The politics of institutionalizing preventive health

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ARTICLE INFO	ABSTRACT
	Prevention is an attractive idea to policymakers in theory, particularly in health where the burden of spending and care is increasingly taken up by complex and chronic conditions associated with lifestyle choices. However, prevention in general, and preventive health in particular, has proven hard to implement in practice. In this paper, we look to one tangible legacy of the recent rise of the prevention agenda: agencies with responsibility for preventive health policy. We ask how this form of institutionalizing preventive health happens in practice, and what consequences it has for the advancement of the prevention agenda. We draw on qualitative data to compare the trajectories of newly formed agencies in Australia, New Zealand and England. We find that building and maintaining legitimacy for such agencies may come at the expense of quick progress or radical action in service of the prevention agenda.

1. Introduction

Advocates of preventive health are fond of using the metaphor of the ambulance at the bottom of the cliff to describe the overwhelming political attention and government funding devoted to acute health services. They argue that short-term political priorities and 'siloed' governance structures perpetuate the dominant vision of healthcare as providing a 'sickness service' rather than a 'wellness service'. They point instead to the rising burden of non-communicable diseases (NCDs) on healthcare systems. They call for greater attention towards a range of measures to rope off the top of the cliff before the problem arises rather than parking an ambulance at the bottom when it is all but too late.

But *institutionalizing* prevention, by turning this persuasive logic into policymaking rules and action, has proven very difficult in practice. From calls for fundamental reform to include 'health-in-all policies' through to more modest proposals for targeted action on issues like product reformulation, 'sin' taxes, or regulation of advertising and marketing, change has been slow, limited, piecemeal, and more often thwarted altogether. Cross-national studies of progress on this agenda suggest that such efforts continue to be hampered by a lack of clarity, funding, leadership and/or 'ownership' and accountability (Guglielmin et al., 2018).

To address this shortfall, there have been growing calls to embed prevention within the institutional architecture of government itself. In practice, advocacy has coalesced especially around the idea of establishing executive agencies - bodies with operational autonomy from government departments and direct access to the executive - with responsibility for preventive health. The hope is that these agencies can act as vehicles to coordinate resources, provide leadership and momentum, and influence decision-makers from inside government, lifting the cause of preventive health above politics-as-usual and enabling meaningful policy change in the long term (Moody et al., 2008; WHO, 2015).

In recent times, this approach to institutionalizing preventive health has been relatively successful. But is the proliferation of agencies really such a boon for the prevention agenda in health? Are agencies the effective vehicles for driving significant, long-term policy change that their advocates hope for? Some thoughtful research in public health begins to unpack some of the trade-offs and challenges these agencies face in practice (Schang et al., 2011). Delving deeper into the policy and administration literature reveals that agencies in general are typically fragile (James et al., 2016; Boin et al., 2010). Most fail in the short to medium-term, and even those which succeed in the long-term can be subject to swingeing cuts (Dommett and Skelcher, 2014; O'Leary, 2015). Agencies should not be treated as a simple fix.

We investigate recent efforts to institutionalize preventive health via dedicated agencies. We ask how this form of institutionalisation happens in practice, and what consequences it has for the advancement of the prevention agenda. We conduct a comparative case analysis that tracks the birth, life and (in one case) death of new agencies with responsibility for preventive health in Australia, New Zealand and

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England. Drawing on policy documents and semi-structured interviews with 25 officials and stakeholders, we explain the different failings of the Australian National Preventive Health Agency (ANPHA) and New Zealand's Health Promotion Association (HPA), and the *relative* success of Public Health England (PHE). We show that an agency is far from a silver bullet for the prevention cause. Instead, we identify the key dilemmas that the advocates and architects of these new bodies face: whether to court or avoid conflict with key stakeholders, how to shape the remit of agency activities and responsibilities in contested policy terrain, and how to establish long-term credibility. Our account of the distinct trajectories of these three agencies highlights key lessons for the public health community:

a) creating agencies cannot *solve* the prevention problem, as the viability of agencies depends on a complex configuration of factors which shift over time;

b) such agencies may actually serve this agenda better by emphasising technical public health programmes and sneaking prevention in the back door rather than by offering the bold advocacy many envisage; and

c) building and maintaining widespread legitimacy for such agencies, and their work, may come at the expense of quick progress or radical act ion.

The paper proceeds in five sections. The first provides a critical review of the prevention agenda, focused on the institutionalisation of preventive health through dedicated agencies. The second synthesises the policy and administration scholarship on the challenges and successes of agencies to develop an analytical framework for the case studies. The third explains the case selection and data collection. The fourth presents the three cases, and clarifies the affinities and discrepancies across them. The fifth draws together these findings to identify the key implications for the prevention agenda in health.

