The Politics of Evidence-based ‘Health in All Policies’

Abstract. This a short and preliminary paper that sets out key themes relevant to strategies such as ‘prevention’ and ‘health in all policies’ (HIAP). It follows a recent workshop in London in which we had quite a lively discussion of first principles when I tried to lay out some important differences in the assumptions that people – in public health, policy, and political science – seem to make when they try to propose or reflect on public health policy change. For me, the big discussion related to the assumptions we make about the extent to which policymakers or governments understand, and can control or coordinate, policy processes (I am much closer, than most people, to the ‘not much’ end of the spectrum). This paper’s discussion will rely initially on completed work on the politics of evidence-based policymaking and prevention policy in the UK (by Cairney and St Denny). After workshop feedback, we will use these insights as a lens through which to analyse a systematic review of the HIAP literature (designed and conducted initially by St Denny and Mitchell).

Introduction

Fafard and Cassola ask how we can design public health policies that actually improve population health. They note that a popular response in public health - to recommend ‘evidence based’ policymaking (EBPM) – is undermined by a lack of appreciation of politics. For example, EBPM enthusiasts try to establish a causal link between a lack of policy progress and the lack of political will in individuals (often to defy commercial interests). To take the field forward, we need convincing accounts ‘of the role of politics in public health policy writ large’.

In policy studies, political science accounts connect policy change to two key limits to individuals and governments: the role of bounded rationality in limiting attention to, and understanding of, policy problems; and, complex policymaking environments over which policymakers have low knowledge and even less control (Cairney, 2019a; Cairney et al, 2019). Both factors represent ever-present limits to policy changes driven by individual policymakers or central governments. In other words, they apply to policymakers regardless of their sincerity, commitment, or will. A sole focus on individual policymakers, and their motivation or energy, (a) helps us understand how they combine cognition and emotion to address bounded rationality, and perhaps their governing competence, but also (b) distracts us from a focus on the limits to their resources in relation to their policymaking environments.

Key examples of this topic relate to the general idea of prevention policy and preventive policymaking or specific phrases such as Health in All Policies (Cairney and St Denny, 2020). This language is particularly strong or frequent in certain countries, including the US and Canada, the UK, Australia, New Zealand, and some Nordic and Western European countries.

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1 The unsuccessful plan was to keep it to 4000 words. I would appreciate some feedback on what can be removed, to free up space for subsequent HIAP analysis, without removing essential context (e.g. the policy process turtle, which is not really needed here). Then, I can tighten up and redraft (partly because some of this material is an attempt to consolidate/synthesise work that appears elsewhere).
In each case, there appears to be high support in public health networks for a collection of aims and principles, including the pursuit of EBPM and holistic governance to address the social and economic determinants of health.

Yet, it is often (generally?) difficult to find clear substantive policy progress beyond the commitment of governments to a vague idiom – ‘prevention is better than cure’ - or broad HIAP strategies. In some cases, advocates for policy change identify a frustrating gap between their aims and actual government policy. Or, if they are more optimistic, they equate strategic policy change with substantive change. In contrast, in the same countries, there is usually a much more tangible sense of cumulative and substantive policy progress in the more specific – and often totemic - example of tobacco control (Cairney et al, 2012).

Indeed, although they may not seem directly comparable as policy projects, analytical comparisons of prevention and tobacco policy are instructive (Cairney, 2019b; Cairney and St Denny, 2020). In both cases, many accounts outside of political science have related limited policy progress to a lack of political will and insufficient political respect for the role of evidence-informed interventions (at least until heroic researchers overcome this position with strong evidence). Such discussions may be important, but do not really need to rely on political science-informed policy studies. Rather, the latter help situate discussions of politics and policy change in a wider policymaking context, focusing on key comparisons relating to: levels of policy ambiguity; the nature of the policymaking environment; and, in our case, ‘windows of opportunity’ for substantive policy change (Cairney and St Denny, 2020).

In that context, our plan is as follows:

1. We outline in more detail some key assumptions and expectations underpinning public health approaches to policy change.
2. We connect these expectations to government action, to help articulate a common concern that policy change is not proportionate to public health evidence.
3. We compare such accounts with our approach – to the analysis of prevention - derived from political science and policy theory, focusing on ambiguity, complexity, and windows of opportunity, and drawing primarily on lessons from the UK and Scottish governments. The comparison with tobacco policy is instructive.
4. We use this analysis to signal the ways in which we intend to interpret findings from a systematic review of published studies of HIAP.

