A cross-disciplinary study on formulating child health policy with a focus on the social determinants of health – an Australian perspective

by

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Abbreviations

Australian States/Territories

ACT - Australian Capital Territory

NSW - New South Wales

NT - Northern Territory

QLD - Queensland

SA - South Australia

TAS - Tasmania

VIC - Victoria

WA - Western Australia

Other

ACF - Advocacy Coalition Framework

AIHW - Australian Institute of Health and Welfare

ALP - Australian Labor Party

ARACY - Australian Research Alliance for Children and Youth

ARC - Australian Research Council

ATSI - Aboriginal and Torres Strait Islander

CAAH - Centre for the Advancement of Adolescent Health

CIS - Critical Interpretive Synthesis

COAG - Council of Australian Governments

CSDH - Commission on the Social Determinants of Health

ECD - Early Childhood Development

Greens - The Australian Greens Political Party

HE - Health Equity

IDC - Inter Departmental Committee

LIB – Liberal–National Coalition Party of Australia

LGBTIQ - Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Questioning

MS - Multiple Streams

NGO – Non-government Organization

NPAPH - National Partnership Agreement on Preventative Health

OECD - Office of Economic Cooperation and Development

PE - Policy Entrepreneur

SDH - Social Determinants of Health

UNICEF - United Nations International Children's Emergency Fund

WHO - World Health Organization

Related Peer Reviewed Article

Phillips, C., M. Fisher, F. E. Baum, C. J. MacDougall, L. A. Newman and McDermott, D.R. (2016) “To what extent do Australian child and youth health policies address the social determinants of health and health equity? A document analysis study.” *BMC Public Health* **16**: 512.

Related Conference Presentation

Phillips, C., M. Fisher, F. E. Baum and C. MacDougall (2014) “Australian child/youth health policies: are we taking action on the social determinants of health?” Paper presented at SA State Population Health Conference. Adelaide, South Australia. October 2014.

Abstract

Background: There is a wide range of research that suggests policy action on the social determinants of health (SDH) is required to reduce child health inequities across the social gradient. However, there has been limited action in this area in Australia. Political will has been identified as a barrier to applying a SDH approach in policy, however, few public health scholars have conducted research which adopts a political science perspective to explore this issue. This thesis addresses this gap in the literature.

Methods: In this thesis, I conducted a critical interpretive review and synthesis of the public health and political science literature (study 1); document analysis of 17 strategic level child health policies across Australia, using an *a priori* coding framework specifically developed to assess the extent to which health departments address the social determinants of child health and health equity (study 2); and four policy case studies with 27 semi-structured interviews with policy actors directly involved in the development of Australian child health policy, using a range of political science theories and frameworks to guide design and analysis (study 3).

Findings: The findings from study 1 suggested that there was a relatively small amount of empirical research that adopted a political science perspective to explore this topic. I identified four theoretical constructs, namely politics, ideology, leadership and credibility, which together synthesised the literature in this cross-disciplinary field of research. The findings from study 2 showed that all Australian child health policies addressed health inequities to some extent, with the best examples being in Aboriginal or child protection policies, and whole of government policies with strong links to departments of health. However, there appeared to be limited action on the social determinants of child health within Australian health departments because while all policies acknowledged or audited the evidence on the SDH at the beginning of the policy, only 10% of strategies committed to action in this area. The findings from study 3 showed that the Australian child health policies which did most to apply a SDH approach in child health policy were supported by a cohesive policy network, including a range of leaders. In addition, in several cases the support of a guiding institution and/or community consultation were facilitators for policy change. The framing of the issues varied across cases, with early childhood development, health equity, and child rights being clear motivators for policy action in this area. Finally, throughout the policy formulation process, applying a SDH approach in Australian child health policy

was constrained by neoliberal policy measures that preference individualised healthcare and/or behavioural strategies to improve child health.

Discussion: To better understand the circumstances that facilitated (or constrained) policy action on the social determinants of child health I further developed the four synthetic constructs identified in study 1, politics, ideology, leadership and credibility. I identified and discussed four policy formulation tactics that emerged through this thesis where policy actors constructed different storylines to 'sell' a SDH agenda to Australian health departments. The policy formulation tactics presented (and the associated storylines) were divided into four categories: extension, selective, adaptive and diversion. Drawing on the findings from across all three studies in this thesis, I presented a policy formulation model which illustrated how the four synthetic constructs, policy formulation tactics and storylines operated within the Australia child health policy environment. This thesis demonstrates the usefulness of cross-disciplinary research (public health and political science) in understanding the complex policy environment within which child health policy is formulated in Australia. In particular, the underlying assumptions, policy formulation tactics and constructed storylines offer a better understanding of what is required to gain legitimacy in Australian health departments for alternative health policy agendas such as the social determinants of child health.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Clare Littleton Phillips

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CHAPTER 1. INTRODUCTION

In this thesis I report on three cross-disciplinary studies that were conducted to explore how child health policy is formulated in an Australian context, with a focus on the social determinants of health (SDH).

1.1 Aims and objectives

The aims and objectives are outlined below:

Aim 1: To explore and synthesise academic literature that explores the politics of formulating health policy, specifically the agenda setting and policy formulation processes.

Objective 1: To review systematically and synthesise research that explores this topic across two disciplines – public health and political science

Aim 2: To assess the extent to which current Australian child health policy addresses the social determinants of health and health equity

Objective 2: To review systematically a selected set of current Australian child health policies

Aim 3: To explore policy actors' perceptions of the factors that facilitate or constrain the formulation of Australian child health policies that focus on the social determinants of health

Objective 3: To conduct semi-structured interviews with policy actors involved in the formulation of Australian child health policy.

1.2 Background

Current child health inequities in Australia

The health and wellbeing of children and youth in Australia has been well documented (Australian Department of Education and Training 2016, AIHW 2016, ARACY 2018, Australian Child Rights Taskforce 2018) and reports concur that while most are faring well, certain groups are disadvantaged by the failure of government policies and have poorer health, including Aboriginal and Torres Strait

Islander children, children with disability, LGBTIQ children, asylum seeker and refugee children, children living in regional and remote areas and children in out-of-home care (UNICEF 2018). These differences in health status are known as health inequities, which are understood as differences in health that are 'systematically, and socially produced (and therefore modifiable) and unfair' (Dahlgren and Whitehead 2006a, p. 2). For this study, 'equity groups' are defined as groups of children who are known to be subject to social, economic, locational or cultural disadvantage and to experience worse health outcomes than non-members of that group.

Health inequities between Indigenous and non-Indigenous children and youth in Australia can be seen in infant mortality rates (7.2 and 4.2 per 1000 births respectively); child mortality rates (25 and 12 deaths per 100,000 respectively); developmental vulnerability (21% and 9%); psychological distress for youth aged 18–24 (32.4% and 15.4%) and suicide rates for those aged 15–24 years (39.2 and 12.7 deaths per 100,000) (AIHW 2012, Australian Department of Education and Training 2016, ARACY 2018). These inequities are comparable with those between Indigenous and non-Indigenous children in other developed countries (NCCAH 2014). Health inequities between children of low and high economic statuses are also seen in developmental vulnerability (32% and 16%); dental decay at 6 years old (63% and 47%); and obesity rates (31% and 18%) (AIHW 2012).

