got a lot here to be able to – I've got a feeling that we could get drawn in to making a judgement because it's been written on behalf of the PCT and I feel quite uneasy actually. I suspect the status quo should not exist, but I think you're in a Catch 22, you've brought yourselves here, and I'm not sure that this is the right forum to bail you out frankly. Sorry'.

Chair: 'No, no, no'.

GP: 'It's not very helpful'.

Chair: 'No, I think it's a very helpful point'. (Priorities Forum transcript 7)

A little later in the same discussion another GP reinforces this point:

GP: 'We don't have any sort of clinical input here. We've got none of her medical records, her history. I mean whether she would consent to that, but I think that as a GP, I would feel more comfortable, getting some, you know, have more medical background and what, you know, hospital reports have said. There may well be, you know, elements of truth in all this, but a PCT spin put on this, which is making us all very doubting and dubious. Now, that may or may not be fair to the patient, I don't know. But speaking as a doctor, we need to see the patient's perspective'. (Priorities Forum transcript 7)

And in another extract, taken from the follow-up discussion about hospital discharge, we see a GP member making a point from her experience 'on the ground' about the significance of 'failed discharges', which is subsequently

acknowledged by the Chair and other members as highlighting an important aspect of the policy issue not presented in the data. We also see this member appealing to the specific concerns of her audience of PCT managers, by addressing the cost issues of failed discharges:

GP: 'I thought there was another [point] as well about failed discharges. And they often have a very short period of time, they call it within 24 hours if you have to get readmitted, but there are lots of cases of patients, within say a week would seem, you know – I haven't got a set figure for what's appropriate, but failed discharges, although you're paying, are you paying twice? Or would they consider that the lengthening of the original stay, because we're seeing more and more of those.... if you cannot cope at home, for example, I had a patient a few weeks ago, a hip replacement lady discharged after two days, couldn't walk, lives in a flat, can't cope – has to go back. Is that a second stay or?'

Public health specialist: 'Well, we didn't look at the data actually to see if there were readmissions, we only found one'.

Chair: 'But the question is, is it a separate admission?'

GP: 'Yes'.

Public health specialist: 'Yes'

Chair: 'It's a separate admission and we'd pay all over again'.

GP: 'And if you look at those figures, I'm sure other GPs would feel the same, I would assume it's going up and up as the length of stay is reducing. So we're in a lose-lose situation. We're paying more because we're having to support them at home, we're paying more because they're having to go into hospital more, and we're all paying twice'. (Priorities Forum transcript 6)

In the final example, the focus on practical knowledge has been prompted by the Chair describing the case of a particular patient, whose circumstances have, unusually, formed a case-study in the background paper for an agenda item to identify the ethical considerations that should be taken into account when the PCT is determining who should receive continuing care and where it should be provided. One of the interesting features of this exchange is the apparent ambivalence the Chair expresses towards the status of more personalised, practical knowledge, simultaneously drawing on it to powerful effect whilst playing down the value of a singular example (*'one example doesn't prove anything'*), and responding to the patient representative who is drawn into the specifics of the case with a comment about not getting *'too bogged down with specific examples'*. The Forum member nevertheless continues to make her point, drawing on her personal knowledge and experience as a district nurse, although unlike some of the GP contributions above, does not seem to manage to re-frame the discussion, which the Chair

brings back to a consideration of the Forum's framework of principles (see section 6.4.3).

Chair: 'And there's a real example, although it's anonymised in this paper, about a patient we've got, who is paralysed from the neck down, he's on a ventilator for nearly 24 hours every day, he's being cared for at home at an absolutely massive cost. About £350,000 a year. Always assuming that it was clinically appropriate for him to be at Hospital X [specialist rehabilitation], and having discussed the generality of this with them, it would probably cost about £200,000 for him to be in Hospital X [specialist rehabilitation]. And in terms of clinical effectiveness, because of the skills that they've got there, because of the equipment that they've got there, because of the expertise and experience, it's very likely he'd have a very much better quality of care, a more clinically effective care. The disadvantage of course is that he wouldn't be at home, and his mates and his family would have to travel further to see him.'

GP: 'And it's a long way to go.'

Chair: 'It is quite a long way to go, yes.'

Patient representative 1: 'What are the chances of his rehabilitation?'

Chair: 'I don't want to get too tied down with that particular individual, but ... but as a concept, and at that particular hospital, some people stay there for many, many years. Years, and years and years. But one example doesn't prove anything. If I just give you one which stuck in my mind – there was a guy who had been involved in a motor accident, and had severe brain damage. He eventually got to Hospital X [specialist rehabilitation] and they helped him to use a computer, because there are special ways of using a mouse and whatever. And the first thing he wrote was a message to his wife, who he hadn't spoken to for 16 years, and he said, 'I love you.' They were able to enable him to do that, which nobody else had been able to do, because they didn't have the expertise, the occupational therapy or whatever. Now, I don't want to get bogged down in that one case, but in terms of clinical effectiveness the argument could be that in certain circumstances, care in a special unit is more clinically effective than care at home or in the local hospital or whatever that might be.'

Patient representative 2: 'But you'll never change the person's.....'

Chair: 'I don't want to get bogged down with particular examples.'

Patient representative 2: 'But I'm saying, from what, from the experience I've had as a district nurse for many, many years, home is home and you know, you know, deep down inside that they probably would be much, much better off with better care than any district nurses could give, we visited – but we didn't have the amount of

backup that they have now. But still, people would prefer to go, to have less chances if you like and still be in their own bed and in their own home than the most wonderful places that you can think of. And I think that is something you just never can get over. Unless you turn round and say, 'We will not be paying for certain types of patients to be nursed in their own home,' and then wait for the bomb to drop.'

Chair: 'That was actually my very next point because our second principle is cost effectiveness. And we say that we should not be paying for things which are not cost effective, other than in certain exceptional circumstances. And it may be that certain types of care are better provided in an institution, a hospital, special type of home, whatever it might be, than in the community. Or in a place that people just want to go to because it appears to them to be a nice place to be. And then there's an issue of equity and there are two components to that. Cost, at the moment, because there's an opportunity cost for everything, and if you spend money on one thing, you can't use that same piece of money for something else. Therefore if you spend a disproportionate sum of money for one person, you are depriving somebody else of those resources. But equally, we should not be forcing people into organisations which are on, for example, cultural grounds or on religious grounds, are inappropriate for them. So I'm trying to suggest in this paper that you may be able to take a transparent, but also robust approach to helping to, contributing towards controlling what is an escalating cost of continuing care, by following the main principles that we have'. (Priorities Forum transcript 2)

Our overall argument in this section is that in the above examples Priorities Forum members are drawing on a different sort of knowledge to that invoked by the 'framing by numbers' discourse. The distinction Aristotle drew between formal, theoretical knowledge, 'episteme', i.e. knowledge focused on objects and ideas abstracted from a social context, and 'phronesis', a 'practical wisdom' concerned with prudent action in a social world, is relevant here. We see instances of Forum members talking from their own professional and personal experiences, expressing values from the 'life-world' rather than 'system-world' (Habermas, 1987), and using words that convey their emotional connection to what they are saying: '*it's difficult for me sitting here*', '*I feel quite uneasy...*', '*I would feel more comfortable...*', '*from the experience I've had .. for many, many years*', and so on. Although it is difficult to convey the overall sense and scope of individuals' contributions from these short extracts, we suggest that what we see are examples of 'phronesis', as members direct attention to what they see as the morally relevant features of a situation or argument through particular rhetorical moves.