2. Institutionalizing prevention: the long and difficult journey from ideas to action

Prevention is part of an intuitively appealing slogan: intervening early to stop bad outcomes from arising is better than fixing them when they have emerged, particularly if it saves lives and money. However, 'prevention is better than cure' remains an idiom and vague ambition until policymakers cooperate to turn it into specific policies and policymaking practices. To do so, they must make choices regarding: *how to define the problem* (such as in relation to costs or inequalities); *which interventions to* support (such as by redistributing income, encouraging behavioural change, or regulating individual behaviour); *when to intervene in people's lives* (focusing on the whole population, high risk, or already affected groups); and, *how to connect prevention to complementary aims* such as 'evidence based policymaking', 'joined up government' and local or service-user driven services (Cairney and St Denny, 2019). During this process, contentious choice undermines superficial consensus (Billis, 1981: 367). Although prevention advocates may see prevention 'ecologically', as a large collection of actions that interact to become greater than the sum of their parts (McLeroy et al., 1988; Stokols, 1996), policymakers are under pressure to make and defend specific choices.

In that context, Cairney and St Denny (2019) identify commonly described obstacles to prevention, which can be summed up in the following narrative. Policymakers do not realise the scale of their task until they start to define prevention in practice, to produce strategies and detailed objectives. In doing so, they encounter major trade-offs between long-term preventive aims and their short-term objectives, such as to remain popular by demonstrating their competence to govern reactive public services. They devote most resources, such as attention, staffing, spending, and performance management to reactive services. Even when opportunity to devote limited resources to prevention

presents itself, it is seldom clear what policy options they ought to prioritise or support. They find the evidence base to be limited and no substitute for political choice. They engage with a range of public health experts, some of whom advocate vociferously for policy change and others who do not want to get ahead of the evidence. By making choices, they signal their intention to regulate individual, family, and social life and portray many people and their 'lifestyle choices' negatively. These choices are divisive, generating mixed public support and some dissent among the organisations and professionals responsible for delivery. Many policymakers begin to think of problems as too 'wicked' to solve meaningfully with the resources at their disposal (Rittell and Webber, 1973; McConnell, 2018).

This narrative highlights the historical difficulties in moving prevention from abstract ideal to concrete *institutionalisation*: the processes by which policy-related rules, ideas, procedures, and goals take on "a rulelike status in social thought and action" (Meyer and Rowan, 1991: 42). There are many different forms of institutionalisation, from rules that are fundamental, permanent and wide-ranging to exhortations that are more symbolic, fleeting or narrowly limited.

At the ambitious end of the scale, the ultimate aim of the prevention agenda may be mainstreaming: the "(re)organisation, improvement, development and evaluation of policy processes so that a [certain policy perspective] is incorporated in all policies at all levels and at all stages, by actors normally involved in policymaking" (Council of Europe, 1998: 15). The goal is to counter the impact of entrenched biases on the (re)production of inequalities and suboptimal outcomes (Donaghy, 2004). Mainstreaming prevention in health is an idea that finds common expression in 'healthy public policy' or the notion of 'health-in-all-policies', whereby all government policies and programmes are evaluated on the basis of their impact on population health and health equity (The Helsinki Statement on Health in All Policies, 2014).

However, the obstacles to encoding regulations and practices associated with mainstreaming prevention go far beyond a vague notion of low 'political will' to include low clarity about what prevention means – and should mean - in practice. Most public health advocates are pragmatic enough to see mainstreaming as a long term ambition. In the meantime, they focus on joining up more moderate and specific policy proposals; the 'low-hanging fruit' of feasible and attractive solutions for policymakers which can, when applied together in a synergistic manner, have a positive impact on prevention (Boswell, 2016, Ch 2). Measures in this 'ecology' of intervention include: product reformulation; restrictions on marketing of unhealthy products; and taxes on alcohol, tobacco and unhealthy foods. Yet, progress even on this more modest agenda has been slow and frustrating.

Ultimately, where public health advocates have been able to achieve a greater measure of success in the last two decades is in an alternative approach known more broadly as substantive institutionalisation (Corcoran, 2011). It refers to the creation of positions or functions in government dedicated to promoting and developing a particular service, policy goal or agenda. Though substantive institutionalisation can take a variety of forms (Hogwood et al., 2001), in this sector it is associated especially with the establishment of departmental executive agencies. Agencies are dedicated bodies with operational autonomy from line departments and (usually) direct access to the executive. They are integrated within government (to help coordinate policymaking functions) but operate sufficiently autonomously to ensure that their implementation objectives are not necessarily affected by changing political context and elected policymakers' fluctuating attention (Verhoest, 2013: 52).

Due partly to celebrated 'success stories' like VicHealth (in the Australian state of Victoria) and the Thai Health Promotion Foundation (McQueen, 2016), preventive health advocates see executive agencies as useful vehicles for driving policy change (for examples in public health scholarship, see Harris and Mortimer, 2009; Catford, 2009; Perez, 2013; Friel, 2013; McQueen, 2016; for examples in public health advocacy, see Watt, 2005; Moodie et al., 2008; WHO, 2015;

Sopitarchasak et al., 2015). Across many jurisdictions, advocates have fought for the establishment of agencies which can concentrate re-sources, ensure access to key decision-makers, and boost the leadership required to challenge the dominant healthcare paradigm and lift pre-vention policies beyond the realm of politics-as-usual.