The Australian Research Alliance of Children and Youth (ARACY) found that, overall, Australia was 'on average only middle of the pack', and ranked in the top third of performance for only 26 out of 75 indicators of child and youth wellbeing when compared with other OECD countries (ARACY 2018 p. 4). This evidence clearly demonstrates that governments need to do more to improve child and youth health and reduce inequities in Australia.

Applying a social determinants approach in child health policy

There is a significant body of evidence that highlights the importance of addressing the social determinants of child and youth health in policy to address these inequities (Irwin et al. 2007, Eckersley 2008, Mustard 2008). The social determinants of health that are specifically related to child and youth policy development can be broadly divided into the following categories: a) social and economic conditions—income/employment, adequate/affordable childcare and flexibility in the workplace for parents, affordable housing, parental educational levels, social connectedness, positive family

relationships, and access to clean water and healthy food; b) early childhood development (ECD)—addressing the physical, social/emotional, and language/cognitive domains of development; c) education—primary, secondary and further education; d) healthy settings—urban planning, safe local communities, green space, playgrounds, childcare, schools, workplaces; e) access to health services—availability, affordability, acceptability (organizational, social and cultural); f) sociocultural conditions—gender, class, colonialism, environmental dispossession and culturally safe spaces (in health and education settings), racism and other forms of discrimination; and g) environmental, corporate and global forces—pollution/climate change, food production and the marketing of global corporations, media consumption and regulation, individualism and materialism (Eckersley 2008, MacDougall et al. 2014, ARACY 2018).

Australian governments are therefore being called upon to devise policies that address the evidence on social determinants of health (SDH) (Stanley et al. 2005, Holland 2013). The *Final Report of the Commission on the Social Determinants of Health* (CSDH 2008) from the World Health Organization, and endorsement by the Australian Senate of action on social determinants of health (Holland 2013) provide practical frameworks for translation of such evidence into policy action. While both documents indicate that cross-sector action is particularly effective at addressing SDH, they urge health departments to take a stewardship role. This involves showing leadership on SDH both in health departments and in other sectors (CSDH 2008, Holland 2013). Furthermore, healthcare systems are in a key position to influence the health of children, youth and their parents (Irwin et al. 2007).

Despite the range of evidence available on the social determinants of health, recent debates from within the discipline of political science highlight the limitations of this term within the context of the policy process (Cairney 2016). Cairney et al. (2019) suggests that, alongside governments, policy actors who make a claim to understand this term often lack the ability to translate both the problem and the solution into policy. Therefore, while advocacy efforts may gain strategic support at a government level for a SDH approach initially, policy actors may find that as they progress through the policy development process there could be limited policy change. Cairney et al. (2019) argue this is exacerbated when advocates for a social determinants approach attempt to translate a more sophisticated definition of this term (as outlined above) into language that all stakeholders will

understand and resort to ‘superficial and unsustainable idioms (like prevention is better than a cure) and vague ambitions (like health in all policies)’ to explain this term (p.4).
This debate highlights the usefulness of the cross disciplinary nature of this thesis which facilitates a discussion on how public health terms and definitions are understood in other disciplines, and vice versa.

Definition of health policy

To understand how applying a social determinants of health approach in child health policy assists in improving child health across the social gradient it is important to establish a definition of policy (De Leeuw et al. 2014). Dye (1972) defines policy as ‘anything a government chooses to do or not to do’ (p. 2). Furthermore, policy is an official government response or activity to a particular problem or issue. Smith and Katikireddi (2013) suggest the term ‘public policy’ describes the official activity that demonstrates a government's intentions to act or distribute resources in a particular area. Bryant (2009) provides another layer to this definition to include values, where policy is seen as the result of a ‘course of action that is anchored in a set of values regarding appropriate public goals and a set of beliefs about the best way to achieve these goals’ (p. 1). In the political science literature, policy making is mostly referred to as a policy process, and the term has been sub-divided into the following stages: agenda setting, policy development or formulation, implementation and evaluation (Walt et al. 2008, Anderson 2011). The term *policy processes* will be explored further in Chapter 4. Policy processes result in written policy documents that outline values, goals, objectives and strategies linking the accountability of government to the intended outcomes. The focus of this study is on Australian child health policy, including the written documents and the agenda setting and policy formulation phases that shape the final policy outcome.

Health policy is a subset of public policy. It has been argued that the development of health policy is inherently political and that this is because of the range of competing priorities in this sector, with different groups in society competing for limited resources (Bambra et al. 2005). Nutbeam (1998) describes health policy as ‘a formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures’ (p. 357). This implies that health policy represents the distribution of limited

resources in society as dictated by institutions, political circumstances and the societal context of the day. Lewis (2005) suggests that policy actors from within and outside government interact at many levels to develop arguments that influence the direction of government health policies.

De Leeuw et al. (2014) propose that there are several types of health policy, including those that make disease prevention and illness a priority with a focus on the individual, and those that make the social determinants of health a priority with a focus on the whole population. Research from industrialized countries indicates that the majority of health policies fall into the first category (Newman et al. 2006, Alvaro et al. 2010). Milio (1987) proposed that government policy is a powerful tool to address health inequities and bring about change and suggests that 'healthy public policy' should 'improve the conditions under which people live: including secure, safe, adequate, and sustainable livelihoods, lifestyles, and environments, including housing, education, nutrition, information exchange, child care, transportation, and necessary community and personal social and health services' (p. 622). This description of policy implies a human rights perspective where politicians and governments play a pivotal role in ensuring the conditions that people live in create an environment that promotes good health outcomes for all. This view is also espoused in the United Nations Convention on the Rights of the Child, which states that 'governments should ensure that children survive and develop healthily (article 6)….governments should ensure that children are properly cared for and protect them (article 19)….and that children have the right to good quality health care, clean water, nutritious food and a clean environment so that they will stay healthy (article 24)' (UNICEF 1990). The recently developed 'health in all policies' approach to policy development builds on the above definition of healthy public policy, offering a way for policy actors to address health and wellbeing across sectors (Leppo et al. 2013).

For the purposes of this study, child health policy is defined as published, strategic level, health sector policy that describes the action government intends to take to improve child and youth health at a population level, and which shows a commitment to implementing the recommended activities.

Health policy development in Australia

To set the context in which the policies from this thesis were developed, in this section I provide an overview of the current Australian health policy environment. In Australia, health policy development is divided between the federal (national) and State (SA, NSW, VIC, WA, QLD, TAS) or Territory (ACT and NT) governments. The health budget has increased steadily over the past ten years from $95 billion in 2003–04 to an estimated $155 billion in 2013–14 (AIHW 2016). National health policy co-ordination occurs through the Council of Australian Governments (COAG) Health Council and its advisory body, the Australian Health Ministers' Advisory Council.

