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WHY ISN'T GOVERNMENT POLICY MORE PREVENTIVE?

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Prevention Policy as the Ultimate 'Wicked' Problem

This book shows how to analyse, and seek to solve, the most enduring, puzzling, and important problems in public policy. Policy scholars often begin by relating such problems to two broad questions: why does policymaker attention and action seem disproportionate to the size of policy problems, and why is there such a gap between their policy aims and outcomes? The answer relates to (a) the limited resources of policymakers, in relation to (b) the complexity of their environments: policymakers only have the ability to pay attention to, and influence, a tiny proportion of their responsibilities, and they engage in a policymaking environment of which they have limited understanding and even less control. This insight resonates particularly in Westminster systems, in which most political debate rests on the idea that ministers are accountable because they can exert central government control. Rather, policymaking systems are complex and 'multi-centric' (Cairney et al., 2019), and a focus on the choices of a small number of powerful actors does not help us understand the system as a whole (Baumgartner et al., 2018).

Although these insights could apply to all types of policy issue, many scholars focus on a subset of policy problems that seem impossible to define and understand, far less solve. This limitation does not stop policymakers from *trying*, but it seems to stop them *succeeding*. 'Prevention' or 'preventive policy' is the ultimate example of a policy problem with an intuitively appealing, but ultimately elusive, solution. Many generations of policymakers have used a simple idiom—*prevention is better than cure*—to signal a desire to reform policy and policymaking fundamentally. They use a simple slogan as a way to sell a package of profound changes to policy and policymaking. New policies would engage with potential societal problems before they arise or become acute, not when they are damaging and expensive. New ways of thinking about policymaking would help reform public services, involve more stakeholders and users, and encourage 'evidence-based' approaches.

Yet, each generation appears to have failed to articulate and understand, far less solve, the problem they raised. In that context, we need new ways to use (a) knowledge and insights from the long-term study of these processes, to inform (b) debates on their design and delivery. New agendas—including 'practical

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lessons from policy theories' (Weible and Cairney, 2018) and the 'New Policy Sciences' (Cairney and Weible, 2017)—signal the *general* need to re-establish a strong connection between policy theory and policy analysis. However, their value will be established by more *specific* empirical applications to complex and pressing policy problems summed up by terms like 'prevention'.

Therefore, in this book we show how to use policy theory to understand and address major problems in policy and policymaking. We do not seek to fill conceptual 'gaps' by adding yet more terms to the political science dictionary. Rather, we synthesize and apply cumulative knowledge from multiple policy theories to analyse new empirical studies and encourage policymakers to maintain an institutional memory (see Cairney, 2016a, 2019a; Cairney and Jones, 2016; Heikkila and Cairney, 2018; Cairney et al., 2019). We use the metaphor of a telescope, in which we *zoom out* to understand the dynamics of complex policymaking systems or environments as a whole and use specific conceptual lenses to *zoom in* to specific aspects of policy processes.

If Prevention is Better than Cure, why isn't Policy more Preventive?

Many governments use a simple idiom to propose profound policy aims and fundamental policymaking reforms: *prevention is better than cure*. Prevention policy refers to government actions to intervene early in people's lives, to reduce their need for acute and reactive public services. Preventive policymaking describes major governance reforms to support this policy, including budgeting and performance management reforms, localism and service user-driven public services, joined-up or holistic policymaking, and the pursuit of 'evidence-based policymaking'. For decades, prevention has represented an 'almost irresistible ambition' (Billis, 1981: 367) because policymakers think it could reduce social inequalities *and* the cost of public services. However, they have rarely been able to translate this vague ambition into precise policy objectives or reform their policymaking environment to secure their desired policy outcomes.

Prevention policy is puzzling because the gap between continuously high political support and low policy delivery is unusually wide. UK and devolved governments and political parties generally agree that policy strategies should focus more on early intervention to prevent major social problems, and public services should be less reactive. Yet, the gap between their expectations and outcomes remains wide. We do not identify the usual implementation gap, in which policymakers only fulfil *some* of their objectives (Marsh and Rhodes, 1992), or the usual 'expectations gap' in which the public has unrealistic expectations for policy change (Sikka et al., 1998). Rather, there is great potential for governments to pursue *contradictory* policies at the *complete expense* of their prevention

agendas. We could witness a *complete* gap between the initial expectations of policymakers and actual policy outcomes. The most important policy and policymaking agenda of our time may never get off the ground.

It is tempting to assume—without evidence—that the cause of the problem and solution to this puzzle is simple: high rhetoric but low political will. Politicians make too many promises they know they won't keep, and fail routinely to deliver. Such assumptions are popular in some relevant fields (and public health in particular—see Cairney et al., 2012) but too vague to offer meaningful insight. More importantly, they often get in the way of the types of policy and policymaking analysis that could help reduce the expectations gap. Instead, consider the proposition that governments tend to articulate their aims to allow them to demonstrate success in government by fulfilling a high proportion of pre-election pledges (Bara, 2005). They do not routinely propose policies that they know they will fail to deliver, because such failures undermine their image of governing competence. This is what makes the pursuit of prevention policies puzzling: why would they make such an enthusiastic and public commitment to an impossible-looking policy agenda (often by stating that they will succeed even though their predecessors failed)? Our answer is that they do not think it is impossible when they make the commitment, and they only face specific obstacles when they try to fulfil it.

The assumption of low political will also produces potentially damaging advice. If new policymakers truly think that the problem was the low commitment and low competence of their predecessors, they will begin with the same high hopes about the impact *they* can make, only to become disenchanted when they see the difference between their abstract aims and real world outcomes. Our explanation, based on systematic theoretical and empirical analysis, does not produce a 'magic bullet' to solve that problem, but it helps us understand the prevention puzzle enough to warn against repeating many mistakes of the past. Even when policymakers display sincerity and high political will, they still face major obstacles to policy delivery. Theory-informed policy analysis can help anticipate most of these problems, and overcome many. Policymakers would still be addressing problems that they find difficult to solve, but would be less likely to exacerbate the policymaking problems they face.

The main obstacles to prevention policy and preventive policymaking

We use multiple insights from policy theory to identify the *general problems* that actors face whenever they try to make policy, and show how they contribute to *specific problems* associated with prevention. Put most generally, all policymakers face 'bounded rationality' (Simon, 1976). To all intents and purposes, they must

ignore most information most of the time, and they can only pay attention to a small proportion of their responsibilities (Baumgartner, 2017). Further, they engage in a policymaking environment over which they have limited knowledge and even less control. Policymaking environments contain a large number of policymakers and influencers spread across many levels and types of government, producing myriad rules, networks, beliefs, and ways to respond to socio-economic conditions and events. These processes are not in the control of a single 'centre' of government (Cairney and Weible, 2017; Heikkila and Cairney, 2018). Rather, we use the phrase 'multi-centric policymaking' to sum up the cognitive and organizational limits of policymakers and the necessity of sharing power across political systems and subsystems (Cairney et al., 2019).

This general story of policymaking represents the conventional wisdom within a large collection of policy theories developed in the US, applied as frequently in studies of European policymaking (Weible and Sabatier, 2018; Cairney, 2019a), and told in comparable ways in UK-focused accounts of governance (Rhodes, 1997; Bache and Flinders, 2004; Kerr and Kettell, 2006). It helps us identify three main obstacles to prevention policy and preventive policymaking:

1. Policymakers show support for policy before they understand what it means, beyond the vague idiom that 'prevention is better than cure'. They choose a vague solution to an unclear problem.
2. When they begin to make enough sense of prevention policy to produce specific aims and objectives, their high-level attention is fleeting. When they relate prevention to their wider agenda, it becomes a relatively low priority, often secondary to—or undermined directly by—other policy aims.
3. Policymakers try to deliver governance reforms within a complex policymaking environment over which they have limited understanding and even less control. In many cases, to counteract the illusory nature of their control, they often settle for the *appearance* of success, based on the popularity of their response or narrow indicators of outcomes, without addressing the 'root cause' of the problem they profess to be solving.

Throughout this process, their commitment to prevention policy can be sincere but unfulfilled. They do not articulate fully what prevention means or appreciate the scale of their task. When they try to deliver prevention strategies, they face several problems, which, on their own, would seem daunting. Most of the problems they seek to prevent are difficult to define and seemingly impossible to solve, such as poverty, unemployment, low-quality housing and homelessness, crime, and health and education inequalities (Rittell and Webber's 1973 term 'wicked' is still a shorthand for such problems, but compare with Newman and Head, 2017; McConnell, 2018; Turnbull and Hoppe, 2018). They face stark choices on how far they should go to shift the balance between state and market, to redistribute

wealth and income, distribute public resources, and/or focus on individualist solutions. They face criticism—either in relation to 'paternalism' or a 'nanny state'—when they intervene in people's lives to change their behaviour and ways of thinking. Their long-term focus faces major competition from more salient short-term policy issues that prompt them to maintain reactive public services. Their, often sincere, desire to localize policymaking often gives way to Westminster-style democracy, in which central governments face pressure to make policy from the 'top' and be decisive to project governing competence. Their pursuit of 'evidence-based' policymaking often reveals a lack of evidence about which policy interventions work and the extent to which they can be 'scaled up' successfully (Cairney, 2017).

These problems will continue if policymakers do not understand them from the beginning. If they do not anticipate key obstacles, they can conclude very quickly that their task is impossible. There is high potential for an initial period of enthusiasm and activity to be replaced by disenchantment and inactivity, and for this cycle to be repeated without resolution. Alternatively, our analysis can help policymakers reassess their task, and take forward the most important social policy agenda of our time. Theoretical and empirical policy analysis will not solve the prevention puzzle, but it will help policymakers make more informed choices.

Our approach to solving the prevention puzzle should begin by defining prevention policy. In fact, any attempt to reduce ambiguity actually highlights the incredible range of definitions in use, from a new philosophy of government to a set of individual policy interventions. This range matters, because it shows that a policymaker's commitment to 'prevention policy' is incomplete—and almost meaningless—without a statement on what they think prevention is and how far they are willing to go to pursue it. To identify prevention policy and policy change in practice, we describe the policy 'tools' or specific policy instruments they *could* use to take forward a prevention agenda, and the ways in which we can create clear narratives about the policy tools they *actually* use.

We then show how theory-driven policy analysis can help produce greater clarity, by explaining preventive policymaking and the environment in which it takes place, showing how policy and policymaking differ across case studies—involving different governments and policy areas—and identifying the normative choices that policymakers must make regarding the extent to which they want to intervene in people's lives, reform government, and use particular types of evidence. We relate these issues to contemporary debates in policymaking regarding 'evidence-based policymaking' (EBPM), identifying the (highly unlikely) conditions under which evidence could ever 'win the day' or prevent the need for stark political choices. In each case, we compare preventive policy and policymaking by the UK and Scottish governments. We show that, although the scale of their task and their respective policy 'styles' matter, both governments have faced and addressed preventive policymaking in similar ways. Neither has solved the

prevention puzzles they sought to address, but we can use an analysis of their experiences to identify what they could do next.

What Exactly is Prevention Policy and Preventive Policymaking?

