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Why is health improvement policy so difficult to secure?

Most governments have signed-up to improve the health of their populations and reduce health inequalities. Many governments made this commitment energetically and sincerely. Some describe the belief that 'preventive' action to foster population health is better than responding to acute health crises. Some are committed to get beyond the usual focus on individual lifestyles or healthcare, towards addressing (1) social influences on health inequalities (which relate to safe and healthy environments, education and employment, marginalisation, and economic inequality) and (2) commercial influence on policy and society.

Despite this high political commitment, there remains an unusually large gap between policy statements, practices, and outcomes. Why is this gap so large? Why does it endure despite often high commitment to promote population health? What can be done to close that gap, and end a dispiriting cycle of enthusiasm and disappointment?

We describe two – hopefully complementary – ways to address those questions, drawing on an informal academic-practitioner workshop we co-organised to discuss the future of health improvement policy in Scotland. The context is COVID-19, which necessitated a temporary shift of resources from health improvement to health protection (in other words, from longer-term work to prevent 'non-communicable diseases' – NCDs - including cardiovascular and respiratory diseases, cancer, and diabetes, towards an intense pandemic response). The transition, in 2022, towards an 'endemic phase' of health protection provides a new impetus to consider the immediate and long-term future of health improvement policies. Our aim was to focus on policy to prevent NCDs, including:

1. Specific policies, such as to address smoking, alcohol consumption, and diet.
2. A broader focus on collaborative policymaking, to recognise the fact that most health-relevant policies are not in the control of health departments.

We followed the format from previous workshops in Scotland and England, beginning with an academic overview (based on the paper *Why is health improvement policy so difficult to secure?*), followed by informal discussions on current challenges and next steps.

Please note that these are Cairney's notes on proceedings. While we gave each participant the chance to comment on the draft, and made some changes as a result, Cairney still takes responsibility for the following text.

The academic argument

We describe a general problem with 'preventive' policies and 'joined-up' policymaking. On the one hand, the idea of prevention has widespread rhetorical appeal, suggesting that governments can save money and reduce inequalities by preventing problems happening or getting worse. On the other, there is a large gap between rhetorical commitment and actual practices (although Cairney and St. Denny show that these general prevention problems are less apparent in relation to specific agendas such as tobacco control).

We identify three main explanations for this gap:

1. *Clarity: if prevention means everything, maybe it means nothing*.

The language of prevention is vague. This ambiguity helps to maximise initial support (who would be against it?) but stores up trouble for later. People face more obstacles – including opposition to policy change - when they have to translate a broad aim into tangible policy instruments.

2. *Congruity: prevention is out of step with routine government business*.

Preventive policymaking focuses on relatively hard-to-measure, long-term outcomes. It competes badly – for attention and resources - with more-pressing issues with short-term targets. Its push for radically different, holistic, policymaking does not fit with well-established rules and norms. Attempts to 'institutionalise' health improvement either lead to public health agencies with very limited powers, or cross-government initiatives that remain unfulfilled.

3. *Capacity: low support for major investments with uncertain rewards*.

No policy can improves live, and reduces inequalities, while avoiding political and financial costs. Rather, preventive policies involve 'hard choices' with political costs, and are akin to capital investment: spend now, and receive benefits in the future. This offer of short term costs for uncertain long-term benefits is not attractive to governments seeking to avoid controversy and reduce state spending.

Cairney, St.Denny, and Mitchell show how these factors play out in studies of Health in All Policies (HIAP) strategies. On the one hand, HiAP research demonstrates high levels of coherence in relation to its:

- *Story*. Treat health as a human right, identify the 'social determinants of health' and the 'upstream' solutions to reduce inequalities, promote intersectoral action, and seek high political commitment.
- *'Playbook'*. For example, connect HiAP to current government agendas, focus on 'win-win' solutions, avoid the perception of 'health imperialism', and foster policy champions.

On the other hand, regular reports of slow progress relates to problems with:

1. *Clarity*. The HiAP terminology is abstract and subject to different interpretations. For some, it involves a radical plan to redistribute money and power to reduce health inequalities. For others, it is a vague ambition to encourage collaboration inside and outside of government.
2. *Congruity*. Advocates seek to 'mainstream' health into all policies, but find low or superficial interest from other sectors, or opposition to public health interference in other government business.
3. *Capacity*. Few advocates have made a winning economic case for HiAP investment. Most initiatives are about zero-cost cooperation (undermined by low *clarity* and *congruity*).

While these experiences are dispiriting, they were at least predictable, particularly in states that were not conducive to economic redistribution and high state intervention. However, COVID-19 added an ironic twist: it should have prompted governments to connect the dots between health improvement and protection strategies, to address the unequal spread of the NCDs that

caused unequal illness and death. Instead, rapid and radical changes to foster health protection came at the expense of health improvement.

These experiences provide cautionary tales to underpin future strategies. They show that vague political agreement – to mainstream health across government - is no guarantee of substantial action, and the production of a new strategy is futile without knowing if it will dovetail with routine government business.