But the story does not end there. The generalist public administra-tion and public policy literature tell us that agencies are no simple fix. They remain vulnerable to damaging or fatal public contestation and political interference. There is a need to interrogate whether agencies with responsibility for preventive health are durable solutions that can live up to the hopes advocates have invested in them. We ask: how has this form of institutionalizing preventive health happened in practice, and what consequences has it had for the advancement of the preven-tion agenda? The following section sets out a framework for answering these questions.

3. Understanding the vicissitudes of agencies: a framework for interpretation

The literature on agencies in public administration has ballooned in response to their widespread proliferation in the last two or three decades. Tremendous empirical focus has gone into explaining the variation in their 'success', understood usually in terms of their long-evity and perceived legitimacy. But attempts to map success on these grounds have failed to reveal clear patterns. Indeed, an authoritative meta-analysis writes off their fate as 'random' (Verhoest et al., 2012).

However, recent scholarship emphasises the importance of an *in-terpretive* orientation to understanding patterns of organisational birth and death based on in-depth qualitative research (Elston, 2014, 2017). Interpretivists see organisations not as fixed structures that determine political and policy outcomes, but as contingent and fluid configura-tions that reflect and reinforce prevailing political dynamics (Bevir and Rhodes, 2003). Simply-expressed 'variables' cannot explain organisa-tions' fate across time and space. They are liable to change over time and to have different meanings and implications in different contexts. As such, turning to insights from qualitative, interpretive forms of re-search can help us gain deeper insight into the configuration of factors that influence the success or failure of agencies (Flinders and Skelcher, 2012; Flinders et al., 2014). A critical review of this literature suggests that issues of *salience*, *scope* and *standing* are particularly crucial to explain their success.

3.1. Salience: the extent to which the substantive area in which an agency works is politicised by controversial media coverage or association with partisan alignment

Governments *appear* less likely to surrender control to an agency in the context of a politically salient issue. Further, actors within and outside government are more likely to impugn the legitimacy of ex-isting agencies that intersect with salient political issues, particularly if their genesis is associated with a rival party (Koop, 2011; Park, 2013; Bertelli et al., 2015; James et al., 2016). Yet, agencies are also 'useful' when they help depoliticise contentious issues; governments portray the issue as above party politics and 'kick it to the long grass' to insulate themselves from blame (Hood, 2002; Flinders, 2008; Lavertu, 2015). Recent case research shows how these dynamics intersect in messy ways. Wood's (forthcoming) comparative analysis of agencies - devoted to environmental protection, health prioritisation and water govern-ance - reveals that increasing salience does not determine the fate of an agency either way. Rather, it presents actors with new challenges and opportunities. Their response to different dynamics shapes the future political terrain. Overall, to gain analytical purchase, we need to know what salience means in practice, when policymakers judge between competing incentives.

3.2. Scope: the size of an agency's policy remit, its overall budget and its staff

The prevailing logic is that a larger agency, with a wider range of responsibilities, bigger staff and larger budget, is likely to be more ro-bust to the whims of government (Lewis, 2002; Carpenter and Lewis, 2004; Berry et al., 2010). Yet, the empirical evidence is unclear (Boin et al., 2010). Further, interpretive research shows that scope is not as objectively fixed and measurable as might be expected. The remit and capacity of an agency shifts over time, and the trajectory of this movement feeds into broader perceptions of its legitimacy. For ex-ample, Corbett and Howard (2017) analysis of the fate of the Australian aid agency shows that the larger and better funded the agency became, the bigger the target it presented, bringing it into conflict with other government departments and making it more vulnerable to partisan politics.

3.3. Standing: (a) the formal arrangements that structure the position and work of an agency and (b) the informal or perceived legitimacy of the agency among key policy actors

Large-n research on agencies seeks to disentangle the effects of different formal arrangements. The idea is to test whether certain sorts of agency configurations— conferring more independence or less; possessing decision-making functions or charged with implementation or mere scrutiny—enable greater success than others (Boin et al., 2010; O'Leary, 2015; Bertelli and Sinclair, 2016). Empirical patterns are un-clear (Verhoest et al., 2012). Further, interpretive work flips this pre-sumption on its head: institutional configurations should not be seen as arbitrary variables that set in motion political dynamics. They are themselves products of political contestation (Howard, 2016) and not fixed and determining. They can shift in response to perceived success or failure. For example, Boswell's (2018) account of the contrasting trajectories of two arms-length bodies in the British health sector, shows how legal standing confers a *formal* authority that remains contingent on *informal* legitimacy.

Overall, then, there is great value in adopting an interpretive or-ientation in unpacking the effects of salience, scope and standing on agency performance and survival. Such an approach is ideally suited to explaining the complex dynamics underpinning the fate of newly formed preventive health agencies.