When viewed as a *simple slogan or idiom*, 'prevention is better than cure' seems intuitively appealing. Dedicating resources to stopping adverse outcomes from arising is more desirable than fixing them once they have emerged. Idioms have communicative power, based on their ability to be quickly understood, supported as conventional policy wisdom, and used as a policymaking principle, to justify more or less state intervention. Consequently, when described so broadly, prevention policy can generate widespread and long-term consensus, to bring together groups on the 'left', seeking to reduce poverty and inequality, and on the 'right', seeking to reduce economic inactivity and the costs of public services (Billis, 1981: 367). In the UK, it has been pursued in official reports, during Labour and Conservative governments, during almost all of the post-Second World War era (1981: 368). It also generates high levels of 'ownership' among the public sector, stakeholders and the interested public. Indeed, few people criticize the general sentiment until we move on to more specific questions, such as: what should be prevented, how should it done, who should pay for it, and which groups should win or lose after policy change?

Such consensus, created over ambiguous and vague terms, is superficial and illusory, only to break down when actors seek to turn broad agendas into concrete policies. Recurrent themes include reducing inequalities and costs, giving children and young people the best start in life, and the 'co-production' of policy by policymakers and stakeholders or service users. These ambitions describe a broad philosophy of policy and policymaking. They do not shed light on the many ways in which inequalities might be defined and addressed, or the ways in which policymakers will address inevitable trade-offs between so many policymaking aims. One approach might focus on tailoring services to the needs of disparate communities—even if it means spending or redistributing more—whereas another may privilege sanctions and deterrence as a means of protecting populations from negative social outcomes linked to behaviours that are considered risky or transgressive. Some approaches encourage individuals and communities to participate in the design and delivery of services through consultation and co-production, while many other initiatives seem more 'paternalistic' than participatory.

Further, this difficulty in making sense of prevention policy reflects wider debate about the meaning and value of key supportive principles. For example, Starmans et al. (2017) argue that people are more likely to support policies

underpinned by economic *fairness* than *equality*, while Johnson (2018) argues that 'fair' lacks meaning, and Sznycer et al. (2017) argue that fairness is 'a notion that feels intuitive but often rests on multiple inconsistent principles'. Overall, prevention seems so unclear, and open to so many interpretations, that a commitment to prevention is meaningless without reference to a detailed strategy.

Policymakers address such problems initially by making choices about how to define problems and solutions. This process of 'operationalizing' prevention appears to be relatively manageable within a single organization producing a single document. Yet, preventive policymaking involves the major diffusion of power, from one central government to many local authorities, public bodies, stakeholders, and service users. Definitional issues become further complicated when multiple actors produce their own understanding of prevention and interact with other actors who do not share their perspective. Problem definition has a direct impact on policy and policymaking. The question 'what does prevention mean?' moves from an intellectual concern to a key question for policymakers trying to work together, since the ways in which actors understand prevention from the beginning will influence how they make and deliver policy for the long term.

In other words, prevention *policy* is really a *collection of policies* designed to intervene as early as possible in people's lives to improve their well-being and/or reduce demand for acute services. One aim is for governments to address a wide range of long-standing problems—including crime and anti-social behaviour, ill health and unhealthy behaviour, low educational attainment, unemployment and low employability, and newer problems relating to climate change and anti-environmental behaviour—by addressing them at their source, before they become too severe and relatively expensive. Prevention has the potential to help solve more than one major policy problem, such as the need to reduce socio-economic inequalities or government spending. Further, the motivation for policymakers to pursue prevention is rising, as a period of 'austerity', combined with a growing older population, prompts them to consider new ways to reduce demand for public services ('prevention' and 'preventive spending' are often used interchangeably).

Yet, since there are so many relevant concepts and potential problems to solve, policymakers cannot pay attention to, or seek to solve, them all. Instead, we identify prevention policy in practice by examining how policymakers define the problem and which solutions they are willing and able to select, including redistributive policies to reduce 'structural' causes of poverty and inequality, or 'neo-liberal' policies to reduce state intervention and encourage individuals to become more 'resilient' in the market.

These definitional problems worsen if prevention also describes new forms of policymaking, in which governments reform their practices to support prevention policy. Popular commitments include to pursue 'holistic' or 'joined-up' government, delegate responsibilities to local public bodies, involve users in the design of

services, and/or make 'evidence-based' policy. Consequently, 'prevention is better than cure' is not the only unclear phrase. Terms associated with making prevention policy, such as 'localism', 'coproducing policy', and the 'assets base' of service users, are often as vague and open to multiple interpretations.

In Table 1.1 we show the ways in which prevention could describe a large number of policy interventions and policymaking practices, motivated by many different aims. Policy actions can include defining problems and proposing solutions. Policymaking aims can refer to a shift of procedural emphasis, to change some ways in which policy is decided or delivered, or to more significant governance reforms, using the prevention agenda to prompt further transformations to the ways in which they, and actors across the private, public, and non-profit sectors, take responsibility for individual and collective action. Until policymakers make more sense of 'prevention', and turn it into a series of specific policies, underpinned by specific policymaking practices, it remains little more than an idiom. Or, the same vague idea may be used in very different, and often contradictory, ways by different policymakers.

The connection between prevention, early intervention, and well-being policies

Prevention can be linked closely to 'early intervention', and the terms may often be used interchangeably, but they are not synonymous. Early intervention often refers to those aimed at young children, to describe pre-school or parenting programmes. Prevention can also include strategies for older people (such as falls prevention). Nevertheless, both relate to a notional spectrum, from action to stop problems arising or to stop more harm occurring (Freeman, 1999; Gough, 2013: 3):

1. *Primary prevention*. Focus on the whole population to stop a problem occurring by investing early and/or modifying the social or physical environment. Common examples are whole-population immunizations.
2. *Secondary prevention*. Focus on at-risk groups to identify a problem at a very early stage to minimize harm. Targeted breast cancer screenings are a classic example in health, while social policy can be based on behavioural indicators of risk.
3. *Tertiary prevention*. Focus on affected groups to stop a problem getting worse. Examples in health are interventions to manage chronic conditions, such as diabetes or dementia. In social policy, crisis intervention may be designed to prevent family homelessness.

As described, 'prevention' is vague enough to cover most government activity. Unless policymakers identify a specific commitment to primary or secondary

Table 1.1 Potential aims of prevention policy and policymaking

Type of aim	Aims	Examples
Policy action: define a problem	*To identify or address particular sources of inequalities*	Wealth, occupation, income, race, ethnicity, gender, sexuality, disability, mental health (and their intersection or cumulative impact)
	To accentuate measures of inequalities	Health and healthy behaviour, education attainment, well-being, crime, and imprisonment
Policy action: identify a solution	*To solve a major policy problem*	To reduce poverty and socio-economic inequalities To reduce public service costs, particularly during a period of 'austerity'
	To produce social or economic benefit	To improve quality of life To reduce spending or increase value for money
	To accentuate particular prevention policy 'tools'	Redistributive policies to address 'structural' causes of poverty and inequality Individual-focused policies to: (a) boost the mental 'resilience' of public service users, (b) oblige, or (c) exhort people to change behaviour
Policymaking: procedural changes	*To intervene as early as possible in people's lives*	Primary, secondary, and tertiary prevention Preventive spending and resource allocation
	To promote particular forms of 'evidence-based policymaking'	Using randomized control trials and systematic review to identify the best interventions Using 'improvement' methods to experiment on a small scale and share best practice
	To promote long-term thinking. A focus on redistribution from reactive to preventive services	National strategies for long-term outcomes, coupled with agreements with (or targets for) local authorities
Policymaking: governance reforms	*To reform policymaking, using prevention as a philosophy of government*	Localism and service user-driven public services Joined-up or holistic policymaking
Political aims	*To solve an alleged political crisis*	To avert a funding crisis To address unsustainable or indefensible socio-economic inequalities To address a crisis of governing legitimacy

Source: Author original text.

prevention, the ambiguity allows them to make a commitment to 'prevention' policies which are similar to reactive policies dealing with current problems. Or, service providers can rebrand their activities as preventive without shifting their approach.

The difficulty is compounded when we try to produce a common understanding of primary/secondary/tertiary prevention in different policy fields. The classification works well in health: primary prevention as whole-population programmes aimed at preventing the spread of communicable diseases; secondary prevention as targeted screening programmes for at-risk groups with the intention of identifying disease at the earliest possible stage; and tertiary prevention as programmes to minimize the impact of diagnosed diseases. This is *somewhat* comparable to aspects of education, including work by Heckman (2017), which ties major social problems to factors such as 'low levels of skill and ability in society' and recommends 'early interventions'. One can also focus on whole populations or target disadvantaged populations in social policy (Melhuish, 2003: 5). However, it is harder to relate to less-well-understood social problems related to areas such as crime and social work, where prevention could relate to a mix between all types and age-related interventions. For example, the prevention of substance misuse in prisons may also help prevent intergenerational drug use or incarceration further down the line without being used for that purpose.

Prevention is also often linked to notions of 'well-being'. A 'well-being' agenda refers very broadly to the use of (individual and population) 'quality of life' measures to guide policy (Bache, 2012; Wallace, 2019). It often relates to prevention and early intervention, but not in a straightforward way. One distinctive 'well-being' question regards the extent to which we can measure it, use that measure to compete with economic measures of a country's success (annual growth in the Gross Domestic Product, GDP), and avoid the unintended consequences of economic measures on public policies (Bache and Reardon, 2013; Coyle, 2014). Initial measures included 'educational achievement, life expectancy, poverty levels, and crime rates', and the Human Development Index (HDI) combines life expectancy, access to knowledge, *and* an economic measure of standard of living (Bache, 2012: 24–5). So, prevention, early intervention, and well-being agendas *could* all be used to generate new priorities and measures of long-term whole-population outcomes, but they could also become separate terms used to promote separate agendas.

Preventive policymaking as the solution to financial, social, and political crises

Prevention is often described, too heroically, as the solution to three major crises in British politics (Cairney and St Denny, 2015). First, if we don't make

fundamental changes to the way we fund and deliver services, they will go bust. Prevention symbolizes the desire to shift from expensive demand-led reactive services—such as acute care hospitals, jails, and police and social work interventions for 'troubled families'—towards intervening as early as possible in people's lives to improve their life chances and reduce their reliance on the state. The classic intervention may be a public health policy to encourage healthy behaviour, or an early intervention programme to improve the life chances of teenage mothers and their children. However prevention is also broad enough to include a campaign to reduce accidents and other causes of older people being admitted to National Health Service (NHS) beds (on the assumption that many do not leave NHS care after admittance).

Second, we can reduce major inequalities by addressing the 'root causes' of social problems such as poverty, social exclusion, and poor accommodation. This view can be predicated on a normative argument linking inequality to unfairness, and/or an empirical argument regarding the negative consequences of inequality to a country's economic performance or its population's well-being (Wilkinson and Pickett, 2010). Or, it is possible to accept inequality while rejecting unfairness (Starmans et al., 2017). For example, notions of inequality as natural, or as an incentive and prerequisite for economic growth and prosperity, have underpinned Conservative party ideology (Hickson, 2009). Further, the New Labour government focused on providing responses to specific social problems, such as poverty and unemployment, rather than inequality defined more broadly. Many initiatives that are designed ostensibly to address inequalities actually focus on the 'resilience' of individuals, to improve people's mental health or well-being by encouraging them to participate in society and develop meaningful social networks, ultimately to maximize the proportion of people in education, training, or employment (Taylor-Gooby, 2012; Amery, 2019).