**Public health approaches to policy change: assumptions and expectations**

I used a recent workshop hosted by Public Health England (June 12th) to sense check the following list of assumptions/ expectations that I associate with public health studies of public policy (and, with apologies to Oliver and Parkhurst, hope to do the same thing at York University). Unless stated otherwise, this list is based on literature reviews and documentary analysis underpinning studies of tobacco policy (e.g. Cairney et al, 2012) and prevention policy (Cairney and St Denny, 2020), as well as more impressionistic reflections from peer-reviewing many papers on this topic and attending relevant conferences (usually to speak to practitioners about the politics of EBPM). I am relying primarily on (a) the sense, often described in
qualitative research, of a ‘saturation point’ to feel confident that more research will not unearth more categories, than (b) counting the frequency of term-use in each category, or (c) network analysis to identify the nature of a self-defined public health profession or community. As such, the focus is on the assumptions that scholars in this field often seem to take for granted, and often do not feel the need to explain. Its purpose is logical and conditional: if these are the assumptions, these are the expectations.

On that basis, I present a common narrative of the policy problem, how to understand it, and the processes necessary to address it:

- Focus on preventing ill health rather than treating it when it becomes too severe.
- Distinguish between types of prevention: primary (focus on the whole population to stop a problem occurring by investing early and/or modifying the social or physical environment); secondary (focus on at-risk groups to identify a problem at a very early stage to minimise harm); tertiary (focus on affected groups to stop a problem getting worse)
- Focus on the social determinants of health inequalities, defined by the WHO (2019) as ‘the unfair and avoidable differences in health status’ that are ‘shaped by the distribution of money, power and resources’ and ‘the conditions in which people are born, grow, live, work and age’.
- Promote ‘upstream’ measures designed to influence the health of the whole population (or health inequalities) rather than ‘downstream’ measures targeting individuals (although we discussed some debate/confusion about the meaning of upstream).
- Use scientific evidence to identify the nature of problems and most effective solutions.
- Define scientific evidence in a particular way, such as in relation to a ‘hierarchy’ in which (a) the systematic review of randomised control trials often represents the gold standard, and (b) systems modelling plays a key role. Or, in fewer cases, challenge that hierarchy energetically.
- Promote major policymaking reforms, including a focus on holistic or joined-up government, since the responsibility for health improvement goes well beyond health departments. Prevention (or preventive policymaking) is a classic term, and ‘health in all policies’ (HIAP) is currently a key term.
- Focus strongly on the role of industry as ‘vested interests’ causing public health problems (the ‘commercial determinants of health’) and, often, the lack of political will to regulate commercial activity.
- Treat public health and prevention as a form of social protection (new category after PHE). Often, actors describe a moral imperative to intervene (in which case, the opposite argument relates to individual responsibility and opposition to the ‘nanny state’ – see also Cairney et al, 2012 on ‘secular morality’).
- Use tobacco control as a model for other specific issues (e.g. alcohol use, obesity, salt) and the prevention agenda more generally (Studlar and Cairney, 2019).
Focus on identifying policy changes that represent a ‘win-win’ scenario in which all parties benefit from the policy outcome (in terms of their health), rather than identifying political winners and losers from the policy choice itself (new category - Baum et al, 2014).

Such assumptions underpin expectations for the role of government, and provide a frame of reference for assessing the overall direction of policy. In that context, ‘prevention’ sums up an overall policy goal and ‘preventive policymaking’ is an approach to that end.

Many governments sometimes adopt similar arguments or commitments

Cairney and St Denny (2020) identify the extent to which UK and devolved governments (and the Scottish Government in particular) have taken on this way of thinking. They find that:

- Many successive UK and devolved governments have used the general language of prevention (and related terms such as early intervention) to describe policy agendas in health and other fields (including ‘families policy’ and justice policies).

- Most recently, ‘prevention is better than cure’ is the title of the most recent discussion paper by the Department of Health and Social Care (2018), while NHS England’s (2014: 3) *Forward View* argued that, ‘the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health’.