The workshop discussion: opportunities and challenges

There were many positive messages peppered throughout our discussions, suggesting that Scottish policy and policymaking is conducive to health improvement progress. Participants highlighted a lower tendency (than in Westminster) to focus on individual responsibility, in favour of more collectivist solutions. There is political leadership and cross party consensus behind the argument that we need to fix shameful health inequalities.

These positive factors could help to boost a current focus on 'place', to foster local collaboration to join-up services to improve wellbeing (such as via well maintained streets, good quality spaces, places to meet, and a sense of belonging and control). People care about what happens in local communities, which could bring together many different NCD-related aims – such as in alcohol, tobacco, gambling, diet, exercise – that would otherwise be siloed.

There is also some enthusiasm to extend a 'public health approach' to several policy problems - such as in criminal justice (including knife crime reduction), or housing – if it helps to break down silos (and if enough people know what a public health approach is).

Further, there is enough evidence of success in long-term thinking to think that it could be successful again. One key example is setting a target date of 2034 to produce a 'tobacco free generation'). The 2034 goal has cross-party commitment and fits the current trajectory of government policy. Having this target allows organisations and the Scottish Parliament to hold the government to account for progress (regardless of the party in government), and allows the government to resist commercial pressure to soften key measures. Compared to 'prevention' in general, it comes with more tangible measures of progress that allow policy actors to know if they are on track towards long-term success.

However, our discussion began with general agreement about the challenges of health improvement when governments move from promise to practice, which we relate to three categories:

Clarity

- The appearance of general agreement (on defining the policy problem) hides the many differences of perspectives and approaches across organisations and professions that undermine discussions of solutions.
- There are unresolved debates about the policies to prioritise to reduce health inequalities (for example, not everyone favours economic redistribution).
- It is disingenuous to build false consensus on the idea that health improvement policies reduce costs.

Congruity

- Key Scottish Government policies have been consistent with HiAP and wider preventive aims. For example, the National Performance Framework is a genuine attempt to move from damaging short-term performance management and policymaking silos. However, it did not change the main drivers of the public sector or change the way that individual public sector players get measured. Short-term and silo-based accountability mechanisms remain within the Scottish Government (and the accountability measures of Scottish Parliament committees), producing contradictory incentives.
- Policy should be about making health improvement everyone's business, and changing performance management to be more conducive to prevention. However, acute services are always the priority.
- Similarly, Community Planning Partnerships are a good idea, but there are not enough resources to back them up.
- Relationships and trust are at the heart of collaborative policymaking, but there is not enough respect for these skills. There is a tendency to produce 'hard' reforms at the expense of more valuable 'soft' skills.
- Third sector organisations often struggle to justify cross-sectoral working if it departs from a narrow description of their activities.
- A focus on individual activities – for example, smoking, drinking, gambling – takes attention from the interconnectedness of the causes of NCDs. While national level organisations have addressed this issue by focusing on NCDs, progress is more difficult at local community levels.
- Commercial interests have the power to use existing rules to block policy progress.
- Wider UK developments may undermine progress further. For example, when making impact assessments, is there a greater UK government focus on business than climate or health?

Capacity

- Public health policies and organisation do not receive proportionate attention or resources.
- Each experience of limited progress may undermine the belief that major change is possible.
- These general problems are exacerbated by constitutional uncertainty. Constitutional debates take up political time and energy, at the expense of the capacity to think long term and design effective policies. Many supporters of Scottish independence want to focus on governing competence and stability, not policies that would court controversy.

Challenging questions for policymakers

We then invited some challenging questions for policymakers, such as to ask how and when will key organisations 'reboot' health improvement policies after the COVID-19 emergency response? Or, given there is such political will to support health improvement, would it make more sense to focus on 'rethinking' rather than 'rebooting' policy delivery?

Participants recognised that COVID-19 caused inevitable delays to the development of Public Health Scotland (PHS, which launched in April 2020). Health improvement work did not stop completely (in PHS or the Scottish Government), and a clear strategic plan - supporting a

targeted list priorities (including child poverty, underlying causes of poverty and inequality, and place based approaches) will help to deliver a new programme of work.

However, when prompted to identify areas for concern, individuals provided the following answers from their perspective (*in other words, their inclusion does not suggest that the whole group agreed with the following points*):

1. *Encourage the Scottish Government to be less directive.*

Recognise that we are dealing with a very large system that is less directable in a local community environment. Political leaders need to let go more, to give space to local groupings of policymakers, citizens, and service deliverers. This change requires us to:

- Get past the idea that only the Scottish Government can make the change (e.g. with legislation)
- Take different accountability measures seriously (e.g. not focused so much on ministers).
- Recognise the lack of trust between ministers and local authority leaders, and between many civil servants and council employees, and think about how to build it.

Also, reflect on what happens when the Scottish Government suddenly devotes higher attention and resources to a problem – such as drugs-related deaths – when it becomes a salient political issue. This heavy-handed approach produces immense pressure, unintended consequences, and the sense that you can get your issue higher up the agenda if you create a political storm.