Third, prevention may be sold as part of a solution to a crisis of government. A preventive policymaking philosophy often goes hand in hand with an equally vague governance philosophy that identifies the failures of top-down centralist government, when governments try to do things *to* you, in favour of making policy *with* you. Consequently, prevention tends to come with a commitment to:

- pursue 'joined-up' or 'holistic' government, to foster cooperation between departments, public bodies and stakeholders at several levels of government, or coordinate a range of government objectives to address problems that cut across traditional departments (Ling, 2002: 616);
- redefine the role of central government by encouraging (a) 'localism', or fostering the capacity of local communities to tailor national policies to their areas (Lowndes and Pratchett, 2012; Evans et al., 2013; Hickson, 2013), and/or (b) the sharing of policymaking responsibility across the public sector and in partnership with non-governmental bodies;

- tailor public services to their users, encouraging a focus on the 'assets' of individuals, and inviting users to participate and 'co-produce' their services;
- move away from unhelpful short-term targets (as proxies for the success of policy solutions) and performance management which produces major unintended consequences, towards more meaningful and long-term outcomes-based measures of policy success and population well-being;
- rely extensively on 'evidence-based policymaking' (EBPM) to identify which projects produce the most benefit and deserve investment.

For example, the Scottish Government's (2011a) commitment to a 'decisive shift to prevention' connected strongly to a 'Scottish Approach' to policymaking which emphasized these governance messages (Chapter 6). However, this kind of—albeit often vague and uncoordinated—agenda can be found much earlier in UK government policymaking. Chapter 5 shows how the New Labour government emphasized joined-up government as a strategy to address 'wicked issues', the causes and consequences of which: implicated different departments and agencies, straddled several administrative levels, and spanned the boundary of multiple policy areas (Kavanagh and Richards, 2001; Christensen and Lægreid, 2007: 1060). It also described EBPM as part of its 'modernization' agenda, expressing hopes for the greater use of scientific evidence to inform policymaking, and emphasizing 'what works' to 'depoliticize' policy solutions and reduce the emphasis on party political ideology (Davies, et al., 1999; Sanderson, 2002; Boaz et al., 2008: 246; Head, 2008: 2; Sullivan, 2011; Wood and Flinders, 2014). These types of initiatives are not 'preventive' per se, but their reoccurrence and reinvention are an indispensable part of the prevention policy story.

Prevention as an Unfulfilled Aim: What are the Key Obstacles?

Taken as a collection of *aims*, to reduce costs and inequalities, and *practices*, to join up, localize, and foster evidence-based policymaking, prevention sounds like it is set up as a panacea. If so, the gap between expectations and outcomes will be unusually large. When policymakers move from an idiom and broad governance principles towards specific policies and practices, they find a collection of obstacles over and above the usual limits to central government policymaking, including:

The scale of the task becomes overwhelming. Elected policymakers may decide that preventive principles are sound but that the problems they face are intractable in their four to five-year electoral term. This problem is double-sided, to combine many possible policy solutions *and* reform public services fundamentally. Even if governments could select from existing and well-proven policies, their full effects may still take a generation to see.

There is competition for policymaking resources such as attention and money. As a broad, long-term, low-key aspiration, prevention suffers in competition with highly salient short-term problems that politicians feel compelled to solve first. Prevention projects are akin to capital investments with no guarantee of a future return of investment. During periods of high and growing public expenditure, prevention can be sold as a long-term investment. During periods of austerity, vague promises of long-term savings rarely prompt immediate action. Reductions in funding for reactive, acute, 'fire-fighting', 'frontline' services to pay for new prevention initiatives, that may only produce results after a generation, are hard to sell. As a result, governments tend to invest in prevention in small steps, and that investment is vulnerable when money is needed quickly to fund public service crises.

The benefits are difficult to measure and see. Short-term impacts are hard to measure and long-term impacts are hard to attribute to a single intervention. Further, prevention does not necessarily save money. In some cases, it can increase costs, when people live longer lives in need of care. In others, it does not reduce resource demand enough to withdraw a service completely and produce 'cashable' savings. In contrast, reactive policies, such as to reduce hospital waiting times, increase the number of teachers or the presence of police officers in the streets, address more urgent problems and have a more visible impact on the public consciousness.

Problems are 'wicked'. Getting to the 'root causes' of problems is not straightforward; policymakers often have no clear sense of the cause of problems or effect of solutions. Few aspects of prevention in social policy resemble disease prevention, in which we know the cause of many diseases, how to screen for them, and how to prevent them in a population with the same biological characteristics. Or, there is a large evidence base on the 'social determinants' of inequalities and *models* of the effects of 'upstream' or population-wide measures to solve them, which on their own do not give policymakers the confidence to invest heavily in policy change.

Performance management is not conducive to prevention. Performance management systems and statutory requirements encourage public sector managers to focus on their services' short-term and measurable targets more than shared aims with public service partners or the general well-being of their local populations. Performance management is about setting priorities when governments have too many aims to fulfil. When central governments encourage local bodies to form long-term partnerships to address inequalities *and* meet short-term public service targets, the latter comes first.

Governments face major ethical dilemmas. Underpinning each discussion is an ethical question about what level of government intervention is appropriate. Specific political choices co-exist with wider normative judgements concerning our understanding of the policy problem in relation to the role of the state and

personal responsibility. Normative issues combine with empirical evaluations—on an intervention's likely success and impact on different groups—to inform debate on the most appropriate policy. Although analytically distinct, the ethical and scientific basis for intervention cannot be separated in practice. In each case, the 'target populations', desirable social behaviour, and trade-offs between individual liberties and government intervention, may all need to be justified explicitly, often undermining any cross-party agreement that existed in the abstract.

One aspect of prevention may undermine the other. Central governments may select prevention as the solution to excessive public sector costs while also delegating policymaking responsibility to, and reducing the budgets of, local public bodies. If so, long-term prevention initiatives are undermined as public bodies struggle to address their most pressing needs and performance targets.

Evidence does not settle the matter. 'Evidence' can take many forms on a notional spectrum, from evaluation based on evidence-based medicine, which favours randomized control trials and their systematic review, to practice-based evidence which favours professional experience and service user-based feedback. There is no academic or political agreement on how to produce and select the 'best' evidence (Cairney, 2016a, 2017; Cairney and Oliver, 2017). Moreover, the contemporary localism agenda raises new issues about how to implement and 'scale up' evidence of best practice: from uniform models that are centrally prescribed, to policy developed more flexibly by sharing and learning from users' and practitioners' experiences.

Someone must be held to account. If everybody is involved in making and shaping policy, it becomes unclear who can be held to account over the results. This outcome is inconsistent with Westminster-style democratic accountability in which we know who is responsible and therefore who to praise or blame. Consequently, central government policymakers seek ways to address two contradictory pressures: to delegate and share responsibility in the name of pragmatic or preventive policymaking, and to centralize policymaking to meet an electoral imperative.

Prevention Policy in Practice: Policy Tools, Instruments, and Stories

A focus on 'tools' or policy instruments that policymakers use to turn their aims into outcomes is essential for our theory-informed policy analysis. We need to identify prevention policy in practice, to distinguish between vague aims and actual choices, and to consider if those choices form part of a coherent package (or a collection of often contradictory measures). For example, do they select the 'low-hanging fruit' policies with minimal investment and risk, or signal a determination to make 'hard choices' with significant distributional consequences?

We can approach this task in three main ways. First, by asking the classic 'what is policy?' question. If we define policy as, 'the sum total of government action, from signals of intent to the final outcomes', we can raise key issues about defining and measuring prevention policy and policy change (Cairney, 2012a: 5):

- Does 'government action' include what policymakers promise *and* actually do? An unfulfilled promise may not seem like 'policy', particularly in an area like prevention in which it is possible to rebrand existing policies as preventive. So, we need some evidence that a commitment to prevention had tangible actions and results.
- Does it include policy action *and* outcomes? A focus on policy outcomes helps us think about the strength of commitment to prevention, even if those outcomes are influenced by many factors other than government policy.
- What is 'the government'? Many policymakers are unelected and many actors influence policy, particularly since preventive policymaking is built so much on the diffusion of power to public bodies, local partnerships, and even service users.
- Does policy include what governments *don't* do? Agenda-setting is about the issues that are on *and* off the government agenda, and the opportunities that are taken *and* squandered. This is particularly important to the prevention agenda, in which governments address some inequalities but not others.

Second, by identifying policy tools and instruments, we can provide some measures of policy intent and change. Lowi's (1964, 1972) provocative phrase 'policies determine politics' suggests that the nature of the policy measure, and the *level of coercion required to implement it*, plays a key part in policy selection. Actors may have ambitious aims tempered by their knowledge of the limits to their ambitions. For example, regulatory policies, which place a burden on the behaviour of some groups, or distributive policies, in which one group benefits from government funding, may be more attractive than redistributive policies, in which the government ensures that one group clearly benefits at another's expense.

Hood (1983, 2007) and Hood and Margetts' (2007: 5–6) four-part categorization of policy tools expands a government's options somewhat. *Nodality* describes being at the centre of the information network that underpins policy development. *Authority* refers to the power of policymakers provided by the constitution or the country's laws (such as to produce regulations to set, monitor, and enforce standards—Lodge and Wegrich, 2012). *Treasure* describes the money or resources available to support their policy decisions. *Organization* describes the resources—such as staff, buildings, and technology—at their disposal. Further, John (2011, 2018) adds a focus on persuasion and the rise of psychological techniques to influence social behaviour, including the now famous 'nudge' method based

on exploiting the ways in which people process information to make choices (Thaler and Sunstein, 2008). Pykett et al. (2017) describe nudge in relation to 'psychological governance' to shape the way that citizens think or behave, perhaps contrasting with a more positive relationship with citizens during the 'co-production' of policy with service users (Durose and Richardson, 2015; Durose et al., 2017) and the 'tools of policy formulation' used to generate good information before making choices (Jordan and Turnpenny, 2015).

Most lists of specific policy instruments are long, and Cairney (2012a: 26–7) identifies sixteen possibilities. However, they tend to revolve around the extent to which governments: use legislation, regulation, education, or economic incentives/benefits to influence population behaviour, or organize public services and work with other actors to deliver public policy (Sabatier and Jenkins-Smith, 1993: 227; Birkland, 2009; Howlett et al., 2009; Bardach and Patashnik, 2015). Prevention policies could include instruments relating to:

- public expenditure, including the reallocation of budgets from reactive to preventive services;
- attempts to link government-controlled benefits to behaviour, such as obliging people to seek work to qualify for unemployment benefits;
- regulations, legal sanctions, economic incentives, public services, or education to influence behaviour;
- funding organizations (such as the Early Intervention Foundation) to conduct and disseminate research;
- creating new units within a government department or a reform of local government structures, or providing services via non-governmental organizations.

In other words, the range of possible measures is wide, from the broad measures that are focused most directly on poverty and low income (including social security, minimum wage, and wage inequality measures), to measures on working flexibility (including childcare), redistribution (including income and wealth taxation), inequalities in quality of life (including social housing), and to boost individual well-being and 'resilience' or reduce inequalities in indicators such as health and education (including early intervention and families policies, cognitive behavioural therapy, as well as public health and education programmes).

Therefore, third, we need to produce narratives of policy change based on the identification of these measures and our deduction of the motives of policymakers. This task involves identifying:

- how much we expect policy to change, based on factors such as our assessment of the size and importance of the problem, and perhaps our normative stance (in other words, many scholars criticize governments for using

regulations or individualist measures, rather than the redistribution of wealth and income);
- how sincere we believe policymakers are when they describe an intention to change policy;
- how policy change looks from the 'top' (central government intentions combined with tools) and the 'bottom' (how policy is delivered or produced locally);
- specific measures of policy change, such as a shift in resources from reactive to preventive services;
- the cumulative effect and coherence of policy measures, particularly when governments simultaneously pursue preventive and reactive policies which compete with each other for resources.