- UK and devolved governments have tied prevention policy to an approach to policymaking, emphasising one or more of: joined-up and evidence based policymaking, localism, service-user-driven policymaking (‘we need to make policy with you, not do it to you’), partnerships between government departments and the public sector, and a rejection of short term public service targets in favour of long term measures of quality of life (Cairney and St Denny, 2015).

- Some emphasise the need to reduce health and other inequalities, while others emphasise the need to reduce the costs of acute or reactive services. Some describe a fanciful win-win scenario in which a reduction of inequalities also helps reduce costs.

Further, this experience is by no means unique. Internationally, concepts such as Healthy Public Policy and Health in all Policies can be found in the strategy documents of a non-trivial amount of governments (at this point in the discussion, Paul will make special reference to Canada while in Canada).

The gap between public health hopes, government action, and policy outcomes
Still, there is generally a gap between (a) what public health actors would like governments to do, (b) what governments do, and (c) the policy outcomes. For example, in the UK:

- Each renewal of prevention policy comes with a criticism by the current government of the failure of its predecessor (unusually so, I think).
- The long-term cumulative impact/ image is of continuous renewal of a strategy described by successive governments as a failure.
- This story contrasts with policymaker stories of tobacco control, in which each policy instrument represents progress towards – or a reinforcement of – comprehensive tobacco control.

Cairney and St Denny (2020) describe this prevention narrative as follows:

‘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’.

In prevention, this argument contributes to the sense of three ever-present obstacles to major policy change in the spirit of prevention:

1. Policymakers show support for policy before they understand what it means, beyond the vague idiom that ‘prevention is better than cure’. They choose a vague solution to an unclear problem.

2. When they begin to make enough sense of prevention policy to produce specific aims and objectives, their high-level attention is fleeting. When they relate prevention to their wider agenda, it becomes a relatively low priority, often secondary to – or undermined directly by – other policy aims (the classic example is hospital deficits solved by transfers from public health).

3. Policymakers try to deliver governance reforms within a complex policymaking environment over which they have limited understanding and even less control. In many cases, to counteract the illusory nature of their control, they often settle for the appearance of success, based on the popularity of their response or narrow indicators of outcomes, without addressing the ‘root cause’ of the problem they profess to be solving.
Insights from policy theory: beyond the usual explanations for limited progress

Perhaps the simplest explanation for this repetitive outcome is that policymakers know what they are doing. They deliberately choose a vague policy solution. They engage in creative or strategic ambiguity. The language of prevention – and evidence-based policymaking – helps them to depoliticise issues and generate broad, superficial, or temporary cross-party or public support. While doing so, they do not intend to deliver on their promises, or have no belief that they will follow through. They measure their success (in McConnell’s, 2010 terms) according to how popular the policy makes them, or how easy it is to process, rather than the long-term health and wellbeing outcomes. They exhibit low commitment and low political will.

However, we push back against this argument for three main reasons. First, the assumption of high cynicism or low will can exacerbate the problem that public health actors want to solve:

if new policymakers truly think that the problem was the low commitment and low competence of their predecessors, they will begin with the same high hopes about the impact they can make, only to become disenchanted when they see the difference between their abstract aims and real world outcomes (Cairney and St Denny, 2020).

Second, we focus on the obstacles – related to policy ambiguity and policymaking complexity - that would still be there even if policymakers exhibited high competence, commitment, energy, and will.

Third, we focus on the political trade-offs that arise when policymakers address ambiguity by making more specific choices, including between: funding for preventive/ reactive services; (one version of) EBPM versus localist or participatory policymaking; and, mainstreaming public health or concentrating public health aims in a single strategy or agency (Boswell et al, 2019).

Instead, our research connects these themes to key concepts in policy studies, which suggest (rather starkly) that (a) policymakers can only pay attention to – and understand - a small proportion of their responsibilities and (b) they engage in a policy process over which they have limited knowledge and even less control. These conclusions derive from studies of bounded rationality and policymaking complexity.

