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New political science analysis of the renewed push for preventive health: 'Can it be any different this time around?'

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ABSTRACT

The idea that 'prevention is better than cure' is often treated as self-evident in health policymaking: who would not want to shift resources from mitigating acute problems to their prevention? However, there is always a gap between rhetorical commitments and practice, producing cycles of enthusiasm then limited progress. If prevention returns to the top of the agenda, how can this time be different? To answer that question, we applied new political science analysis to recent efforts to promote prevention via Integrated Care Systems (ICSs) in England. We theorise persistent barriers to prevention caused by limited: *clarity* regarding its meaning in practice, *congruity* with routine policy delivery, and *capacity* to sustain major changes. We engaged with local and national health and care policy practitioners to explore how these barriers have manifested in practice. We convened seven focus groups (2024) containing sixty participants, then used qualitative thematic analysis to categorise challenges and responses. This approach helped to identify barriers including: short-termism; financial and operational pressures; routine limits to cooperation; untapped community assets; and limited opportunities for peer learning. It also sparked discussion on feasible enablers, including: systems leadership; collaboration to make the wider determinants of health 'everyone's business'; techniques to frame preventive projects as deliverable and evidence-backed; 'institutionalising' prevention; and the better use of data. Paradigm shift towards prevention requires long-term repeated efforts to bolster political support for change and support local collaboration to build and maintain systemic capacity. Political science-driven analysis helps to frame and support this process.

1. Introduction: the politics of prevention

The idiom 'prevention is better than cure' is often treated as self-evident in policy initiatives across the globe: it is better to prevent a problem than solve it once it has occurred. In public health, it underpins the broad idea that governments can reduce health inequalities and the cost of public services by intervening early or at a population level to prevent problems from arising or getting worse (Cairney and St.Denny, 2020). This may be done with reference to whole population measures (primary prevention), identifying at risk groups (secondary), preventing known problems from worsening (tertiary), or a combination of measures to address multiple causes of morbidity or ill health (Williams et al., 2008).

UK governments have used this idiom repeatedly over eight decades to signal a major change in *policy*, to shift resources from reactive to preventive services, and *policymaking*, to enable services to collaborate across the public sector and with stakeholders outside of government (Billis, 1981; Cairney and St.Denny, 2020). In the last decade, UK health organisations and commissioned reports to government use the prevention lexicon to signal that, without a shift in policy and policymaking, the National Health Service (NHS) in England will face profound crisis (NHS England, 2014; Hewitt Review, 2023; Darzi Review, 2024). This call for a shift to prevention enjoys remarkably high support, including cross-party support in Parliament and reports from academics, professional associations and think tanks.

The most recent call for prevention arose from reforms of health and social care in England: the establishment of Integrated Care Systems (ICSs). In 2022, the UK government legally established 42 ICSs as vehicles to encourage health and social care improvement via collaboration among NHS, local government, and voluntary, community, and

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social enterprise (VCSE) organisations. A key element of reform is to promote a shift to prevention, as described by the Hewitt Review (2023), central government policy (NHS England, 2024) and the strategies produced by Integrated Care System (ICS) partners (NHS Confederation, 2024).

However, evidence from political science research shows that there has always been a large gap between prevention policy and practice. Reviews of global progress towards preventive health strategies highlight bursts of enthusiasm then disenchantment (Cairney et al., 2021). In the UK, prevention efforts in multiple policy sectors come and go without becoming 'institutionalised' or showing a substantive impact (Boswell et al., 2019; Cairney and Cairney and St.Denny, 2020). Therefore, it is imperative to learn why prevention is easy to promote but difficult to deliver, and incorporate these lessons into policymaking. Too little reliance on political science and policy science evidence produces ineffective approaches to policy and practice.

Our novel contribution is to adopt a political science-driven framework to understand the challenges and opportunities facing preventive health policy in England during this transition to ICSs. We synthesise then operationalise key insights from political science to guide new research, conducting focus groups with policy actors across England to identify the current barriers to, and potential enablers of, prevention in the work of ICSs. Our analysis revealed familiar challenges around defining and measuring prevention activity, and building and sustaining preventive action in a context of financial stress. The analysis also unveiled some politically-aware ideas for promoting prevention in future through the strategic alignment of short- and long-term imperatives, more effective means of benchmarking and measuring preventive action, and clever use of new data infrastructures and skills. Our novel method helped to uncover wider contextual factors that hinder progress in preventive health, but also to share ideas for navigating and combatting those hindrances.

2. Theoretical framework

We generated a new political science-driven model for research and practice. We designed this model to (1) synthesise a wealth of political science research insights to (2) inform more sophisticated policy and practice that anticipates systemic barriers in policymaking. This broad focus on systems is familiar to the public health scholars and practitioners (Rutter et al., 2017). It also resonates with research inspired by Pawson's (2013) 'realist' approach to policy evaluation, to infuse evaluative frameworks with an appreciation of the difficulty of pinpointing the outcomes of health and social policy interventions (by identifying how they worked, for whom, and in what context).

We take such research forward by conceptualising and responding to the political dynamics of policymaking. Complex systems analysis already sheds valuable light on the complexity of *policy problems* and the need to relate the impact of one policy instrument to a wider *policy mix* of many instruments (e.g. a 'soft drinks levy' is one of many means to influence population diet and health – Rutter et al., 2017: 2). In addition, our approach engages with the – analytically distinct - dynamics of complex *policymaking systems*. In other words, we analyse the policy process as a complex system, exhibiting 'emergent' practices or outcomes that defy central control, requiring a greater understanding of how many semi-autonomous local actors make decisions (Cairney, 2012). For example, we emphasise the practical and political challenges associated with local actors trying to collaborate to solve policy problems that cut across traditional governance sectors, levels and jurisdictions. Further, the typical evaluation in public health seeks to zero-in on the delivery mechanisms that enable or hinder interventions. It misses the wider *governance context* for those interventions, such as to examine *what* is delivered and *how*, including the extent to which policymaking is fuelled by collaboration or competition (Cairney, 2017; Cairney and Toomey, 2024). This focus on governance is a key concern for policy actors seeking collaborative approaches to complex problems, as exemplified by growing attention – in research and practice - to the idea of 'systems leadership' (Cairney and Toomey, 2025a, 2025b).