In prevention, it is possible to produce many different narratives of policy change, from maximal to minimal commitment. We can generate a narrow picture by focusing only on prevention strategies, or try to generate a wider picture of prevention in relation to policies that are *not* designed to be preventive. The latter—reactive services such as hospitals—tend to receive more resources and stronger policy tools, with the potential to undermine prevention policies. Further, governments generally know how their policy tools look to the wider public, and may pay lip service to some tools while actually using many more. Or, they simply add new instruments to a pile of existing measures, without knowing how they will all interact (Peters et al., 2018: 8).

In that context, Table 1.2 describes three potential models of maximal, tentative, or minimal commitment to policy change. We use it suggest that three trends have emerged in the use of policy tools to pursue prevention in the UK.

First, prevention policy seems to be linked closely to nodality and governance principles that are relatively 'hands off'. Rather than provide services directly, the UK and Scottish governments seek to set strategy and standards, coordinate policies that cross-cut government departments, and encourage 'localism' or shared policymaking with a large number of public, third, and private sector bodies. They also stress the development of community or user-driven service design. In each case, they act largely as nodes of evidence on 'what works', or fund bodies (including What Works centres) for that purpose. Although both governments set aims and standards, there is a rhetorical emphasis on a move away from simplistic short-term targets and punitive performance management towards long-term outcomes-based measures of policy success that are more difficult to monitor and enforce (such as by measuring community well-being). Further, more short-term performance measures still exist for reactive services, which can help them remain higher on the political agenda.

Second, since prevention is often sold as a way to address 'austerity', strategies often come with enhanced rhetorical commitment but reduced budgets. Third,

Table 1.2 Models of prevention policy, from maximal to minimal

Model of prevention	Policy tools	Exemplar policy instruments
Maximal	Nodality	Ambitious and specific prevention policy strategies, combined with funded research on policy solutions
	Authority	Reformed performance measures to favour long-term outcomes, prioritized over previous system
		Regulations to influence individual behaviour and encourage 'resilience'
	Treasure	Progressive taxation, social security, and minimum wage policies, investment in childcare and social housing,
	Organization	major reallocations of public service budgets
		New prevention units or increased staffing in new roles, new local partnerships
Tentative	Nodality	Ambitious policy strategies, combined with funded research on policy solutions
	Authority	New performance measures for long-term outcomes, undermined by short-term measures
		Regulations to influence individual behaviour and encourage 'resilience'
	Treasure	Existing tax and spending system, minimal reallocations
	Organization	New local partnerships
Minimal	Nodality	Prevention policy strategies
	Authority	Regulations to influence individual behaviour and encourage 'resilience'
	Treasure	Reduced budgets for government departments and local bodies
	Organization	New local partnerships

Source: Author text, using Hood and Margett's (2007) categories.

these strategies suggest that prevention policies will not compete well with the services that currently dominate policymaker attention and resources, because acute or reactive public services are generally accompanied by more specific commitments on staffing, funding, and short-term performance management. *If governments pursue prevention largely via nodality, and more acute services via authority, treasure, and organization, we can expect limited progress in shifting the balance between preventive and reactive services*. Regardless of their sincerity, policymakers are often pursuing a prevention agenda while also making funding and governance decisions that undermine that agenda. In making claims for prevention, not backed up with resources or regulations, they create a large gap between the expectations of central government policymakers and local policy outcomes.

Therefore, our discussion of policy tools and instruments provides a sense of the many possible combinations of policies that governments could use to make sense of prevention. A prevention strategy could be little more than an exercise in

'nodality', in which the central government becomes the hub for general strategic planning and information sharing, without the more direct interventions that we would associate with a more energetic policy agenda. The latter requires additional effort to expend more 'political weight' and to prompt many 'windows of opportunity' to introduce specific measures.

How do we Analyse and Help Solve the Prevention Puzzle? The Structure of the Book

Our broad aim is to establish what happens when a 'window of opportunity' to address a policy problem opens; 'prevention' is the solution that policymakers have the motive and opportunity to select, but it proves to be too vague to deliver. If so, to what extent do different governments, and different government departments and public bodies, give different meanings to the same basic ideas? Our specific objectives are to demonstrate how this process plays out in different parts of the UK political system, compare the policy solutions that have developed in several government departments, and compare the solutions of the UK and Scottish governments.

We show that both governments use remarkably similar language, to get at the 'root causes' of societal problems and encourage 'localism' in policymaking, but often produce what often appear to be very different policies. Or, in cases such as public health, they understand and address policy problems in very similar ways, to reflect ever-present obstacles to policy change. Our comparative empirical analysis provides insight into the dynamics of policymaking in multi-centric systems, and helps us determine if cross-departmental policies add up to a coherent government strategy. We combine theoretical, empirical, and normative analysis to provide a full account of, and explanation for, this problem. We focus on what happens after governments make that initial commitment to radical changes in policy and policymaking. In each case, this empirical analysis helps show why government policy is not preventive (at least in the ways that governments describe). This analysis will help policymakers reconsider their approach and seek ways to deliver a more effective, long-term prevention strategy.

The role of policy theories: explaining the limits to prevention policy

Theories help us structure empirical analysis by giving us a language to make sense of and explain events and decisions, and produce general insights from many case studies. Combining the insights of several theories is not

straightforward, but it helps us fill gaps in analysis or generate more than one perspective on empirical data (Cairney, 2013a). In the case of prevention, we show in Chapters 2 and 3 the value of combining insights from three approaches which help illuminate different aspects of the policy process:

The initial focus on an ambiguous problem and unclear solution

'Multiple streams analysis' (MSA) helps us identify two very different categories of 'window of opportunity' (Kingdon, 1984). The first is the opportunity to select a vague solution to a confusing problem. The second is a series of opportunities to select more specific policy instruments. We initially highlight a perception within the UK and Scottish governments that they have produced prevention policy successfully during a window of opportunity for transformative policy change. In other words, they paid disproportionate attention to the problems of high inequalities, costs, and low trust in politics, sought feasible solutions to each problem, and had the motive and opportunity to select prevention as the best solution to all of them. Yet, the actual development of prevention policy suggests that they paid attention to an ill-defined problem and produced a solution that proved to be too vague to operationalize in a simple way. The consequences of such an unclear decision are difficult to predict, and therefore require considerable empirical analysis.

The simple but profound rules used by policymakers to respond to policy ambiguity and make sense of prevention

'Social construction and policy design' (SCPD) helps us identify the ways in which policymakers combine cognition and emotion as informational short cuts to make sense of complex problems, from using limited sources of evidence to designing policies for 'target populations' based on crude stereotypes (Schneider et al., 2014). Uncertainty and ambiguity do not stop policymakers doing *something* (Zahariadis, 2007: 66). Rather, they seek often quick and simple solutions to manage complex problems and processes. Social construction, drawing on gut-level, emotional, and deeply held ideological beliefs, and stereotypes of target populations, is one of those solutions. Simple judgements, about which populations are most deserving of public benefits and sanctions, provide key context for government departments and public bodies. They operate alongside the more 'rational' processes associated with terms such as 'evidence-based policymaking' (Cairney, 2016a). We identify the ways in which different policymakers combine the same basic concepts, such as prevention and early intervention, with their emotional or ideological beliefs about the populations they seek to influence, to produce a wide variety of policies. This allows us to explain why, for example, the UK and Scottish governments use similar indicators to identify high-risk groups in need of relatively high interventions, but only the UK Conservative-led government uses the language of 'troubled families'.

The limited effect of their solutions on existing practices in a complex policymaking environment

Many concepts help us identify the dynamics of policymaking *environments*, and they require careful analysis to tell a coherent story of policymaking. For example, complexity theory helps us describe *systems* and the patterns of policymaking that seem to 'emerge' from them, often in the absence of central government control (Geyer and Cairney, 2015). It is not obvious how policymakers should engage with their environment to turn their aims into long-term policy outcomes. Even if they had clear aims, and prevention remained at the top of the policy agenda, they would face the need to transform the functions and role of government. Their task involves the management of a huge number of issues across many departments, and changing the rules of government departments, public bodies, and delivery partnerships. However, policymakers can only pay attention to, and seek to influence, a small proportion of that activity. They inherit the commitments of their predecessors, reproduce many of the rules that already exist in organizations, and rely on a large number of actors—in the public, third, and private sectors—to help deliver their policies, many of which have their own ideas about how to make sense of prevention. We show how such policymaking systems operate, and how actors within them can amplify or dampen policies. If so, our expectations for policy practices and outcomes can vary dramatically: the prevention agenda can have no impact whatsoever, or produce a small change in rules in key institutions to produce a completely different way to consider and produce policy.

Comparative empirical analysis: 1. How different governments address the same obstacles to prevention

Since it is such an ambiguous concept, governments can produce a wide range of different policies in the name of prevention. There is high potential for 'business as usual', as government departments and public services rearticulate their actions as preventive while maintaining existing practices. Alternatively, key actors can seek to use the prevention agenda as a way to challenge existing practices. In other words, a window of opportunity for prevention *policy* becomes a prompt for potentially numerous *policies*, as different policymaking rules exist across government and many policymakers make quick, emotional judgements about target populations. Consequently, to understand what happens next, we need to examine in depth, and compare, many case studies of prevention policy (see the Preface for a discussion of methods). In each case, this task requires us to identify which actors are involved, their ways of thinking, the rules they follow, the networks in which they participate, the socio-economic context in which they operate, and their use of knowledge to underpin decisions. We also need to understand which

tools policymakers use to turn broad prevention aims into specific objectives designed to produce policy outcomes.

In Chapter 4, we explore the extent to which so-called 'majoritarian' and 'consensus' democracies could produce different models of prevention. Are the former more prone to 'top-down' policymaking and the latter more likely to facilitate central governments trying to 'let go' and encourage 'localism' (Matthews, 2016)? This question is central to UK and Scottish comparisons if we describe the UK as the majoritarian archetype and Scottish devolution as an attempt to produce a more consensus-based model. Yet, we show that their 'policy styles' exhibit more subtle differences. The UK contains elements that we would associate with consensus democracies, and the Scottish system is part of the 'Westminster family'. Therefore, both governments make policy with reference to two stories about the need to: centralize policymaking to foster Westminster-style democratic accountability, *and* decentralize to foster other forms of accountability and deal pragmatically with complexity. Their models of prevention policy and policymaking often differ, but not in a consistent way, and not to the extent suggested by labels such as majoritarian versus consensus. To demonstrate these dynamics, we focus on how they make sense of a broad desire to pursue 'evidence-based' and preventive policymaking.

A wide range of UK policies could be included under the umbrella term 'prevention', from attempts to measure policy success in new ways (including well-being measures as an alternative to GDP), to the introduction of very specific initiatives aimed at 'high-risk' groups, such as the *Troubled Families* programme. However, in Chapter 5, we focus in particular on *Sure Start* as an exemplar case study of the ways in which UK governments—from the election of New Labour in 1997 onwards—have approached prevention. It shows an initial desire to focus on prevention and early intervention to reduce inequalities, foster joined-up government and local participation, and produce 'evidence-based policy', followed by a shift of focus to demonstrate central control, bolster government popularity and, more recently, to deal with 'austerity'. Throughout, we identify a particular challenge in the UK, to move to new measures of success, when the UK government has focused for so long on short-term targets and encouraged public sector markets and competition over collaboration.

