Integrative Mechanisms for Addressing Spatial Justice and Territorial Inequalities in Europe

D6.4 Summary report on evidenced-based policy learning

Version 1.3

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Acronyms and Abbreviations

CES	Centre for Effective Services
CHSs	Community Health Services
DEIS	Delivering Equal Opportunity in Schools
EU	European Union
EBPM	Evidence Based Policy Learning
GM	Gender Mainstreaming
HIA	Health Impact Assessment
HIAP	'Health in all Policies'
HPP	Healthy Public Policy
IA	Intersectoral Action
IPH	Institute for Public Health
IPHP	Integrated Public Health Programmes
NACWG	National Advisory Council on Women and Girls
OECD	Organisation for Economic Co-operation and Development
SDH	Social Determinants of Health

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Summary

This report summarises the ways in which we are working with policymakers and their advisers to: make sense of a complex multi-level policymaking environment, and use research on the evidence of policy success to encourage policy learning between governments. It builds on Deliverable 6.1 (Conceptual Framework for Empirical Research) and Deliverable 6.2 (Summary Report on Multi-level Policymaking (the exercise to 'map' policymaking responsibilities for reducing inequalities)). This work currently consists of three case studies at different stages of development.

1. We produced a report on gender mainstreaming to reduce inequalities in relation to gender, commissioned by the *National Advisory Council on Women and Girls* (NACWG) in Scotland (see NACWG, 2020).
2. We are co-producing (with the *Institute for Public Health in Ireland*) a mid-term review of the Northern Ireland Executive's public health strategy *Making Life Better*, which focuses on 'health in all policies' to reduce health inequalities.
3. We seek to generate lessons from the Ireland government's success in addressing inequalities in education attainment via its *Delivering Equality of Opportunity in Schools* (DEIS) programme (see Deliverable 6.1 for the rationale).

In theory, these case study exercises help identify policy learning opportunities across the European Union, combining a systematic review of published research with new case study evidence. We focused initially on the UK and Ireland, largely because (a) these exercises require good relationships with policymakers, (b) fostered over a long period. Further, as we describe in Deliverable 6.2, parts of the work require a degree of expertise to identify the spread of policymaking responsibilities across levels of government. However, even so, our experiences highlight major constraints to research for policy learning.

Positive outcomes from the first two case studies include the opportunity to work with practitioners to ask new research questions, and to use these questions to examine a variety of ways in which different countries have sought to reduce inequalities. In both cases, we responded to key organisations seeking additional research and engagement. Their approaches represent our window of opportunity to meet demand. The latter case study is at the least-advanced stage of development, despite initially being our highest priority. In this case, there is no equivalent to a window of opportunity, since we are initiating the proposed exchange. We reflect on this comparison of case studies in our conclusion.

1. Background and Context

Our framework for policy learning is outlined fully in Deliverable 6.1, which defines learning broadly as the use of new information to update policy-relevant knowledge (see Dunlop and Radaelli, 2013). The following background text[1] summarises the ways in which we apply the framework to ongoing case studies. Our general aim is to (a) examine how governments try to reduce territorial inequalities, then (b) generate ways to identify the most successful examples (identifying an initial story of success, then

[1] We produced this text initially for the introduction to an article under review in *Territory, Politics, Governance* (Special Issue on territorial inequalities co-edited by Michael Keating).

identifying what evidence supports it), and (c) recommend the transfer of that success to other jurisdictions in the EU. As described, this aim seems deceptively simple and akin to a technical process of 'evidence based policymaking' (EBPM). However, it forms part of a highly contested process of political choice that takes place in a complex system over which policymakers have limited knowledge and control (Cairney, 2016; Cairney and St Denny, 2020).

It is not realistic to propose a technical, comprehensive, expert-driven model for policy learning, or seek to transfer policy lessons or solutions from one government to another without considering their policymaking contexts (Dunlop, 2017; Dunlop and Radaelli, 2013; 2018; Dolowitz and Marsh, 1996; 2000). Rather, policy learning is subject to 'bounded rationality' (Simon, 1976), in which policy actors can only process limited information about a small number of government experiences, and are unable to predict the effect of policy transfer. It is also a political process in which actors compete to define policy problems according to how they: interpret inequalities, identify technically and politically feasible solutions, and negotiate who should be responsible for their adoption and delivery in multi-level policymaking systems. Policies to reduce inequalities tend to cut across traditional boundaries of government departments, and responsibility for relevant policy instruments is spread across many levels and types of government. Supranational, national, and subnational governments cooperate or compete to take the lead (see D6.2).