Bounded rationality and the profundity of ambiguity

Policymakers and policymaking organizations do not possess the cognitive and organizational capacity to gather and process all information relevant to their decisions, then make clear, consistent, and well-ranked choices. Rather, they face ‘bounded rationality’ (Simon, 1976), in which their possession and grasp of evidence, and their ability to make and implement consistent policy choices, is limited. Individuals combine cognition and emotion to address bounded rationality. Organisations may have more capacity, but they still rely on rules or standard operating procedures to help them ignore most information (Cairney, 2019a; Baumgartner et al, 2018; Koski and Workman, 2018). Policymakers prioritise some issues, some ways to define them as problems, and some information about them, and ignore the rest. Further, these problems do not decrease as our ability to produce more information increases (Cairney and Kwiatkowski, 2017; Botterill and Hindmoor, 2012: 367).
This focus on bounded rationality helps identify the important distinction between policy
uncertainty (describing a lack of information on a policy problem) and ambiguity (describing
a lack of agreement on how to define the problem) (compare with ‘radical uncertainty’ in
Tuckett and Nicolic, 2017). Actors produce more information to reduce uncertainty, but frame
problems to reduce ambiguity (Cairney, 2019c). They exercise power to (a) cooperate with
some actors, and compete with others, to (b) limit attention to specific ways to understand
public health policy problems and possible solutions, to (c) inform policy priorities and the
selection of policy instruments to focus. Ambiguity is crucial because, although there may be
a clear consensus on how to define policy agendas such as prevention in the abstract, it
becomes illusory in practice:

- We find a tendency among a small number of people in public health to believe that
  they know the precise meaning of key terms like prevention, social determinants, and
  health in all policies. Or, when things are not going well, they rediscover or reinvent
  phrases to sum up the same policy intent in new ways.

- However, phrases like HIAP suggest that this understanding needs to extend beyond
  such a small group, which suggests that in-group meaning is of limited value.

- For example, policymakers often use this language without making sense of it. They
  express superficial and unsustainable support for idioms (like ‘prevention is better than
cure’) and vague ambitions (like ‘health in all policies’). Then, they struggle to find a
  way to turn a broad aim or strategy into concrete objectives and actions.

- Part of the problem in resolving ambiguity is that it is a political process to address
  policy choice (e.g. on what problems do we focus? What should be the balance of
  funding between preventive/ reactive services?) and policymaking trade-offs (e.g. can
  you pursue ‘evidence-based’, localist and participatory policymaking simultaneously?). To resolve ambiguity is only the first step in making policy.

**Complex policymaking environments**

Policy theories identify five or six conceptual elements – Figure 1 - to describe the
‘environment’ in which policymaking takes place (Heikkila and Cairney, 2018; John, 2003;
compare with elements of complex policymaking ‘systems’ – Cairney, 2012):

1. **Actors.** A huge number of actors (people and organisations) make and influence policy
   across many levels and types of government. It is difficult to conceive of a small group
   of actors directing policy outcomes from the ‘centre’ (Cairney et al, 2019).

2. **Institutions.** This proliferation of actors contributes to a myriad of formal and informal
   rules across many policymaking ‘venues’ (defined as arenas for authoritative choice).
   Some rules are written down and understood widely. Others are implicit and may not
   even be communicated verbally (Ostrom, 2007). In studies of EBPM, this insight is key
to actors seeking to promote the same evidence in different venues (Cairney, 2016). In
studies of joined-up government, it presents a major challenge to the idea that different
actors will use the same idea – such as prevention – in similar ways across government.
Rather, they will refer to their own rules to interpret it differently, and it is difficult to
know how they will process new initiatives.
3. **Networks.** Each venue has its own networks of policymakers and influencers. Classic studies of ‘policy communities’ highlight a logic of delegating policy responsibility to relatively junior civil servants, engaged in routine consultation with a limited number of actors who trade information and advice for access (Richardson and Jordan, 1979, Jordan and Maloney, 1997; Jordan and Cairney, 2013). If so, most policy is processed out of the spotlight, at a low level of central government, in silos that often seem to defy central coordination. Or, policymaking reforms, such as localism, encourage the delegation of powers – and shift of policy communities - outside of central government departments altogether (Cairney and St Denny, 2020).

4. **Ideas.** The existence of many different venues, with their own rules and networks, contributes to the endurance of many different ways to understand the world and key policy problems within it. Terms such as *hegemonic* describe the fundamental ideas dominating discussion in each venue, and *paradigms* describe a tendency for ideas to be taken for granted and not questioned for long periods. The ideas I connected to public health may be taken for granted in one venue, but in others we may find entirely different logical starting points and frames of reference.