The paradox is that whilst these sorts of contributions are an apparent part of the use of evidence in practice, and can be seen to sometimes have a powerful effect on discussion, they remain largely unacknowledged in formal and public accounts of the Forum's work. The ideas of the discourse theorist, Mikhail Bakhtin, can help in understanding this apparent paradox. Bakhtin

saw in any social situation a constant discursive struggle between the 'centripetal forces' of an official, dominant discourse and centrifugal forces that work to disrupt the dominant order (Maybin, 2001). Davies et al, describe the way in which:

'...centripetal forces attempt to create a communicative totality with defined and seemingly fixed features, to systematise and prescribe, and to identify and enforce 'proper ways of talking' and proper modes of conduct and interaction which signify, produce and reproduce social institutions. Centrifugal forces at the same time disorganise systems, create exceptions and resist attempts at order' (Davies et al., 2006).

The rhetorical deliberation of members can be seen as part of a 'centrifugal force', but struggles against the dominant discourses of evidence-based medicine and instrumental rationality, constructed both through the Priorities Forum's background papers as discussed above, and additionally through reference to a 'framework of principles', to which our attention now turns.

6.3.3 The discourse of 'principalism'

In the formal conceptualisation of the Priorities Forum as '*a mechanism to ensure a robust ethical and evidence-based process for identifying treatment priorities in [the Primary Care Trust]*', the framework of principles is central. The framework, drawn up initially by the Director of Health Improvement (the Chair of the Forum) and endorsed at a preliminary meeting of the Forum, is frequently appended to Priorities Forum papers, and on occasions proposed additions and revisions are discussed at Forum meetings. The framework describes how the PCT will:

'apply a number of 'principles', and balance these against each other, when determining what are the most appropriate services and most appropriate treatments that we will give priority to for both the populations we serve and for individual patient treatment requests.'

The principles include those of clinical effectiveness, cost effectiveness, affordability, equity, quality and safety, the four biomedical ethical principles of autonomy, beneficence, non-maleficence and distributive justice, and principles concerned with due process such as transparency, accountability, an appeals process, and probity. The detailed statement of these principles comprises a six page document, referred to as the 'framework of principles'.

Our data suggests that in the same way as 'framing by numbers' marginalises more qualitative knowledge from discussion and constructs a particular view of what constitutes a robust 'evidence-based' process, so the framework of principles serves to construct a particular view of what constitutes a robust process of ethical decision-making. The framework of principles creates a context in which ethicality becomes defined by the principles. At the most basic level, the decisions the group comes to are considered ethical because a clear statement of principles exists (which includes the four classic

principles of bioethics) and the group makes frequent reference to them. Only once in the discussions we analysed was there any explicit problematisation of the principles, in terms of their inherent incommensurability. In this instance a public health specialist from a neighbouring PCT suggested that:

'the problem with the principles is they often will direct you to different answers, cost effectiveness and clinical effectiveness can often be at odds with, say, the equalities agenda or the distributive justice agenda'.

The Chair of the Forum responded to this point with the following comment:

'We use the principles more for individual patient treatment requests simply because we have more of those. Rarely do we end up with the decision using those principles which is made simply on one. What usually happens is that there are arguments both ways for all of them, and you end up balancing something. But what the principles force you to do is to consider formally a number of different components and you seek to come to a judgement. One of the other findings that I think [the research team] have come up with is that this whole process is not something where you can just take those figures and stuff them in a machine, press the button, have a cup of tea and come back and there's a correct answer. Actually there is no correct answer. Ultimately it is subjective. But it's sort of objectively subjective! You've thought through it rather than just a knee jerk response'. (Chair, Priorities Forum transcript 6)

The principles are important therefore in providing a kind of checklist of issues to consider. And in this way, they seemingly help in making decision-making more objective. This viewpoint is also illustrated in the following extract, in which the Chair of the Forum distinguishes the framework of principles from the subjectivity of members' value judgements.

GP: 'I agree with what [the patient representative] has said [about the need for a more holistic, systematic approach]. My problem is how you do it.... I find it extremely difficult to judge between early intervention psychosis and IVF, for example. So perhaps the first thing we need is a list of what treatments, probably high cost treatments that this PCT is funding. And the criteria we need to apply. I think we need a more fundamental look than just saying A versus B, because – which is A, which is B? Where do you draw the boundaries around them? And I think that is important'.

Patient representative: 'It depends whether you're in A, how important it is, whether you're in B, how important it is. People who sit at home waiting, you know, 'I've only got two more days before my period, am I going to be pregnant?' Unless, I think, you can really understand their feelings, I don't think it is possible to compare A with B. Each has such a great priority, to that particular patient. If you've got chronic heart failure, chronic heart disease, that's important. But if I

said it doesn't matter which disease it is or which illness or what it is, it's just as important to that one patient. And that's what I think this Forum has to remember more than anything else. It's easy for us, but not so easy for the person sitting outside'.

Director of Nursing: 'I guess, building on that, you have to recognise that we're all sitting here with our own personal experience, also being patients and our family being patients. And then when we make value judgements, some of that feeds into it'.

Patient representative: 'It is totally human nature, it can never be any different'.

Chair: 'Which is partly why we've got the principles so we've got a framework'.

Director of Nursing: 'Absolutely'. (Priorities Forum transcript 1)

The narrative about principles constructed here is one in which the principles are seen to foster a robust decision-making process by enabling the group to *'consider formally a number of different components and... come to a judgement'*. However, our data suggest that paradoxically the principles also restrict ethical deliberation. The principles are presented to the group as representing the values of the group, they are considered to be the principles the group has signed up to, and as such ethical values come pre-defined, rather than emerging through deliberation. What we are observing here is the distinction between principle-based and narrative ethics. A principle-based approach to ethics considers that general ethical principles can be applied universally and in a logico-deductive way in order to reach a 'rational' or 'robust' decision about what is right. We see this approach represented in an account of the Oxfordshire Priorities Forum (which provided a model for the PCT in our study): *'One aim of the forum... is to make decisions on the right grounds'*. The 'right grounds' are laid out in an ethical framework that focuses on three key areas: evidence of effectiveness, equity, and patient choice (Hope et al., 1998). By contrast, a narrative ethics defines as ethical what is constructed as the right thing to do through shared moral inquiry and rhetorical deliberation. A narrative approach to ethics emphasises situational judgement and aims through communication to draw out people's engagement with their moral selves. Importantly, it recognises the role of emotion in coming to an ethical decision, seeing emotions as essential elements of human intelligence (Nussbaum, 2001) rather than suggesting that emotions 'get in the way' and need to be put on one side for robust decision-making. As Garsten says of the role of emotions – they *'lead us to identify certain moments as presenting a choice and also to identify which material is relevant to making that choice. Many deliberations include a moral component, and emotions help to define which considerations seem morally relevant'* (Garsten, 2006).

In the previous section we suggested that in Priorities Forum discussions we sometimes see examples of rhetorical deliberation, critical thinking and

expressions of moral judgements that open the door to this sort of narrative ethics approach. However, these are isolated fragments that stand out from the greater part of discussions. We argue that in the main, the dominant discourse of what makes for a 'robust ethical and evidence-based process' gives little legitimacy to such an approach and rather than facilitating ethical deliberation serves to distance members of the Forum from engaging as active moral participants.

Loughlin suggests that principle-based approaches to ethics in health care management have become a substitute for *'sincere critical thinking about right and wrong... as if the very fact that an "ethical code" exists can settle a substantial question about how we ought to behave....'* (Loughlin, 2002). Marinker and Giacomini et al use the metaphor of a 'litany' to problematise statements of principles and values that have become such a customary part of policy discourse (Giacomini et al., 2004; Marinker, 2006). Litanies, they acknowledge, can play a constructive role in policy thinking: they provide convenient reference, help decision makers keep values in mind, and offer orientation. However, they warn that *'litanies can also have a kind of "yadada, yadada, yadada..." quality – they may be recited dutifully, but their contents may lack meaning or force when values are simply named and not well elaborated, deliberated, or acted upon'* (Giacomini et al., 2001). Sometimes we see this in the Priorities Forum – we see the naming of principles (and often simply a general reference to them as 'the principles') standing in for any further discussion of ethics. Because there is an assumption that the principles represent the 'common sense' of the group, standing for public reason, they are assumed not to require or prompt further debate. And so when, for example in a discussion about whether the PCT should approve funding for the drug Sorafenib as treatment of primary liver cancer (Jan 08 Priorities Forum), and the Chair of the Forum makes the comment that *'we won't fund things just because there's no alternative treatment available. It seems harsh but it's one of our principles'*, the fact that it's one of the PCT principles seems to be presented and interpreted as putting it beyond debate. Similarly, throughout discussions the principle of utilitarianism is not debated or contested as a principle, but rather taken for granted as the morally right thing to do because it is a principle. What we see is the way in which pre-defined principles act as rules that minimise rather than open up space for deliberation and judgement (Garsten, 2006; Schwandt, 2001).