The federal government is responsible for Medicare general practitioner services, the Pharmaceutical Benefits Scheme, community controlled Aboriginal and Torres Straits Islander (ATSI) primary health care, healthcare for service veterans, medical research and access to regulation of private health services. The states/territories are primarily responsible for the management of public hospitals, the licensing of private hospitals, public community-based primary health care services, screening and immunisation programs and ambulance services. Federal and state/territory governments share responsibility for regulation of the health workforce, regulation of pharmaceuticals and pharmacies, funding of public health programs and services, and funding of ATSI services (AIHW 2016). However, the division of responsibilities between these different levels of government is becoming more political, and in some instances this results in a lack of responsibility for a particular area of health (AIHW 2016, Wutzke et al. 2018). See appendix 1 for summary.

It has been argued that prevention is an area that is often moved from one level of government to the other (Wutzke et al. 2018). For example, in the period during which this study was conducted there was a shift in the allocation of funds towards prevention in Australia which was motivated by governments' desire to reduce the prevalence of chronic disease in Australia (NPAPH 2008). Much of the funding came from a large investment of funds ($872 million from 2008 to 2014) from the federal government through the National Partnership Agreement on Preventative Health (NPAPH 2008). These funds were administered by the National Preventive Health Taskforce and divided between the states and territories. Because this was a federal directive, to receive funds the states and territories had to meet a set of conditions around achieving predetermined objectives through state-level policy (Wutzke et al. 2018). However, a change of federal government in 2013 resulted in the cancellation of

these funds, leaving many policymakers disillusioned with the relationship between the federal government and the states/territories (Wutzke et al. 2018).

In this thesis I aim to conduct cross-disciplinary research (public health and political science) to understanding the complex policy environment within which child health policy is formulated in Australia, with a focus on the social determinants of health.

1.3 Structure of this thesis

For this thesis I conducted three studies to explore how child health policy with a focus on the SDH is formulated in an Australian context. The structure of the thesis is as follows. In Chapter 2, *Critical Interpretive Synthesis (CIS) of the Literature (Study 1),* I detail the process of systematically reviewing and synthesising public health and political science literature and identify the relatively small amount of empirical research that adopts a political science perspective to explore this topic. I identify 25 peer-reviewed articles that report on empirical research, 12 of which were of rigorous quality and used a political science approach to inform both the design of the study and analysis while 13 were of rigorous quality but only used political science theory to guide analysis. In this chapter, I report on the main themes and sub-themes extracted from the studies included in the review. I then use these as a basis to generate four theoretical constructs: politics, ideology, credibility and leadership. Using these constructs, I synthesise the literature in this cross-disciplinary field of research and provide a basis from which to identify gaps in the literature and develop the aims and objectives for studies 2 and 3.

In Chapter 3, *Document Analysis (Study 2),* I detail the public health theories and qualitative methods used to analyse 17 strategic child and youth health policies across Australia using an *a priori* coding framework specifically developed to assess the extent to which health departments address the social determinants of child and youth health and health equity (Wilkinson and Marmot 2003, Carter et al. 2009, Baum 2016). I present the findings and discuss them in relation to the broader public health and political science literature, before drawing a range of conclusions.

In Chapter 4, *Four Policy Case Studies (Study 3),* I detail the methodology, including the political science theories and frameworks used to guide this study (Sabatier and Jenkins-Smith 1988, Lewis 2005, Shiffman and Smith 2007, Kingdon 2011) and the qualitative methods employed, including semi-structured interviews with 27 policy actors from inside and outside Australian health departments. The

Shiffman and Smith (2007) framework is the predominant political science framework used in the analysis. I present the findings, discussion and conclusions for each policy case study separately. Next, I present a table based on the Shiffman and Smith (2007) framework to provide a comprehensive picture of the data across cases, highlighting the key factors identified throughout this study and the strategies employed by policy actors in attempts to apply a social determinants of child health approach in Australian child health policy.

In Chapter 5, *Overall Discussion*, I discuss the findings from all three studies. To do this, I further develop and describe the four synthetic constructs from study 1 then discuss my interpretation in relation to the broader literature with examples from studies 2 and 3. Secondly, I identify and discuss four policy development tactics (and associated storylines) that emerged from the data in this thesis, where policy actors constructed different storylines to 'sell' a SDH agenda to Australian health departments. The policy development tactics were divided into four categories, extension, selective, adaptive and divergent. I then present a policy formulation model that illustrates how the synthetic constructs, policy development tactics and associated storylines operate within the Australia child health policy environment. Finally, I present my methodological reflections and highlight the strengths and weaknesses of the thesis.

In Chapter 6, *Conclusion*, I summarize the main findings and discuss my contributions to this cross-disciplinary area of research, which used public health and political science perspectives to explore how complex health issues and solutions, such as the social determinants of child health, gain legitimacy in Australian health departments.

CHAPTER 2: CRITICAL INTERPRETIVE SYNTHESIS (CIS) OF THE PUBLIC HEALTH AND POLITICAL SCIENCE LITERATURE (STUDY 1)

In this chapter I report on study 1 which involved a critical interpretive review and synthesis (CIS) of the public health and political science literature. First, I detail the guiding questions and identify the search terms and initial inclusion/exclusion criteria that provided the basis for a systematic search of the academic literature on this topic. I explain the processes of purposeful and theoretical sampling and assessment of the quality of articles and present the results in a PRISMA flow diagram (Moher et al. 2009). There were 25 articles included in this review and I used a further 17 theoretical or background articles to inform my discussion and conclusions throughout the thesis. A full description of these articles is presented in Tables 1 (p. 28) and 2 (p. 31).

The process of data extraction is described next and I show how, in conformity to the CIS method, the guiding questions were modified. In the initial analysis of the included articles I used reciprocal translational analysis (RTA) to extract key metaphors, themes and concepts from across the selected literature. Through this process I developed four main themes and several sub-themes that were related to the main themes but appeared less often in the literature and which highlighted gaps or weaknesses embedded within the main themes and thus indicated areas worthy of further study. I then synthesised the literature and developed an argument that went beyond description to develop a theoretical base from which to understand the evidence across the literature. Through this process I generated four synthetic constructs, leadership, credibility, ideology and politics.

Finally, I identify a range of gaps in the literature and use these and the synthetic constructs as a basis to develop the aims and objectives for study 2 (Chapter 3) and study 3 (Chapter 4), which are outlined at the end of this chapter.

The aims and objectives for study 1 are detailed below:

Aim 1: To explore and synthesise academic literature that explores the politics of developing health policy, specifically the agenda setting and the policy development processes.

Objective 1: To review systematically and synthesise research that explores this topic across two discipline – public health and political science

2.1 Systematic search

To address the complexity and cross-disciplinary nature of this topic, I selected the CIS method developed by Dixon-Woods et al. (2006) to guide the review, because it provides a framework to conduct a 'critical interpretive synthesis' (CIS) on a diverse literature (Dixon-Woods et al. 2006 p. 2). This method takes into account the formal process of conducting a systematic review, but uses both induction and interpretation to synthesise the data (Dixon-Woods et al. 2006). In line with the CIS method, several preliminary questions were chosen to guide the systematic search.

2.1.1 Guiding questions

Dixon-Woods et al. (2006) suggest that guiding questions should be developed at the beginning of a CIS literature review but advise that the questions will need to be refined often as the review progresses. In the first iteration, the guiding questions for the review were as follows.

a) What political (and other) factors influence the rise and fall of specific health issues from the health policy agenda?

b) What theories and methods have been used to explore the politics of developing health policy, specifically the agenda setting and policy formulation process?

c) What health issues have been explored in this area of study?