There is clear value to understanding the political context and its impacts on policymaking. Explaining the lack of tangible action and earmarked funding for prevention needs to involve much more than frustrated claims about a lack of 'political will' or assumptions of bad faith from political leaders (these vague assertions remain prevalent in academic public health discourse – Post et al., 2010; Cairney et al., 2021). We also need to grapple with the systemic political dynamics that afflict policymaking across all setting and sectors, particularly in approaches such as prevention that are as much about collaboration to produce and maintain policies as their delivery (NHS Confederation, 2021) and the 'micro politics' that can affect collaboration (Clarke et al., 2021: 3; Waring et al., 2023a). Taking politics seriously means turning to political science, which offers theoretical insights and methodological tools to explain, anticipate, and address the challenges of pursuing preventive public health in policy and practice.

Our framework synthesises political science evidence to explain key barriers to progress. Our 3Cs framework identifies limited: *clarity* regarding the meaning of 'prevention' in practice, *congruity* with routine policy delivery, and *capacity* to sustain major changes in the name of prevention (Cairney et al., 2021).

2.1. Clarity: if prevention means everything, maybe it means nothing

Political science research shows that ambiguity can begin as a blessing then become a curse. Research on the discursive dynamics of policymaking – including 'frame', 'narrative', and 'discourse' analysis (e.g. van Hulst et al., 2024; Hajer, 1995) – affirm the value of an ambiguous goal in sustaining a coalition of actors who would not otherwise agree. Yet, ambiguity can then lead to fragmented or limited action. It delays difficult conversations, prompts people to talk at cross purposes, and gives more powerful and better-resourced actors room to ensure their interpretations are favoured when turning vague promises into action (Zahariadis, 2003; Boswell, 2016).

In this context, the vague language of prevention helps to maximise initial support: who would be against preventing problems? However, it also delays essential discussion on how to translate abstract aims into concrete action: who can collaborate without knowing how and why? When discussions take place, we find intense debates about the *main priority*, such as reducing inequalities or costs, and *preferred policy tools*, from providing individuals with information, to regulating behaviour, reorganising services, or taxing/spending to redistribute income. These differences can reflect profound disagreement on the role of the state: to intervene and redistribute resources, or to foster individual responsibility for health and wellbeing. The scale of investable activity is also vast in relation to primary/secondary/tertiary initiatives.

2.2. Congruity: prevention is out of step with routine government business

A core focus of political science is on the institutions – rules and norms - that shape and frustrate policy action (Lowndes and Roberts, 2013). Institutions sustain government business: siloed public bodies with fixed lines of responsibility, standard operating procedures that favour established ways of planning and measuring interventions, and routine short-term budgeting and electoral cycles. Extensive scholarship outlines the real-world barriers that frustrate efforts towards joined-up work (Boswell, 2023; Cairney and Toomey, 2024). Further, it is a truism in policy studies that any policy mix will produce unintended consequences that undermine coherent action (Peters, 2018; Cairney, 2025), and that performance measures and funding incentives can encourage 'gaming' in systems (Hood, 2007).

In that context, preventive may be sidelined whenever it is incongruous to the 'way things work around here' (Cairney et al., 2022). When governments make sense of prevention, they struggle to relate it to more pressing higher priority aims. For national governments,

prevention does not deliver economic growth or 'cashable' savings. Public service reorganisation is not a quick fix, and the prospect of taxing and spending to redistribute resources 'upstream' or impose new 'nanny state' laws to regulate behaviour is not appealing. Further, prevention's offer of long-term improvements to health or wellbeing does not help an elected government measure and declare short term success. For local public bodies, prevention sounds like a great way to collaborate, but only after they deliver their high stakes statutory commitments and respond to immediate demands. Academic and grey studies of 'systems leadership' in health and social care in England also highlight these difficulties even when actors across systems express a sincere commitment to change how they do things (e.g. Timmins, 2015; Miller, 2020; Gordon et al., 2023; Walker et al., 2022; Goss, 2021; Cairney and Toomey, 2025a; 2025b).

Hence, reformers have two unappealing choices. First, by definition, the promise of radically different ways of making policy clash with the established ways of doing things, and change will be tough. Second, the promise to align preventive aims with current business will lead to major compromises, involving the need to balance short- and long-term challenges. Indeed, we have found that specialist prevention-focused agencies (e.g. public health agencies) have too-limited powers, and 'mainstreaming' policy is difficult when most service delivery organisations have more pressing priorities (Boswell et al., 2019).

2.3. Capacity: low support for major investments with uncertain rewards

Political science insights relate policymaking challenges to a background of state retrenchment and austerity in recent decades (e.g. Marsh et al., 2024). Put simply, UK central governments have limited resources *and* 'levers' to pursue a prevention agenda (Cairney and St Denny, 2020). They rely on actors from other governmental departments or sectors to make and deliver policy, and they struggle to make the case for upfront investment in interventions that promise return on long and uncertain timescales (Boswell, 2023; Cairney et al., 2024).