Finally, it seems that discursively we see associations drawn between what is ethical and what is evidence-based. Not only does using a set of principles make decisions ethical, but so does using evidence. A blurring occurs between what is ethical and what is evidence-based, indeed, in the following quote we see the suggestion that being evidence-based is what being ethical is about.

Local Council member: 'Surely what this Forum must try and do is not to be emotional, not to put yourself in the position of the person waiting, but try and come back to the evidence that we have. That's all you can do. And people are always going to challenge the decision. But you have to go through it as rigorously as you can. So I think that's

just something you have to do. And we, as a Forum, we have to decide which has a greater priority. And yes, it's invidious choosing between intervention on psychosis and IVF, but that's the reality and there's no point in us being here if we're not prepared to face up to making those decisions. [...] ...ethics must in the end be about – in these contexts – be about making decisions on the evidence. And you have to have experts to give you that evidence.' (Priorities Forum transcript 1)

7. Conclusion

The focus of this report has been on policymaking as problem representation. We drew on the work of political theorists to suggest that the essence of policymaking is the 'struggle over ideas' (Stone, 1988). We see our work as contributing to a growing body of research that highlights the agency of individual actors in the policymaking process, their 'meaning-making' practices, the situated nature of evidence, and policymaking as a collection of arguments in favour of different ways of seeing the world.

We drew attention to a number of inherent tensions enacted in the work of the Priorities Forum and to the different meanings of evidential knowledge. We contend that these tensions and differences are manifestations of broader visions about the nature of priority setting. On the one hand priority setting, and policymaking more generally, can be seen as a 'decision science', with its privileging of an instrumental, technical rationality, reflecting and shaping the discourses of evidence based policy, managerialism and principalism. On the other hand we can see priority setting as rhetorical deliberation in action, with its emphasis on human judgement, personal knowledge and experiential wisdom.

Of course, these ways of interpreting priority setting are ideal types that inevitably do not correspond with an empirical reality, and run the risk of polarising complex and nuanced practices and creating an artificial dichotomy. Nevertheless we suggest these constructs are useful as analytic tools for synthesising a variety of ideas and practices and highlighting assumptions (Lefstein, 2005). We drew on Bakhtinian ideas about the multiplicity of languages within social interactions to consider priority setting discussions as a discursive struggle between these different visions. In this sense our research offered a case study in the politics of representation (Maybin, 2001; Mehan, 1996). We highlighted the way in which certain representations of evidence, ethics, priority setting etc. came to have legitimacy and prevail over others. And we saw how through the processes of 'information reductionism' and 'commensuration' the social world comes to be more and more abstractly represented, and everyday experience, practical reasoning and empathetic identification become increasingly irrelevant bases for judgement (Espeland & Stevens, 1998; Garsten, 2006; Schwandt, 1997; Tsoukas, 1997). In Table 3 below we depict these different visions of priority setting, with reference to many of the themes discussed in the report.

We suggest that the theoretical concept of rhetorical deliberation provides an alternative conceptualisation of rationality, one that we contend is highly relevant to the work of the Priorities Forum. Rhetorical deliberation connects the notion of 'muddling through' (a term used in Forum discussions to describe an inferior process to that of a 'robust mechanism') with rich ideas from philosophy and political science stretching back as far as Aristotle, which acknowledge the validity of a range of forms of knowledge that underpin 'practical wisdom' (including emotion, imagination, values, etc). Rorty adds

the following contribution to our understanding of this rather different conceptualisation of rationality:

‘In one sense ... to be rational is to be methodical: that is, to have criteria for success laid down in advance... the other meaning is ‘sane’ or ‘reasonable’ rather than ‘methodical’. It names a set of moral virtues: tolerance, respect for the opinions of those around one, willingness to listen, reliance on persuasion rather than force. These are the virtues which members of a civilized society must possess if the society is to endure. In this sense of ‘rational’, the word means something more like ‘civilized’ than like ‘methodical’ (Rorty, 1991).

Table 3: Ways of seeing priority setting

	Priority setting as ‘decision science’ (the technical application of EBM and ethical principles)	Priority setting as rhetorical deliberation
Epistemology	Instrumental rationality	Experiential wisdom
Ontological assumptions	The social world can be represented through quantitative indicators	Irreducibility and incommensurability as inherent features of the social world
Nature of knowledge and reality	Certainty (predictability)	Contingency (messiness)
Source of authority	Scientific evidence	Personal knowledge and experience
Method	Scientific technique	Argument
‘Good’ priority setting is a function of...	Technical method	Wise judgement, active moral engagement, ‘phronesis’
‘Good’ priority setting is characterised by...	Robust mechanisms for decision-making	Muddling through

(Adapted from Lefstein’s exploration of ‘technical’ versus ‘personal’ approaches to teaching (Lefstein, 2005))

An aim of this research was not only to contribute to the academic knowledge base but also to support reflection and stimulate debate about the complex nature and demands of policymaking among practitioners. We hope that

making visible the role of language, argument and discourse in policy discussions can perform a useful role in giving policymakers new insights into their work, and increasing awareness of the conditions that shape their actions and choices. Rein and Schon's work suggests that increased 'frame reflective discourse' can help expose the meanings, values, and preferences from which policymakers argue; how they construct and position their audience; and how 'problems' and 'solutions' are constructed through discussion (Rein & Schon, 1993). The suggestion is that this increased awareness opens up possibilities for alternative framings, and thus opportunities for policymakers to engage in creative thinking about the complex problems they face.

To develop the work presented here, and to take forward Rein and Schon's call for further research on the conditions for frame-reflective policy discourse, we have sought funding for a follow-on research study. Our aim is to explore the transferable insights from our preliminary findings from one deliberative forum in one PCT to other settings, and engage a number of Primary Care Trusts in a process of organisational learning and change. Specifically we intend to document the range of approaches taken by PCTs in dealing with one particular, increasingly prominent and controversial, aspect of resource allocation – that of individual treatment funding requests, typically requests for funding of high-cost cancer drugs. We propose to develop our study within an action research framework that attempts to explicitly facilitate frame-reflective discourse about resource allocation, enabling professionals and lay people to develop their understandings of the practices in which they are engaged. At the time of writing, we await a decision about funding from the NHS National Institute for Health Research, and hope to produce a further report on progress in around two years' time.

Appendix 1

Topics discussed at Priorities Forum meetings (Jun 05 – Nov 07)

Should the PCT invest more money in an existing service?

- Assisted conception services. Is assisted conception a treatment of sufficient priority for the PCT to want to invest more money to reduce the waiting list? Should the PCT stay with its current provider or change to one whose success rate is better but whose prices are higher?
- Should the PCT fund the appointment of a medical consultant to enable earlier discharge of elderly people from acute hospital beds to a community-based service (prompting a subsequent review of hospital discharge procedures for non-elective orthopaedic and acute elderly patients)?
- Should the PCT be providing more cardiac rehabilitation and if so to which groups?

Should the PCT start funding a new innovative service?

- Should the PCT set up a Fracture Liaison Service for elderly people at risk of osteoporotic fracture?
- Should the PCT support a home non-invasive ventilation service for patients with chronic respiratory failure?

Should the PCT stop funding an existing service?