4. Method: case selection, data collection and interpretive analysis

The empirical analysis draws on in-depth qualitative research across three cases – the Australian National Preventive Health Agency (ANPHA), New Zealand's Health Promotion Agency (HPA) and Public Health England (PHE). In this section, we justify case selection, outline and reflect on the dataset, and explain the analytical process.

One reason for drawing this comparison is the contemporaneous nature of the cases. Both policy and academic discussion on agencies with responsibility for preventive health tends to be dominated by 'success stories' – shining examples like VicHealth that have been es-tablished for decades. Yet, as our review of the agency literature shows, such success is preciously rare and historically contingent. Our three cases all emerged in the last decade at the height of the prevention agenda, and so their contrasting fates are likely to provide more re-levant lessons for both research and practice. Moreover, comparing case material across these three countries is a proven selection strategy in political science and public administration scholarship (Rhodes et al., 2009; Marsh and Miller, 2012; Grube and Howard, 2016). Australia, New Zealand and England share a set of 'family resemblances' that enable fruitful comparison Boswell et al. forthcoming. Not all back-ground features are kept constant since, for example, New Zealand is relatively small, Australia has a federal system of government, and

Table 1
Breakdown of interview participants.

	Australia	New Zealand	England	Total
Agency official	3	1 (via email correspondence)	2	**6**
Other civil servant	1	1	3	**5**
Expert advocate	6	5	3	**14**
Total	**10**	**7**	**8**	**25**

England has complex multi-level governance arrangements that intersect and overlap. Nevertheless, the three cases share an inherited set of cultural, political and administrative features and traditions, and they remain entangled in (mostly) informal relationships that enable sharing and mutual learning across policy sectors. Indeed, many of our interview participants had professional experience across these jurisdictions and almost all had strong familiarity and close personal ties. These recurring traits, traditions and ties can help to structure comparative analysis and provide lessons from the contrasting experiences of ANPHA, HPA and PHE.

Data collection for each case entailed extensive background desk research, focused on Parliamentary Hansard surrounding the establishment of each agency, policy documents outlining and refining its remit and responsibilities, and public-facing material archived on relevant web pages. The bulk of the analysis, however, draws on the material collected through 25 semi-structured interviews with former and current agency executives and board members, and with stakeholders in government (across relevant departments and agencies) and beyond (including professional, charity and industry representatives), conducted between September 2016 and October 2017 (Table 1).

We were able to access key individuals across the Australian (10 interviewees) and English (8 interviewees) cases with relative ease, but found the New Zealand case more challenging. No one with formal links to HPA (board member, executive or official) was willing to commit to an interview (though one person did agree to formal correspondence via email) and several experts and advocacy group representatives were not at liberty to speak with us because of ongoing legal action. These challenges are indicative of the polarisation of preventive health in this case and the lack of legitimacy that the HPA enjoys among stakeholders.

We identified actors through purposive sampling instructed by the initial documentary analysis, with a small degree of 'snowballing' from initial research participants. We obtained ethical clearance from the University of Southampton before embarking on the fieldwork, a condition of which was that we promise to protect participant anonymity where possible. In practice, because of the small and intimate nature of the policy networks surrounding these agencies, it was not possible to guarantee anonymity for all actors. In such cases, we obtained consent to quote participants 'on the record' and in some instances sent a transcript of audio-recorded interviews to participants for vetting and revision.

We coded the interview data via a process of abduction common to interpretive research (Yanow and Schwartz-Shea, 2012). It entails moving between the findings emerging in the empirical data and key themes emerging through critical engagement with the literature. It is an iterative - not hydraulic and stepwise – process which prioritises reflection and refinement of the analytical categories and significant deliberation and judgment.

Boswell contacted participants, conducted the interviews and manually coded the interview material. Cairney and St Denny produced a 'synthetic' review of policy theory and the secondary literature on prevention policy and institutionalisation (see Cairney and St Denny, 2019) to help situate the initial enquiry and present the eventual findings.

4.1. Case 1: The Australian National Preventive Health Agency

The Australian National Preventive Health Agency was established in 2011 on the back of concerted public health advocacy. Its chief value, as expressed by Health Minister Nicola Roxon in the initial mission documents, was to offer national leadership in the "ramping up" of the prevention agenda:

> [There] has never been a more important time to tackle preventable diseases. That is why the Gillard Government established the Australian National Preventive Health Agency (ANPHA) as Australia's first national preventive health agency with the capacity to lead, support and coordinate the "ramping up" of prevention and health promotion effort. (Roxon in ANPHA, 2011)

The agency lasted less than 2 years before being de-funded in 2013. The incoming Coalition government had attempted to shut it down on the basis of 'duplication of effort' with its parent Department of Health, but could not achieve the requisite numbers in the House. ANPHA therefore reached a messy denouement, de-funded but not abolished amid a climate of distrust. This disquiet spilled over into a scandal in the local tabloid newspapers, regarding an acrimonious contractual dispute between the government and ANPHA's chief executive. What generated this antipathy and controversy?