These insights help to demonstrate that no policy can improve lives, reduce inequalities, and avoid political and financial costs. Preventive policies involve a multi-pronged approach and necessitate 'hard choices'. They are often akin to capital investment - spend now and receive future benefits – but without a clear and agreed way to demonstrate a return to investment (or support for new ways to demonstrate public value). This offer is not attractive to governments seeking to avoid controversial investments and reduce spending. Prevention may represent an investment of political capital akin to a 'leap of faith' that few policymakers are willing to take, and require a level of systemic capacity that is difficult to find.

3. Methods

Design: Our aim was to understand how actors within ICSs have been using their new systems to promote prevention. Our design was informed by an interpretive orientation. This style of research, common in political science and policy studies, foregrounds the experiences and perceptions of policy actors and privileges rich qualitative insight. Given the rapid timeframe of the project (to complete the research to inform policy before the next UK General Election) we opted for focus groups rather than one-to-one interviews. We could speak to many more people in a shorter space of time, and the whole research team could attend the focus groups to accelerate collective analysis. We arranged most focus groups around a common 'level' or 'role type', with representatives across a diversity of systems, to help participants feel freer to reflect on obstacles and blockages across the system, and learn about each other's experiences.

We finished with a focus group that featured actors across a single exemplar ICS that made demonstrable progress on prevention and from which we might learn. In practice, the insights from this group were not notably different from those that had already emerged. Participants were not as upbeat about their experiences and expectations as we anticipated (partly because they were now facing budget cutbacks), and discussion largely confirming previous accounts of many challenges and some possible enablers.

Recruitment: The NHS Confederation team led on recruitment, drawing on their relationships and convening power. An open call for participants was placed in February 2024, drawing 80 responses. The project team selected a mix of participants for each focus group (subject to adjustments relating to diary coordination). We ran 7 focus groups with 6–12 participants, totalling 60 participants across 22 different systems, and all 7 NHS regions in England (March–April 2024). We used Microsoft Teams web-conferencing.

Stimulus and Data Collection: We used the 3Cs framework to guide group discussion (Cairney et al., 2022). Participants were sent a blog post in advance (summarising Cairney et al., 2022), then a short presentation at each group. It helped to explain the topic guide (Table 1), then prompt spontaneous reflections, and discussion on 'what might be different this time?'

We encouraged participants to ask questions, prompt debate, and identify aspects of prevention that we did not address fully (aided by suggestions from our project partner and advisory group - NHS Confederation, 2024). This approach helped to keep discussions open but focused enough to aid cross-group comparison and analysis. A few participants challenged aspects of our framing, although largely to translate or contextualise our key themes, rather than reject them or their underlying premises. Others built their discussions on our framing. Either way, the academic provocation boosted useful interactions on our key themes.

We recorded but anonymised responses to encourage frank discussion among groups. We then drafted a practice report: generating key themes and constructing storylines that combine insights from one or more participants rather than providing direct quotations (unless they encapsulate a point perfectly, and gave permission). Discussions lasted around 90 min, transcribed using MS Teams software and aided by research team notes. To comply with the ethical approval received from the Universities of Stirling and Southampton, only Cairney and Boswell had access to the transcripts (although all authors attended the focus groups).

Analysis and write-up: The thematic analysis reflected a process of moving between the 3Cs framework derived from policy theory and patterns that emerged more organically in the discussions – in other words, a form of abductive reasoning which is core to the interpretive approach to policy analysis (e.g. Schwartz-Shea and Yanow, 2013). We

Table 1
The 3Cs framework and topic guide.

Clarity	Congruity	Capacity
What do we mean by prevention?	Do you have a vision or aspiration for your prevention work? Is this formalised in a plan or strategy?	Are ICSs able to unlock the required resources for prevention?
What interventions sit within this definition?	How does your prevention work align with other priorities?	How can central government support prevention?
Is there an agreed definition of prevention in your ICS?	Can you provide any examples of how to embed prevention across all system partners, making it routine business?	Who leads prevention work in your ICS? How do all leaders across system partners enable the shift towards prevention?
Would it be helpful to have nationally defined set of preventative interventions?	Who holds responsibility/ accountability for aligning prevention work across your system?	Can you provide an example of/from a local area or system where effective leadership is unlocking or augmenting capacity for preventive action?

began by focusing on key barriers then enablers (informed partly by discussion of 'good practices'). We tested emerging findings in multiple ways: (1) 'storyboarding' the findings with the project team, (2) sharing findings with latter focus groups, and (3) engaging with our project partner and advisory group. This process informed a short practitioner report focusing on policy recommendations (NHS Confederation, 2024). Here, we use the 3Cs structure to explain the role of political science concepts and new research on prevention politics and policymaking.

4. Findings

4.1. Barriers relating to clarity: competing values, perspectives, timescales, and language

Has the prevention agenda been able to avoid the mixed blessing associated with pleasing buzzwords that lose their power and purpose through the long march of policymaking? Participants certainly expressed familiarity with these dynamics. Discussions revealed alternative strategies for dealing with the problem of defining prevention: some want to use existing attention around prevention to assert a stronger public health ethos (the moral case); some want to use attention to generate gains without causing conflict (the pragmatic case); others believe prevention has become problematically vague and favour a newer, bolder framing.

4.1.1. A moral case or a pragmatic case?

For some, prevention should be a vehicle for winning hearts and minds: the moral case for state intervention, to foster the public good, and challenge the idea that individuals should take sole responsibility for health. For example, social justice frames emphasise anger about the inequity higher levels of illness and mortality in deprived areas, racialised inequalities in opportunities for health, and routine exclusion in relation to disability. Advocates argue that the moral case should always be emphasised, informing conversations to foster humanity, to care, to use empathy to frame why health creation is vital. The prevention agenda helps to surface values, such as to ask why – in practice, if not in policy – we value the health of some communities and social groups while others feel like they are 'left to rot'. This frame often informs a focus on the 'social determinants of health', which suggests that most influences on population health – including income and wealth, education, and access to safe and healthy homes and environments - are not to do with healthcare (World Health Organisation, 2020). In addition, advocates of preventive mental health described the value of social or non-clinical approaches.