- Is there sufficient evidence for the PCT to continue its contract for homeopathic treatment at the Royal London Homeopathic Hospital?
- Is there sufficient evidence for the PCT to continue to contract for other complementary treatments at the Royal London Homeopathic Hospital?
- Review of wisdom teeth extractions

Should the PCT shift funding from one form of service provision to another for a particular patient group?

- A review of the evidence for exercise schemes in the Fitness for Life Programme
- A review of local dermatology services with a view to shifting patients from secondary to primary care
- Should the PCT change the care pathway and service specification for

children and young people with eating disorders?

- Is the care being provided for three high-cost individual patients appropriate, bearing in mind its clinical effectiveness, cost effectiveness and affordability?

Discussion of the process by which the Priorities Forum makes decisions

- How can the PCT take a more strategic approach to prioritisation to meet the increasing financial pressures of having to fund high-cost drugs such as Herceptin?
- Consideration of a proposal to introduce an additional principle of affordability into the Priorities' Forum's principles
- How should the PCT make funding decisions, especially on individual patient treatment requests, when NICE guidance has not yet been published?
- Review of the process for handling individual patient treatment requests
- Discussion of a proposed policy for responding to individual patient treatment requests for age-related macular degeneration

Consideration of ethical issues in PCT work

- Should the PCT extend the role of the Priorities Forum to include a clinical ethics function?
- What ethical considerations should be taken into account when the PCT is determining who should receive continuing care and where should it be provided?
- What are the ethical issues the PCT needs to consider in relation to a body mass index measurement programme in local schoolchildren?
- How should the PCT prioritise services and treatment in the event of a flu pandemic?

Miscellaneous items

- An audit of 'low priority' treatments being carried out in local hospitals.
- A discussion of a national initiative 'The Integrated Service Improvement Programme' intended to stimulate changes in the way services are provided to enable health gain.

Appendix 2

Extract from an agenda item considering whether the PCT should set up a fracture liaison service for elderly people at risk of osteoporotic fracture

Public health specialist: Well what I did in looking at the proposals which came through from [the local consultant and the Chair of the Priorities Forum] was to see, well what is the need for this service in [our PCT], what levels of prescribing, what's the prevalence rate, and what would be the effect of introducing this service. So if I sort of go through the paper bit by bit, and I actually found an example of the Fracture Liaison Service that was set up in Glasgow in 2000 and there are a couple of good publications on it regarding the number of people they've assessed, the number of people they've dexamerscanned, and the number of people who subsequently would end up on various medication. And from this study, and I used some of the data to extrapolate that from [our own PCT] figures to see what would be the implications for [our PCT]. But in this study, they admitted that although it was, it was obviously a beneficial way of, in having a Fracture Liaison clinic, which is where you identify people coming in to the Fracture Clinic, who may have osteoporosis due to a low impact fracture.... So even though they've admitted they could identify, I think it's 82% of people who have had a BMD test and found to be osteoporotic or osteoporotic and those people may subsequently have been put on bisphosphonate or a calcium supplement, they could not prove that that actually reduced the number of fractured neck of femurs who were admitted to hospital, because there is no direct link. Actually you can do it by looking at the BMD measurements and saying, 'Okay this patient, at this time, if we administer bisphosphonate, will not lose any further density of the bone. So therefore, because that doesn't occur, that reduces the risk of sustaining a fracture. And that's how it's calculated in terms of numbers that appear on the paper. But it's not actually been assessed in terms of practicalities, following up a patient group and seeing, is this group getting it and is this group not getting it – has a higher admission rate. So that's not come out. And that is one of the problems that we've come up against in this paper. But what I did look at was I looked at the instance of fractured neck of femur which is going down, very, very slowly but it is going down. But also if you look at the data on page four, it's erratic. So, you know, there could be a number of factors that contribute to this. I also, but I didn't actually put this in the paper, but when I had a look at it, I had more time later on, I broke it down looking at this specific age groups and it's quite interesting, because if you look at the 80 years and over, and I'm sorry this isn't in colour, the number of admissions over the last few years amongst people 80 years and over, has not gone down. So, and that could be, I'm just over to conjecture here, it could be that the impact of the increases in bisphosphonate prescribing locally have not impacted on that age group. They primarily might be impacting on a low age group. But that's all conjecture. Okay. The other thing, of course, that contributes to breaking

bones and particularly fracturing neck of femur in older people, is the rate of falls. And on page five, we've got a list of the falls that took place between 2004 and 2005....

... But the interesting thing is that in the 80 plus group, which is where a lot of falls are unspecified and some of this is due to confusion, shock, people in this age groups have, when they have a fall. So you can see that the admissions in that age group are not really coming down. And also the unspecified falls are not diminishing. So that's again a question that we need to ask ourselves. It's, are our services that we are offering appropriate, and particularly in terms of the Falls Service. And one thing I may have missed in doing this paper is rather significant, because not only have we had RB approach us in terms of having or developing a fracture liaison service at [the local acute] hospital, but also [another nearby acute hospital] are tending to look down this road as well, whether they need a fracture liaison clinic. But it also does have an impact on what we do about the causes of things.

Okay, the next thing I looked at was the bisphosphonate prescribing and the prescribing of calcium and vitamin D tablets, because this really does have an impact, or hopefully will have an impact in numbers of fractures coming through to A & E as well as the admissions. And we can see, since the year 2001, 2002, that the prescribing rate has definitely increased. In fact it's almost doubled. And if the rate keeps going, then I can see us trying to hold on to the reins a bit. But on the other hand, when I looked at the GP data, the rate of prescribing in general practice varies significantly between surgery and surgery. And we don't really understand the reasons for that. Perhaps we need to look at it further down the line, as also the rate for referral for DEXA scans, which is almost like an x-ray which monitors the bone mineral density. That's also inconsistent. And perhaps we need to look at that in a little bit more detail. But, as I said earlier, maybe the impact yet of this rise in prescribing of this bisphosphonate hasn't really had time to work its way through in terms of reducing the number of fractures.

So what I did was to try and assess what sort of gap we had, how many patients that are out there that could have osteoporosis and may need to be in receipt of one or another prescription. And so I used the World Health Organisation data, estimates of the prevalence of osteoporosis. I couldn't find one for males. Males unfortunately are neglected in this area probably because osteoporosis is higher, there's a higher incidence in women, but there is a significant number of men out there who will also experience osteoporosis. And that could well increase if the dietary intake and other things doesn't match. So, what I did, in looking at the ONS projections and also the Scottish guidelines, where are we – Scottish Intercollegiate Guidelines and Estimates, which include some estimates for males. And I came up with a total of 19,529 people in [our PCT] with osteoporosis. Now that doesn't necessarily mean that they all have severe osteoporosis, they could have very low bone density, and of course, as we know, it gets worse the older you tend to get. But, once diagnosed with osteoporosis, there should be some measure, some prescription that is advanced. And that is for a low bone density, it would probably be calcium, HRT, and vitamin D

supplements for a period of time. And then, as your osteoporosis becomes worse, and if you look at the chart on 8, page 8, so the prescriptive regime alters.

The most indicative factor in whether a person goes on bisphosphonate is whether they've had a fracture, so picking people up at the point at which they have their first fracture is quite important. Okay? So some people will be picked up prior to having a fracture, but they might have an illness of which osteoporosis is a secondary factor, or in the case of a woman, they may have had a very early menopause. And that's a clear indicator. And that woman may well be subject to a DEXA scan. But in the majority of cases it would be the person's first fracture that actually is what flags up that there could be an underlying cause of that.

So I estimated 19,529 patients, a proportion of whom will be on treatment. And that's why the only way to look at and got the data for the number of people on one or other medication, and [X] kindly went through and looked at all the scripts issued, estimated the number of scripts that one patient would take over a period of time, and wrapped this up. And the estimate for the number of people on bisphosphonate, on page 10, was 3,776 people. And for a calcium supplement, vitamin C supplement – 7,913. Now people taking bisphosphonate should also be taking a calcium supplement. So that means, you know, we can perhaps deduct 3,776 and the remainder would be those people only on calcium and vitamin D supplement, which would be those people with a low BMD reading. Okay.