4.1.1. Salience: too hot

ANPHA was an idea that had been floating around in Australia for a long time. It was pushed strongly by influential public health expert advocates who had been instrumental in the success of VicHealth and its world-leading role in tobacco control policy (Galbally, 2004). This long-cherished plan for institutional leadership gained traction with the election of a Labor Government in 2007, after four terms of John Howard's conservative Coalition. Labor had signalled greater emphasis on preventive health in the lead-up to the campaign and the new Minister of Health, Nicola Roxon, was especially receptive to prevention ideas. The specific plan for a dedicated agency first emerged formally on the national agenda as a Big Idea thrown up in the 2020 Summit (a showpiece innovation in expert engagement early in the new government's term). It was fleshed out in the National Preventive Health Taskforce (expert panel convened by the government).

This history highlights two related problems in relation to salience. First, it made ANPHA a partisan institution. Its origin thwarted the efforts of ANPHA's leadership to build and sustain relationships with the Opposition. Second, these initial institutional processes left an unfortunate legacy: ANPHA's remit echoed that of the Taskforce, clustered around the major causes of preventable non-communicable diseases (tobacco, alcohol, obesity). Exemplifying the staunch industry resistance in Baker et al. (2017) recent account of the politics surrounding obesity in Australia, ANPHA was constituted directly in opposition to Big Tobacco, Big Alcohol and Big Food. It had powerful enemies from the outset, as one official mused:

> [We] got rung by the secretary and told to lay off the alcohol industry. [The alcohol industry] were in with the Minister. The Minister's advisor was telling us they weren't so bad, and to lay off them. This is a Labor Minister!

4.1.2. Scope: small capacity, unruly remit

ANPHA's remit was to produce a wide variety of outputs. As forgers of a brand new agency, the initial staff spent its early life working out what to do. An industry representative put it witheringly:

> I think it was set up as a gesture to the public health lobby, saying 'Okay, you've asked for it, so here it is.' And I suspect the public health lobby were surprised when they got this, and they hadn't thought enough and given the government enough insight as to what they expected it would do. I think it was the classic case of, you

know, 'Be careful for what you ask for because you might actually get it!'

From the perspective of public health advocates and the officials involved, the issue was a lack of resources and capacity. ANPHA was run on a shoestring, with a skeleton staff mostly relocated to a small office across town from the Health Department. This combination made ANPHA's sustainability unlikely. It had a big and unruly remit and routine contact with other powerful bodies. In particular, the Department of Health's leadership was widely seen as patch protective. Most of the interview participants noted intense hostility to ANPHA (although few were willing to go on the record):

> Jane Halton, the Secretary of the Department, was really opposed to the idea and it was only really that the Minister said, 'No, it's going to happen,' that ANPHA was created. But it was always a bit constrained in terms of its budget, its operational capacity, its independence.

The task of appealing to and appeasing these stakeholders was, in the word of one experienced campaigner, 'like dancing with an octopus'.

4.1.3. Standing: No 'quick wins'

Many of our participants attributed ANPHA's failure to a lack of strong institutional standing. Although branded as an agency, in practice ANPHA lacked many features associated with a fully autonomous status. It remained under the thumb of the Department, lacking its own protected budget, direct line to the Minister or Treasury, or independent and empowered board. One advisory group member surmised:

> What we wanted to happen was clear: we wanted a separate agency that would be responsible for prevention policy. And the structure was wrong from the outset.

This institutional architecture reflected and reinforced the wariness that key actors in and outside government had about the new agency (see also Baker et al., 2017). A senior civil servant explained:

> [Public health] people really wanted – you know, if it was going to be able to do the things that the Commonwealth Department couldn't do – they wanted it to be really independent. But that was a very hard ask, especially when, increasingly, Treasuries don't want a plethora of new agencies and bodies.

In any case, the failure to get 'quick wins' sealed its fate. The unclear remit and piecemeal programme of work made it difficult to build a reputation for credible performance. It had only a small, short-term tranche of funding for research grants, and otherwise largely absorbed existing social marketing programmes from the line department. In fact, there was a strong feeling that absorbing this work might have done ANPHA more reputational harm than good:

> I think they felt a bit constrained as far as what they could do, so they kind of had to prove themselves by not being too controversial. … Really I was pretty frustrated with that … it was spectacularly unsuccessful.

The leadership of ANPHA, hamstrung by capacity constraints, could not produce the sort of outcomes that would make it an indispensable part of the machinery of government. It thus became an obvious target of the incoming Coalition government's plans for 'quangocide', and has lain dormant since.