For others, prevention appeals more as a vehicle for pragmatic and health service-focused changes. Otherwise, it can be seen as too overwhelming. A focus on achievable aims – in relation to specific groups or priorities - can make the difference between action and inaction. From a 'top-down perspective', the first aim is to persuade national policymakers and central government departments (including His Majesty's Treasury) that a preventive initiative works better than the alternative. To that end, focus on prevention to reduce the burden of disease in the population, producing results that are societally beneficial and free up healthcare resources by preventing readmissions to emergency care. For example, lung disease prevention combines (a) national policy instruments like taxation and regulation of tobacco and smoking, (b) smoking cessation services, and (c) targeted lung health checks, and all add up to transformed population outcomes.

These moral and pragmatic cases could reflect contrasting value judgements about the balance between state and individual responsibility. Yet, some respondents see potential to combine frames to appeal to different audiences or maximise motivation. For example, some use the moral case to win hearts and the practical case to win minds: treat prevention as intrinsically important *and* a contributor to healthcare economics; demonstrate the social value of initiatives *and* demonstrate the return to investment (ROI). Some seek to persuade policymakers to prioritise the moral case: remind people that reducing NHS demand is a *proxy* for aims such as population wellbeing, not an *end*; challenge the tendency to prioritise 'choking off demand' for the NHS, and ask broader questions about what interventions are for and what good outcomes from intervention entail. The argument is that a focus on cost-saving may be part of a necessary political game, but we also need to challenge that thinking, such as to maintain morale if some are alienated by the translation of ill health into a £ cost or a devaluation of state intervention.

This emphasis on moral and pragmatic cases informs discussions of the balance of priorities between three broad categories of prevention: the primary focus on whole population measures to intervene as early and broadly as possible, the secondary focus on identifying groups at-risk of health harm and prioritising resources on specific kinds of prevention, and the tertiary focus on more reactive service changes to prevent existing conditions getting worse. While the moral case may begin with a whole population approach and prioritise addressing inequalities, many see value in secondary and tertiary prevention. Early detection helps to make targeted use of scarce resources, long-term condition management helps people to live with conditions (e.g. diabetes, cardiovascular disease) and prevent worse health, while reactive services - such as mental health crisis support – have an immediate impact on wellbeing.

4.1.2. 'I hate that word prevention'

We were struck not only by the diversity of responses on what prevention means in practice, but also some opposition to the term 'prevention'. Some thought that its vagueness undermined its value because it has proven impossible to come to a common understanding. Some find other phrases more useful. We heard passionate discussion of what phrases to use to explain (a) the policy problem and (b) the mindset or systemic changes required to solve it. Different terms - social determinants, wider determinants, living conditions - motivate different audiences, and some metaphors gain more traction during meetings to establish the value of prevention. Examples include.

- The 'wider determinants of health' describes the need for a mindset shift from the medical model to social and living conditions. Many described an 80/20 split to explain: 80 % of health determinants are outside of healthcare services, and 20 % comes from healthcare.
- 'Shift to the left' describes the left-part of a graph of activity over time (not 'left-wing' beliefs), signalling the need to do things earlier in health pathways rather than waiting to treat people when sick (e.g. Graphnet Health, 2024).
- 'Health creation' is a community-centred and positive term that challenges the deficit model of the burden of disease and connects to wider aims such as patient-driven change.
- Focus on issues such as homelessness to prompt collaboration around a tangible problem (where responders know their role).

4.2. Barriers relating to congruity: short-termism and the old ways of doing things

The move to integrated care systems promises a break from the institutional status quo, and thus a 'window of opportunity' for preventive health in England (see Kingdon, 1984; Cairney et al., 2021). So, we asked, is anything different this time around? We found that providing space for participants to name policymaking barriers and share experiences is key to collaboration. Such 'forewarned is forearmed' discussions are essential to maintain institutional memory and underpin a collective shift towards discussions of solutions. During this phase, we were struck by the wide range of barriers and the sense among many participants that some challenges were worsening and placing greater limits on preventive work (focus groups took place towards the end of 14 years of Conservative-led government, which began in 2010 with a push for 'austerity' – Cairney and Kippin, 2024). This discussion

helped to identify challenges faced by professionals at the 'front line'.

4.2.1. Short-term pressures

Participants near-unanimously reflected that the classic challenge is to maintain a long-term preventive agenda during short-term health and care pressures. The NHS 'runs so hot' that there are limited resources for prevention to take off the pressure, and inadequate leadership 'bandwidth' to think and act differently. There is less 'airtime' for wider determinants during overwhelming winter pressure on NHS capacity. The main priorities are immediate issues such as hospital discharge, which overshadow longer term issues of equity and prevention across primary, secondary and community care.

In theory, there is scope to relate such pressures to a longer-term focus on prevention, such as to identify the negative impact of ignoring at-risk groups and the long-term conditions likely to drive Accident and Emergency (A&E) demand. Indeed, this challenging focus on the biggest sources of healthcare spending – such as emergency pathways and acute hospital trusts - is crucial to preventive efforts and reallocation of resources towards preventive budgets. For example, the core spend on health and social care is huge compared to pockets of money for preventive initiatives. However, discussion revealed the difficulties of translating theory to practice during periods of crisis. Issues such as waiting lists are 'proximal', while long term strategies, investment, and anti-poverty measures are 'distal' (seen as too far away, too abstract, too hard).