I conducted a systematic search of the academic literature starting with academic databases. After consultation with an academic librarian at Flinders University on the cross-disciplinary nature of my topic I selected Proquest and Scopus for my search. Scopus is known for its comprehensive overview of scientific literature across all disciplines, while Proquest is a multi-disciplinary database that covers the social and political sciences.

2.1.2 Search terms and initial inclusion/exclusion criteria

A systematic search of the literature requires the researcher to set the parameters for the search at the beginning of the process (Saks and Allsop 2007). The following search terms and initial inclusion/exclusion criteria were selected.

1. politics, agenda/priority setting (politic* OR government AND agenda OR priorit* OR framing OR multiple stream OR decision-making);

2. policy, the policy process, policy development (policy OR policies OR develop OR process)

3. health policy and public health issues (health policy AND health policies OR public health or health*).

To limit the number of articles retrieved the following criteria were used: English language, peer-reviewed, full text, from the high-income countries United Kingdom, United States, Australia, New Zealand, Sweden, Denmark, Belgium, Turkey, Germany and the Netherlands. Because the health agendas from these countries are often global, articles that covered global health issues were also considered for inclusion. At this stage, to achieve a manageable number of results, books and grey literature were excluded.

The initial literature search was completed in 2013, during my first year of candidature. That review was used to identify gaps in the literature at that time, develop the proposal for my PhD and justify the three studies contained in this thesis. Literature post-2013 were collected in an ongoing fashion, during conduct of the three studies, with the final literature search being completed in 2018. The review of literature in this chapter only includes literature published up to and including 2013 (since it formed the basis and argument for the three studies), and literature post-2013 is included in the discussion sections of subsequent chapters. Overall the results from the first round of searching resulted in 838 articles from Scopus and 952 from Proquest Central, a total of 1790.

2.1.3 Purposeful sampling

The first step in the CIS method is purposeful sampling to limit the number of studies included in a CIS review (Dixon-Woods et al. 2006). All duplicate records were excluded, and the titles and abstracts of all articles were reviewed for relevance to the guiding question and only those articles

that were highly relevant were included. To be considered highly relevant to the politics of developing health policy an article had to match several of the search terms listed above. All articles had to match search term **3** health or public health issue, and each selected paper had to match either search term **1** politics OR **2** policy.

At this stage, many articles were excluded because they focused on individual or clinical health issues, were not related to policy, were not about high-income countries, were focused on planning and evaluation or implementation only, provided general evidence on Australian health priorities or the social determinants of health, or were focused on environmental, disability or other issues not directly related to health.

This process resulted in the inclusion of 38 articles that were entered into EndNote where the full articles were downloaded. Following the CIS method, at this stage other methods were used to find key articles relevant to the guiding questions, including citation tracing of retrieved articles and recommended literature from experts and scholars in the field (Dixon-Woods et al. 2006). This resulted in a further five articles being included in the review, resulting in a total of 43 articles at this stage.

2.1.4 Theoretical sampling

Theoretical sampling is the next iterative phase to remove articles identified as no longer relevant to the guiding questions (Dixon-Woods et al. 2006). A two-pronged approach was used to determine each paper's continued relevance to the guiding questions and its quality. Firstly, JBI Critical Appraisal Tools (Lockwood et al. 2015) were used to review rigour and quality. This assessment tool was chosen because it is known as a quality tool to 'assess the methodological quality of a study and to determine the extent to which a study has addressed the possibility of bias in its design, conduct and analysis' (Lockwood et al. 2015 p. 15). Two researchers, myself and my principal supervisor, independently completed a critical appraisal sheet for each article and then discussed inclusions and exclusions. Secondly, each paper was read again in full and was weighted using a 4-point grading scale of A–D. Articles not considered to be of sufficient quality were graded D, while articles that were theoretical or with background information (i.e. not empirical) were graded C. Articles graded B were empirical articles of rigorous quality that had high relevance to the guiding questions but had not used political science theory to inform data collection and analysis (with some only using political science

theories in either the analysis or the discussion). Articles graded A were empirical articles of rigorous quality with high relevance to the guiding question that used political science theory to inform both the design of methods and analysis.

Of the original 43 articles 12 were graded A, 13 were graded B, 17 were graded C, and 1 was graded D. This paper was removed because the accompanying methods paper that gave a full description of the methods was written in French and therefore did not meet inclusion criteria. Articles graded A and B were reports of empirical research that was considered of rigorous quality and these were used to identify the main themes and concepts for this review (see Table 1). Articles graded C were theoretical and were used in the background and discussion sections of this review, and in the remaining sections of the thesis. It should be noted that the decision to exclude articles graded C from the review was not a decision based on the quality of the papers rather because they did not fit the criteria of being articles based on empirical research. This is a limitation of this research because the importance of theoretical articles is acknowledged across both the discipline of political science and public health. It is also acknowledged that if papers graded C were included, the findings produced from this search may have been different. In addition, although this review could be seen as a narrow search of the literature from a political science perspective this is accounted for in this study because this type of research is common practice with the discipline of public health research, and, the review has the particular aim of searching for depth not breadth, thus aiming to focus on particular social factors that interact with the policy development process. More details about A, B and C weighted articles can be found in Tables 1 and 2. The process of article selection is summarised in the PRISMA flow diagram (Figure 1).