I also on page 8, if you want to come back, is calculated the admission costs. And I was quite surprised actually to find the admission cost, just for a fracture neck of forearm, sorry, fracture of forearm, was £262,000. I can't really work out why people are admitted just for a forearm, it's probably shock and other conditions, bruising, maybe open wound. Okay.

The other thing I looked at was looking at the referrals for DEXA scanning, and it was quite difficult, because the data I had for this was just sort of grouped. And so I couldn't really say well how many people have been referred from outpatients, follow up appointment after a fracture. And we don't know that, and we do need to try and get hold of that data if we can, because we don't want, we wouldn't want to set up a fracture liaison clinic only to find a high proportion of these people had been referred by the outpatient appointments that follow a fracture or by a GP, but the referral rate there is inconsistent. So I found there were 538 referrals in all to the RNOH. We couldn't get the referrals from [a nearby acute hospital used by local residents]. But looking at the GP referrals, it appeared that all the GPs in [our PCT] were referring to the RNOH. I don't know if we had to have just the one contract. I'm not sure.

GP: There are two.

Public health specialist: So there probably is a proportion of people who went for scan via the RNOH, okay. And the number of GP referrals was 467.

So that, to me, doesn't look too bad, but it's difficult because I can't find comparative indicators or measures. So people are being referred, but what we don't know exactly is the number of people referred immediately following a fracture. And that, so that definitely needs to be tightened up if we're going to make sure that these people don't fall through the gap.

Okay, on page 11, I estimated, using the prevalence data, the number of people on bisphosphonate – how many people perhaps are not getting a prescription, or who could benefit from having a prescription, of one or other, either the calcium or vitamin D or the bisphosphonate. And I estimated here that 5,458 patients may need to be put on a prescription. Or offered a prescription. You have to remember that not all prescriptions are tolerated by everybody. You know, so there will be a proportion who are unable to take a prescription. This figure will also be distorted by the number of people who start on the prescription and then stop. So, and with the sort of non-compliance rate of 45%, it could be that patients, you know, that actually been more patients than this, have had prescriptions but they're not taking it. My understanding is that even if you take the prescription for 6 months, that is still beneficial, you don't go back to square one. And, you know, so that is still protective. But again, perhaps there's something we need to do about ensuring better compliance and supporting people. It's not always a very pleasant prescription to take.

Right, the next step was to look at, well OK if we set up this clinic will there be a saving? Well, I've already said in the first part, it's very difficult to match A with a B and to say, 'Well okay, if we identify these people, it would reduce admissions to hospital.' On the other hand, the Falls Clinic and a lot of services have been set up without that positive link. The Falls Clinics were set up on the recommendation of NICE. And the same as the prescribing of bisphosphonates is on the recommendation of NICE.....

... So what I subsequently looked at is if we were to, if we were able to identify these people, and DEXA them and prescribe for them, the cost would be £34,571 as against the cost of one fractured neck of femur which would be £42,000. So that would be a saving. The problem is, is you have the administrative and processing costs. So now if we recruited the nurse at £32,675, then the cost of setting up a Fracture Liaison Clinic on this model, would not be realistic if we assume that we get one saving of a fractured neck of femur. But we might get two. We don't know how many we'll get. You know, it's difficult to know this. And alternatively, it may be that we can fill these gaps and ensure that people are picked up and sent for scanning and put on prescribing without having a fracture liaison service, somehow plugging those gaps. So there are a number of alternative models we can use. In the paper I did put a variety of models on the assumption that we would set up a Fracture Liaison Clinic. Or did not set up one. I didn't actually propose that perhaps we don't do either of this, and that the route could be ensuring that the protocols and the way they work really do wrap up into the Fracture Liaison or into the fracture service. And it seems to me that perhaps the Fracture Clinic may have been perhaps not brought to the fore in terms of the

role that the clinic can play in identifying people or working alongside these other services.

So, having done all this work, we still felt it was worth bringing the paper to the committee, even though I'm unable, based on evidence, to recommend that we fund the service on the grounds that it's cost effective, because I haven't been able to conclusively provide that evidence.

Annex: Value-based argument in a policymaking forum. By Emma Byrne

This annex examines the use of arguments over values as part of the “action context” in policymaking. It expands on the ways in which rhetorical argumentation is different to the “pure logic” of the rationalist approach to evidence based policymaking. It also shows that “healthy rhetoric” differs from eristic argumentation, in which the use of power and compulsion determines the eventual outcome. This annex then discusses the role of values as a vital element of the action context of policymaking. It presents a working definition of “values” and explains how these have been identified in the discourses that have been studied. Finally this annex presents extracts from policymaking discussions where value-based arguments have been made. It demonstrates that there are many occasions where values are engaged with in a way that is rhetorically “healthy” (rhetorical argumentation). It also presents examples of exchanges where values are not engaged with and argued about. Rather they are dismissed through eristic argumentation or from a failure to recognise values as valid subjects for discussion in a policymaking arena (objective argumentation). This annex concludes that rhetorical argumentation is used for the evaluation of value-based arguments, but that its use is not consistent. This indicates that the role and importance of this type of argumentation is not widely recognised in this particular policymaking setting.

Rhetorical argument: what it is and is not

Priority setting falls within the domain of practical reasoning. In contrast to logic, which is concerned with questions of “what is the case?”, practical reasoning is that which is directed towards determining “what should be done”. Argumentation is the means by which evidence is assessed. It is through argumentation that parties decide on a course of action that is acceptable to all parties.

The process of applying evidence to policymaking can be broadly characterised as one of three competing approaches (See **Error! Reference source not found.**). The first of these, the instrumental view, is part of the naïve rationalist approach to policymaking. In this approach, evidence must be in a form that is provably true, or has some known probability of being correct. Acceptable evidence is thus restricted to “hard facts”, which are used to address gaps in knowledge. According to the naïve rationalist point of view, once these gaps are filled, the “right” policy will emerge. This approach rests on the assumption that concrete facts are the only evidence that is desirable in making policy decisions.