In Chapter 6, we identify the, often unfulfilled, potential for distinctive Scottish Government policy and policymaking. It enjoys a *reputation* for addressing cross-cutting policy problems by consulting widely with relevant groups, and working in partnership with delivery bodies, while making a firm political commitment to 'a decisive shift to prevention'. However, the Scottish experience often demonstrates that similar policymaking pressures undermine different policymaking 'styles'.

A focus on the UK government alone would be important, to show how vague ideas impact on existing policymaking practices across a wide range of departments and services. The additional comparative element allows us to examine the

extent to which our explanations are 'universal', driven by policy processes that we could find in any system, or 'territorial', linked to specific ways of thinking and making policy in particular systems. We argue that, if almost anything can happen after an initial window of opportunity for prevention, then common patterns are significant. Both governments may face the same problems and act the same way to solve them, even when they use different rhetoric and pursue change in different institutional settings. All governments make policy despite uncertainty, ambiguity, and complexity.

Prevention policy's rise on the agenda has also coincided recently with a reduction in government spending and a shift of governance strategy. The UK and Scottish governments are searching for new ways to deliver services at a lower cost. The articulation of an agenda based on localism, and policy strategies designed to foster partnerships and involve communities and service users, combined with a reduction in budgets, has major implications. Both governments are pursuing a prevention agenda, but also making funding and governance decisions that could undermine that agenda. There is major uncertainty about the links between the *expectations of central government policymakers*, driven largely by exhortation and information sharing rather than regulation or by forming new organizations, and *local practices and outcomes*, driven increasingly by public bodies with greater control over reduced budgets.

The UK and Scottish governments also face distinctive problems and policymaking contexts. For example, the Scottish Government remains part of a UK process in which monetary and fiscal policies are determined largely by HM Treasury, with the Scottish Government's primary role to spend and invest. It could not address health and education inequalities by using redistributive taxation policies to address income inequalities, nor does it control its 'employability' agenda.

Comparative empirical analysis: 2. Case studies of prevention

In Chapters 7 to 10 we compare the UK and Scottish government experiences in four in-depth case studies of preventive policymaking: healthcare and public health; mental health and employability; social policies focusing on families; and criminal justice (in addition to broader discussions of early intervention in childhood in Chapters 5 and 6). The case studies demonstrate the large amount of cross-cutting issues that can be addressed under the term 'prevention', as well as the different ways in which government departments define and seek to solve problems. As such, *these chapters do not follow a uniform structure*. Rather, Chapters 7 and 8 focus more on the balancing act between preventive and reactive services, while Chapters 9 and 10 focus more on the social construction of target populations.

Chapter 7 describes health policy as the traditional home of preventive policies. Public health is at the heart of policies designed to improve population health, and potentially reduce health inequalities, through changes in behaviour at an early age. However, it also demonstrates the tensions between preventive and reactive policies, and the tendency for the latter to be higher on the agenda and receive more resources. In the post-war period, several successive governments have signalled the need for major public health reforms to reduce health inequalities, often in tandem with policies to address 'structural' or 'root' causes related to economic inequalities, but they still describe the need for prevention in relation to past policy failures.

Chapter 8 shows how these problems are exacerbated in distinctive ways in 'public mental health'. Mental health is an issue in which the idea of prevention or well-being is difficult to incorporate, since it contains populations with illnesses that are often managed rather than prevented. Therefore, prevention can refer to promoting well-being and preventing depression, and early intervention to reduce the impact of severe and enduring conditions, in the context of a push for 'parity' in mental and physical health services. We examine how each government seeks to balance prevention for large populations with the maintenance of acute services for groups with greater needs, and how wider policies such as parity translate into action.

We then highlight how reforms in other departments can undermine mental health and prevention policy. In particular, there are major tensions between mental health and social security policies in relation to employment, in which the UK government has reformed the rules on the relationship between disability and the ability to work. UK policy change is summed up by a famous move from doctors providing a 'written sick note' to an 'electronic fit note'. In this case, the language of prevention, to highlight the benefits of employment to mental and physical health, mixes with the broader rhetoric on welfare retrenchment, to produce a policy with the potential to contradict preventive policies in other departments.

Chapter 9 shows how UK and Scottish governments use the language of prevention and early intervention to identify the disproportionate societal impact of 'problem' or 'troubled' families. The UK fosters 'secondary' prevention, using proxies of risk to identify such families, focusing on indicators such as truancy, crime, and parental employment. The Scottish Government does not have a direct equivalent to the UK's 'troubled families' programme, but it faces the same need to strike a balance between universal prevention policies, which often benefit 'middle class' populations disproportionately, and targeted programmes with the dual potential to address greater need and stigmatize target populations. This case study shows the extent to which two governments, using similar ideas to intervene early in the lives of individuals and families, can produce (what appear to be) profoundly different policies.

Chapter 10 shows that the UK and Scottish government approaches to criminal justice often differ, in a context in which they both manage the same tensions between relatively *punitive and individual* versus *supportive and population-wide* measures to reduce crime as part of an overall cross-cutting focus on prevention and early intervention. The UK experience demonstrates a greater imbalance towards criminal over social justice, in which the salience of crime, and projection of 'toughness' by successive UK governments, may undermine more supportive measures in areas such as drugs policy and harm prevention. In contrast, the recent Scottish experience suggests that public health ideas play a greater role in the framing of drugs and serious violent crime prevention. However, both have a history in which they accentuate criminal justice, and deliver it in practice, while public health prevention remains a new idea not yet operationalized.

Overall, these more in-depth case studies help us identify the tensions that arise from policy ambiguity and policymaking complexity: policymakers struggle to define a distinctive prevention agenda, and they further undermine its meaning in practice by pursuing contradictory policies. Preventive and reactive services compete for resources. Policies to support mental health seem to be undermined by punitive policies on social security and employment. Families policies are supportive and punitive. Criminal justice overshadows social justice.

The Role of Normative Analysis: Explaining how Governments try to Redefine Policymaking, and Helping to Solve the Prevention Puzzle

This empirical analysis helps us to re-examine the idea of a 'window of opportunity' for major policy change. There may be a new opportunity to produce a broad change in policymaker commitment to a policy solution, but that choice may only represent the beginning of a long, drawn-out process of potential policy change. Describing prevention as a policy 'solution' is a rather misleading description of a vague agenda, in which everyone can agree on the aims but not the objectives. Advocates of prevention policy may be pushing at an open door, but the door opens to a maze of further possibilities.

We show that governments contribute to a major 'expectations gap' even if they are completely sincere in their aims when they pursue prevention policies. A key explanation is the dynamic of the political system in which they operate. Their major policy dilemma is that prevention does not compete well with policies for acute and reactive services: policymakers want to invest for the long term, but are rewarded for dealing effectively with short-term problems. Their policymaking dilemma is that their political aims appear to be contradictory: a focus on local devolution and community engagement contradicts their commitment to traditional forms of democratic accountability (further, elected local *authority* control

is not necessarily conducive to local *community*-led initiatives). Governments seek ways to share policymaking responsibility with delegated public bodies, elected local authorities, communities, and service users. However, they know that, particularly in Westminster systems, the dominant way of articulating policymaking authority and responsibility is via the accountability of ministers to the public via Parliament. To maintain this image requires governments to try to appear to be in control. Both UK and Scottish governments seek pragmatic responses to these dilemmas, by making changes to increase prevention budgets that are always vulnerable to reversals, and delegating responsibility while maintaining an image of control and governing competence.

Our aim in the concluding chapter is to help produce practical lessons for policymakers. We use a comparison between (a) a specific example of policy success in prevention (tobacco policy), and (b) the relative failure of a more general and ambiguous prevention agenda, to explain potential solutions to the prevention puzzle: reduce uncertainty by making policy more evidence informed *and* reduce ambiguity by defining prevention more clearly; create a policymaking environment more conducive to evidence-informed preventive solutions; and exploit *many windows of opportunity* to adopt many specific policy instruments rather than treating a 'decisive shift' to prevention as a one-off event.

11
Conclusion: Revisiting the Prevention Puzzle

Prevention is the ultimate example of a policy problem with an intuitively appealing, but ultimately elusive, solution. There is a profound gap between policymaker expectations and policy outcomes. Governments describe a high commitment to radical changes in prevention policy and preventive policymaking, but fail to deliver. We reject the idea that this puzzle can be explained primarily with reference to insincere politics or low political will. The danger with such conclusions is that they encourage a cycle of failure. Each new generation of policymakers will think that it will perform differently, and make a difference, simply because it exhibits high and sincere commitment. Or, each new generation of advocates will think that they just have to get the evidence, strategy, and language right, to inspire politicians to make the kinds of 'evidence-based' decisions whose value they take for granted. Advocates will struggle to understand their failure to close an 'evidence–policy gap', and policymakers will fall into the same basic trap which we describe in Chapter 1 and explore in this chapter. Instead, our explanation helps policymakers and practitioners solve the puzzle of prevention policy by facing up to its ever-present challenges.

This explanation begins with a broad overall narrative of prevention policy and preventive policymaking. Policymakers describe, in vague terms, something akin to a window of opportunity for prevention policy and preventive policymaking. However, they do not appreciate the scale of their task until they define prevention while producing strategies and detailed objectives. They encounter major trade-offs between long-term preventive aims and short-term objectives, such as to remain popular by demonstrating their competence to govern public services. They devote most resources to reactive services. When devoting their attention to prevention, they find the evidence base to be limited and no substitute for political choice. By making choices, they signal their intention to regulate individual, family, and social life and portray many populations negatively. Their choices are divisive, generating some dissent among both the public and the practitioners responsible for delivery. Policymakers begin to think of problems as too 'wicked' to solve. They use prevention as a quick fix, passing on responsibility *and* providing less funding to delivery bodies. Central governments are still held responsible for national policy outcomes, but they focus on telling a too-optimistic or self-serving story of their success rather than achieving it.

Why Isn't Government Policy More Preventive? Paul Cairney and Emily St Denny, Oxford University Press (2020).

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This narrative suggests that initial sincere commitment is only one piece of the puzzle. Therefore, to decry a lack of political commitment does not help explain the lack of progress on prevention or solve the problem well. We argue that a more useful approach is to draw on *policy theory*, to better explain the environmental or systemic obstacles to policymaking, and *case studies*, to identify and compare major gaps in expectations and outcomes. Only then can we base recommendations on real world policymaking rather than wishful thinking.

We do so with caution, while exhibiting necessary modesty. If our concluding chapter claimed that we could solve a policymaking puzzle that has stumped all UK and Scottish governments, you would think that we were selling a throwaway airport book on business management rather than a theory-driven research monograph. The latter requires us to explain why prevention policy has remained such a puzzle, and what happens when governments try to solve it, to help situate possible solutions in a more realistic context. Making policy more preventive sounds appealing largely because the aim is ambiguous. Policy and policymaking could become more preventive, but prevention is never a magic bullet to solve major socio-economic or budgetary problems. Rather, 'prevention policy' is shorthand for a large number of often-disparate choices whose benefits and costs are necessarily distributed unequally across the population.