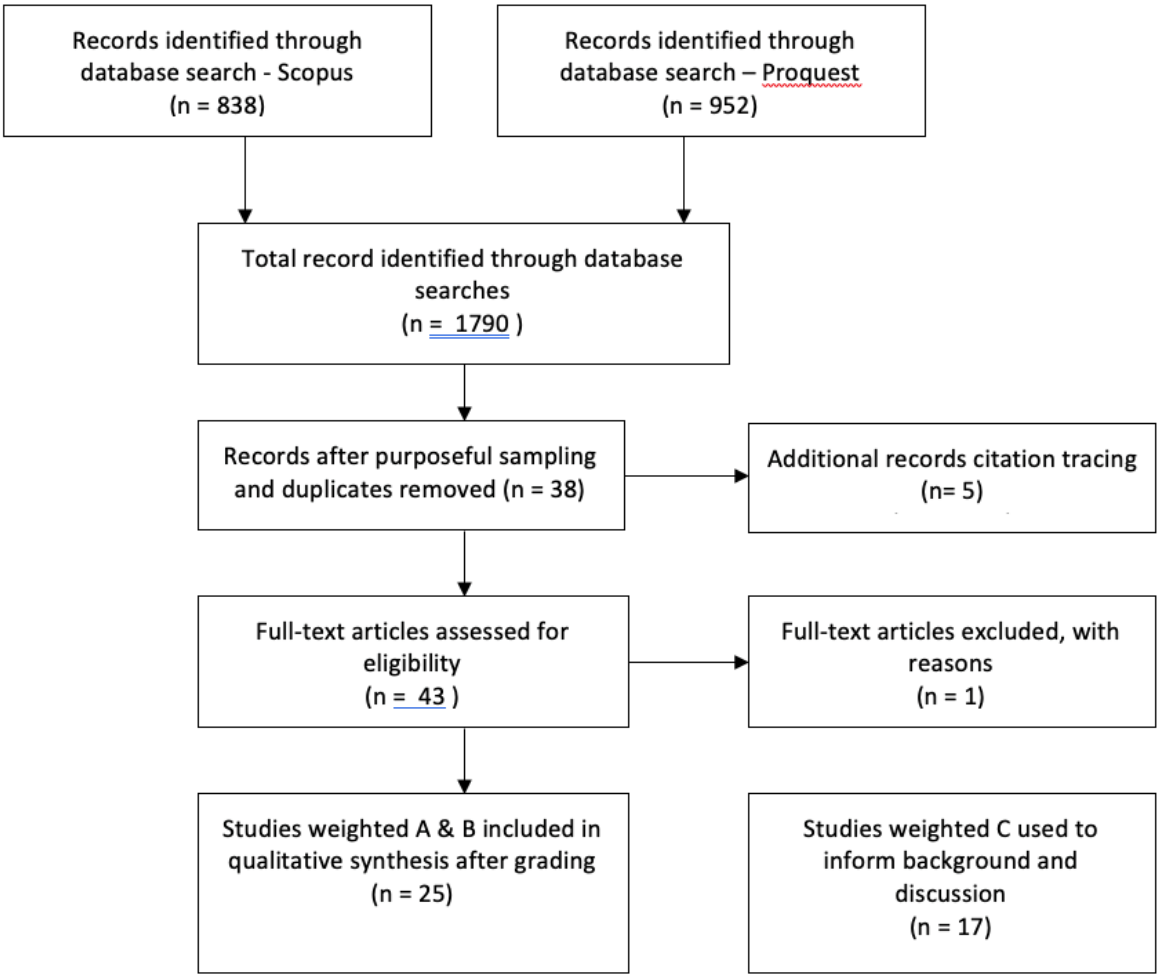

Figure 1: PRISMA flow diagram (Moher et al. 2009)

Table 1: *Articles from CIS literature review weighted A or B – empirical (25 articles)*

Author/Year	Title	Location	Health Issue/focus	Methods/data collection/analysis	Political science or other theories	Relevance (A or B)
(Baum et al. 2013)	Never mind the logic, give me the numbers: Former Australian health ministers' perspectives on the social determinants of health	Australia	Social determinants of health and health equity	Qualitative - 20 semi-structured interviews	Some political science discussed in discussion but not used to inform study design	B
(Bowen 2007)	The relationship between evidence and policy: A tracer study of promoting health equity through early childhood intervention in Australia	Australia	Family First Policy NSW Health equity	Thesis - Policy tracer study 23 interviews with policy actors, media and gov. transcript analysis	Mostly about evidence translation – used diffusion of innovation theory	B
(Bowen et al. 2009)	Killer facts, politics and other influences: What evidence triggered early childhood intervention policies in Australia?	Australia	Family First Policy NSW Health equity	Policy tracer study 23 interviews with policy actors, media and gov. transcript analysis	Thematic analysis Used Kingdon (2011) to explain some findings	B
(Breton et al. 2008)	Health promotion research and practice require sound policy analysis models: The case of Quebec's Tobacco Act	Canada	Quebec Tobacco Act	39 semi-structured interviews 569 newspaper articles 200 documents Case study design	Advocacy Coalition Framework Lemieux's (1998) theory – coalition framing	A
(Bump et al. 2013)	Diarrhoeal diseases and the global health agenda: Measuring and changing priority	Global	Control of diarrhoeal diseases & child survival	16 semi-structured interviews with experts in this field – academics, global health institutions, foundations etc. Literature review and statistical analysis re number of articles published over time on this topic	Reich's (1999) political streams used to guide data collection and analysis.	A
(Collins et al. 2007)	Knowledge into action? Understanding ideological barriers to addressing health inequalities at the local level	Canada	Social determinants of health framework	Postal survey to active citizens – 241 participated	N/A	B
(Craig et al. 2010)	Public health professionals as policy entrepreneurs: Arkansas's childhood obesity policy experience	USA	Childhood obesity	23 structured interviews with policymakers	Kingdon (2011) multiple streams theory used to guide analysis	B
(Deas et al. 2013)	Intelligent policy making? Key actors' perspectives on the development and implementation of an early years' initiative in Scotland's public health arena	Scotland	Child oral health	Case study design Document analysis Observations 12 interviews with key policy actors (Covers development and implementation)	Discusses political science but doesn't use in methods. Uses Ritchie and Spencer (1994) framework for thematic analysis of interviews	B
(Dionne et al. 2008)	Decision makers' views on priority setting in the Vancouver Island Health Authority	Canada	Health care	Semi-structured interviews with 18 senior managers and medical directors	N/A	B

(Guldbrandsson and Fossum 2009)	An exploration of the theoretical concepts, policy windows and policy entrepreneurs at the Swedish public health arena	Sweden	Child health 9 agendas within this broad area were the focus of each case study, including: - Physical activity - Growing up conditions - Drug and alcohol - Language development - Traffic and playground conditions - Adolescence influence - Safety	Case studies with 55 semi-structured interviews and document analysis – ie media, minutes of meeting, gov. doc. etc.	Kingdon (2011) multiple streams theory used to develop questions and during analysis	A
(Guldbrandsson et al. 2005)	What makes things happen? An analysis of the development of nine health-promoting measures aimed at children and adolescents in three Swedish municipalities	Sweden	As above	As above	As above	A
(Hoeijmakers et al. 2007)	Local health policy development processes in the Netherlands: An expanded toolbox for health promotion	Netherlands	Health promotion agenda	Semi-structured interviews with stakeholders Participant observation in meetings Document analysis Stakeholder and network analysis	Kingdon (2011) MS theory Stakeholder analysis Network theory	A
(Holden and Lin 2011)	Network structures and their relevance to the policy cycle: A case study of The National Male Health Policy of Australia	Australia	Men's health policy	Case study – analysis of networks 56 actors were included	Network theory (Skok 1995)	A
(Larsen et al. 2006)	Advocacy coalitions and pharmacy policy in Denmark—Solid cores with fuzzy edges	Denmark	Pharmaceutical – OTC medicine	Case study - interviews with policy actors and doc analysis	Advocacy Coalition Framework (1988) guided design, interviews and analysis	A
(Lewis 2006)	Being around and knowing the players: Networks of influence in health policy	Australia	Medical influence on health policy agenda	Focuses on analysis of policy actors influence – mapping of networks	Social network analysis using reputation as a starting point	A
(Maclennan et al. 2013)	Local government alcohol policy development: Case studies in three New Zealand communities	New Zealand	Alcohol policy	Case studies Document analysis Interviews with 7 participants in metro areas	Kingdon (2011) multiple streams to inform data collection and analysis	A
(Macnaughton et al. 2013)	Bringing politics and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada	Canada	Homeless, mental health and housing	19 interviews with policy actors	Constructivist grounded theory. Referred to Kingdon's (2011) MS theory in intro and analysis but didn't use specifically to guide study.	B
(Mosier 2013)	Cookies, candy, and coke: Examining state sugar-sweetened-beverage tax policy from a multiple streams approach	USA	Obesity	9 interviews Doc review Observations	Kingdon (2011) multiple streams	B