4.2. Case 2: New Zealand's Health Promotion Agency

The Health Promotion Agency was established in 2012. It was envisaged as an institution that would build on recent successes in reforming and enhancing primary healthcare and community health in New Zealand:

> The bill's intention with the Health Promotion Agency is first and foremost to create an agency that will deliver better public health outcomes for New Zealanders … A more integrated and efficient approach to health promotion across the range of public health issues will, in turn, deliver better public health outcomes. NZPD (22 May 2012)

The HPA's establishment was impacted by the legacy of an earlier effort at substantive institutionalisation in preventive health, the quickly aborted Public Health Commission in the mid-1990s. Mirroring ANPHA's more recent experience in Australia, the Commission had been quickly disestablished due largely to an antagonistic relationship with the Ministry of Health and powerful vested interests in industry (see Hornblow, 1997). As such, HPA was to take a very different tack. Its officials set about quietly notching up 'quick wins' on uncontroversial issues and cultivating a subterranean public profile that would not draw the agency into controversy. However, the HPA was suddenly thrust into the national spotlight when it was implicated in investigative journalist Nikki Hager's (2014) explosive *Dirty Politics*. Hager's book, which took over the national news cycle when launched during the 2014 General Election campaign, impugned the reputation of the National government and revealed the role of government officials and aides in a 'black ops' communications strategy. It had emerged in the course of Hager's investigation that Katherine Rich, former National MP, HPA board member and then head of NZ's peak food lobby group, had links to a PR firm which consistently planted and promoted stories attacking the credibility of public health advocates. These revelations sparked outrage in the public health community. The scandal set in train an acrimonious debate, including a public letter signed by 33 scientists asking the government to respond to a perceived conflict of interest on the HPA board. The outcry was followed swiftly by litigation on both sides. The response of the HPA has been to go to ground again, such that there was sufficient anxiety, *over two years later*, that no one would speak with us directly.

HPA has thus enjoyed greater 'success' than its ANPHA counterpart in terms of *longevity*, but has thus far been equally limited in terms of its capacity to institutionalize preventive health. How might we explain this?

4.2.1. Salience: too cold

HPA's relationship to political salience is in many respects the opposite extreme to the experience of ANPHA. First, HPA began life with a tightly circumscribed remit on health promotion, especially via social marketing. Social marketing, in the absence of broader structural changes, is often characterised often as something that governments like to do *to be seen* to tackle chronic disease without making any of the hard or contentious decisions involved (Boswell and Corbett, 2015; Rayner et al., 2006).

Second, HPA entailed a rather uneasy and incoherent compromise between the progressive forces of preventive health and the conservative National-led government and its allies in industry. The clearest symbol was the installation of Rich on the board, given her National Party background and role as food lobbyist. Preventive health advocates were caught in an awkward but familiar bind - whether to work with the new institution for change from within or to critique it from the outside:

> This is a small country. We don't have that many experts in anything that you can ensure that everybody's a pure independent on everything, unless they're so independent they've got no idea what they're doing …. Quite simply, if I join the ones trying to get rid of Katherine Rich: (a) I know it wouldn't work and (b) I'd probably lose [existing influence]. I'm not prepared to sacrifice all the other useful things we do for the sake of trying to pin one person.

4.2.2. Scope: reasonable capacity, narrow remit

HPA seeks to be *apolitical*, to project the arms-length independence that has long been central to the appeal of agencies. Even when under attack from public health advocates and Opposition MPs in the wake of the *Dirty Politics* scandal, HPA leadership has tried to ride out the controversy. They have sought refuge in the agency's technical policy mission, and downplayed or entirely ignored political implications, as journalist Peter Newport (2015) captured in a feature on the scandal for *Metro* magazine:

> It took almost a week to get one sentence from their chair, Dr Lee Mathias … "What about the detailed points in the scientists' letter about a conflict of interest?" I persisted. [A communications manager] pointed out we had received the HPA's official "single sentence statement" and hung up.

Its capacity is tightly channelled and constrained. Health promotion is interpreted as a technical exercise in administration and implementation.

4.2.3. Standing: subordinate

HPA continues to enjoy legal standing as an arms-length agency, and a valuable source of expertise within government on social marketing. However, its informal standing among key stakeholders and in the public sphere is poor. At the time, prominent public health expert Professor Boyd Swinburn expressed outrage in his media commentary:

> [Katherine Rich is] sitting on the board of the Health Promotion Agency, while at the same time she's denigrating public health professionals, and undermining public health policy (Radio NZ, 2014, Sept6).

HPA is a stark example of how institutional 'success' as measured in longevity, capacity and formal standing does not equal 'success' in terms of policy advocacy or outcomes. Although there are suggestions NZ's new Labour-led government may induce changes in the institutional landscape around prevention, HPA has historically been more of an obstacle than a vehicle for leadership on preventive health policy.

4.3. Case 3: Public Health England

Public Health England (PHE) came about through the major health service reforms under David Cameron's Coalition government. It brought together under one umbrella some pre-existing arms-length bodies and new dedicated functions:

> By creating this new integrated public health organisation, we believe Public Health England can develop to be a global leader in translating evidence into practice, and in tackling hitherto intractable problems. (Healthy Lives: Healthy People, p16).

Though subject to teething problems and controversy in its short history, PHE has enjoyed a happier combination of institutional 'success' and policymaking gains on preventive health. How has it managed this?

4.3.1. Salience: just right

Two factors explain its salience. First, it was set up by the Coalition government but retains a bipartisan public image. The legislation establishing PHE received strong support from all main parties. Indeed, the main delays to this aspect of the Bill concerned a call for amendments to *strengthen* the independent standing of the new agency, supported and advocated by Peers on all sides (see House of Lords 2012). This was a deliberate, orchestrated campaign to shore up the informal legitimacy of the new body.