Our more modest claim is that we can identify profoundly important links between theory, empirical study, normative debates, and practical next steps. To that end, first, we summarize the contribution of policy theory to the study of prevention policy and policymaking. Second, we show how empirical case studies add depth to theory-driven research. Our comparison of the UK and Scottish governments helps identify the extent to which different policymakers, at different scales and with different styles, face and address the same policy problems. Our comparison across policy areas—health, mental health and employability, families, and justice—helps identify the extent to which substantively different issues present new obstacles or opportunities to prevention but produce the same sense that governments are pursuing contradictory policies simultaneously. Third, we identify the normative issues that have arisen regarding the governance of prevention in a *complex* or *multi-centric* policymaking system, when central governments identify their pursuit of specific policy aims but also delegate responsibility for delivery and outcomes. In such circumstances, should we hold central government policymakers responsible for any large gaps between their expectations and actual policy outcomes?

Fourth, we use the tobacco policy experience as a way to organize the analysis of three potential solutions:

1. Reduce uncertainty by making policy more 'evidence based', and reduce ambiguity by defining prevention more clearly.
2. Create a policymaking environment more conducive to evidence-informed preventive solutions.
3. Exploit many windows of opportunity to adopt many new policy instruments.

However, we strike a note of caution about each solution. We have identified many episodic experiences of government optimism and despair, which suggests that the problem is systemic. A collection of 'wicked' problems will not be solved simply by renewed commitment around a better-defined model of prevention. Instead, prevention could continue to represent an attractive aim that remains largely unfulfilled, before it is rebooted or rebranded and the cycle of enthusiasm and despair begins again. This experience provides a cautionary tale for policy scholars and practitioners: focus on the need to make choices, and gauge their unequal effect on target populations, rather than describing mythical solutions that will somehow benefit all populations. We may not be able to hold elected policymakers to account for the outcomes beyond their control. However, we can, at the very least, call out their claims to be in control and to have found a magic bullet solution to all of our problems.

Continuous Obstacles to Prevention: Policy Ambiguity and Multi-centric Policymaking

It is possible for words such as 'prevention' to mean almost everything and therefore almost nothing (Wildavsky, 1979; Hogwood, 1986). Its ambiguity allows it to generate widespread and superficial support and, in the process, undermine critical scrutiny of political choice. For potential left-wing supporters, it can form part of a misleading story of reducing socio-economic inequalities simply by intervening early in people's lives. For potential right-wing supporters, it can be oversold as a way to reduce the costs of providing expensive public services to target populations whose behaviour could allegedly be anticipated and influenced in advance. Therefore, for actors operating in the centre ground, it can seem like a tempting way to generate cross-party support for policies containing the promise of widespread benefits without major political costs. Prevention may be sold misleadingly as a way to make sure that everyone benefits or that no one benefits at someone else's expense.

Similarly, a focus on preventive policymaking can appear to satisfy multiple audiences. For central governments, it offers a way to 'join up' policymaking; pursue EBPM; delegate responsibility to local public bodies *and* maintain central control; generate 'ownership' via consultation and the co-production of policy with stakeholders and service users; and present a narrative to the public of creating policy *with you* rather than doing it *to you*.

Yet, any universal consensus must evaporate when policymakers have to make sense of prevention and make choices with unequal effects across populations. Resolving ambiguity is not the same as resolving uncertainty. Actors process more information to reduce uncertainty, and this activity can often seem relatively technical. In contrast, they deal with ambiguity by exercising power to frame issues, to influence or make choices which benefit some at the expense of

others. Key choices relate to the behaviours or outcomes to be prevented, the target populations to receive government benefits or burdens, and the line between state, market, family life, and individual choice. They also include debates on who should pay for policy change, including which taxpayers should face higher or lower contributions and which public services should face expansion or closure.

In that context, any description of universally supported prevention is itself a political statement or strategy: its vague rhetoric masks the unequal benefits and burdens of specific choices. Further, we draw on the 'social construction and policy design' literature (Chapter 2) to explain how policymakers turn vague and well-supported aims into specific and more controversial actions:

- Policymakers react emotionally to policy problems, or exploit social stereotypes of target populations strategically, to determine who should gain or lose from public policy.
- Their choices often have a long-term effect on policy design, from statements of policy intent to the rules governing policy delivery and user participation.
- Policy design influences public participation by signalling to some populations that they are valued and that their engagement can influence future policy design, but to others that they are subject to sanctions, excluded from benefits, and unlikely to influence policymaker choice.

In other words, specific choices shift the image of prevention dramatically, from a vague policy with universal benefits, to a collection of policy instruments with targeted benefits and exclusions. Such exclusion is most visible when policymakers engage with salient issues and make public pronouncements about target populations such as 'troubled families' (Chapter 9). However, it is also important during less visible processes, such as when service users are—to all intents and purposes—excluded from debates when evidence and expertise wins the day or helps minimize debate on social values (Schneider and Ingram, 1997: 153, 167).

Such choices take place in multi-centric policymaking systems over which individual policymakers have limited control (Cairney et al., 2019). UK central governments share power *vertically*, with supranational, devolved, and local governments, and *horizontally*, with the public, private, and third sector bodies influencing and delivering policy. Power diffusion is partly the result of *choice* to share responsibilities formally with governments. However, it is largely borne of *necessity*: they must deal with their cognitive and organizational limits by delegating most policy attention and decisions across government departments and the wider public sector. Subsequently, many policymaking 'centres' have influence over policy. Each centre has its own rules and norms which shape the framing and delivery of prevention policies, either through a web of policy networks in which

some ideas or ways of thinking dominate discussion, or relatively independently during local policy delivery. Socio-economic conditions and events influence such action continuously; they help determine the nature and immediacy of problems and the likelihood that solutions will be effective.

These factors all contribute to an unpredictable environment for preventive policymaking. Ambiguity rises exponentially when policymaking moves from a single central government producing a single strategy document, to the involvement of many government departments, local authorities, public bodies, stakeholders, and service users. All have their own interpretations of preventable policy problems and the value of each solution, and their own norms and standard operating procedures, networks, and fundamental ways of seeing the world and responding to crises. Many parts of the policymaking environment have their own rules and 'currency' of policy debate.

In that context, policy theories generally question the extent to which a central government can control policymaking environments and policy outcomes (Cairney et al., 2019). Indeed, Chapter 3 identifies a tendency of complexity theorists to suggest that elected policymakers should replace their pursuit of control with pragmatism and delegation, to give local actors the flexibility to respond to an ever-changing context. In some cases, central governments appear to build such pragmatism into policy design, and foster new forms of accountability, from a focus on chief executives of agencies or delivery bodies to localism and co-production with service users. However, they also respond to party competition, and traditional modes of democratic accountability within Westminster systems, by presenting an image of governing competence built on the central control of public services and policy outcomes. Central governments entertain potentially contradictory approaches by mixing different performance management systems and forms of accountability.

The overall result is a frequently unpredictable process in which policymakers have to prioritize a small number of issues, ignore almost all of their responsibilities, and rely on a large number of actors to make and deliver policy. They draw on informational shortcuts to make sense of prevention, set the agenda, and make quick decisions about key target populations. Their initial choices have a profound effect on prevention policy, but they represent one of many causes of policy outcomes in a complex system. To understand those outcomes in more depth, we need more empirical case studies spread across multiple political systems and policy areas.

Preventive Policy Styles in the UK and Scottish Governments

An abstract discussion of ambiguity and complexity suggests that many policy dynamics are universal rather than specific to political systems. However, a

detailed and comparative focus helps identify important variations in policy processes. For example, all governments face the need to make choices to reduce ambiguity, and therefore the need to benefit some populations and not others, but what story of target populations do specific policymakers pursue? Many organizations have their own informal rules, but what are the specific rules in the organizations we study? Governments face the need to project control and accept their limitations, but how do different governments balance such contradictory pressures? To answer these questions, we focus on the prevention policies and preventive policy styles of the UK and Scottish governments. We explore the extent to which the scale of government presents different constraints or opportunities, and if their respective policy styles help solve or exacerbate the prevention puzzle (Chapter 4).

If we focus only on face-value policymaking reputations, based on formal institutions, we might expect to find a major difference between majoritarian UK and consensus Scottish democracies. The UK's style of Westminster electoral politics seems more likely to exacerbate a short-term partisan culture in which governments seek quick fixes and centralize power to present an image of governing competence. If so, Westminster-style democratic accountability may undermine preventive policymaking. Scotland's more proportional electoral system and alleged culture of consensus-seeking, combined with its smaller scale, and narrower set of responsibilities, could make it more suited to preventive policymaking. Their respective levels of stakeholder engagement could matter, because consultation aimed at consensus-seeking can influence levels of policy 'ownership' across populations. Their governance styles could matter, since the 'Scottish approach' seems more conducive to the relatively bottom-up, localist, or stakeholder-led policymaking we often associate with prevention. However, many commentators *assert* rather than *demonstrate* such differences, while empirical studies reveal a more mixed picture (Chapter 4).

In practice, the UK and Scottish government differences are often subtle rather than dichotomous. Or, it is difficult to connect a general willingness to consult widely, and form partnerships with other public sector bodies, with the sense that prevention policy is more advanced or coherent in Scotland. Rather, both governments juggle the need to centralize to demonstrate governing competence, *and* delegate to deal pragmatically with the limits of their control.

UK and Scottish Government Approaches to 'Evidence-based' Prevention Policy

A key way to understand this dilemma, about how to centralize *and* accept decentred policymaking, is to see it through the lens of the vague pursuit of 'evidence-based policymaking' (EBPM). Governments make their governance

choice, to centralize or localize policy delivery, at the same time as they make choices on what evidence counts. For example, some actors advocate a hierarchy of evidence based on the specific value of experimental methods (such as randomized control trials) and their systematic review. Others flip that hierarchy to favour practitioner experience and user feedback, on the assumption that every interaction with a service user is complex and distinctive rather than uniform. Or, policymakers often adopt a more pragmatic and eclectic use of evidence from many sources. These choices have a major impact on the ways in which policymakers pursue preventive EBPM, with Table 4.1 highlighting three internally consistent but competing approaches, including the use of RCTs to roll out uniform interventions, storytelling approaches which prioritize respect for localism and service users, and improvement methods built on some supportive knowledge followed by local practitioner experimentation.

One might assume, from the UK government's majoritarian reputation that it would seem to drive policies from the top down. Further, its approach seems most consistent with the use of RCT evidence to produce a uniform policy intervention pushed from the centre. Certainly, New Labour seemed to push this approach by using the phrase 'what matters is what works' and looking to RCT evidence from the US to justify policies such as *Sure Start*. Similarly, given the Scottish Government's reputation for more bottom-up styles of governance, and explicit support for the improvement method—such as when developing the Early Years Collaborative—one might expect to find a very different approach to EBPM.

Instead, both governments juggle three—more or less centralist, and more or less committed to a hierarchy of evidence—models of EBPM according to factors including their framing of the policy problem (such as primarily a health or healthcare intervention) and the profession or academic discipline most involved. In some cases, they roll out uniform models with an international reputation built on RCT evidence of success, such as the *Family Nurse Partnership*. In others, they encourage practitioner discretion to share stories of local success, and produce locally tailored policies built on governance rather than narrow evidential principles, such as in *My Home Life*. Or, they combine rather contradictory ideas, such as when the UK government built *Sure Start* on RCT evidence but then fostered the kinds of local discretion and experimentation that we associate with very different approaches.