2. *Address implementation gaps and delays.*

We need to see the progress reports on delivery plans, and reboot the governance and accountability process. The wider agenda on public health reform, embedded across government, seems to have gone. Not all of the public health priorities enjoy the same support (e.g. healthy weight/ diet seems low priority).

The Scottish Government had a good tobacco strategy in 2013, and passed legislation in 2016. After some years of relative inactivity on tobacco, the Scottish Government is moving to enact provisions in legislation passed in 2016. PHS seems less active on tobacco control, such as in relation to: gaps in data on young people smoking and vaping, tracking changes in use of novel tobacco related products, including tobacco in place-based approaches to addiction, and connecting national third sector with PHS in-house expertise (although it has focused more strongly on wider tobacco issues, including how they relate to the underlying causes of poverty and inequality).

It seems – to some workshop participants - that the evidence threshold, required to bring about change, has shifted fundamentally over 10 years. There is a far higher bar to clear before governments will act (relating, in few cases, to anticipating the threat of litigation). Some recent inertia could relate to uncertainty around the (post-Brexit) UK Internal Market Act, but there are emerging signs of greater flexibility. Further, a current PHS focus - on working with stakeholders and citizens to understand the quantitative and qualitative evidence – could help to address that perception of inertia.

A focus on 'place' could allow public health professionals to situate evidence-use in a wider context, to reflect on powerful work from local communities on how people experience and

describe the problems they face, to help prioritise issues without requiring loads of scientific evidence. This approach is a priority in PHS's strategic plan.

3. *Support capacity development*.

People are so stretched, and the turnover of experienced people (with expertise and connections) is high. There is less opportunity for informal and serendipitous conversation, less capacity for reflection, less of a feeling of being part of something bigger than the day-to-day.

The cross-party commitment is there in principle, but to what extent will it be reflected in delivery? Where are the accountability mechanisms to support the changes associated with 'whole system' work (beyond the – often narrower - scrutiny in parliamentary committees)?

Reflections on these discussions

Academics often question the extent to which their engagement with practitioners is fruitful to both parties, or conclude that 'little is known about what works'. In our case, the value is reflected in a fairly common academic-practitioner (a) focus on health improvement policy, and (b) language to describe the issues involved. Key examples of common topics include:

1. *The search for clarity: how should we understand and frame the problem?*

To define the problem is to draw attention to different perspectives that can have distributional consequences.

For example, we described the workshop in relation to 'health improvement' in general. Should we describe 'health inequalities' in particular? The latter concern is taken for granted by some, but not a priority for others (especially if it involves economic redistribution).

We focused on NCDs, which perhaps draws attention to medical interpretations of the problem and separates the agenda into component parts (e.g. tobacco, alcohol, diet). Do many people, outside of public health, use this language, or is it alienating to most? Would it be better to focus on people and places? Does a focus on 'place' (in which health improvement plays one part) solve this problem? Or, does it help to reduce public health as a priority?

2. *The search for congruity: identifying limits to Westminster-style accountability and evidence-informed policymaking.*

Policy agendas reflect and reinforce the contradictory pressures that encourage *and* discourage health improvement.

For example, governments want to pursue a preventive agenda, but also produce the policies that undermine it. They seek a long-term agenda with meaningful measures of change, but undermine it with short-term and narrow measures, producing unintended consequences. Our discussions related this problem to the dilemmas of accountability measures, in which Scottish Government ministers need to let go, to encourage decentralised policymaking, but know that they will still be held to account for whatever happens.

Governments may also seek evidence- or knowledge-informed policymaking, but struggle to connect very different elements. First, people present very different claims to knowledge (such as scientific and experiential) that cannot simply be added together or resolved during 'co-production' exercises. Second, they relate these claims to competing ideas on who should

gather and use evidence to make policy (e.g. centralise and roll out the same policy versus decentralise and create policy diversity). Any selection of an evidence-informed model of policymaking is political and contested, and not amenable to simple technical solutions.

See also: Maintaining strict adherence to evidence standards is like tying your hands behind your back

3. *The search for capacity in complex systems.*

Finally, when we talk about the need for more health improvement capacity, what exactly do we mean? One answer is that most participants are not seeking more 'political will' or top-down direction. Some seek to avoid the sense that policy change requires major organisational upheavals. Rather, we need to assign more value to the 'soft' skills required to built trust and meaningful collaboration across (and outside) the public sector (as described by Carey & Crammond, and Holt et al).

Some use the language of complex systems in a suitably challenging way. Too often, people describe 'systems thinking' to highlight control: 'If we engage in systems thinking effectively, we can understand systems well enough to control, manage, or influence them'. The alternative is to recognise that policy outcomes 'emerge from complex systems in the absence of: (a) central government control and often (b) policymaker awareness. We need to acknowledge these limitations properly, to accept our limitations', and act accordingly. Our discussions highlighted the expectation that these systems are less directable in local community environments, requiring a change in expectations and the need to let go. This advice makes sense, and is consistent with the usual advice in complexity studies. However, it will get nowhere as long as everyone expects Scottish Government ministers to be in charge and control of all policy outcomes.

See: The language of complexity does not mix well with the language of Westminster-style accountability