4.2.2. Measuring success

It is difficult to connect a long-term preventive agenda to short-term measures of performance, particularly if seeking to measure the benefits of trust and cooperation. Participants described frustration with the dominant currency of evaluation and the 'artificial precision' of measures of £ per quality adjusted life year (QALY). It is difficult to quantify the health impact of complex and joined-up measures in this way. Rather, they seek more meaningful tailored measures, such as qualitative evidence to produce a 'community-led evidence base'.

Participants described prevention as evaluated unfairly in relation to core NHS activity. Prevention is under greater pressure to demonstrate return to investment than other interventions (e.g. surgery for heart disease). The promise of spending now to save money later is only a requirement for prevention. This emphasis on measurement can cause 'transactional fatigue' when asked constantly for evidence for what works. For example, asking community groups to prove that a small project worked prompts a high VCSE labour cost, and it makes activity look transactional rather than transformational and collaborative.

4.2.3. The challenges of doing cross-system cooperation

Participants reflected on these challenges of meaningful integration in a fragmented system. Problems include organisations or silos operating according to different incentives and having access to different policy 'levers' whose overall impact is difficult to coordinate. To some extent, participants related this problem to 'micro politics' and turf wars, following a legacy of a UK-government driven internal market that pitted public services against each other (see Clarke et al., 2021: 3; Waring et al., 2022, 2023a, 2023b; Anandaciva, 2018). These old tensions may still exist in relation to informal divisions of roles, in which healthcare actors may seek to follow local authorities or more established public health initiatives rather than share responsibility for leading prevention initiatives. The existence of multiple initiatives with different badges – such as health prevention and local 'place' based initiatives – may also contribute to the separation. The latter is a key reflection, since 'place' is the new ambiguous phrase used to focus local public service collaboration (Atkinson et al., 2015; Local Government Association, 2018).

4.2.4. Perverse incentives and unintended consequences

Participants related incoherence to a general sense that the UK political system provides organisations with strong incentives for hospitals and primary care doctors to disinvest in 'wider determinants' in favour of medical treatment and reactive services, even while professing the need for investment in preventive care. The unintended consequence is to push more people towards NHS services then asking services to do more prevention. They described a need to take costs out of the NHS system, cope with current pressures, *and* spend to anticipate future costs. It is too difficult to do all three well, and the third option loses out.

4.3. Barriers relating to capacity: limited core funding, low morale, and untapped cross-system potential

Public health research often uses the vague term 'low political will' to connect blame for limited progress to elected or senior policymakers (Post et al., 2010; Cairney et al., 2021). Here, we focus on low systemic capacity, which includes financial resources and the sense that most capacity is embodied in public service staff numbers and how they use their time. In that context, does a shift to integrated care help to unlock this capacity?

4.3.1. A lack of substantive and sustainable funding

We learned that chronic and acute financial challenges make it hard to present a case for health investment even in contexts of earnest enthusiasm. Funding for prevention projects is often non-recurrent, and the continuous need to make the business case is resource intensive and described as strange if the case for prevention has been won. Public health professionals complained about a 'double standard' of heightened scepticism applied to preventive health, whereby the evidence required to make the case for a non-health intervention can seem much higher than those applied to clinical or pharmaceutical interventions. Yet, if organisations do not play the finance game, prevention initiatives will lose out to interventions whose effects are more immediate or measurable. Participants described this dynamic as worsening during financial crisis. Funding pressures are immediate and the impact of acute funding is visible, which adds pressure to translate a prevention agenda into an eye-catching way to support 'quick fixes'.

4.3.2. Low morale

It is common to identify reduced morale in organisations where people have been through many dispiriting crises or initiatives with limited results, producing mistrust associated with 'initiativitis' (Paton, 2016; Gibson et al., 2023). Participants may also be demoralised if playing but losing dispiriting political games: they accept the limited impact of a moral case and seek practical ways to make a pragmatic strategic case for prevention, but still find that their cases are harder to make when buzzwords become overused then devalued among policymakers. For example, arguments with reduced traction include describing the economic productivity gains of preventing illness, a social return to investment, or the language of 'early intervention'. These problems continue towards prospective evaluation and investment: participants need 'quick wins' and success stories to demonstrate the value of non-health approaches, and there is high demand for 'social value' tools, but many successes are local, connected to key individuals, and difficult to scale up.

In that context, some participants describe the importance of intrinsic motivation and leadership as an initial boost to prevention work, but with limited prospects for public service maintenance. NHS and medical practices may be working on the wider determinants of health but without being incentivised to do so, while dealing with siloed budgets and limited access to wider support. The will to do more is strong, but people are 'firefighting' while looking out for new opportunities to do more, such as by exploring initiatives like social prescribing and seeking to diversify income via grants. This problem seemed most dispiriting in ICS areas previously deemed to be inspirational sources of good practice, but now facing acute financial pressures and an imperative to prioritise emergency services, limiting preventive

work.

4.3.3. The untapped potential for VCSE involvement

Focus groups identified the untapped potential of VCSE organisations. Some suggest that VCSE have much to contribute at the *strategic level*, to change how leaders describe prevention and provide more access to meaningful engagement with citizens, and *operational level*, to work 'upstream' and provide more holistic social support in relation to pressing issues like hospital discharge and waiting list management. VCSE is valued in mental health prevention focused on creating communities that keep people well and literate in mental health rather than waiting to go to the NHS. If so, ICSs need VCSE help to be more agile, quicker, have access to different voices, and set a different tone.

