NZ SSC, VUW & ANZSOG present:

PREVENTION IS BETTER THAN CURE: SO WHY AREN’T WE DOING MORE OF IT?

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MODERATOR

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DO YOU HAVE A QUESTION ABOUT TODAY’S TOPIC?

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ALL QUESTIONS WILL BE ANSWERED AT THE END OF THE PRESENTATION

SLIDES FROM TODAY’S PRESENTATION WILL BE AVAILABLE ON THE ANZSOG WEBSITE
Prevention is better than cure, so why aren’t we doing more of it?

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See blog for full discussion:
https://paulcairney.wordpress.com/
What is prevention?

1. Policy

Intervening earlier to:

- improve wellbeing
- reduce inequality
- reduce costs
What is prevention?

2. Policymaking

- Joined-up government & ‘wicked’ problems
- Local and service-user responsibility
- ‘Assets based’ & doing it with you, not to you
- Long-term outcomes, not short-term targets

3. ‘Evidence based’
Three reasons for limited success:

1. Ambiguity

*Policymakers don’t know what prevention means.*

They face problems when they define it.
Three reasons for limited success:

2. Complexity

They engage in a policymaking system that is too complex to control.

They need to:

- localise *and* centralise.
- share *and* take responsibility
- be pragmatic *and* decisive
Three reasons for limited success:

3. ‘Bounded rationality’

They are unable & unwilling to produce ‘evidence based policymaking’.

Or:

- their use of evidence is pragmatic
- they have to ignore most of it
- evidence reduces uncertainty, not ambiguity
The danger of misdiagnosing this problem

Avoid too-simple explanations: ‘low political will’ or ‘incompetent politicians’

Why?

New policymakers will assume they are different ....
... producing a cycle of despair:

(a) initial period of enthusiasm and activity replaced by

(b) disenchantment and inactivity

and

(c) potential for this cycle to be repeated without resolution.
Pause for breath/to avoid despair

Any questions so far?
What makes prevention so difficult to define?

1. *What problem are we trying to solve?*

Inequalities, funding, governance
What makes prevention so difficult to define?

2. On what problem should we focus?

Inequalities.
Wealth, occupation, income, race, ethnicity, gender, sexuality, disability, mental health?

Measures.
Economic, health, healthy behaviour, education attainment, wellbeing, punishment.
What makes prevention so difficult to define?

3. On what solution should we focus?

Reduce poverty
Reduce inequality
Improve general wellbeing
Reduce costs
Increase value for money
What makes prevention so difficult to define?

4. Which ‘tools’ or policy instruments should we use?

Redistributive and ‘structural’, to reduce poverty?

Individual-focused to:
(a) boost ‘resilience’ of public service users,
(b) make or ask people to change behaviour.
What makes prevention so difficult to define?

5. How do we intervene as early as possible in people’s lives?

Primary
Secondary
Tertiary
### 6. How do we pursue ‘evidence based policymaking’?

<table>
<thead>
<tr>
<th>How should you gather evidence?</th>
<th>Implementation science</th>
<th>Story telling</th>
<th>Improvement method</th>
</tr>
</thead>
<tbody>
<tr>
<td>How should you ‘scale up’ from best practice?</td>
<td>Hierarchy of evidence, RCTs</td>
<td>Practitioner knowledge, Service user feedback</td>
<td>Mix of evidence, Trained practitioners, experimenting, and evaluating</td>
</tr>
<tr>
<td>What aim should you prioritise?</td>
<td>Uniform model, Fidelity to dosage</td>
<td>Tell stories, invite people to learn</td>
<td>If you think your practice is working, keep doing it</td>
</tr>
<tr>
<td></td>
<td>Administer the active ingredient</td>
<td>Governance principles: localism, respect</td>
<td>Training, experimenting, feedback</td>
</tr>
</tbody>
</table>
What makes prevention so difficult to define?

7. How does evidence gathering connect to long-term policymaking?

Central government driven?

Agreements with or targets for local authorities?
What makes prevention so difficult to define?

8. *Is preventive policymaking a philosophy or a profound reform process?*

E.g. holding on or letting go?
What makes prevention so difficult to define?

9. What is the nature of state intervention?

Supportive?

Punitive?
Any questions so far?
Making ‘hard choices’: what problems arise when politics meets policymaking?
What problems arise?

*The scale of the task becomes overwhelming, and not suited to electoral cycles.*
What problems arise?

*Competition for attention and money*
What problems arise?

*The benefits are relatively difficult to measure and see.*
What problems arise?

*Policy problems are ‘wicked’*
What problems arise?

*Performance management (overall) is not conducive to prevention.*
What problems arise?

Major ethical dilemmas on state intervention.
What problems arise?

One aspect of prevention may undermine the other

E.g. devolve budgets locally, reduce budgets
What problems arise?

*Someone must be held to account*

So, how can you share accountability?
Any questions so far?
‘The evidence’ is not a ‘magic bullet’
‘The evidence’ is not a ‘magic bullet’

Qualitative evaluation & counterfactual (FIPs)

Randomised control trials (FNP, Triple P, IY)
‘The evidence’ is not a ‘magic bullet’

The evidence on ‘scaling up’ for primary prevention is relatively weak

E.g. fidelity and training

E.g. scaling up/ transferring success
‘The evidence’ is not a ‘magic bullet’

The evidence on secondary versus tertiary early intervention presents a dilemma

E.g. clinically referred v risk predictors

E.g. focused minds v relatively suspicious

Is tertiary prevention really prevention?
Conclusion:

Prevention is part of an excellent idiom but not a magic bullet for policy problems

Vague consensus is no substitute for political choice

Understanding problems = addressing them

Beware the ‘political will’ conclusion
THANK YOU

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Politics of policy making

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www.sustainablecities.org.nz
www.resilienturbanfutures.org.nz
Who has the power?