(Orton et al. 2011)	Prioritising public health: A qualitative study of decision making to reduce health inequalities	UK	Cardiovascular disease and health equity	Case study 40 semi-structured interviews and focus groups with decision makers Purposeful sampling Thematic analysis	No political science theory	B
(Schmidt et al. 2010)	Generating political priority to tackle health disparities: A case study in the Dutch city of The Hague	Netherlands	Health equity	Case study 22 interviews with policy actors Document analysis	Agenda setting was discussed but no political science theories used to inform methods	B
(Schwartz and Johnson, 2010)	Problems, policies and politics: A comparative case study of contraband tobacco from the 1990s to the present in the Canadian context	Canada	Tobacco policy	47 semi-structured interviews with key informants and four expert focus panels	Kingdon's (2011) multiple streams theory	A
(Shiffman and Smith 2007)	Generation of political priority for global health initiatives: A framework and case study of maternal mortality	Global	Global Safe Motherhood initiative	Process tracing - 23 interviews with policymakers & archival research on history of initiative	Used political science literature (Kingdon 2011 & ACF 1988) to develop framework for researching agenda/priority setting.	A
(Smith 2007)	Health inequalities in Scotland and England: The contrasting journeys of ideas from research into policy.	UK	Health inequities	58 semi-structured interviews with key actors in the field of health inequalities research and policymaking	- Two communities theory - Kingdon (2011) multiple streams These theories were used in analysis and discussion but didn't appear to be used to inform data collection	B
(Strand and Fosse 2011)	Tackling health inequalities in Norway: Applying linear and non-linear models in the policy-making process	Norway	Health inequities	Case study design	Whitehead (2007) and Kingdon (2011)	A
(Yeatman 2003)	Food and nutrition policy at the local level: Key factors that influence the policy development process	Australia	Food and nutrition policy	4 case studies – 33 semi-structured interviews; doc analysis; thematic analysis	Some political science discussed in intro but not used to inform study	B

Table 2: Articles from CIS literature review weighted C – theoretical or background (17 articles)

Author	Year	Title	Relevance A–C
(Alvaro et al. 2010)	2010	Moving Canadian governmental policies beyond a focus on individual lifestyle: Some insights from complexity and critical theories	C
(Atkins et al. 2013)	2013	Making policy when the evidence is in dispute	C
(Bambra et al. 2005)	2005	Towards a politics of health	C
(Baum and Sanders 2011)	2011	Ottawa 25 years on: A more radical agenda for health equity is still required	C
(Benoit et al. 2010)	2010	Medical dominance and neoliberalization in maternal care provision: The evidence from Canada and Australia	C
(Bernier and Clavier 2011)	2011	Public health policy research: Making the case for a political science approach	C
(Cairney 2007)	2007	A 'multiple lenses' approach to policy change: The case of tobacco policy in the UK	C
(Cairney 2009)	2009	The role of ideas in policy transfer: The case of UK smoking bans since devolution	C
(Exworthy 2008)	2008	Policy to tackle the social determinants of health: Using conceptual models to understand the policy process	C
(Fafard 2008)	2008	Evidence and healthy public policy: Insights from health and political sciences	C
(Greathouse et al. 2005)	2005	Passing a smoke-free law in a pro-tobacco culture: A multiple streams approach	C
(Kickbusch 2012)	2012	Addressing the interface of the political and commercial determinants of health	C
(Liverani et al. 2013)	2013	Political and institutional influences on the use of evidence in public health policy. A systematic review	C
(Milio 1987)	1987	Making healthy public policy; developing the science by learning the art: An ecological framework for policy studies	C
(Nutbeam 2003)	2003	How does evidence influence public health policy? Tackling health inequalities in England	C
(Oliver 2006)	2006	The politics of public health policy	C
(Shiffman 2009)	2009	A social explanation for the rise and fall of global health issues	C

2.1.5 Data extraction

All A and B weighted articles were rigorously examined and the guiding questions were revised to ensure that they were still adequate to guide the extraction, analysis and critique of the data (Dixon-Woods et al. 2006). In this second iteration, the questions were:

a) What are the barriers and facilitators that influence the inclusion or exclusion of specific health issues from the health policy agenda?
b) What theories underpin empirical research in this area?

The third guiding question related to health issues covered in empirical research and findings are presented in Table 1, so the question was removed at this stage.

When dealing with a relatively small number of articles, Dixon-Woods et al. (2006) suggests that an appropriate approach for the initial analysis is 'reciprocal translational analysis (RTA)' (p. 5). In this approach, key metaphors, themes and concepts are identified from across the selected literature as a whole (Dixon-Woods et al. 2006). The main aim is to assess relationships, similarities and differences between themes by cross-referencing evidence across the articles. The difficult part of this process is making 'judgements about the ability of the concept of one study to capture concepts from others', however, as the researcher becomes immersed in the body of literature these decisions become easier because they are 'based on attributes of the themes themselves, and the concept that is "most adequate" is chosen' (Dixon-Woods et al. 2006 p. 5).

Through the process of reviewing articles and grouping data I developed four main themes: networks, policy entrepreneurs, evidence and political context. These themes represented the most commonly discussed topics across the literature as a whole. The sub-themes of leadership, credibility, framing of ideas, competition and opposing networks, beliefs, dominant policy agendas, trust and diversity were related to the main themes but appeared less often in the literature and overlapped with the main themes. While the main themes illuminated areas in the literature that were well established, the sub-themes highlighted the gaps or weaknesses embedded in the main themes, thus indicating areas worthy of further study.

2.2 Findings

In the following section, the main themes identified in this review are critically appraised and discussed and their relationships to the sub-themes are demonstrated. In accordance with the reciprocal translational analysis (RTA) approach this was an iterative process where data were continually critically analysed and decisions made that melded the concepts from across articles together (Dixon-Woods et al. 2006).

2.2.1 Main theme – Networks

Networks was the most common theme found in this review (Larsen et al. 2006, Lewis 2006, Shiffman and Smith 2007, Breton et al. 2008, Dionne et al. 2008, Bowen 2009, Guldbrandsson and Fossum 2009, Craig et al. 2010, Schmidt et al. 2010, Schwartz and Johnson 2010, Holden and Lin 2011, Baum et al. 2013, Deas et al. 2013, Maclennan et al. 2013, Macnaughton et al. 2013). The data suggest that networks involved in the development of policy are broadly associated with the membership, interaction and power relations of a collective group of policy actors seeking to influence the political priority given to a specific health policy agenda. Policy actors became members of a network by way of a common interest, mostly through personal or professional association. The policy actors in this study who were members of networks involved in the development of health policy were from community, grassroots or interest groups, non-government organizations (NGOs) or not for profit organizations, public servants or bureaucrats within government, academics, politicians or ministers, and industry representatives.