5. **Policy conditions and events.** Socioeconomic factors such as geography, demography, social attitudes, and economic activity are often out of the control of policymakers, and they contribute to non-routine events such as ‘crises’ relating to specific social groups or public services. Routine events such as elections can also produce major shifts in policy energy.

**Figure 1 the policy process as a turtle**

![Figure 1 the policy process as a turtle](source: Cairney (2018b)).

These factors contribute to the sense that elected policymakers or central governments are not in control of policymaking processes (at least in the way required of them to coordinate prevention-style policymaking). Rather, they set high-level policy aims but rely on many other
actors to make sense of and deliver them. There is debate within policy studies about the extent to which central governments can control policy outcomes (compare Bevir, 2013 with Sørensen and Torfing, 2009). One reading of the literatures on ‘multi-level’, ‘polycentric’, or ‘complex governance’ suggests that elected policymakers should not seek control (Cairney et al, 2019). Instead, they should be pragmatic enough to diffuse policymaking responsibility across political systems to give local actors the flexibility to respond to an ever-changing context (or accept that this power diffusion will happen anyway). Elected governments may still try to project an image of central control, but primarily to address their need to be held to account (particularly in a Westminster system).

Even in accounts more sympathetic to the idea of central government control, we can find a story that policymakers have to prioritise a small number of issues and ignore almost all of their responsibilities, while the delivery of their aims depends on the behaviour of a large number of actors. Clearly, they can set the policy agenda, by identifying the target populations most worthy of support, and directing resources towards some problems at the expense of others. However, a sole focus on these initial choices ignores the wider policymaking context over which they have far less control. An additional focus on implementation helps, but also opens a can of worms regarding how we understand and seek to promote it [PAC: check if it is clear that a focus on policymaking environments – or complex systems - is one way to study implementation without using the word ‘implementation’].

Identifying this context is crucial to any long-term consideration of prevention or initiatives such as HIAP. Although it is tempting to conclude simply that such policies fail because politicians do not engage sincerely or energetically, we argue that even the most sincere and committed policymakers would face major obstacles that they may never overcome. Political will and enthusiasm is not a good predictor of policy outcomes. Rather, policymaker stoicism may reflect a more practical realisation that they can only enjoy limited success (Boswell and Corbett, 2015).

**Ambiguity, complexity, and windows of opportunity: comparing prevention with tobacco**

A key way to understand the effect of ambiguity and complexity on prevention is with reference to a whistle stop tour of multiple streams analysis (Kingdon, 1984; Zahariadis, 2007; Herweg et al, 2018; Cairney and Jones, 2016; Cairney, 2019b; Cairney and St Denny, 2020). It suggests that major policy change will not occur unless three separate ‘streams’ come together during a ‘window of opportunity’:

- **Problem stream.** Policymaker attention rises to (a) a problem, and (b) a particular way in which to frame or understand it. This attention is fleeting, and based partly on the assumption that the problem is solvable.

- **Policy stream.** A technically and feasible solution already exists. To describe a policy solution as technically feasible, it should be specific enough to allow us to describe its likely or actual policy impact. This assessment differs from political feasibility, in which support could relate to something vaguer, and specificity could cause support to rise or fall.
Politics stream. Policymakers have the motive and opportunity to select that solution. The extent to which these windows open and close is a function of the environment rather than key individuals (with some exceptions that do not seem comparable to our focus). To all intents and purposes, Kingdon’s metaphors describe a complex policymaking environment over which no one has control. Rather, key actors – such as ‘policy entrepreneurs’ – are akin to ‘surfers waiting for the big wave’ (Kingdon, 1984; Cairney, 2018a: 200). They help the relatively long-term development of feasible policy solutions, and wait for the right time to exploit a (a) lurch of policymaker attention to a problem, and (b) temporary rise in motivation to solve it.