Of course, a bipartisan image does not just emerge in a vacuum. It has to be fought for, courted and reinforced. Importantly, the logic underpinning the establishment of PHE lay in administrative efficiency rather than a more overtly political drive for preventive policy

outcomes. Though the Coalition government's health reforms under Andrew Lansley were extremely controversial and divisive on the whole, the particular move to shift public health away from Westminster responsibility and towards the jurisdiction of local government was widely seen as long overdue common sense. One public health advocate explained:

> Establishing PHE was a sort of necessity once the decision had been taken by the then Secretary of State to move public health into local government. It required, you know, an aggregation of the public health resources that were in regional offices.… I see the move of public health from the NHS to local government as an historic and necessary move.

The second key factor has been the organisation's wily engagement with salient issues. One key facilitator is their willingness to engage. The distinction here with the HPA in NZ is instructive: PHE does not 'go to ground' or refuse to countenance political topics. It tackles them, and is forthright in its public defence of stated positions. Its approach to engagement is sufficiently low key: PHE has been careful to follow established protocols of independent advice and, in doing so, not to always side with the progressive public health lobby. The organisation engages, but only on the basis of being a 'knowledge broker', which allows it to perform and reinforce its independence. The most famous example has been around e-cigarettes. A PHE review in 2015 claimed that e-cigarettes were 95% safer than traditional tobacco, making headlines around the world (Public Health England, 2015). The stance of most public health advocates is that the harms of e-cigarettes are not well understood, and the motives and practices of the corporations producing them ought to give reason for suspicion. The 95% safer verdict, then, was received with considerable hostility. One expert advocate reflected in our interview:

> It has been the most difficult area certainly. Arguably Public Health England is out of step with not just the rest of the world but even within the British Isles. We are working on the principle that we'll disagree in private and hope to come to positive, common views in the public.

4.3.2. Scope: big capacity, flexible remit

Of the three bodies in our analysis, PHE enjoys by far the greatest capacity. Size is often assumed to correlate with agency success but the relationship is not straightforward. For example, the merger of smaller bodies – including the Health Protection Agency and the National Treatment Agency for Substance Misuse – into PHE entailed some degree of conflict, as the actors within constituent parts were bedded into a new structure that reduced some of their autonomy and cut into budgets. One official, directly affected by the process, put it in personal terms:

> The main issue on the transfer into Public Health England was, for example, for me personally, I'd been at the top table … I came into Public Health England lower down the hierarchy, and the resources that I'd been able to draw on directly were dispersed into other parts of PHE.

But the trade-off from these internal organisational challenges has been greater flexibility in terms of PHE's remit on prevention. It enjoys greater capacity and a larger budget than its counterparts in NZ and Australia, so has more discretionary resources to dedicate to preventive issues.

4.3.3. Standing: prevention 'ninjas'

PHE enjoys strong legal independence, albeit primarily in an advisory function. The story behind its formal status is complex and contingent. There was particular sensitivity around absorbing the functions of the Health Protection Agency – an organisation staffed by clinicians and scientists rather than bureaucrats – many of whom would

balk at any semblance of political interference. One of the architects of the transition to PHE explained the balancing act in its founding Framework Agreement:

> So we talk about 'operational autonomy' for PHE. The way that I was trying to articulate it was you can talk about public health evidence, but Public Health England should just accept that Ministers take decisions at the end of the day and they will take a variety of issues into account.

Formal independence obviously does not translate into policy action. More surprisingly, it does not necessarily translate into bold leadership on the prevention agenda either. PHE was from the outset in an excellent position to get 'quick wins' within government. It has done so chiefly by foregrounding the more technical, uncontroversial aspects of its work that it was able to carry on with. In particular, a handful of established features and functions that became amalgamated within PHE – for example, drug treatment programmes – ensure support, respect and profile for the organisation as a whole. These 'core responsibilities' give others in PHE the freedom to work on thornier prevention issues around obesity or alcohol and tobacco consumption, but subject to a scientific identity which appears to constrain the willingness of researchers to be seen to act too politically. Put simply by one of our departmental interviewees, PHE officials often bind their own hands in the promotion of prevention policies; they are desperate to avoid any appearance of going beyond the evidence in support of the key policy goals of public health advocates.

Even in more expressly contentious work, PHE has been careful to walk a fine line: upholding independence from government, but being careful not to lapse into preventive health 'lobbying'. This tendency towards muted advocacy has drawn the ire of some in public health. One official explained:

> I think it's difficult for stakeholders sometimes to understand how policy is made. I can remember one person saying to me, about five years ago, [taps on table] 'You just need to tell the minister they need to spend more money on alcohol treatment. If you give them the right facts, they'll do it.'