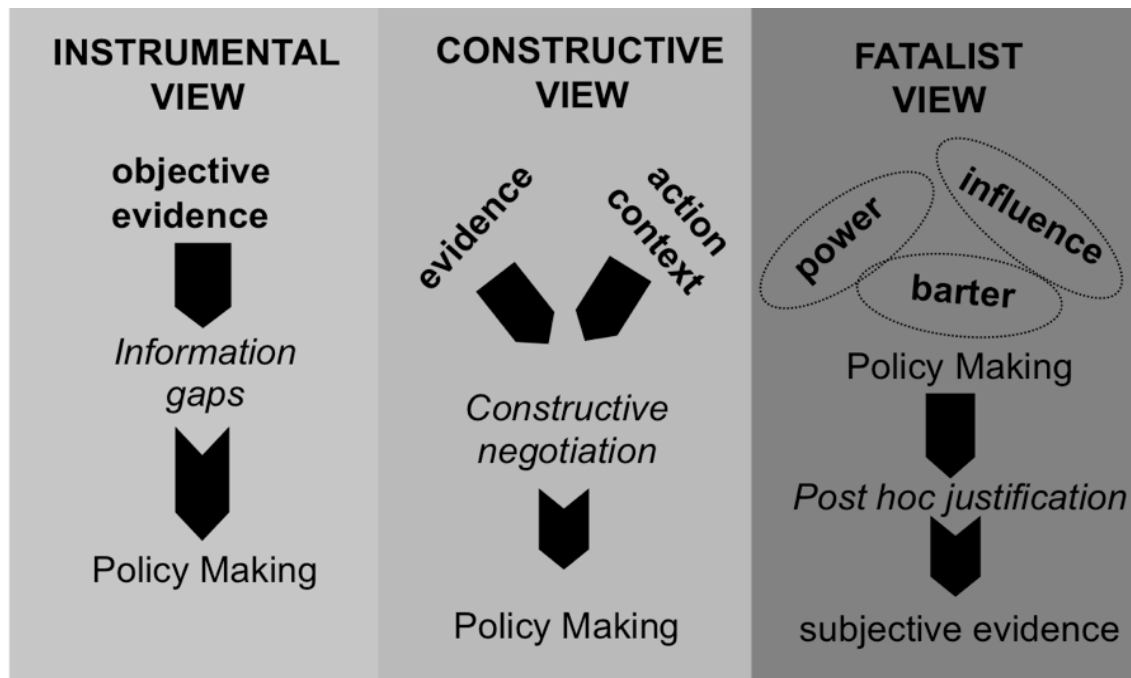


Figure 1: Three contrasting views of policymaking

This approach is usually contrasted with the fatalist view. The fatalist characterisation of deliberation also stems from the naïve rationalist approach to policymaking which can be caricatured as the belief that arguments are either “deductive or defective”. In this view, policymaking that is based on anything other than concrete “evidence” must be defective. Otherwise, policymaking will be reduced to an exercise in power broking.

The fatalist view of policymaking does not need a normative argumentation. Eristic argumentation is a struggle between speaker and audience in which the speaker attempts to compel the audience to accept the arguments put forward by threats or bargaining. Eristic arguments can usually be condensed to a two word summary: “...or else.”

Eristic argumentation is generally considered a highly undesirable form of argumentation. Policy makers usually claim for themselves the mantle of “democratic expertise.” As such they commit to representing or at least to canvassing the views of all stakeholders. To then allow policymaking to become an exercise in power broking is to neglect this duty.

According to the naïve rationalist approach, argumentation that is not objective must be eristic. This would seem to lead to an impasse: neither form of argumentation is appropriate for policymaking. However, if we adopt the constructive view of policymaking, another form of argumentation becomes available.

Objective Argumentation	Rhetorical Argumentation	Eristic Argumentation
One “truth”	Several interpretations	One “party line”
Necessary or probable	Justifiable	Imposed by threats, fear or power
Aims to convince	Aims to persuade	Aims to compel

Figure 1: Characteristics of three types of argumentation

It becomes possible to bring to bear argumentation that includes a richer set of evidence, including pathos and ethos, that do not result in a process in which power prevails. These approaches are built on what can be considered a “healthy” rhetoric (for a more detailed exploration of the case for persuasive rhetoric being considered a positive force see Section 4 of the main report: the Value of Rhetoric).

A rhetorical approach to policymaking is advanced through argumentation. The three views of policymaking suggest three very different types of argumentation. The instrumental view requires a form of argumentation that is strongly normed: it is binding and based on logical inference or probabilistic reasoning. The audience, when it hears the arguments, should be convinced of their truth, and compelled to accept them. As indicated in the main report, Perelman and Olbrechts-Tyteca characterise the case for rhetoric in policymaking as follows:

Only the existence of an argumentation that is neither compelling nor arbitrary can give meaning to human freedom, a state in which a reasonable choice can be exercised. If freedom was no more than adherence to a previously given natural order, it would exclude all possibility of choice; and if the exercise of freedom were not based on reasons, every choice would be irrational and would be reduced to an arbitrary decision operating in an intellectual void’ (Perelman & Olbrechts-Tyteca, 1971)

Section 2.2 of the main report gives an example of where a course of action (the introduction of “padded knickers” to prevent hip fractures) was considered on the strength of objective argumentation. The scientific evidence from a systematic review of research on falls in the elderly demonstrated that padded hip protectors were an effective intervention in reducing hip fractures. However, the objective argumentation did not, indeed could not, include the

“action context”. That is to say, all of the vitally important “non-factual” considerations, about the effect on patients’ dignity for example, found no place in the objective argumentation.

Various argumentation frameworks have been proposed to support the analysis and practice of practical reasoning. These argumentation frameworks aim to enable the generation of a coherent set of propositions that, whilst not proven, can be plausibly defended. Further, their defensibility can be systematically examined by means of critical questions (Blair 2001, Walton 1996, 1998).

In formal logic arguments will fail if they are invalid (the conclusion does not necessarily follow from the premises) or unsound (a premise is false). In practical reasoning such constraints need not apply – the arguer need only show that the proposed course of action will plausibly have a desired effect. Critical questions may be used to test that plausibility. However, in practical reasoning one is not compelled to accept a plausible argument: other proposed courses of action may equally plausibly appear to result in more desirable outcomes. It is, therefore, entirely possible for an argument in practical reasoning to be both sound and valid but to still fail to persuade.

The end point of argumentation is not agreement over facts, but agreement on a course of action. Whilst factual evidence is necessary to determining what is practical in the policymaking process, policies must also take into account what an audience considers to be plausible.

Values in rhetorical deliberation

Rhetorical deliberation allows the policymaker to take into account other elements of the action context. Values are an important element of the action context, as they lead to discussion over what is ethically and morally desirable:

Argumentation is the key process through which citizens and policymakers arrive at moral judgments and policy choices... Each participant [in policy debates] is encouraged to adjust his view of reality, and even to change his values, as a result of the process of reciprocal persuasion.’ Majone (1989)

Argument frameworks such as those proposed by Walton do not model the effect of the audience’s values on the acceptability of an argument. An alternative approach, the value based argumentation framework (VAF) proposed by Bench-Capon *et al*, has the advantage of addressing the audience’s moral reasoning. Participants in a discussion have hierarchy of values (in the sense of moral or social goods) that they prefer over others. The VAF is a framework such that each argument has a value associated with its acceptance (Bench-Capon 2003). For example “Bob should steal the insulin from Alice” may be associated with the value of “preservation of life” but not with the value “respect for property”.

It is these priorities that the VAF captures. Each audience of one or more people will have a preference over the values that they wish to promote. For example, a VAF analysis indicates that members of a PCT's Priorities Forum sometimes favour the value "staying within budget" above values such as "health benefits", "clinical effectiveness" or "reducing deaths". The audience may not be aware of this *a priori*; however, by an analysis of the arguments that they are prepared to accept, it is possible to determine the audience's value hierarchy.

VAFs do not simply impose a logical consistency on the audience. In addition there is the assumption that an audience acting with goodwill will also be *morally* consistent. An audience is morally consistent if and only if one value is consistently favoured over another. Whilst audiences may not be morally consistent in practice (for example the values of "right to life" and "preservation of property" may change places in my hierarchy depending on whose life and whose property is at stake), an audience surrenders at least some of its right to be considered rational or reasonable if it is not morally consistent.

VAFs allow us to a) identify the values that arguments promote b) identify the values that audiences prefer, in the light of the choices they make concerning the arguments that will or will not persuade them and c) identify where audiences are not morally consistent, in that their preference order over values is not fixed.

We can also use VAFs to predict whether an argument is likely to be rejected by a reasonable audience with a given value preference ordering. We can therefore use VAFs to identify arguments that should be accepted by an audience that is behaving in a morally consistent manner. If these arguments are rejected, we have then identified a discussion in which some other (potentially non-rational) method of persuasion, such as power broking, is in play.

One "healthy" way of countering a value-based argument is to trump the value that it promotes. Legitimate ways of doing this are to suggest that there are (mutually exclusive) courses of action that promote an alternative, more important value. Another way of defeating such an argument would be to highlight a "disvalue" that the suggested course of action would promote. For example, an argument in favour of curfews for under-21s may proceed on the basis that it promotes positive values such as a reduction in alcohol abuse or violent crime (a *protection from harm* argument). This argument may be trumped by an argument in favour of a higher value: that an education campaign would be a better approach because it would *promote individual responsibility*. It may also be defeated because of the "disvalues" it entails (i.e. a reduction in *personal freedom*.)