• Evidence-based or evidence-informed policy?
• Importance of networks
• Scientists can be “sifters, synthesizers & analysers”
• Framing & defining problem – prevention or palliatives?
• Profound change can take 2 or 3 decades
“Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution”.

Public health advocacy

- Starts from recognition structural inequalities shape health
- Need to help set the agenda & frame the issue for policy-makers & public
- Robust solution-focused research
- Randomised community trials provide high quality causal evidence
- Process as important as outcomes
Housing problems
Searching for solutions

• Cold, damp & mouldly homes
• High rate of home injuries
• Health effects of leaky buildings
• Poor quality of unregulated rental housing
• Inadequate stock of accessible housing
• Decline in social housing
• Increasing rates of homelessness
Influence of insulation & heating research on policy

• Framing of problem around co-benefits
  • Housing & health
  • Energy efficiency
  • Climate change
  • Employment creation
  • Regional development
  • Social capital

• Increasing focus on poor quality of rental housing
560 NZ HOUSES assessed from September 2015 to June 2016

46% of households did not heat bedrooms in winter
51% of children's bedrooms were not heated in winter

HEATING HABITS

44% of owned
56% of rented
Mould was most commonly found in bathrooms.
Mould was more commonly observed in houses lacking effective heating, ventilation and insulation.

MOULD

was visible in 49% of all homes
Managing mould

VENTILATION

Only around \( \frac{1}{2} \) of homes had an extractor fan in the bathroom venting to outside
Only around \( \frac{1}{2} \) of homes had an extractor fan in the kitchen extracting to outside

HEATING APPLIANCES

Heat pumps
40% of owner-occupied
25% of rentals
Wood burners
39% of owner-occupied
40% of rentals
Electric heaters
25% of owner-occupied
33% of rentals
Portable oil-filled gas heaters
4% of owner-occupied
15% of rentals

INSULATION

53% could benefit from retrofitted insulation in the roof space and/or subfloor
47% had less than 120mm or insufficient coverage of insulation in the roof space
19% had insufficient coverage of insulation in the subfloor

HOUSE MAINTENANCE

Owned vs rented property

BRANZ House condition survey
Effect of insulating existing houses on health inequality: cluster randomised study in the community

Philippa Howden-Chapman, professor and director, Anna Matheson, PhD student, Julian Crane, professor and codirector, Helen Viggers, data analyst, Malcolm Cunningham, principal analyst, Tony Blakely, professor, Chris Cunningham, professor, Alistair Woodward, professor, Kay Saville-Smith, director, Des O'Dea, lecturer, Martin Kennedy, adviser, Michael Baker, senior lecturer and codirector, Nick Waipara, scientist, Ralph Chapman, associate professor, Gabrielle Davie, biostatistician

He Kainga Oranga, Housing and Health Research Programme, University of Otago, Wellington, PO Box 7343, Wellington South, New Zealand

Department of Medicine, University of Otago

ABSTRACT
Objective To determine whether insulating existing houses increases indoor temperatures and improves occupants' health and wellbeing.
Design Community based, cluster, single blinded randomised study.

INTRODUCTION
The quality of housing affects the health of the population. Improvements to housing could potentially prevent ill health, especially in sections of the population exposed to substandard housing. Several reviews of social interventions, and housing interventions in particular

Study DVD www.healthyhousing.org.nz
Operation Housing
Medical Students for Global Awareness
Figure 1. The frequency of media reports of healthy, unhealthy, damp or cold housing (1995–2015).

Warm Up NZ: Primary Prevention

- Retrofitted insulation & heating
- Inter-sectoral, multi-party, international recognition policy
- Policy piloted locally before implemented nationally
- Major impact on central, regional and local government, NGOs
- Products regulated, process audited
- Previous Labour Govt allocated 1 billion dollars Household Fund, National Govt $383m, funding from current Labour Govt
Policy evaluation: multi-disciplinary

• 330,000 houses retrofitted
• Evaluation commissioned by govt, quasi-experimental study detailed anonymised matching of first 46,655 houses
  • significant drop in metered energy
  • significant reduction in pharmaceutical usage, length of hospitalisation, avoidable mortality for over 65s
• Benefit/cost ratio for adults 3.9:1, children & older people 6:1

Well Homes: Secondary Prevention

Well Homes is a **free** service that may be able to help your whānau with:

- Beds & Bedding
- Carpet
- Curtains
- Heating
- Insulation
- Minor Repairs
- Mould Cleaning Kits
- MSD/Work & Income Assistance
- Other - i.e. Health or Social Referrals
- Social Housing Relocation
- Ventilation

Please phone us on 0800 675 675
Summary: framing & advocacy

- Academics can facilitate translation of research to policy
- Collaborate, look for allies for framing & policy experiments
- Involve communities, local & central govt in framing from beginning
- Conduct robust independent research
- Measure co-benefits, health & wellbeing, powerful population approach
- Demonstrate both public & private benefits
Summary

• Advocacy & research can lead to important multi-party policies
• Reducing inequalities requires all-party support for medium- & long-term strategy
• Solution-based policy options still require govt to make strategic decisions, allocate $$ & concerted implementation
• Small country advantages facilitate state experiments
Questions?

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Speaker: Professor Donald Moynihan

Wellington 1 November 2018

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