In most cases, this positive assessment preceded a list of reasons for limited progress: ICS routines are not conducive to VCSE involvement, and there is limited ability to integrate its role into strategic thinking and service delivery. The main barrier is unsustainable funding and commissioning. There is too much 'throwing us a bone' based on temporary underspends and short-term contracts (for which there is too much competition), which makes it hard to plan or demonstrate success, and causes too much reliance on voluntary labour to fill funding gaps. A greater long-term systemic commitment during service planning and procurement planning (including breaking down huge grants into constituent parts) would be mutually beneficial. It would allow access to community values and knowledge as well as the untapped potential of small projects, which are good for: co-producing work, grass roots initiatives, engagement with a non-clinical language, early intervention on a small scale, and engaging with marginalised social groups to address highly unequal service provision.

5. Discussion: overcoming barriers to prevention

Political science-driven analysis is not to be mistaken with fatalism. Rather, we develop our approach to support 'positive public policy' (Cairney et al., 2024; Flinders et al., 2024). Our imperative is to use political science to highlight and help to boost elements of progress.

Therefore, our next aim was to ask: if there was limited progress last time, what would make the difference next time? What experiences of prevention can help to overcome routine barriers to change? What do systems leaders need to know about the relationship between the challenges they face and the skills and strategies that might help? We visualise the potential enablers and markers of progress in Fig. 1, based on focus group responses and the wider work – on prevention - of the authors.

5.1. Improving clarity: leading the agenda and making the case

Our findings demonstrate the value of taking time to establish common aims, language, and understandings. Some participants want to crack-on with action without becoming mired in definitional issues, while many recognise the need to engage with meaning: what are we preventing, for whom, and how? Some had convened workshops to establish this meaning and its implications, which is essential to defining the policy problem and establishing practical ways to address it.

Such questions help people to debate the pros and cons of two very different prevention-promotion stories. The first encourages actors to be bold, to emphasise the moral case, to describe the immorality of accepting the case for reducing inequalities and improving lives but claiming that it is too difficult to take prevention forward. The second story encourages them to be pragmatic, stealthy, avoiding language that isn't working or makes people defensive, looking for ways to manipulate, to get around barriers to progress (aka 'prevention ninjas', Boswell et al., 2019).

Our discussions unearthed variations of such stories. Some argued that making the moral case without the backup from evidence could devalue the language of prevention among influential audiences. Some suggested that the language of 80/20 has diminishing resonance across ICSs, or are concerned that taken-for-granted concepts in niche groups have less meaning outside of these groups ('health creation' and 'wider determinants' are not meaningful to many). Some expressed concern that oft-used terms had major unintended consequences, such as to provoke defensiveness during attempts at collaboration. For example, if

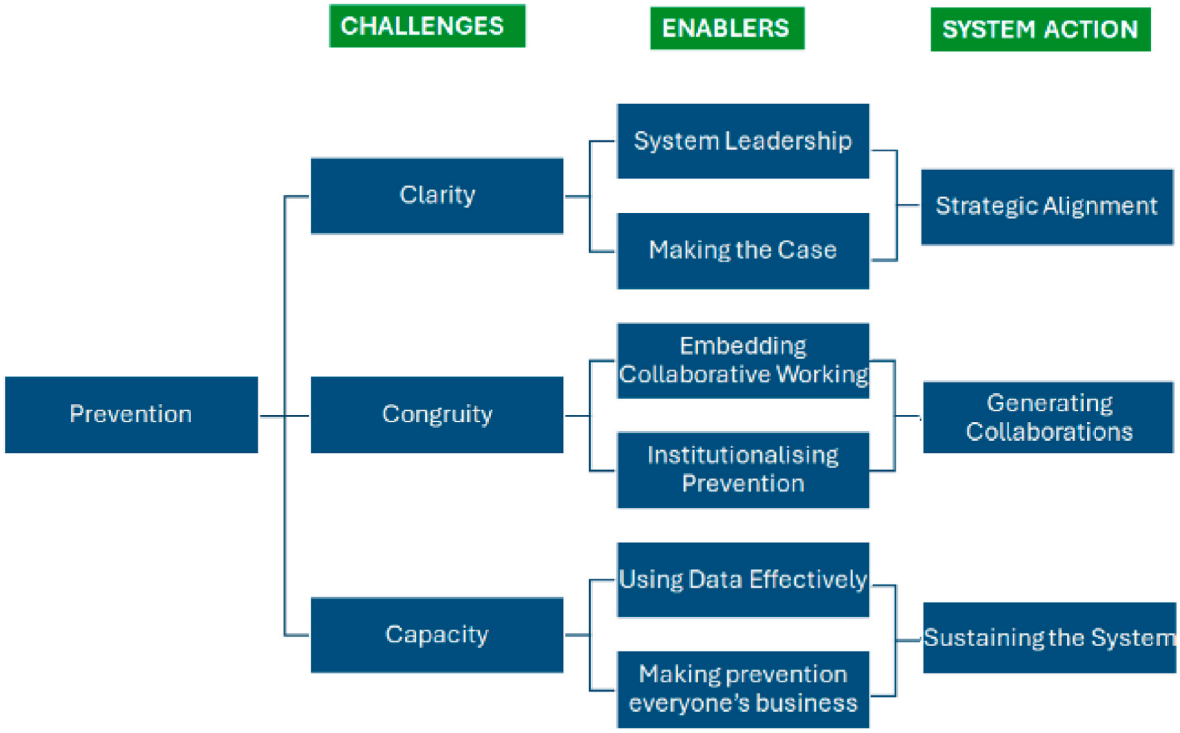

Fig. 1. From prevention challenges to enablers and systemic action.

local authorities see 'prevention' as their responsibility, it may provoke turf wars (compare with 'health imperialism', Cairney et al., 2021).