Identifying values in Priorities Forum deliberations

Values in general are not well defined. For example, Giacomini *et al* (2004) discovered in a study of Canadian Health Policy “values talk” that “decision makers and stakeholders disagree fundamentally about what values essentially *are*.” Giacomini *et al* identified four groups of values: objects, principles, goals and attitudes. Principles include equity, universality, accessibility, fairness, and social justice. Goals include cost effectiveness, efficiency and sustainability. Objects include Medicare, the Canadian health service and the Canada Health Act. Attitudes include pride, dignity and identity.

Giacomini *et al* also suggest a disvalues exercise. It is extremely uncommon to directly argue for the inverse of a value (“inefficiency”, “lack of dignity”, “unfairness”). Instead, a familiar battle is not between those for equality of access and those for inequality of access. Rather it is between those for equality of access and those who believe some other value has higher priority.

Using the Giacomini “disvalues” approach is the first step to identifying value-based arguments in the policymaking deliberations of the Priorities Forum. Applying this approach allows us to identify typical uses of value-based arguments. Values that are commonly named as desirable, either explicitly or implicitly are:

Value	Disvalue
Patient health	Patient illness
Clinical effectiveness	Clinical ineffectiveness
Budgetary constraint	Budgetary irresponsibility
A functioning system	A broken system

Values mentioned in the Priorities Forum and their complementary disvalues

Identifying an individual’s value preferences

Individuals advance arguments for courses of action that will promote one value at the expense of another. Sometimes the two values are contrasted explicitly, sometimes they are not. In the following example we see a clear preference over two values: a choice promotes one value (keeping the system running) and demotes another (clinical effectiveness.)

“If we stick with the criterion of 39 at the time of [IVF] treatment, it is a spanner in the works. *It will stop the system from working...* If we revert to the old system of 37 at time of referral, then the list gets longer and longer and longer, it means women get older, older and older, *they can still have their treatment, even though clinically it would be extremely ineffective and very unlikely to work.*”

[DISCUSSION CONTINUES:]

“I think we have flexibility to say, ‘It’s not 39 at the time of treatment, but it is 37 at the time of referral,’ if this forum thinks that that would be an acceptable way forwards, then it would certainly make life easier...” (Chair, Priorities Forum, transcript 2)

The speaker expresses a preference between two plausible courses of action, based on an (implicit) preference relation. The value of having “a functioning system” is prioritised over the value of “clinical effectiveness”.

Value-based arguments in the Priorities Forum

Values are an essential element of the action context of policymaking. Value-based argumentation is the engagement between different value hierarchies in order to make choices in practical reasoning, based on the negotiation between actors with different value hierarchies.

Such arguments may proceed “healthily” or “unhealthily”. A healthy value-based argument is one in which values are engaged with in a meaningful manner. Suppose that a participant argues that course of action *a* is desirable because it promote value *y*. Arguing on the basis of values must take the form of an argument that either states that:

- a) Course of action *a* directly acts against a more important value, *x*
- b) another course of action *b*, which would render *a* impossible, promotes a value *y* which is more desirable than value *x*
- c) course of action *b* is a better way of achieving value *y*

Whilst we see examples of such arguments in the Priorities Forum, we also see examples where eristic or objective arguments dismiss “values talk”. We characterise these arguments as “unhealthy” as they do not allow values their rightful place in the policy discussion: these arguments fail to acknowledge values as part of the action context.

How values are used

Values arise in a number of places in Priorities Forum discussions. The following examples show various strategies by which speakers present their values. Some speakers justify their value hierarchies with warrants. Some speakers give explicit examples of disvalues and value hierarchies. The following examples illustrate the types of value-based arguments that are advanced.

Values may be warranted

Occasionally, the values attached to an argument are warranted, that is, the speaker gives a reason (his role as patient representative) for championing that value:

“They are trying to close beds to reduce overheads. As a result, I for one as a patient representative can’t support it.” (Patient representative, Priorities Forum transcript 2)

Sometimes a value is warranted by the argument itself, whereas others are attached to an argument without the support of a warrant. In the example below, cost savings are a logical consequence of timely discharge. However, no evidence has been given that early discharge improves quality of care. Nevertheless, the speaker attaches both values to this argument.

“If we managed to get a ... proportion of them discharged [earlier], in cash terms *we are making a saving*. It could well be, *in terms of quality of care, we are improving things for those patients*” (Chair, Priorities Forum transcript 2)

The attachment of the second value (quality of care) to the argument is not warranted by anything that the speaker has said. Whilst it may be the case that early discharge leads to better quality of care, the speaker has not made the case for this.

(Dis)values are sometimes mentioned implicitly, sometimes explicitly

In the following example we see the same argument being made by two different participants in a discussion of the desirability of bed closures. We see that one participant couches his argument in terms of a dis-value “*not achiev[ing] revenue neutrality*”, which appears to be an argument for cost savings that does not use the phrase “cost savings”.

The other participant, who in his role as Chair may be more aware of the acceptability of arguments that support the *cost saving* value in this Forum, does not mention this potential disvalue. In addition, he appears to be comfortable enough with the idea that *cost saving* is the ultimate value that he uses the more direct statement (“*close... acute hospital beds*”) versus the other participant’s less emphatic “*if you leave those beds open.*”

Director of Commissioning “This will not achieve revenue neutrality if you leave those beds open.”

Chair “So what we’re saying is, we want to enable closure of acute hospital beds.” (Priorities Forum transcript 2)

Conflicts over hierarchies are sometimes mentioned explicitly

In the next two examples the speaker makes his hierarchy over values explicit: that patient care should outrank cost savings. He even promotes this value to the extent that any cost savings should be contemplated only if they lead to better patient care, that is, that “saving money” is not, to him, a value in itself.

Patient representative “But this is all in cost terms, this is what concerns me. I thought the hospitals were there to care for the patients who are sick, who need those beds”

Patient representative “[I]f these savings contribute to the beds being closed... then frankly I’m not in favour it, even though in its own terms it makes sense... If on the other hand it can create capacity to treat more patients then I’m all for it. I think it’s fair for me to make my position clear.” (Priorities Forum, transcript 2)

Healthy rhetoric: values lead to choices of course of action

The most common use of values-talk is in advocating for a particular course of action. For example, in the following extract, the speaker advocates that a certain course of action (the introduction of a cardiac rehabilitation service) should not be adopted. Three values are in play: clinical effectiveness, patient health and budgetary constraint. The speaker acknowledges that introducing the service would have a positive impact on the first of these two values: clinical effectiveness and overall patient health. However, he then “trumps” these values with the *ultima ratio* of cost savings.

Chair “I’m going to suggest that what [X]’s work has done is to show how *clinically effective* it is to provide cardiac rehabilitation, that we are meeting the minimum standards of cardiac rehabilitation in [the PCT], *that there would be health benefits and a contribution to our targets of reducing deaths from CHD* by investing more in cardiac rehabilitation. But... there is not potentially sufficient saving in terms of excess hospital costs to pay for the additional cost of cardiac rehabilitation, and *therefore if we were to pay for it, we would need to take some money from somewhere else. And that’s not something that we’re in the position to do today.*” (Priorities Forum, transcript 2)

The speaker makes the case that the investment should not be made. In doing so he demonstrates that he believes the value of cost savings has a higher priority than the values of clinical effectiveness or of patient health. This argument is generally accepted by the audience, leading us to conclude that, for them too, budgetary constraint is of higher priority than clinical effectiveness and patient health.

To make the argument clear, in the table below, the arguments and values are labelled as in argument-type b) above:

Course of action		Value	
a	Adopt cardiac rehab	x	Clinical effectiveness Patient health
b	Don’t adopt cardiac rehab	y	Cost savings

A type b) argument in the Priorities Forum

In this case a single speaker makes both the argument “Action *a* leads to value *x*,” and the argument “Action *b* (which is incompatible with action *a*) leads to more important value *x*. *Therefore favour action b.*”

In another example, two speakers engage over the desirability of a course of action that would change the criteria for IVF treatment. The discussion begins with the example given in Section 0. The speaker argues that the IVF referral system should be changed, in order to make it easier to manage.