This context helps explain the different ways in which people ask learning-related research questions. Policy participants seeking evidence often focus on gathering information to define and solve the problem quickly (e.g. Why can't we just find the evidence on what works? Why can't we just copy Sweden?). Policy scholars supplying information often focus on the need to incorporate key limitations such as policy ambiguity and policymaking complexity (e.g. How evidence-informed can policy learning really be? What types of transfer are feasible in a particular context?) (Cairney, 2016).

A pragmatic response is for scholars to engage directly in the learning process, to: (a) see it through the eyes of participants (how do they define and seek to solve this problem, and under what conditions?), (b) incorporate insights from policy studies to construct a feasible approach, and (c) reflect on this experience to inform research. Policy theories help us produce realistic policy analysis, and feedback from analysis helps us reflect on the value of theories (Cairney and Weible, 2017).

2. Case Studies

2.1 Case Study 1: Gender mainstreaming to reduce inequalities

The National Advisory Council on Women and Girls (NACWG, which reports annually to the Scottish Government's First Minister, Nicola Sturgeon) asked us to identify lessons from gender mainstreaming policies in other nations. Our remit was to produce a quick understanding of current mainstreaming policies in a small number of the most relevant countries to help inform the NACWG (2020) report.

Under those circumstances, we were unable to produce a comprehensive review of all potentially relevant experiences. We responded in three main ways. First, we applied the general framework that we had already developed for the IMAJINE project, partly in anticipation of such demand (Deliverable 6.1). The framework encourages policy learning practices that take into account the interaction between: (1) *politics*, in which actors contest the nature of problems and the feasibility of solutions (2)

bounded rationality, which requires them to use organisational and cognitive shortcuts to gather and use evidence, and (3) *policymaking complexity in multi-level policymaking systems*, which limits a single central government's control over choices and outcomes. These dynamics play out in different ways in each territory, which means that the importers and exporters of lessons are operating in different contexts and addressing an ostensibly-similar policy problem in different ways. Therefore, we must ask how the *importers of information* (seeking policy change) and *exporters of lessons* (who project policy success) think about the issue. How do they define the problem, decide what tools/instruments ('policy solutions') to adopt, establish which government is (or should be) responsible for those instruments, and identify criteria to evaluate the success of solutions?

Second, we demonstrated the connection between multi-level policymaking and the selection of policy instruments. Gender mainstreaming is defined by the Council of Europe as 'the (re)organisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy-making' (Council of Europe, n.d.; see also Booth, 2002; United Nations, 1997). In that context, the overall mix of policy choices often seems incoherent because the sheer weight of measures, combined with the spread of responsibility across many governments, provides high barriers to joined-up government. As Deliverable 6.2 describes, simply *identifying* a full list of relevant policy responsibilities is challenging. Table 1 provides a preliminary map of competencies for policy instruments relevant to a Scottish Government gender mainstreaming strategy in the UK in the EU.

Table 1 Gender mainstreaming policy competencies in the UK and Scotland

Level	Direct Competencies	Indirect Competencies
European Union	European Employment Strategy European Women's Lobby Analysis and dissemination of gender research Crime victims' rights European law on trafficking Sectoral gender equality monitoring EU Funding for gender equality initiatives Promotion of female entrepreneurship Gender budgeting	Fiscal policy Structural Funds Social security directives Citizenship policy Fundamental rights Research funding
EU Agencies	Fundamental rights monitoring and promotion	Development of work-related policies Health and safety monitoring Asylum support
UK/Great Britain Level	Implementation of equality strategy Sexual discrimination and equal pay laws Overall equalities strategy Public Sector Equality Duty Statutory guidance for schools on equal opportunities Armed forces gender policy and recruitment Employment regulation (inc. equal pay)	Criminal law Domestic violence prevention Asylum, refugee, and immigration policy Careers guidance Personal, Social and Health Education (National Curriculum) Welfare and social security policy, provision

	Voluntary equal pay agreements with employers Childcare and early years provision Maternity and paternity leave allowances Women specific health issues and screening (e.g. cervical cancer) Reproductive health provision Tax Credits Pensions Child Poverty Reduction Carers allowance Forced marriage policy, outreach, and casework Domestic violence courts Training for justice system employees Rape support centres Funding for women's organisations Anti-FGM strategy and awareness	Women's empowerment programmes in international development Prison and detention service management Pensions Transport provision Funding for equalities training and awareness Trade union relations Labour market regulation Overall fiscal and budgetary policy and strategy
UK/GB National Agencies	Monitoring and recommendations on equal opportunities Support for women seeking political office	Media regulation Serious organised crime policing (human trafficking) Immigration, refugee, and immigration processing and management
Scottish Parliament and Government	Implementation of equality strategy Equality research Implementation of Equality Act Childcare and early years provision Early years framework Reproductive health provision Abortion provision Prisons and woman offenders Forced Marriage Protection Orders Anti-violence strategy for women and girls Abortion provision Prisons and women offenders	Criminal law Trafficking victim support services and awareness Trade union relations Welfare eligibility criteria
Scottish Government agencies	Prisons and sentencing Social security payments Promotion of awareness, understanding and respect for human rights Councillor codes of conduct	Public sector pensions management Charity regulation Courts and tribunals Housing regulation Safeguarding children's rights
Local authorities	Implementation of public sector equality duty Anti-violence against women and girls strategies Women's political representation strategy Social care provision	Recruitment, pay and conditions of local government employees (including gender wage gap) Women's peer support networks Targeted apprenticeships for women