Fruitful discussion of dual strategies – making the moral *and* practical case – prompted reflection on how to overcome barriers to prevention. Some described ideological barriers to their preferred (social determinants) form of prevention by people who maintain different (individualist) views regarding the purpose of the state. Many local and national politicians in England favour individual responsibility for health and wellbeing, prompting a desire among multiple focus group participants to make a more persuasive case for social justice and investment to tackle social determinants of ill health. Others focused on how to work within the current system to accumulate incremental improvements, signalling a wealth of experience about overcoming organisational or systemic barriers to effective action.

In practice, we find elements of both stories in relation to key initiatives such as primary care delivery plans. The overall aim may be to tell new prevention stories in relation to healthier and happier populations seeking more wellbeing or joy. This does not detract from more immediate aims such as to improve direct patient care by ensuring more equal access to services or supporting people to access a referral pathway to prevention. Indeed, establishing the value of prevention to direct patient care could be the most effective way to overcome routine barriers to sustainable funding and cooperation (although participants expressed uncertainty regarding exactly how to make that case).

5.2. Improving congruity: institutionalising prevention and collaboration

Participants identify the role of new spaces for discussion, effective arguments, and rule changes to improve the fit between prevention and routine government business. For example, if many leaders don't have the 'bandwidth' to think differently during crisis, how can they make that leap of faith to prevention? There is demonstrable value for leaders to protect space to speak with voluntary sector groups and local citizens. They can provide a concrete sense of what preventive ideas look like in day-to-day life, in relation to better homes, jobs, lighting to feel safe at night, and green spaces. This regular and effective challenging voice to elected leaders helps to ward off their temptation to return to easy soundbites about personal responsibility for health.

Other examples include:

Concept-focused initiatives to focus attention on a common reference point, such as a 'trauma-informed approach' to whole systems collaboration. The aim is to build relationships between people using or influencing services and the public service workforce. The general aim - to not retraumatise people while they seek support – helps to produce tailored support and allow peers to share challenges and successes (see also 'compassionate systems leadership' – West et al., 2017).

Problem-focused initiatives to combine multiple professional roles in a single service, such as to provide housing expertise in NHS Trusts, employ mental health nurses in local authority housing teams, draw on Citizens Advice in patient mental health wards, or use public health capacity to better effect across ICSs. For example, initiatives may focus on engaging with mental health issues earlier, to foster more timely conversations and produce system benefits (e.g. to reduce homelessness or prevent readmissions to mental health wards that relate primarily to the stress or anxiety of social and economic pressures). These positive measures can mitigate concerns – felt by public health professionals - that their attempts to mainstream health across policy sectors produce defensiveness in relation to professional identities and turf.

Communities-focused approaches value the routine conversations with people normally left out of policymaking. Continuous professional development should include time to speak directly with communities, and strategic discussions should involve routine non-tokenistic meetings between service leaders, stakeholders, and citizens.

It may also be possible to change 'how things are done around here'. For example, NHS England's Mental Health Investment Standard (MHIS) required key organisations 'to increase their planned spending on Mental Health services by a greater proportion than their overall increase in budget allocation each year'. Further, reforms to GP or pharmacy contracts have the potential to shift incentives from treating ill-health to identifying ways to boost preventive healthy behaviour (although we do not underestimate the difficulty of such reforms, especially during tense negotiation on pay and conditions).

5.3. Improving capacity: making prevention everyone's business and using data well

Much focus group discussion connected to the idea of political will, such as to describe the need for 'bravery' to tackle unsustainable models and redirect our focus towards wellbeing and health creation. One aspect of this story is to identify an external national cause of problems – such as the impact of Westminster party politics on government health policy – but scope for a positive local response. Some described the potential for major changes when powerful national leaders champion a cause, such as when the former UK Prime Minister Rishi Sunak supported a smokefree generation (since then, current PM Keir Starmer has renewed UK government commitment to prevention – Eaton, 2024). Others described more local champions, such as a local government mental health champion scheme which can recruit powerful people to take up mental health issues, make the case for change in a language familiar to their audience, and use human stories to bring an issue to life.

There was also some discussion of boosting systemic capacity, on the grounds that many leaders will not engage with prevention-relevant policy problems if they do not see evidence for the feasibility of solutions. For example, the general idea of 'systems leadership' has taken off across ICSs and healthcare, to shift from heroic leaders making policy from the top towards distributed and collaborative leader*ship* shared by actors across a system (e.g. NHS England, 2018; NHS Confederation, 2021; reviewed in Cairney and Toomey, 2025a).

That said, some expressed concern that making prevention 'everyone's business' can mean that it is tricky to pin down who has prevention in their portfolio and that no one takes responsibility for key choices and outcomes. Here, we find a difficult balancing act: prevention needs to be part of the day job of more people, finding the 'headroom' to invest their time when facing other pressures; but there also needs to be someone or an organisation to oversee the whole system and strategic direction (these themes resonate in the wider systems leadership literature – Cairney and Toomey, 2025a; 2025b).

This responsibility should not only be in the hands of a policy champion, since we need to maintain wide ownership, longevity, and corporate memory in systems where there is inevitable staffing 'churn'. This responsibility can vary by organisation, which can help innovation and learning between ICSs and its partners, but only if the responsibility is clear in each case. For example, we heard of initiatives to identify primary, secondary, tertiary, and structural aspects of prevention and use these categories to identify responsibilities and actions, backed up by a strong Director of public health and public health team which is crucial to keeping wider determinants on the agenda. We also heard of the value of Consensus Statements to foster a vision, design a plan, identify key roles for partners, and show how to assess progress.

