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Why Isn't Government Policy More Preventive?

Chapter 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 as follows. 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 the public and 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* less funding to delivery bodies. Central governments are still held responsible for national policy outcomes, but they focus on telling a story of their success rather than achieving it.

This narrative suggests that initially 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 socioeconomic or budgetary problems. Rather, 'prevention policy' is a shorthand to describe 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 summarise 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 organise the analysis of potential solutions to the prevention puzzle:

1. Reduce uncertainty by making policy more 'evidence based', and reduce ambiguity define 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 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. Therefore, 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 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 minimise 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 organisational 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. Socioeconomic 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 with their own interpretations of preventable policy problems and the value of each solution, 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 prioritise 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 organisations have their own informal rules, but what are the specific rules in the organisations 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 centralise 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 centralise 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 centralise *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 centralise or localise 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 randomised 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 prioritise 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 matter 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 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 such as 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 suggests 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 socioeconomic determinants of inequalities in areas such as health and education. Its introduction of the *Sure Start* programme exemplified

this period, in which it criticised 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 criticised 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 socioeconomic 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 15 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 socioeconomic 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 prioritise 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 policymaking 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 stigmatising language contrasts with the approach of the Scottish Government *and itself*. Its focus on prevention can involve positive frames, relating to new measures of wellbeing 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 unintended consequence. There is some sense of strategy in its use of punitive language to justify major funding on 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 criticises 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 suggest 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 concrete evidence on 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 wellbeing 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 minsters criticise 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 10-year standoff with almost every relevant mental health organisation in England regarding mental health law reform (compared to a much quicker and more consensual process in Scotland). More recently, these tensions result 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 (Health) and agreed among most mental health organisations.

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* stigmatise target populations deemed to be at greater risk of dysfunction. At first, both governments appeared to produce similar ‘waves’ of policy, emphasising:

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 emphasised 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, has 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 need to espouse 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 agendas 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 wide range of 'policymakers' using their own cognitive short-cuts 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 operationalise.

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 be 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 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 helps 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 the prevention of a 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 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 centralisation 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 socioeconomic 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 in which the evidence and cause of harm seems unequivocal and we know how individual policy instruments contribute 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 socioeconomic 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 socioeconomic 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 symbolise 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 centralise 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 identify 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-organisational 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 organisations and professions help reduce the 'transactions costs' of working together, and the spillovers associated with one organisations' policies undermining another's (Swann and Kim, 2019). While no advocate of this type of approach describe it as a panacea (Heikkila and Andersson, 2018), it seems preferable to the unpredictable and damaging mix of ad hoc centralisation and delegation that characterises 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 7-10 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

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:

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.
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 centralise 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.
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 depoliticise 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.