		Demographic monitoring and data collection Funding for community organisations Jobs guarantees and employment schemes Equalities awareness projects Relations with local employers Housing allocation Trading standards Environmental health Licensing

This picture is complicated by two additional factors. First, the overlap of responsibilities in practice, such as when the UK sets overall targets and guidelines, but Scottish and local governments become responsible for delivery. This dynamic takes place within a wider context in which, for example, the UK devolves only some aspects of policy (primarily social policies including health, education, and social work, as well as criminal justice and aspects of transport, tax, and social security) and allocates the Scottish Government budget. The UK Government can, simultaneously, place an equality duty on the Scottish government *and* produce policies which undermine it, such as recent welfare reforms that have affected women disproportionately (Cain, 2015). Second, a key aspect of GM strategies is to empower women through continuous policy co-production, and rigid boundaries of policymaking responsibility are not conducive to this approach (Engeli and Mazur, 2018).

Third, we show how policy actors address the limits to comprehensive policy learning by examining few possibilities. We chose three exemplar case studies of mainstreaming according to perceived levels of ambition and required policy change: maximal (Sweden), medial (Canada), and minimal (UK). Sweden and Canada were identified by stakeholders as key reference points, and the UK has special relevance since it controls aspects of Scottish policy.

This three-case comparison suggests that many of the difficulties experienced in achieving policy change are not country-specific:

- Some stem from policy ambiguity and contestation to define the policy problem. Policy is often deliberately ambiguous to generate support, and contemporary mainstreaming strategies could make gender all things to all people, producing the risk is that if 'gender is everybody's responsibility in general, then it's nobody's responsibility in particular' (Pollack and Hafner-Burton, 2000: 452).
- Some difficulties relate to priorities: policymakers take gender seriously, but most of their attention is focused on more general and higher profile economic and constitutional issues in which gender often plays a subordinate role (Cairney and Rummery, 2018).
- In multi-level policymaking systems, tensions remain between the need for (a) singular control, to define policy precisely and be held to account for progress, and (b) power diffusion and democratisation, to debate policy continuously and embed new norms and behaviours in policy and society.

Further, the 3-exemplar-comparison helps us define the meaning of success in such contexts. In this field, the case for policies designed to reduce gender inequalities may rest as much on the *belief that it is the right thing to do* as the *expectation of a substantive and measurable payoff*. In other words, we have necessarily moved a long way from the idea of 'evidence based' policy learning towards incorporating deliberation and values.

2.2 Case Study 2: Health in all policies

We are working with the *Institute for Public Health in Ireland* to help produce a mid-term review of the Northern Ireland Executive's public health strategy. Our initial report to the IPH is due at the end of March, followed by a joint report by the end of April 2020. As such, we describe the ongoing ways in which we have been conducting a systematic qualitative review of the literature on relevant public health strategies, supplemented by a more in-depth examination of key comparator countries. We are using IPH guidance (on which lessons are most relevant to our governmental audience) to seek lessons from the experiences of governments in the Netherlands, Scotland, and Ireland, and combining our systematic review with a small number of qualitative interviews with policymakers and experts. To do so, we:

1. identify relevant background and context from the lesson-providing country (in this report, the Netherlands)
2. map key policymaking responsibilities (following the rationale in D6.2)
3. examine developments in policy
4. examine developments in policymaking, and
5. reflect, so far, on what is missing from such analysis (partly to help frame additional interview-based research).

2.2.1 Learning about 'health in all policies' (HIAP)

Making Life Better is a public health strategy designed partly to meet the principles of the global 'Health in all policies' (HIAP) agenda. HIAP is a broad term to describe the need to address:

1. a *policy problem* (the 'social determinants' of health inequalities), with
2. a collection of evidence-informed *solutions* (policy instruments to reduce inequalities), combined with
3. a *policy style* (associated with terms such as 'joined-up government', 'whole systems' approaches, and 'collaborative governance'), and
4. high political commitment.

As such, it shares with gender mainstreaming a focus on (a) combining specific policy solutions with (b) a policymaking style that emphasises co-production inside and outside of government. It also shares with mainstreaming the sense that there is a major gap between high level ambitions (such as to reduce inequalities) and actual practices and outcomes, and very few governments have filled that gap in a meaningful way.