The main purpose of a policy network was to develop policy; however, this often involved competing with other networks to gain political attention for a preferred policy agenda. The language most often used to describe the success or failure of such campaigns to influence a policy agenda referred to ‘strong’ or ‘weak’ policy networks. However, throughout the literature, the meaning of these terms were often vague or ambiguous. The most substantial and cogent explanation regarding this topic was that the leadership of a policy entrepreneur and/or a guiding institution was the link to a policy network's success or failure. In the following section, I highlight some of the analysis that provides details of how leadership is linked to the work of networks.

Leadership

As mentioned above, policy networks that were supported by strong leadership were seen as particularly influential on the health policy agenda. The concept of policy entrepreneurs is well established in the political science literature but there were few studies in this review that elaborated on how networks benefited from a leader who drove the efforts of their collective action in the health policy environment.

An example that exemplifies this point is a Canadian study in which the development of a housing initiative to support people with mental illness was explored. The authors described how the leadership of a prominent politician resulted in the opportunity to develop an initiative to address this health issue. The main strategy used by the politician was to ensure he had a network of people who were supportive of the initiative before lobbying the government and on whom he could rely for support if he gained political support for the project. Once he gained government support, he was able to mobilise these policy actors quickly to form an advisory group. Thus, there was no-one in the policy network who would block the initiative at this point (Macnaughton et al. 2013). Without this leadership and co-ordination of the policy network at the right time, the opportunity may have been missed. The authors suggest that trust in and credibility of the policy entrepreneur who was considered 'an insider' was key to the success of this initiative (Macnaughton et al. 2013). Credibility is a theme that was evident across several articles in this review and could be related back to networks (Shiffman and Smith 2007, Holden and Lin 2011, Deas et al. 2013). The below discussion explores this concept further.

Credibility

While the example above relates to the success of a policy network, the next example shows how a lack of leadership can lead to a lack of credibility and severely constrain the collective action of a policy network. More specifically, when a policy network is poorly coordinated or lacks leadership its credibility is questioned. Shiffman and Smith (2007) found that in the case of the Safe Motherhood initiative (addressing maternal mortality), internal tensions and disagreement within the policy community on the solution to the problem meant that the initiative initially gained limited political support at a global level. In the beginning, there were two opposing networks, one advocating for

community care including traditional birthing attendants and the other advocating for a more emergency style of obstetric care. Shiffman and Smith (2007) suggested that these 'disagreements' led to a lack of 'credibility with international and national political leaders' (p. 1373). Although some compromises were made later and some network members started see other points of view, the authors concluded that 'a widely embraced leader could have helped surmount historical difficulties of policy community fragmentation, weak guiding institutions, and little civil society mobilisation....however, no such figure emerged' (Shiffman and Smith 2007, p.1375). An Australian study of men's health policy also concluded that lack of co-ordination and leadership in a predominantly grassroots network limited the group's credibility within government, which resulted in limited action in this policy domain (Holden and Lin 2011, p. 232). The concepts of leadership and credibility are sub-themes that relate to how networks operate in the health policy environment.

Guiding institution

A guiding institution can support the work of a policy network. An interesting finding in relation to policy networks was the way opposing policy networks, with different preferred policy solutions, competed to gain political attention for a specific health issue. The following example provides some insight into this process and includes detailed analysis about the strategies employed to influence the policy agenda.

Breton et al. (2008) explored two dominant policy networks that were seeking to influence the adoption of Quebec's *Tobacco Act* (Canada). On one side was the anti-tobacco coalition campaign (made up of 18 Regional Public Health Directors, the Health Minister, NGOs, health care organizations and journalists) and they were opposed by the tobacco industry coalition (made up of the workers' Union, farmers' associations, and the Tobacco Industry Council). The findings suggested that while both networks were 'strong' in the beginning, the anti-tobacco campaign was eventually successful because it influenced the framing of the issue and funded an NGO that could continue to drive the agenda outside of government. This strategy was employed by the Health Minister who funded an NGO called the Quebec Coalition for Tobacco Control. With the Health Minister's leadership, this organization had the resources (and credibility) to oppose the tobacco industry. Their distance from government was important because it meant the government was shielded from any bad publicity arising from the decision (Breton et al. 2008). This paper is particularly useful in

explaining how a combination of strategies came together to support a policy network seeking to influence the health policy agenda. The concepts of framing and institutions are sub-themes which relate to the main theme of networks in this study.

Framing and beliefs

Data from this study suggest that framing and beliefs are linked to networks because a particular re-framing of an issue can cause members of an opposing network to change their overall position, regardless of their professional or political beliefs. An example can be seen in a study that explored the deregulation of medicines in pharmacies in Denmark (Larsen et al. 2006). In this case, there were two dominant networks, one of which wanted to maintain state control of the sale of over-the-counter drugs and another who wanted the market to have more control (Larsen et al. 2006). Initially, because of their loyalty to the ideology of their political party, some politicians were situated in the state control network. However, the network that favoured market reform re-framed the issue through a focus on more technical issues, such as rural areas struggling to maintain the presence of a pharmacy without some market re-orientation. This raised concerns about being able to regulate safety, including youth overdose. At this stage, both networks became more willing to compromise on their position, regardless of their beliefs. This case provides some insight into how policy actors can develop strategies to divert attention away from personal and professional beliefs, but this may only be possible when a particular framing of an issue is put forward (Larsen et al. 2006).

Dominant ideas in the health policy domain

This leads to a discussion around dominant ideas in the health policy domain. A sub-theme that emerged in this study in relation to networks was the dominance of biomedical networks over networks that focus on the broader determinants of health. For example, Baum et al. (2013) found that policy networks involved in collective action to move the social determinants of health onto the health policy agenda in Australia were in direct competition with the dominant ‘doctor lobby groups’ that former health ministers reported were ‘always in the forefront, leaving little room for public health efforts’ (p. 142). Several other studies also found that a medical approach dominated the health policy agenda, leaving limited space for more marginalised health issues (Hoeijmakers et al. 2007, Orton et al. 2011). Lewis (2006) found that the medical profession were influential on health policy outcomes in

Australia, suggesting that regardless of whether a policy actor works for government (politician or public servant), academia, in healthcare, an NGO or a professional association, 'a medical degree provides a useful entrée into health policy networks, providing personal and positional resources' (p. 2134). These findings suggest that the medical profession has a level of power within the health system and that this may be used to maintain the *status quo* (medical dominance) or to assist in bringing about change. This is area of research that needs further investigation, especially in relation to specific strategies that can be used by policy actors in less dominant networks to change the balance of power.

In summary, a strong policy network was seen as a facilitator for policy change, and conversely, a weak policy community constrained some health issues from reaching the health policy agenda. There were several sub-themes that related to the main theme of networks, including leadership, credibility, timing of influence, framing of ideas, competition and opposing networks, beliefs and dominant policy agendas such as a biomedical approach. Very few empirical studies were identified that used theory to provide explanations for the patterns of involvement and advocacy of policy networks that influenced the development of health policy, showing that more research is needed in this area.

2.2.2 Main theme – Policy entrepreneurs

Although policy entrepreneurs were mentioned under the main theme of networks, this concept was the second most common theme in the review and therefore is now discussed further.