Variations *within* the UK and Scotland

Indeed, Chapters 5 and 6 suggest that a more striking aspect of UK and Scottish prevention policy is change over time, and variations from issue to issue, *within each system*. In the UK, there appeared to be relatively low activity until 1997. New

Labour made a marked commitment to prevention and linked it strongly to socio-economic determinants of inequalities in areas such as health and education. Its introduction of the *Sure Start* programme exemplified this period, in which it criticized previous governments for inactivity while announcing an ambitious new programme, and linked policy change to policymaking initiatives such as joined-up government, localism, participatory governance, and EBPM. Yet, its level of new financial commitment—a key measure of the size of a shift from reactive to preventive services—became difficult to measure. It became frustrated with limited success in joining-up government. Local participation quickly reverted to consultation. It used evidence primarily to present the rationale for new initiatives rather than introducing systematic ways to monitor and evaluate progress. It eventually changed its approach to policy design, focusing more on *Sure Start*'s effect on the party's popularity, and shifting its focus to childcare, employability, and reactive public services.

The Conservative-led coalition government (from 2010) expressed a similar amount of sincere commitment to prevention and early intervention, EBPM, joined-up working, and to delegate policymaking responsibilities to local authorities and public bodies, in partnership with third sector and other non-governmental actors. Indeed, it began by performing the classic preventive policymaking act: commissioning work that criticized a lack of progress under its predecessor. Its language to describe prevention and early intervention often has a harder edge, replacing New Labour's early focus on structural or socio-economic determinants of inequalities towards a focus on austerity and the economic cost of late intervention. It also accelerated Labour's increased willingness, around the mid-2000s, to judge negatively the target populations most subject to early intervention (for example, by accentuating the 'problem families' rhetoric to announce the *Troubled Families* programme).

In Chapter 6, we describe a similar break from the past in Scotland in *2011*, almost 12 years after devolution and 14 years after a similar period of enthusiasm in the UK. We can link *some* of this delay to the fact that the UK government retained control of key policy areas, such as the ability to redistribute via taxation and spending, and the *Sure Start* programme which it initiated on behalf of the UK and devolved governments. Further, from 1999 the Scottish Government developed the kinds of policy*making* that we associate with prevention (Chapter 1), as well as initiatives to address issues such as social inclusion. Nevertheless, the first twelve years of devolution involved a general focus on reactive public services and the numbers and wages of public services staff, which exacerbated or had no clear focus on socio-economic inequalities. The greatest rises in expenditure were devoted to public service inputs and short-term metrics, such as major investments in healthcare to address waiting times; teachers' pay and numbers; police officer numbers; and to reduce, then abolish, University tuition fees.

In that context, the report of the Christie commission in 2011 described a wake-up call to prioritize prevention policy and preventive policymaking. In its response, the Scottish Government (2011a) announced a 'decisive shift towards prevention'. However, it did so by branding a large number of its existing activities as preventive, and often emulating New Labour's approach. It delegated policy-making responsibility locally with little prospect of monitoring or evaluating policy change (such as in its flagship *Early Years Collaborative*). It encouraged the same collection of interventions whose value relates to RCTs. It also used the same phrase 'progressive universalism' to describe the use of universal services to identify target populations requiring more intervention.

A Profound Divergence in Policy Rhetoric

The main—and often profound—difference in UK and Scottish government policymaking relates to the ways in which they describe target populations. UK ministers seem more likely to use negative social stereotypes and the language of muscular government to justify punitive policies. This language varies markedly over time, by issue, and according to the party of government. Indeed, the UK government's description of target populations is often contradictory during the same time period, raising the possibility that its stigmatizing language contrasts with the approach of the Scottish Government *and itself*. Its focus on prevention can involve positive frames, relating to new measures of well-being to compete with GDP as a measure of a country's progress (Bache and Reardon, 2013), or negative frames about the anti-social behaviour of 'troubled families'. In some cases, it combines both, either as a strategy or an unintended consequence. There is some sense of strategy in its use of punitive language to justify major funding for families that tend to receive minimal public sympathy (Chapter 9). There is a greater sense of muddled thinking when it uses public mental health to encourage recovery or reduce stigma, but also criticizes excessive welfare dependence to justify major reforms in the way that people using mental health services receive (or do not receive) unemployment-related benefits (Chapter 8).

Case Studies: Public and Mental Health, Employability, Families, and Justice

We focus on case studies of prevention policies, partly to explore the extent to which the purported nature of a policy problem influences the nature of policymaking. An abstract discussion of ambiguity and complexity suggests that prevention puzzles exist across government, but a multiple case study approach helps identify important variations. In each case, the meaning of prevention becomes clearer when we piece

together the policy instruments that governments use to make more specific sense of their broad commitments. In particular, clear tensions arise when policymakers try to resolve policy ambiguity and relate new policies to existing commitments, or combine multiple commitments in rather inconsistent ways.

Chapter 7 shows how preventive and reactive services compete for resources, with public health generally secondary to healthcare in UK and Scottish government policy. The UK government still uses the phrase 'prevention is better than cure' to make a *rhetorical* commitment to a shift in resources, but each NHS strategy has combined (a) exhortation to change with (b) an admission of minimal change. Indeed, health provides the classic case of high but unfulfilled commitment based on:

- vague ambitions
- uncertainty about how to describe and address the determinants of health inequalities
- the dispiriting appearance of overwhelming policy problems that seem impossible to solve simply by reconfiguring health and related services
- the lack of technically or politically feasible solutions
- the tendency for acute services to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence.

Chapter 8 shows that mental health accentuates these limitations in relation to health and prevention. The idea of public mental health seems relatively vague, and preventive measures can range from promoting well-being and preventing low mood, to early intervention to reduce the impact of severe and enduring conditions, and even preventive detention to avert serious violent crime. There is a push by the UK and Scottish governments for a major change towards 'parity' between mental and physical health, but it often serves to remind us of existing problems: public health already struggles to compete with healthcare, and mental health services are not as well-resourced as their physical health counterparts. Indeed, the UK experience suggests that health ministers criticize this discrepancy in public, but accept it in practice (by delegating such decisions to public bodies).

Chapter 8 also demonstrates a tendency for multiple policymaking departments to undermine each other's agendas. The classic example under New Labour was the highly punitive criminal justice agenda that produced a ten-year standoff with almost every relevant mental health organization in England regarding mental health law reform (compared to a much quicker and more consensual process in Scotland). More recently, these tensions have resulted from the increasingly punitive policies to meet highly salient and short-term social security and employment objectives at the expense of long-term mental health recovery

strategies (across the UK). One notionally preventive measure—to improve mental health with employment—designed and managed within one department (Work and Pensions), undermines a much wider strategy produced by another department (Health) and agreed with most mental health organizations.

Chapter 9 tells a similar story about the internal contradictions caused by tensions between competing—supportive versus punitive—tools to support policies for families. Both governments face the same need to strike a balance between universal prevention policies, which often contribute to inequalities, and targeted programmes with the potential to address greater need *and* stigmatize target populations deemed to be at greater risk of dysfunction. At first, both governments appeared to produce similar 'waves' of policy, emphasizing:

1. the need to promote social inclusion, then shifting their focus to
2. anti-social behaviour and respect, before converging on
3. 'whole family' approaches based on domestic evidence on family intervention projects and international evidence on parenting programmes.

This shared background provides key context in which to understand recent major divergence in policy choices, in which the Scottish Government did not follow the UK's decision to identify and try to 'turn around' the lives of a large number of 'troubled families'. Instead, it emphasized a more universalist approach based on its 'early years collaborative' and a (much delayed) 'named person' for every family. The UK's relatively muscular approach, and cynical way to declare successful progress, partly acts as cover for the funding of less punitive local practices, but not to the extent that professional practices are equally supportive across England and Scotland.

Chapter 10 reinforces this sense that the balance between punitive and supportive measures is different across the two governments. In the UK, criminal justice generally overshadows social justice. The wider context is the UK government's grand narrative on target populations who, according to ministers, do not contribute their fair share to society and should not rely so much on the state. Or, the state role should be to regulate their behaviour, by punishment if necessary. Further, long-term trends towards the salience of crime, and a tendency of parties to compete on 'toughness' on crime, have contributed to a relatively punitive approach. This rhetoric matters. In fields such as drugs policy, governments could otherwise frame their approach in terms of harm reduction or prevention, in which facilities for safe drug use could provide a connection to longer-term counselling (and measures coordinated as part of a mental health and addiction strategy). In comparison, recent Scottish Government practices highlight the potential for more public health-oriented approaches to drug prevention (involving some redirection of resources from prisons) as well as issues such as serious violent crime.

However, Chapter 10 also exemplifies the need to be cautious in any assessment of preventive policymaking expressed largely as a strategic aim. Overall, Scottish policy shares a history with the UK, in which preventive measures are part of a twin-track approach to support *and* punishment. Further, the story so far is of a promising language combined with pilots to encourage actors—across the criminal justice, social justice, and health sectors—to use public health tools and methods. As with prevention in general, there is often a window of opportunity for the adoption of a *progressive rhetoric* on policy change, combined with the *intention* to encourage policymaking practices conducive to cross-sectoral and preventive initiatives. In general, actual preventive practices and outcomes remain elusive, or overshadowed by the more reactive nature of business-as-usual public services.

What should be the Role of Central Government in Preventive Policymaking?

Prevention policy aims are so broad that we may not know how they contribute to policy outcomes. Policymaking is too complex to predict or fully understand. Both problems expose slogans such as 'joined-up' government as attempts to *give the appearance of order* to policymaking when we know that:

- policymakers can only pay attention to a small portion of the issues for which they are responsible
- they delegate or devolve most decisions
- different understandings of policy problems, and the rules used to solve them, develop across government
- policy outcomes 'emerge' at local levels.

Power is not concentrated solely in the hands of a small number of people in central government (Cairney et al., 2019). Policymakers identify target populations and different ways to support or punish them, with major implications for the projection of policy and some aspects of policy design, but not to the extent that we can trace a clear line from a coherent policy agenda to outcomes.

In that context, there is a profoundly important tension between the reality of multi-centric policymaking and the assertion of central government accountability, particularly in Westminster systems in which the notion of central control is such a central part of the story:

- Governments develop strategies to deal with the fact that—at key moments—a small number of people in government will be held to account for their actions, via parliamentary scrutiny and regular elections, despite

their powers being limited in practice. People expect ministers to deliver on their promises, and few are brave enough to admit their limitations.

- The reality of government is that they cannot take meaningful responsibility for decisions and outcomes that appear to be out of their control. Instead, they look for new ways to share responsibility with other actors. Such action has a reinforcing effect on the difficulties of understanding the system. Localism agendas produce a large number of 'centres' and a wide range of 'policymakers' using their own cognitive shortcuts to make decisions, developing their own institutions, networks, and ways of thinking, and reacting to policy conditions that vary markedly across the UK.
- The specific field of prevention accentuates this general dynamic. To all intents and purposes, central government policymakers seek to take the credit, or share accountability with many actors, for an agenda that they struggle to describe and operationalize.

The result is a strange mix of two different ways to make policy. Central governments set strategic objectives but share responsibility for outcomes with a large number of bodies in and out of government. The Westminster model's hierarchical and clear lines of democratic accountability operate alongside new forms of institutional, delegated, community, and service-user forms of accountability, for outcomes that often occur after one party has left office. An image of governing competence, so crucial to the story of managing reactive public services to ensure short-term success, is less useful to the long-term outcomes undermined by a short-term focus.