In that context, there is potential to learn from research on the efforts of leading governments to adopt HIAP strategies (in this document we summarise the experience of national and subnational governments in the Netherlands). However, policy learning is by no means straightforward. For

example, our initial aim was to identify and synthesise lessons from peer-reviewed journal articles on HIAP. Our initial guiding questions were:

1. *The 'what works?' question*. What do the authors describe as 'working', for whom, in what circumstances, in what respects and why?
2. *What lessons can be learned, and transferred, to Northern Ireland?* For example, do they identify ways in which policy actors can generate ownership or support for the principle of a public health strategy? For example, how do they connect a broad strategy to specific policy instruments, identify the outcomes, and measure their success?
3. *What factors are crucial to successful transfer?* For example, do they consider the context or conditions in which they were successful, and are they present in Northern Ireland?
4. *Who is responsible for that transfer?* For example, does the study discuss the scale or level of government at which policy is made?

2.2.2 Learning from the Netherlands

1. Background and context

Our initial finding is that vanishingly few studies answer these questions. For example, many Dutch studies assume that HIAP would work as intended if implemented, and are focusing on the measures to detect more or less progress on HIAP 'maturity' (Storm et al, 2014). The general argument is that most of the 'social determinants' of health inequalities (SDH) cannot be solved by the policies of health departments (Box 1). Rather, they need to cooperate with a wide range of organisations – inside and outside government – to make and deliver effective policies.

Box 1 Exemplar quotations: HIAP in Dutch central and local government

On social determinants: 'Only joint efforts of multiple sectors and actors could effectively influence the determinants that underlie health inequalities, such as low income, unemployment, low level of education, unfavourable working conditions, and an unhealthy life style' (Storm et al, 2014: 183)

On joining-up government: 'On a political level, commitment for a HIAP strategy includes whole-of-government elements such as having a broad vision on health, stimulating sectors outside the public health domain to improve population health, supported by a visible and approachable unit, using Health Impact Assessment (HIA), and evaluating the results and effects of HIAP' (2014: 184).

On the ambiguity of HIAP: 'From an analytical point of view the concept of HIAP can be defined in different ways, but also empirically it can mean different things. It has been proven difficult to identify and to measure both processes as well as outcomes of HIAP' (Storm et al, 2014: 184).

On the gap between HIAP aims and actual practices: 'Establishing HIAP has been found to be exceptionally complex. It has, for example, been found difficult to engage other sectors, to link problems and solutions for several sectors, and to take care of a sustainable approach' (2014: 184).

For example, Peters et al (2016: 290-1) describe HIAP as state-of-the-art in thinking about public health policy, and at the aspirational end of a continuum on 'integrated public health policy' in which 'intersectoral action' (IA) is its more modest comparator:

1. IA is 'a one-directional, health-centred approach, involving policy integration in the implementation stage'. It 'involves efforts by the health sector to collaborate with other public

policy sectors to improve health outcomes', with 'goals narrowly related to health and the use of communicative policy instruments to tackle individual lifestyle determinants'

2. HIAP is 'characterized by a systematic examination of SDH, broad goal definitions related to health, well-being and equity, and a dynamic policy response across portfolio boundaries by governance networks, consisting of governmental as well as societal actors'.

However, the practical meaning of HIAP is not clear, and all relevant studies highlight a large gap between a vague statement of intent and actual progress. This problem should caution against the assumption that HIAP is necessarily effective, and to be wary of ill-evidenced stories of success in other countries. These points are reflected in historical lessons from the Netherlands, summarised in Box 2.

Box 2 General lessons from Dutch HIAP research

1. De Leeuw and Polman (1995) describe a long history of policy development from the 1960s, in which HIAP-style reforms received *some attention but insufficient support*.
2. Storm and colleagues (2011; 2014; 2016) initially identify HIAP *aspirations* from 2001, but *limited progress*.

- Their first study (2011) highlights renewed commitment and policy objectives (not outputs or outcomes). The aims are quite general, and the policy solutions are ideas from interviewees, not specific instruments with an evidence base of success.
- Their second (2014) develops a 'maturity model for HIAP' to measure progress at municipality level.
- Their third (2016) identifies the *assumptions* about HIAP's effect on inequalities (if implemented) rather than the evidence.

The overall effect is:

- A 'maturity' model from which we can learn, to identify a problem, outline a proposed solution, and monitor its progress, *but also*
- A story of *assumptions* and *expectations* for better outcomes not demonstrated with evidence, which
- Identifies the importance of a commitment to collaborate to develop shared goals, but does not incorporate wider studies of policymaking and public administration (such as published evidence on joined-up working).