MSA helps us think through two types of potential policy change, summarised in Table 1. It may be worth thinking of them as ideal-types rather than specific examples. The first relates to the success story of tobacco control in countries such as the UK. In this case, we find three mutually reinforcing effects:

1. Attention rises to tobacco as a policy problem, framed primarily in relation to public health terms.
2. This framing reflects and reinforces a policymaking environment conducive to policy change. Health policymakers/ departments take the lead. Their rules favour evidential sources and consultation with health and public health groups. They interpret this information - and perceive shifting socioeconomic conditions (falling rates of smoking, tobacco taxation - through a public health (rather than economic) lens.
3. Both factors help create multiple windows of opportunity for the adoption of many specific policy instruments, which combine to produce comprehensive tobacco control and major policy change.

In comparison, Cairney and St Denny (2020) found generally that most initiatives pursued under the vague banner of ‘prevention’ were not specific enough to produce a similar dynamic. Rather, UK and devolved governments often described something akin to a window of opportunity for policy change, but they were actually describing a vague solution to an ill-defined policy problem. As such, this general agenda had minimal sense of ownership, exacerbated by a complex policymaking environment with multiple rules and networks. There were windows of opportunity for specific policy changes, such as the UK government’s ‘troubled families’ programme (Cairney, 2018b), but they did not contribute to a clear sense of policy change accumulation. Indeed, many advocates of prevention would probably not treat ‘troubled families’ as a good, positive example of prevention and early intervention (rather, the ambiguity of overall aims allows people to attach their solutions to them).

<table>
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<tr>
<th>Conditions for policy change</th>
<th>Tobacco control policy as a specific and clear agenda</th>
<th>Prevention policy as a general and vague agenda</th>
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<td>Table 1 Explaining the difference between tobacco and prevention policy change</td>
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1. Framing to reduce policy ambiguity and encourage new policy solutions.

Tobacco reframed as a public health epidemic, not economic good. There is routine and high attention to policy solutions. Prevention remains ambiguous and there is insufficient agreement on the most technically and politically feasible solutions.

2. A supportive policy environment

The public health frame helped departments of health take the lead, limit information searches to solve an epidemic, foster networks with public health actors, and respond to reduced smoking/opposition to regulation. The vague frame undermines a sense of ownership within government, enabling a proliferation of rules, information searches, networks, and responses to the socioeconomic context.

3. Successful exploitation of regular windows of opportunity

A supportive policy frame and policy environment increased the motive and opportunity for policymakers to select relatively restrictive policy instruments. There was a window for a vague prevention policy agenda with minimal policy direction. Policy solutions come and go, with a tenuous link to prevention.

Overall effect

A snowball effect in which a reframed problem, environment more conducive to policy change, and selection of policy instruments reinforced each other. A muted effect in which an unclear problem, complex environment, and limited policy change reinforce a dispiriting sense of limited progress.

Source: Cairney and St Denny (2020), which was adapted from Cairney and Yamazaki (2018), Cairney (2019b), and Studlar and Cairney (2019)

Comparing expectations for our HIAP review

These discussions help us create two rather different expectations for the direction of initiatives such as HIAP:

1. It is an ambitious, coherent, and feasible approach. A government’s HIAP strategy represents major policy change (first in intent, and then in delivery). I expect this to be the tone of most HIAP articles, written from a public health perspective with little reference to policy theory (connect to reviews by Oliver et al, 2014; Embrett and Randall, 2014).

2. It is an ambiguous approach, exacerbated by policymaking complexity in which no actor or organisation has strong coordinative capacity. A government’s HIAP strategy will come to represent a document of unfulfilled expectations and a substitute for major policy change.

A consensus within one group - on the nature of policy problems, and HIAP as the solution – is not the same as wider understanding and ownership of HIAP. It would not be surprising to find a heterogeneous mix of experiences when many different policy actors try to make sense of HIAP in different contexts. It would be a mistake to treat HIAP as a specific policy to be implemented in full rather than to be discussed, clarified, and amended by the actors - outside of health, in in other government departments – deemed crucial to its success. In this scenario,
the ‘politics’ of HIAP describes democratic processes to make sense of HIAP in the real world, not a pathological process that gets in the way of the aims of HIAP purists.

In that context, we are conducting a systematic* review of the HIAP literature with regard to these two different frames of reference. In doing so, we identify the need to move beyond vague measures of HIAP success, in relation to political will and commitment, and vague indicators of potential progress, such as a strategy to foster joined up government, towards identifying the more specific factors that cause policy progress.

[*discuss and seek feedback on method]

[finish paper]

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