Chair “If we stick with the criterion of 39 at the time of [IVF] treatment, it is a spanner in the works. *It will stop the system from working...* If we revert to the old system of 37 at time of referral, then the list gets longer and longer and longer, it means women get older, older and older, *they can still have their treatment, even though clinically it would be extremely ineffective and very unlikely to work.*”

[DISCUSSION CONTINUES:]

Chair “I think we have flexibility to say, ‘It’s not 39 at the time of treatment, but it is 37 at the time of referral,’ if this forum thinks that that would be an acceptable way forwards, then it would certainly make life easier...”

One of the forum members, a GP, advances a values-based argument against this course of action:

GP “I would, I’m sorry, I would have to dissent. I don’t think it would work, it wouldn’t be correct. Then we’d be leaving our own principles...*We’ll be departing from clinical effectiveness and cost effectiveness.*” (Priorities Forum, transcript 2)

Value	
<i>x</i>	Keep the system working
<i>y</i>	Clinical effectiveness Cost effectiveness

A type a) argument in the Priorities Forum

Note that the counter argument rests entirely on the priority to be given to the different values: it takes the form of argument a) as identified above. The speaker not only advances a healthy values-based argument, he also warrants his priority over values by appealing to the principles of the Forum.

More than one value may be used in an attempt to persuade. In the following example the first speaker attempts to make the case that a choice of action should be preferred because of its effect on costs. The second speaker counters with what (to her) is a higher priority: clinical effectiveness. Rather than attempting to argue that cost savings are a higher priority than clinical effectiveness, the first speaker replies with a “firm suggestion” that the value

of “keeping the ‘higher-ups’ happy” should trump the value of clinical effectiveness.

Chair “There is the potential...to make *real savings* within a year”

Patient representative “But *the clinical ones are going to be difficult*”

Chair “In that case, may I make a firm suggestion, which is that Professor X, who is *the Medical Director* at Hospital Y, *is very keen on this*”. (Priorities Forum, transcript 2)

This argument might be considered unhealthy. In effect the third argument that is advanced is essentially an appeal to authority. However, the argument may be advanced in the guise of a value rather than as an argument for doing something *per se*.

The distinction between appeal to authority and value-based argument is subtle, but runs as follows: an appeal to authority demands compliance with a course of action (or the acceptance of a given statement as true) as disobedience of (dissent from) authority is not an option. However, if the speaker’s second statement is merely promoting the value of “keeping the ‘higher-ups’ happy” then there is the option for the other speaker to argue in return that she does not accept that the Medical Director’s peace of mind has greater priority than clinical effectiveness.

This example demonstrated an essential difficulty in assessing discourse *post hoc*. We do not know whether either or both of the parties in this exchange intended this to be a healthy, values-based argument, or whether the Chair’s final argument was intended to bring an end to the discussion of values by an instance of eristic argumentation.

Unhealthy rhetoric – failure to engage with values as action context:

In healthy rhetoric, value-based arguments must be answered with arguments over the priority of values. However, as the next example shows, some of the arguments advanced in the Priorities Forum fail to engage with values.

In the following example, returning to the discussion about IVF treatment, rather than engage with a value-based argument, the value is dismissed:

[Following the discussion in which the Chair tries to get a consensus for the “refer at 37” (rather than the “treat by 39”) criterion.]

GP “I would, I’m sorry, I would have to dissent. I don’t think it would work, it wouldn’t be correct. Then we’d be leaving our own principles...*We’ll be departing from clinical effectiveness and cost effectiveness.*”

Chair “I think we’re departing already because of the inadequate funds.” (Priorities Forum, transcript 2)

This latter statement is not a legitimate argument over the desirability of values. A valid argument would address the mismatch in the priority over values. It might, for example, attempt to persuade the audience that the values of clinical effectiveness and cost effectiveness are, essentially, meaningless without a functioning system to deliver clinically- and cost-effective treatment.

Instead, the Chair does not address the concerns of the GP. He doesn’t acknowledge the values of clinical- and cost effectiveness as part of the action context. Instead, these values are dismissed as irrelevant by what is, in effect, an admission that the Forum cannot defend its own values, in this case at least.

In another example, the speaker does not engage in discussion of the priority of quality of life versus cost savings. The quality of life value is not engaged with as part of the action context. Instead, it is dismissed as not being appropriate to the Forum. The speaker is told that the Priorities Forum is “not the place” for quality of life arguments:

[A discussion is underway to try to further reduce the number of low priority treatments – tonsillectomies, grommet placements, D&C procedures.]

Patient representative “This refers to grommets... [The] hearing has been adversely affected as a result... that’s too long [for] a small child to miss out on lessons as well as social activities [*quality of life*].

Chair “As I recall these are NICE criteria...

Patient representative “These are the NICE criteria. I can disagree with the NICE criteria and point out the adverse impact they have on children, and their lives, and therefore it needs to be looked at, yes?”

Chair “I’m not denying that you shouldn’t hold that view. *I’m not sure that this is the place where we can take any action on that.*” (Priorities Forum transcript 1)

In this instance the Chair is promulgating the naïve-rationalist view of policymaking: “non-factual” evidence is not to be considered. This is not a healthy value-based argument that pits one value against another (for example, by stating that adherence NICE guidance is a more important value “quality of life”). This is a lack of engagement with a legitimate value position.

Conclusion

This annex highlights several features of value-based argument in this particular policymaking setting. Firstly, it justified the role that rhetoric has in policymaking, and the part that values have to play within that rhetorical approach. It showed the way that value-based arguments are used in the Priorities Forum and demonstrated the healthy and unhealthy ways that value-based arguments are played out in the forum.

The examples presented here are not intended to be an exhaustive audit of the arguments in this particular Priorities Forum. Such an exhaustive analysis would only provide details of how this particular Forum argued on these particular days with this particular group of people. Rather they have been chosen to illustrate the following general points:

Value-based arguments do take place. The examples provided here show just some of the value-based arguments that have been used in a policymaking setting.

Value-based arguments are sometimes disallowed The influence of the dominant discourse of “evidence-based policymaking” may have led to a self-conscious rejection of value-based arguments.

Value-based arguments can be done well, as the examples in Section 0 show. Here we see participants in the Forum using their preferences over values to argue for or against the moral and ethical desirability of a course of action. In these arguments, values are treated as a legitimate element of the action context.

Ignoring value-based arguments can lead to impoverished policy decisions. Section 2.2 of this report describes the “hip protectors/padded knickers” policymaking discussion from a different forum. The paper from which this example was drawn concluded that: “However good the evidence that soft hip protectors would reduce fractures, the idea of asking elderly clients in residential settings to wear padded knickers was completely alien to these participants’ values of respect and dignity.” In other words, in the absence of values-based arguments, there is no space in policymaking fora to debate whether individual dignity has a higher priority than prevention of hip fractures. Only value-based arguments can be used to determine the moral and ethical desirability of such a course of action.

Post-hoc value-based argument analysis is of limited usefulness. As the final example above shows, it sometimes is difficult to determine, post-hoc, whether an argument is intended to promote a value or to compel adherence to a particular course of action. The best arbiters of whether an argument is value-based or not are the participants in the discourse themselves.

In the first instance, the case should be made to policymakers that the “deductive or defective” ethos that arises from the naïve-rationalist approach to evidence-based policy neglects important aspects of the action context. Policymakers should also be equipped with a wider range of rhetorical skills, if policymaking is to be carried out well: whilst value-based argumentation is only one of these skills, it would ensure that policymakers are better able to make arguments and counter-arguments about the moral and ethical desirability of courses of action. These skills must, then, lead to a more comprehensive discussion of policy and, in turn, better policymaking processes.

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