2. Mapping policymaking responsibilities

One key lesson is that HIAP's success is determined by cooperation inside and outside government, and across levels of government. In that context, Table 2 helps us picture the scale of that task. For example, it helps show that local government plays a strong role in HIAP formulation and delivery, primarily via (over 400) municipal governments. Legislation dictates that municipalities are tasked in a general sense with the protection, monitoring, and promotion of their citizens' health and more specifically for 'youth health care, environmental health, socio-medical advice, periodic sanitary inspections, health facilities for asylum-seekers, screening, epidemiological research, health education and community mental health' (Maarse *et al,* 2018).

The framework for public health provision in the Netherlands is underpinned by the 2008 Public Health Act, which sets out the institutional relationships detailed in Table 2. The 1989 Collective Public Health Prevention Act made municipal government responsible for various elements of public health policy,

with a 2008 update to the legislation integrating policy over infectious diseases and quarantine, to create a greater delineation of responsibilities and to introduce the principle of revisiting public health planning and to bring the Netherlands more into line with World Health Organization guidance. Further, Community Health Services (CHSs) are under the purview of municipalities, and both are supported by the National Institute of Public Health and a number of health promotion knowledge institutes (Boot and van Oers, 2015: 180).

There is also a role for regional government. First, many municipalities deal with their small scale and limited reach by pooling resources, such as via regional health services. Second, provincial governments enjoy a limited range of powers over issues such as spatial planning and transport, and environmental regulation, which play an indirect role over health policy generally and public health provision specifically. However, authority to make decisions on public health is largely shared between central government, the municipalities, and regional health services.

Table 2 Public Health Policy Competencies in the Netherlands

Level	**Direct competencies**	**Indirect competencies**
European	Common Agricultural Policy Common safety concerns in public health matters Regulation of medicinal products Cross border health Labour market regulation Consumer and food standards policy	International trade and Investment policy Common agricultural policy Food standards Health and safety standards
National	Public Health regulation, funding, supervision and international collaboration Emergency management Public health data collection and dissemination Agricultural policy Natural conservation Pharmaceutical policy Vaccination policy Welfare system policy and administration	Funding of academic collaboration on; epidemiology, infectious diseases, public mental health, youth health care, environmental health and demographic changes. Broad fiscal and taxation framework Management of health service Housing policy
National Agency	Prevention and control of infectious diseases, the promotion of public health and consumer safety, and environmental protection. Food and product safety Health inspection Health and safety Scientific advice to central government Healthy living promotion Public safety	Transport and public safety Scientific research Environmental assessment Public information provision Land registry and mapping Consumer protection Environmental data Public infrastructure and water management Tax and customs administration Labour, work, and income inspection

	Health and youthcare inspection	
Regional	Emergency health services (ambulances)	Environmental and water regulation
Municipalities	Production of four-yearly public health plans Youth health care Environmental health, Socio-medical advice, Sanitary inspections Health facilities for asylum-seekers Screening Epidemiological research Health education Community mental health	Spatial planning Social security Waterway management

As Deliverable 6.2 suggests, one role of such tables is to highlight that governments may seek to share or learn lessons from each other, but the first step is to identify which level or type of government is responsible. For example, the Northern Ireland executive may be seeking lessons from multiple levels of government on behalf of a different combination of governments in its own system.

3. Analysing policy developments

The Netherlands has pursued a broad range of interventions, initiatives, and regulations, which seek to address three public health priorities of smoking, alcoholism, and overweightness, working with outside organisations such as supermarkets and alcohol producers and sports clubs. It also plays an important role in facilitating upwards and downward flows of information in terms of evidence and information gathering and awareness campaigns (Table 3).

Table 3 Public Health Policy initiatives in the Netherlands

Problem area	**Policy interventions**
Smoking	Increase in excise duty Point of Sale Ban on Tobacco products from 2021 and E-cigarette POS measures Promotion of smoke free public spaces through partnerships Promotion of addiction support for pregnant women Collaboration between different tiers of government on provision of anti-smoking services Public healthcare institutions made smoke-free; public funding for pilot programmes in other healthcare institutions Partnerships with private sector to create 'smoke free' big businesses (top 100), encouragement of tobacco divestment Encouragement/fact finding on 'smoke free government offices'. Company doctors encouraged to promote anti-smoking