The upshot is that, in the imagery of one interviewee, PHE officials feel they are operating as 'prevention ninjas'. Rather than providing outright leadership for preventive health, they pursue this agenda by stealth, building and leveraging good will with other powerful actors. The official explained:

> So, for example, what would be the point of doing something which upset the NHS, if you want them to deliver some evidence-based interventions which are likely to have an impact on public health? So we've got to play canny. It's about using our relationships.

5. : Lessons for the goal of institutionalizing prevention

Our findings, summarized in Table 2, present a nuanced picture. PHE has enjoyed more success than HPA and ANPHA. However, it is hardly a beacon for preventive health leadership. These findings reinforce Schang et al. (2011) conclusion that an agency is no magic bullet for prevention. Its introduction may send a positive message, but does not represent major policy change in itself. In whatever form, the prevention agenda in health bumps up against conflicting ideological values and powerful corporate interests. The quick death of ANPHA and the bubbling controversy over the HPA in NZ highlight what is at stake. Our participants across the three cases were quick to emphasise that achieving policy change in this context is immensely difficult, and that no institutional fix can shortcut or *depoliticise* the process. Institutionalisation simply redefines the terrain on which familiar political battles are fought. The experiences of the agencies allow us to draw three provisional lessons about these political battles.

The first lesson is that the path to substantive institutionalisation is winding and treacherous. The success of agencies dedicated to prevention, understood even in the limited terms of mere survival and reputation, depends on a configuration of factors that is 'just right' for the specific context. PHE and its officials continue to walk a fine line. They have to engage with controversies that emerge while retaining bipartisan buy-in overall. They cover a large policy remit but devote key resources to prevention causes specifically. They shore up their reputation as independent 'knowledge brokers' without straying into overt advocacy. The experiences of ANPHA and the HPA show that failure to maintain the balance in relation to just one of these factors can have problematic consequences for the others. It is a delicate balance to maintain, especially as the prevention agenda and the political context surrounding it evolve over time.

The second lesson is that leadership in preventive health – at least in agencies – may not be best served by bold public advocacy and a strong policy agenda. Bold public advocacy and a heavy emphasis on upstream prevention policy in the Australian case meant powerful enemies and a short lifespan. More subtle persuasion, and a deliberate emphasis on technical 'core responsibilities' over thornier prevention measures in the English case, has contributed to widespread legitimacy. This comparison suggests it may be more profitable to foreground the widely-accepted goods of public health and background the controversial aspects of prevention.

The final lesson is that institutional 'success' does not necessarily go hand-in-hand with policy gains for the prevention agenda. Our cases reveal that the work of building and maintaining political support is not always compatible with the work of advancing preventive health policy. The management of these tensions can frustrate the most vocal proponents of progressive policy action. Indeed, many of our participants—particularly those in Australia burned by ANPHA's failure—were keen to reflect on the limits to the agency model altogether. One concluded our interview by reflecting:

Table 2
Summary of key findings.

	ANPHA (Australia)	HPA (NZ)	PHE (England)
Salience	*Too hot*	*Too cold*	*Just right*
	Setting agency up against key industries ensured it had powerful enemies; also closely linked to Labor's agenda so vulnerable to change of government	Agency directed to promotion/social marketing and away from preventive regulation, with very close links to food and beverage industry.	Agency engages in controversial political issues but is careful not to 'pick sides'; set up under Coalition and enjoys (and courts) a bipartisan image.
Scope	*Small capacity, unruly remit*	*Reasonable capacity, restricted remit*	*Big capacity, flexible remit*
	A skeleton staff and short-term budget left to choose their own adventure, and inevitably cross paths with powerful rivals	A mid-sized staff and stable budget, but a very narrow remit focused on technical support and implementation	Large staff and budget merging respected agencies – some internal squabbles but enables flexibility to pursue aspects of prevention agenda
Standing	*No 'quick wins'*	*Subordinate*	*Prevention 'ninjas'*
	Failed to notch up achievements or build relationships in short time-span	Relationship with industry means they are under siege from public health experts, NGOs and advocates	Independent reputation ensures legitimacy but means the prevention agenda is pursued by stealth rather than through strong leadership

I think in many ways having an agency almost does the work a disservice. It's important for profile. It's important for branding and visibility, etc. But … in a large bureaucracy where governments come and go, it makes you vulnerable. When the pendulum swings and it's time for smaller government, standalone agencies are always going to be the first hit.

Our analysis shows that *institutionalizing* prevention via dedicated agencies seems destined to disappoint, but that some solutions are far less disappointing than others. So far, PHE represents the most feasible success story as the *least-worst option* available to public health advocates and policymakers.

In that context, it is not surprising that many of our interviewees suggested alternative vehicles for leadership on the prevention agenda, within the heart of government departments or outside government entirely, in civil society. Although such suggestions represent an exciting angle for further research and experimentation, we urge caution because it is difficult to connect slow progress specifically to the role of agencies. Rather, many of these obstacles relate to wider issues of prevention – including its ambiguity, which contributes to false and ultimately unsustainable consensus – that would be present regardless of its institutional vehicle.

Acknowledgments

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