Consequently, the unresolved issues of accountability in complex policymaking systems are particularly problematic for prevention: if there is a large gap between the stated aims of central government policymakers and actual outcomes, how can we hold policymakers to account—in a meaningful way—for their choices? Indeed, does it make sense to identify the extent to which policy is 'coherent' if the aims of central governments are necessarily as contradictory as we suggest, partly because there exist so many actors with the discretion to go their own way? In each case, policymaking complexity undermines the extent to which we can hold policymakers to account for outcomes that seem to 'emerge' from complex systems rather than result directly from ministerial decisions.

In that context, to generate a sense of democratic accountability of ministers to the public, via elections, we may do better to focus on their values and therefore the ways in which they socially construct target populations. We may not be able to provide a precise sense of their governing competence in prevention, but we can at least measure the differences (between parties) in their beliefs about how we should treat individuals and social groups. Even then, the implementation of their aims based on these values is not straightforward, particularly since the UK and Scottish governments have chosen to spread responsibility for delivery so widely

and accept the fact that policy changes during delivery. Consequently, it is important to identify the methods, 'tools', or policy instruments that policymakers use to turn their values into aims, and aims into outcomes. In the case of prevention, we can examine the extent to which policy remains a broad statement of intent with symbolic implications but no immediate practical meaning, or if policymakers pursue a sincere and energetic commitment to policy change.

How to make Government Policy more Preventive: Lessons from Tobacco

Tobacco policy sums up the potential for a substantive long-term agenda with measurable effects. It has become a model for many other public health and preventive-focused policies (Chapter 7). Its appeal, as a source of policy learning for advocates of public health, relates primarily to its perceived success in relation to almost all other comparable initiatives (Cairney, 2019e). Tobacco policy has shifted profoundly in the last three decades, from relatively low towards unusually high control (in relation to the past and to other countries). The UK as a whole now has one of the most comprehensive tobacco control policies in the world, and it has produced a major impact on smoking (although the distribution of smoking prevalence suggests that major health inequalities remain). Indeed, the comparison between tobacco as a specific policy agenda, and prevention as a much vaguer agenda, is instructive to show why the more general and ambiguous form of prevention policy exhibits far less evidence of comparable change and impact. The three main differences between these cases help us identify the ways in which government policy could generally become more preventive.

Step 1. Use evidence to reduce uncertainty and power to reduce ambiguity

There is a far clearer framing of tobacco as a policy problem: smoking is a major contributor to preventable death and a preventable non-communicable disease pandemic. There is often a clear story about the cause of the policy problem and obstacles to solutions—in relation to vested interests like Big Tobacco—that provide a rallying cry for policymakers and practitioners. Further, there is a large list of policy solutions whose effectiveness is well established, and the adoption of each instrument adds to the sense of an increasingly coherent and comprehensive strategy. In contrast, 'prevention' remains ambiguous, the nature or cause of the problem is unclear, and there is insufficient agreement on the most technically and politically feasible solutions.

A common narrative in public health studies is that the growing availability and weight of scientific evidence has helped tobacco reach this stage of policy development (see Cairney and Yamazaki, 2018). Put simply, evidence helps policymakers reduce *uncertainty* by identifying the size of the policy problem and the effectiveness of technically feasible solutions. Yet, we know from policy theory-informed EBPM studies that evidence does not speak for itself or settle the matter (Cairney, 2016a: 67–8). Rather, 'the evidence' takes many forms and policymakers will take and use many different evidential sources to come to an overall judgement on policy problems and solutions.

Further, tobacco policy solutions tend to have a national scope and uniform nature, in which (for example) central governments tax products to raise prices, legislate to ban smoking in all public places, and regulate the balance between branding and health information on products. In prevention more generally, there is a more frequent role for local and multi-agency policy delivery, which presents additional problems in turning evidence into practice. Chapter 4 shows that preventive EBPM involves 'scaling-up' projects that represent 'best practice' in very different ways (Table 4.1). These disagreements play out at the same time: epistemological and methodological disagreements on the nature of good evidence; and practical disagreements regarding the best way to translate evidence into policy and practice. Debates may focus on the best way to implement policy when policymakers face the need to adapt it to local circumstances and address the so-called 'not invented here' problem, in which local policymakers are sceptical about importing innovations from elsewhere. Or, they focus on more general normative discussions of centralization versus localism, and the extent to which we should value policy flexibility and local differences as much as policy effectiveness.

A more common narrative in political science is that a major shift in *framing* helped tobacco reach this stage of policy development. Put simply, actors exercise power to reduce *ambiguity*. They use persuasion to establish the primary way in which policymakers should understand the policy problem and interpret its nature—as an urgent and major public health problem, not a matter of economic benefit or civil liberties—and therefore demand evidence to establish its size, and establish the range of politically feasible solutions (Cairney, 2019b).

The prevention agenda requires a comparable sense of purpose. However, there has yet to be an equivalent shift in the way that policymakers describe idioms such as 'prevention is better than cure'. Prevention relates to an ambiguous policy problem. There have been some attempts to reduce ambiguity with reference to one aim (such as to reduce public services costs) rather than another (to reduce health and other inequalities caused by socio-economic inequalities). However, there remains high uncertainty about the urgency that governments attach to prevention as a broad aim, the lengths to which they will go to redraw the balance between reactive and preventive services, or the extent to which they are willing to

intervene early in people's lives. In that context, there is no clear sense of the types of evidence that governments will demand, or the range of evidence-informed solutions that they see as politically feasible. There is no equivalent sense of a grand narrative to show (a) that the evidence and cause of harm is unequivocal, and (b) how each individual policy instrument contributes to a coherent strategy.

Step 2. Create a policymaking environment conducive to prevention policy

Second, the tobacco policymaking environment is conducive to major policy change: health policymakers take the lead, limit their information searches and consultation to health and public health actors, and respond to socio-economic trends that are increasingly supportive of policy change. Prevention's vague framing undermines a sense of ownership within government. Policy could be the responsibility of many government departments, agencies, and local public bodies. If so, many different policymaking centres develop their own ways of doing things, often without reference to each other's activities. Policy networks span many departments, with some groups experiencing privileged access in some and exclusion from others. Many different understandings of policy problems dominate many different networks. The socio-economic context matters, but it is unclear how each centre will interpret its impact and implications for policy. Perhaps most importantly, compared to tobacco, prevention policy seems relatively immune from direction by a single central government.

The prevention agenda requires a relatively well-coordinated sense of overall purpose to which all relevant actors can refer. If so, there are two relevant solutions. The first is to establish a dedicated unit to symbolize a singular approach to a policy problem and coordinate policymaking responses. However, relevant experiences suggest that the impact of this solution will be limited. For example, the Social Exclusion Unit (Chapter 5) did not have the authority or resources to coordinate a programme of its scale, while Public Health England has become a body adept at influencing policy out of the public spotlight rather than setting a clear national agenda (Boswell et al., 2019).

The second is for central governments to accept the necessity of multi-centric policymaking, stop trying to centralize policymaking in an ad hoc way to project a misleading sense of governing competence, and take seriously insights from studies of collaborative governance (Cairney et al., 2019). Such studies outline the conditions under which many policymaking centres will identify, and act on, the sense that their individual and collective aims are best served through inter-organizational cooperation. For example, policy designs that result from a shared set of laws created by multiple centres (not rolled out from a single centre) may help generate a sense of ownership. Quick wins provide positive feedback.

Frequent face-to-face contact, and a reputation for reliability, helps build trust. High levels of trust between organizations and professions help reduce the 'transactions costs' of working together, and the spillovers associated with one organization's policies undermining another's (Swann and Kim, 2018). While no advocate of this type of approach describes it as a panacea (Heikkila and Andersson, 2018), it seems preferable to the unpredictable and damaging mix of ad hoc centralization and delegation that characterizes prevention in the UK.

Step 3. Exploit *many* windows of opportunity for specific policy instruments

In tobacco, a supportive policy frame and policymaking environment ensures relatively high motive and *frequent* opportunity for policymakers to select increasingly restrictive tobacco policy instruments. In prevention, governments often portray the sense that there is a *singular* window of opportunity for a solution to multiple problems. In reality, a window opened for a vague policy solution with minimal policy direction. The next step is to clarify the meaning of prevention in different contexts, help create an environment conducive to further long-term policy development, and exploit multiple windows of opportunity to adopt relatively specific policy instruments. The story of tobacco control shows that individual instruments may be relatively ineffective, but their combination—over several decades—can be transformative. As Chapters 7 to 10 suggest, governments have used many policy tools and instruments in the name of prevention, but have yet to generate the same sense that many actions add up to a coherent whole.

Conclusion

It is tempting to describe prevention as a long-term agenda, based on support for individual service users and local communities, in which it takes years, if not decades, to see a clear relationship between cause and effect. However, we have shown that prevention policies are often vague and symbolic, or described insufficiently in relation to the more reactive services or punitive policies with which they compete. Therefore, the decision to wait for evidence of policy change could result in a range of outcomes, from a zero (or even negative) change to a major change. To simply declare the need for more time is risky or misleading. Unlike tobacco, in which many instruments combined over many years to produce an incremental change with transformative results, the general prevention agenda does not provide such a specific way to identify relevant policy instruments and measure change.

Indeed, the tobacco experience provides a way of thinking about the types of indicators we would need to observe to feel more confident about meaningful changes to prevention policy and preventive policymaking. However, we also suggest that each solution is problematic to some degree:

- Step 1: We recommend the greater use of evidence to improve policy, but phrases such as 'evidence-based policymaking' are unrealistic and often obscure necessary political choices.
    - We recommend the greater clarity on the meaning of prevention, but problem definition produces winners and losers among target populations.
- Step 2: We identify the value of reducing the expectations gaps caused by central governments making grand but vague promises then delegating the responsibility, to make sense of prevention, to other public bodies. However, any attempt to centralize to close the gap will have unintended consequences on local flexibility and alternative forms of democracy and accountability.
    - The alternative is to learn from studies of collaborative governance, but—as with prevention itself—it requires a major investment with no guarantee of a specific payoff.
- Step 3: We identify the need for greater policy coherence during the shift from a vague strategy to specific actions, during many windows of opportunity. However, it is possible that ad hoc adoption of specific policy instruments makes sense to policymakers according to the context in which they make specific choices.
    - The idea of a grand narrative producing a grand coherent plan with a direct impact on policy outcomes may seem rather fanciful. In that sense, tobacco policy may often provide an unhelpful and unrealistic model from which to learn.

Therefore, unless we express such caution, our general solutions to the prevention puzzle may seem as unrealistic as the prevention policy agenda we described with such trepidation in Chapter 1. Instead, each solution is akin to a political choice in which actors compete to determine the nature of the problem and evaluate the consequences of choice.

The idiom 'prevention is better than cure' sounds like a common-sense way to solve a country's most pressing problems, but it has always been intentionally or unintentionally misleading (Cairney and St Denny, 2015). It obscures rather than solves conflict. It contributes to the idea that we can simply depoliticize issues, to deal with political, economic and public service crises in a non-partisan way. Its slow progress only seems surprising if we rely on this misleadingly harmonious idiom rather than a necessary debate on how we should redistribute resources, who should benefit, how much short-term pain we are willing to endure for

uncertain long-term gain, and which kind of governance model we should use to pursue fundamental reforms. It would be wrong to suggest that any action, such as to express platitudes about policy problems or encourage 'evidence-based' solutions, removes the need to make political choices. In democratic political systems, we 'solve' policy problems by electing policymakers to make difficult choices that inevitably benefit some people at the expense of others.