Problematic Drinking	Healthy schools programme to incorporate anti-alcohol messaging and promotion and awareness raising, higher education institutions to increase support, with support from Dutch Brewers Association Research into impact of alcohol on sports advertisements Target to end alcohol advertisements in sports at amateur clubs (phased out within four years) Research into social media advertising of alcohol and impact on children Ban on advertising alcohol free beer to children Research into 'Scottish style' Minimum Unit Pricing Development of early detection platform (in partnership with health services in public and private sectors) Sports clubs to decrease alcohol provision including phasing out of
Obesity	Promotion of 'wheel of five' products (healthy eating guidelines) with private sector partners (e.g. Hotel and Catering Association and supermarkets) - particularly to children Training for supermarket employees on healthy eating Research on avoiding excessive consumption Investigation of 'nudges' and pricing policy to promote better eating in the catering industry Development of advertising code including limitations of branded children's characters on unhealthy food Increased healthy food provision in schools (950 new school canteens) 'Covenant' on healthy sporting events with municipalities Government restaurant facilities and hospitals to offer healthier eating options Encouragement of smaller portions by catering organisations Research and Development in key sectors such as agri-foods Improvement of sports facilities, training and recruitment of sports coaches Development and implementation of healthy schools programme and promotion of healthy childcare (including by social workers) Healthy neighbourhoods agenda Improved diabetes care and coordination between agencies

4. Developments in policymaking

Storm et al (2014: 183) suggest that central and local governments may seek to implement HIAP policies but not know how to measure progress. They outline a 'maturity model for HiAP (MM-HiAP)' and apply it to Dutch municipalities.

Storm et al (2014) developed a six-stage measure of HIAP maturity:

- "Stage 0 'Unrecognized': there is no specific attention for the problem, in this case the problem of health inequalities.
- Stage I 'Recognized': municipalities recognize the problem and the solution of HIAP and there is clarity which activities will alleviate the problem.
- Stage II 'Considered': there are preparatory HIAP actions on parts of the problem. For example, HIAP is described in the local health policy document as a means to reduce health inequalities, collaboration between health and non-health sectors is started (project-based), and there are preparatory actions and activities to influence determinants of health inequalities.

- Stage III 'Implemented': HIAP investments in several problem areas exist. Non-health sectors are involved in the policy making process as well as in the process of policy implementation to reduce health inequalities. Collaboration agreements are made between sectors. Structural consultation with others sectors and the presence of a key person for HIAP are available.
- Stage IV 'Integrated': quality processes are an integrated part of HIAP. There is a broad, shared vision on how to reduce health inequalities by HIAP, and there are visible milestones (both content and process).
- Stage V 'Institutionalized': there is a systematic improvement of HIAP quality. There is political and administrative anchoring of the HIAP approach and HIAP is considered at every municipal policy cycle".

At each stage are factors that relate to *individuals* ('uniform language, existence of good relations, positive experiences'), *organisations* ('shared interest, visible health implications of the sector, sufficient resources, adequate timing') and '*political factors*' ('high sense of urgency, sufficient support') (2014: 185).

Notably, their sample of 50/441 municipalities yielded **16** willing to participate, with non-participation related strongly to non-development of HIAP policies (2014: 186). Further, 3/16 reached Stage 1 (*acknowledging* the role of HIAP), 7 stage II (collaboration on specific projects), 4 Stage III (with a clearly defined programme manager), 2 Stage IV (with elected politicians sharing a collective vision), and zero at Stage V.

In each case, common facilitators included a 'common language', 'good relationships', 'clarity' on how non-health sectors could contribute, resources, and a sense of 'urgency' and support among elected officials at later stages (2014: 189).

Further, Peters et al (2016: 291-2) use documentary analysis (of pilot applications) and interviews with policy officers to analyse the 34 municipal pilot projects under the 'Gezonde Slagkracht Programme' (2009-15). The Dutch Ministry of Health, Welfare and Sports 'provided financial and professional support' for municipal governments to pursue 'integrated public health programmes' (IPHP) on 'overweight, alcohol and drug abuse, and smoking' themes. They found:

1. A tendency for (particularly 'overweight') projects to remain on the IA end of the continuum, in which the public health sector would initiate, health actors would predominate, policy goals were narrowly defined, and initiatives focused on communication and the lifestyles of individuals (2016: 294).
2. Some projects on alcohol and drugs exhibited HPP characteristics, in which more non-health actors initiated and became engaged in policy, and there was more focus on environmental causes of problems, and a greater use of economic and legal policy instruments.
3. Very few projects sought to address all areas, but this focus exhibited most HIAP characteristics, in which actors from many policy sectors (inside and outside government) were involved, there were broadly defined goals (such as on wellbeing), there was a focus on the social determinants of health, and there was a changing mix of policy instruments to reflect new evidence (2016: 293-8).

In other words, they identify 'limited though not negligible degree of policy integration', driven more by political reality than epidemiological evidence, to an extent that represents some progress but 'may not be sufficient to tackle wicked public health problems' (2016: 300).