Many discussions connected broad systems leadership to the need to demonstrate continuous progress. Here, there is understandable nervousness regarding the partially-met need to tell better success stories about the value of early health detection, wider initiatives such as pollution control, and the benefits of interventions in specific neighbourhoods. These stories should connect to tangible information about the progress of promising work, such as to use prevention pilots in diverse and deprived areas to ask 'what works well on the ground?' Piloting and rapid evidence gathering *could* help policymakers see new benefits to service users and allow the roll-out of initiatives on a bigger scale (but there is an expressed need to turn potential to reality more often).

During such discussions, many participants pinned high hopes on the

power of high-quality data and population health management approach (again, this hope is strong in systems leadership and whole-of-government approaches, albeit tempered by issues such as data protection – Cairney and Toomey, 2025a; Bellamy et al., 2005). They described the need to value the collaborative process of gathering, analysing, storing, using, and communicating data. Effective processes require a dedicated data profession and career path including intelligence, advanced analytics, and modelling, a public health profession focusing on the implications of the evidence gathered, and an infrastructure to support this work. These roles are essential to make better use of data on interventions and service performance that are routinely under-analysed or analysed in silos. For example, access to quantitative datasets helps to identify where demand is coming from, areas of greatest need of intervention, and health interventions that work. Further, qualitative data helps to demonstrate social impact in relation to stories of improved lives. Some also described the combination of quantitative and qualitative analysis to support the small proportion of people who need a large proportion of public services, such as to focus on specific individual journeys to foster coordination between organisations.

6. Conclusions

Political science insights explain systemic barriers to preventive approaches to policy and policymaking. These accounts highlight a major gap between the sincere and energetic use of the phrase 'prevention is better than cure' and actual practices and policy outcomes. They suggest that overarching barriers to progress include a lack of clarity on the meaning of prevention, the inability to connect a new policy agenda to the usual ways of doing things in government, and the lack of sustained political support and systemic capacity that would be required for a long-term agenda for policymaking reform.

These insights build on broad 'complex systems' framings of the challenges facing preventive health. Current systems approaches highlight the interconnectedness of social and environmental determinants of poor population health and/or the interaction between many instruments in a policy mix. To this we add an essential focus on the governance context that influences the political feasibility and delivery of that policy mix. In particular, we demonstrate routine obstacles to progress even within a new governance framework devoted to policymaking integration and the pursuit of prevention. Our approach helped to narrate barriers and facilitate practitioner discussion on how to respond (Table 2).

In terms of clarity, we found major differences in values or beliefs about the aim of prevention, informing competing strategies on how to proceed in radical or pragmatic steps, and some attempts to reject and replace 'prevention' with other phrases. In terms of congruity, we found obstacles in relation to short-termism and difficulties in making business cases for long-term investment. In terms of capacity, alongside discussions of low political will we found routine limits to system-wide cooperation, untapped community assets, and limited opportunities for peer learning and improvement. In that context, while we separate potential responses into the 3Cs (clarity, congruity, capacity), we found a confluence of all three in the pursuit of progress: greater clarity was key to a coherent strategy to make better cases and institutionalise new approaches, then foster collaboration in relation to a common reference point (aided by wider initiatives such as to foster systems leadership).

Table 2
Responding to the barriers of low clarity, congruity, and capacity.

	Clarity	Congruity	Capacity
Practical Political Barriers	Competing values, perspectives, timescales, and language	Short-termism and the old ways of doing things	Limited core funding, low morale, and untapped cross-system potential
Politically Aware Strategies	Telling different stories in different contexts to make the best case for prevention	Making prevention 'everyone's business' but still 'someone's responsibility'	Pooling staff and data resources, energies and capacities across the system
Implications for Preventive Practice	Living with ambiguity by embracing discursive dynamism	Mitigating incongruity by modifying institutional norms and routines	Making up for capacity shortfalls by combining skills and evidence in new ways

These discussions do not solve the prevention problem, and nor could they. Just as there is no 'magic bullet' for prevention reforms, the clear identification of barriers does not necessarily help to overcome them. Long-term preventive strategies remain overshadowed by responses to immediate demand and crisis, with the potential to produce bouts of enthusiasm, perceived failure, and despair. In that context, the value of political science insights is to provoke discussion, boost cooperation, and reflect on progress towards long-term aims. Paradigm shift towards prevention requires a long series of repeated efforts to bolster political support for change and support leadership and collaboration to build and maintain systemic capacity, not a one-off injection of energy with radical results (Cianetti, 2024). Insights from political science help to frame and support this process, producing cautionary tales to inform the next round of valuable activity.

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Brief summary of each author's contributions

Bliss and Mahmood (NHS Confederation) commissioned the work and convened the focus groups. Cairney secured ethical approval for the focus groups research and data storage (University of Stirling), including permission to share data only with Boswell. Boswell and Cairney chaired and led focus group discussion. Cairney and Boswell are primarily responsible for paper drafting.

CRediT authorship contribution statement

Paul Cairney: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Data curation, Conceptualization. **John Boswell:** Writing – review & editing, Validation, Project administration, Methodology, Investigation, Data curation, Conceptualization, Writing – original draft. **Hashum Mahmood:** Methodology, Funding acquisition, Writing – review & editing, Visualization, Supervision, Project administration. **Annie Bliss:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition.

Ethics

Paul Cairney received ethical approval for the focus group research from the University of Stirling (23.2.24).

To comply with the ethical approval received from the University of Stirling, only Paul Cairney and John Boswell had access to the recording and verbatim transcripts.

Declaration of competing interest

None.

Data availability

The data that has been used is confidential.

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