5. What is missing from this analysis?

These descriptions help us identify *to some extent* the levels of government responsible for policy, the priorities of each government, and the pursuit of joined up government. However, at this stage of analysis, we identified a need to move from HIAP *assumptions* to *evidence* from more research. For example, there are many more-general literatures on collaboration that provide reviews of relevant evidence, including (for example) Institutional Collective Action (ICA) studies which summarize the conditions under which 'semiautonomous' governing bodies 'overcome barriers to collective action and reduce the risk and uncertainty of collaborative arrangements' (Swann and Kim 2018: 286). More generally, Carey and Crammond's (2015: 1022-8) review of the literature on 'joined-up government' notes that *such initiatives are expensive* and *failure can be demoralising*. In that context, success depends on factors such as:

- a 'supportive architecture', in which agreed aims/ goals are matched to the means to achieve them, but with enough flexibility to allow people to adapt to the dynamics of coordination efforts
- mutually reinforcing changes at multiple levels of government (from central to 'street'), perhaps reinforced by shared targets
- high commitment by politicians, to help cut through 'administrative silos' and address 'turf wars'
- strong 'leadership' at all levels to ensure that all relevant bodies sign up to necessary changes (although note that there is also another large literature on leadership styles)
- skilful actors, in problem-solving, coordination, brokering agreements, engaging with non-governmental actors, and developing high knowledge of the system
- the ability of leaders to be able to work inside and outside formal arrangements, which might include establishing control in new bodies, or roles, to reduce reliance on established rules (although the disjuncture between action and accountability could be a problem)
- focusing on a manageable number of aims and policy instruments
- a powerful narrative to challenge business-as-usual approaches and give different actors a common purpose

These conclusions are supported and supplemented in more recent reviews, such as Molenveld et al's (2020: 9) identification of the need to overcome widespread scepticism about yet more 'joined up government' initiatives, and Elliott's (2020: 9) more specific study of the 'Scottish Approach' to policymaking – from which the Northern Ireland government is learning – to identify the conditions under which people support long-term cultural change. Our aim is to incorporate such insights into the HIAP analysis, and to supplement a general picture of Netherlands policy development with interviews on specific initiatives.

2.3 Case Study 3: Inequalities in education attainment

Case study 3 is still in development. Below, we reproduce the document that we prepared in 2019 to inform interviewees about our plans (although we first began to talk with stakeholders about these

plans in 2018). When it became clear that the access we require would take some time to secure, we focused our resources on case studies 1 and 2.

"Overall purpose of the project

IMAJINE (Integrative Mechanisms for Addressing Spatial Justice and Territorial Inequalities in Europe) is funded by European Research Council Horizon2020 to foster 'spatial justice' and examine how to reduce inequalities across Europe.

What do we plan to do in Ireland?

We plan to conduct qualitative interviews in multiple regions across the EU to examine how policymakers and practitioners (a) describe and seek to address inequalities, and (b) could learn from each other and, in some cases, transfer policies.

We describe this plan initially in How to use evidence to identify, learn from, and transfer policy success and have broken the process into three main themes.

Theme 1. How do policymakers define issues such as inequalities and relate them to their wider national or regional context?

In this case, we focus on definitions of educational inequality in Ireland.

Theme 2. How do they describe their own success?

In Ireland, key policymakers and practitioners have described policy success in reducing education attainment inequalities (such as via DEIS). There is considerable OECD benchmarking evidence (and follow up evaluations in Ireland) to support this claim.

Theme 3. From where/ who do they learn?

In this case, our main focus is on how to generate a story of policy success to share with other policymakers. Our main emphasis is on sharing lessons across EU countries and regions, but there is also some scope for sectoral learning (such as between education and health).

What do we need from the Department of Education and Skills and its partners to complete this project well?

1. *Knowledge*. The Department of Education and Skills possesses indispensable knowledge and insights on the development of policy and practice. We will also be supported by the Centre for Effective Services (CES), drawing on their work in policy and practice in Ireland. CES will act as the local partner to provide context to the project in Ireland and enable dissemination. Its knowledge is essential to help us make sense of our research in context, primarily via regular communication as we conduct research.

2. *Access*. We seek ways to identify and interview key policymakers and practitioners, to help us answer our three thematic questions.

3. *Engagement*. Our aim is to feed back this research, to (a) help our stakeholders reflect on the story we tell of policy success (as relative outsiders), and (b) help us sense check our findings as we communicate them to a wider audience.

Our method

We use qualitative methods to gather new data, focusing primarily on semi-structured interviews (in person, using consent forms for participation and data storage), using written notes rather than audio (to provide anonymity and encourage frank responses). We used this method successfully to produce research for our Oxford University Press (2020) book (*Why Isn't Government Policy More Preventive?*), based partly on interviews with Scottish Government civil servants, while addressing two major issues: (1) heightened political sensitivities before/ after the Scottish independence referendum, and (2) discussion of policy advice to ministers, which necessitated an unusual process to gain clearance for interviews.

What other governments and departments are involved?

The proposal for an Ireland-based case study began as a sole focus on education. However, there may be scope for some comparisons with public health policies (in relation to work conducted by the Institute of Public Health) and connection to preventive spending plans (via preliminary contact with the Prevention & Early Intervention Unit, Department of Public Expenditure and Reform).

In the first instance, I plan to share these insights with civil servants in the Scottish Government (such as via the First Minister's Policy and Delivery Unit responsible for cross-cutting issues such as inequalities).

How will we share our findings?

We aim to convene a roundtable discussion with academics, practitioners, and policymakers. We will provide a case study report in multiple forms:

- a short policy brief for practitioners to inform the discussion,
- a blog post summarising discussions (such as this post for NHS Scotland https://publichealthreform.scot/latest-reform-news-and-blogs/institutionalising-preventive-health)
- publication in a peer reviewed journal (e.g. https://paulcairney.files.wordpress.com/2019/03/boswell-cairney-st-denny-2019-ssm-preventive-health-agencies.pdf)
- a chapter in a proposed book published by a University press (e.g. https://global.oup.com/academic/product/great-policy-successes-9780198843719?cc=nl&lang=en&)"

2.4 Reflection on the case studies so far

Each case study is a work in progress, but our experience so far already raise two kinds of research issues:

1. Practical issues on conducting research in this way

Each case study focuses primarily on seeing the policy issue through the eyes of national or devolved governments. We focused initially on the UK and Ireland, largely because (a) these exercises require good relationships with policymakers, (b) fostered over a long period. However, even under those conditions, our experiences highlight major constraints to research for policy learning.

Case studies 1 and 2 are driven by demand for research in a small window of time. In each case, a government or advisory body sought new evidence during its own review process, and our window of opportunity to encourage policy learning related almost entirely to that demand. As such, if we were willing to adapt, we were able to feed information into a policy learning process already underway. Policy learning in case study 1 was highly limited, and it shows researchers the stark constraints they may face when engaging with policymakers. Our audience sought a very quick (one month) and limited analysis (of key countries, and trends), did not initiate discussions on research design, and did not seek to engage with the complex mapping exercise that we produced. In comparison, case study 2 demonstrates a good model for learning, combining (a) a pragmatic approach to meeting temporary demand for evidence with (b) new research on how potential lessons relate to current practices, building on (c) regular discussions on research design and findings.

In contrast, in case study 3, we are seeking to *generate* demand through engagement, and there is no equivalent window of opportunity. This experience prompts us to reflect on the relative willingness of governments to encourage researchers to (a) *learn somewhat from other governments* (to import general lessons), rather than (b) *examine their own success systematically* (to learn and export specific lessons). The imbalance between research demand and supply is predictable and understandable (indeed, we describe this dynamic in Deliverable 6.1 and Cairney, 2016). However, it also undermines the types of policy learning we recommend in Deliverable 6.1, since governments often appear to be: (a) seeking to learn lessons from others in a too-short space of time, and (b) unwilling to examine their own practices systematically to help others learn from them.

2. Substantive empirical issues on policy/ policymaking to reduce inequalities

A combined focus on new case studies - 'gender mainstreaming' and 'health in all policies' – and our previous work on 'prevention' and 'early intervention' initiatives (Cairney and St Denny, 2020) reveals common lessons about the relationship between policymaking expectations and outcomes in relation to territorial inequalities:

1. Case studies highlight the potential virtues of general approaches, often described as system-wide collaboration, co-production, collaborative (multi-level) governance, or joined-up government.
- However, many of these likely benefits are assumed (particularly in HIAP studies), and more systematic public administration studies may provide more useful lessons.
2. Many strengths of the systems providing lessons appear to rest on a well-developed policymaking infrastructure specific to that country.
- The more we relate policy progress to a country's history and institutions, the less confident we can be about transferring specific lessons about policy instruments.
3. Case studies often highlight the need to balance (a) policy coherence driven by a central government with clear aims (perhaps backed by high capacity to commission research), and

(b) local discretion, to help make and implement decisions at a level closer to the country's citizens, and to co-produce and tailor policies to local communities.

- They raise unresolved issues regarding the trade-offs between centralised and localised action. For example, local initiatives may emerge in a profoundly different form than HIAP (or perhaps gender mainstreaming) scholars envisaged. What happens if emergent policies meet the criteria for collaboration but not for a well-evidenced policy response?

In most cases, these questions can only be addressed with clearly identifiable political choices for which we can hold elected officials (and other actors) to account. In that context, we continue to seek new knowledge on exactly how governments are making such choices.

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