Trust and time

There was a significant amount of research that highlighted the importance of policy entrepreneurs in marketing and advocating for particular health policy agendas to government (Lewis 2006, Hoeijmakers et al. 2007, Shiffman and Smith 2007, Guldbrandsson and Fossum 2009, Craig 2010, Schmidt et al. 2010, Orton et al. 2011, Baum et al. 2013, Deas et al. 2013, Maclennan et al. 2013, Macnaughton et al. 2013). The individual qualities a policy entrepreneur possessed were considered important and most policy entrepreneurs followed the 'classic' policy entrepreneur characteristics described by Kingdon (2011), namely that they were 'much the same as a business entrepreneur, with their willingness to invest resources – time, energy, reputation, and sometimes money – in hope

of future return' (Kingdon 2011, p. 122). For example, in a study of health disparities in The Hague (Netherlands), Schmidt et al. (2010) described the qualities of policy entrepreneurs as 'credible communicators' who 'sought opportune moments to push forward their agendas…through their expertise, trustworthiness and good will' (p. S214).

As with the discussion on policy networks, policy entrepreneurs were viewed in the literature as either strong (and successful) or lacking (and therefore less successful). The role of the policy entrepreneur was viewed as demanding and complex and this was the main explanation for potential leaders not taking on this role (Shiffman and Smith 2007). The other explanation given was because there was another policy entrepreneur associated with the opposing policy network who was stronger and more aligned with the dominant policy agendas in health (Baum et al. 2013).

Diversity of leaders, timing and credibility

However, while the literature established the policy entrepreneur as important, there were few studies that explored this area in detail, and there is a knowledge gap in regard to understanding the diversity of people that play a policy entrepreneurial role. For example, several studies hinted at a hierarchy of policy entrepreneurs who worked at different times in the agenda setting process and/or the policy development process and who were operating from different professional levels. For example, Maclennan et al. (2013) studied the development of alcohol policies in three communities in New Zealand and found that as well as politicians and bureaucrats, there was a subset of policy entrepreneurs working within local communities who influenced the health policy agenda. These included police officers and social workers who used their position in the community and their experience from a significant workload that dealt with alcohol related problems, and who displayed 'sheer persistence' in trying to bring about change in this area (p. 887). Guldbrandsson and Fossum (2009) also described the local policy making environment as conducive to a wide range of policy entrepreneurs including police, educators and public health workers. Furthermore, in a study on childhood obesity policy in the United States, Craig et al. (2010) categorized influential policy actors as either primary or secondary policy entrepreneurs. When public health professionals (secondary) were coupled with a more influential figure – in this case Speaker Cleveland (primary) – change could occur at a policy level.

Several studies pointed to the different stages during the agenda setting and policy development processes at which a specific policy entrepreneur could be influential. For example, Smith (2007) viewed policy entrepreneurs as ‘brokers of ideas’ who had the ability to ‘move things along’, and ‘they are more or less influential at different times, in the policy development process' (p. 1446).

An example of a more sophisticated representation of the policy entrepreneurial role featured academics who demonstrated policy entrepreneurial qualities to get research adopted into policy. Bowen et al. (2009) suggested that the policy entrepreneurial qualities that academics used to engage with policy built credibility within policy networks and with politicians and were vitally important at the beginning of the agenda setting process. Smith (2007) suggested that the credibility, communication style and connections of a researcher were attributes that enabled an idea based on research to cross into policy. In a study that explored the factors that facilitated moving health inequities onto the health policy agenda, Smith (2007) found that to be ‘perceived as credible amongst policy makers….researchers need to be able to communicate clear, policy relevant messages, provide solutions to identifiable problems (rather than solely identify problems), avoid too much hesitancy in conclusions, and gain visible credibility from actors beyond academia’ (p. 1446). Bowen et al. (2009) studied two early childhood interventions in Victoria, focusing on three academics who were considered credible, and therefore influential, within the Victorian policy community. These were Dr Bruce Perry and Professor Graham Vimpani on brain development, and Dr Fraser Mustard on the importance of the early years. These academics were described as having policy entrepreneurial qualities of being able to sell research and opinion, deliver powerful presentations, disseminate messages, convince decision makers, attract media attention and talk to journalists, and to be known well enough to be asked to present at important government events where policymakers were listening. Lewis (2006) also found that policy actors ‘that had been around the health system for a long time’ were more likely to be considered influential (p. 2133).

In summary, the policy entrepreneurial role was recognized throughout this review as important but also as difficult and complex, and most studies showed that the attributes required were similar to those described by Kingdon (2011). This review, however, does point to a gap in the literature highlighting some variations on Kingdon’s ‘classic’ policy entrepreneur description (2011). In particular, the diversity of leaders who took up this role, the timing of influence, the way credibility is

built, the professional level they work at and the number of leaders present within any particular policy development process. Therefore, in this section the sub-themes of leadership, credibility, and timing of influence are built on and the sub-themes of trust and diversity are added.

2.2.3 Main theme – Evidence

Using evidence to inform policy development was mentioned in one-third of the articles included in this review (Hoeijmakers et al. 2007, Breton et al. 2008, Dionne et al. 2008, Bowen et al. 2009, Guldbrandsson and Fossum 2009, Schmidt et al. 2010, Orton et al. 2011, Baum et al. 2013, Bump et al. 2013, Deas et al. 2013, Macnaughton 2013). Most studies viewed evidence as information gathering to frame the issue, define the magnitude of the problem or to justify the proposed solution.

Ideas and framing the issue

The findings from this study show that evidence is used in the agenda setting and policy development processes to frame the issue in a way that is likely to gain political attention. Therefore, evidence was best received by policy actors if it gave them access to information that they could use to convince decision makers and Treasury departments of the need for a particular health policy agenda to be dealt with. For example, Bowen et al. (2009) found that evidence was part of a successful campaign to move early childhood development onto the Victorian health policy agenda. She identified a combination of strategies that were useful in gaining political attention for this issue, including using a credible researcher who had the ability to deliver a powerful presentation to any audience, inclusion of ‘killer facts’ such as the importance of brain development during early childhood, and mentioning a dollar value (which speaks to Treasury departments) (p. 16). Other scholars also suggested that evidence could be used as a strategy to gain political attention for health issues (Breton et al. 2008, Schmidt et al. 2010).

Lack of evidence

In the literature, there was lack of agreement about whether international, national or local evidence was most suitable to inform policy. However, it was strongly suggested that when there was little evidence, personal experiences or values were called upon to convince decision makers of the need to act on a particular health policy issue. For example, Deas et al. (2013) found in a study of children’s

oral health in Scotland that 'it was clear that, when looking for a solution to the problem of poor child oral health, values and ideas had a role to play particularly when no scientific evidence existed' (p. 5).

However, the lack of evidence was perceived as a barrier to a health issue reaching the health policy agenda. This problem was especially relevant when trying to address complex health issues such as the social determinants of health and health inequities (Orton et al. 2011, Baum et al. 2013). Orton et al. (2011) suggested that this reflected the lack of research into the best ways to address health inequities and that more research was needed in this area. Therefore, policy actors advocating for health issues that are easily measurable may find evidence a useful tool when arguing for a particular health issue to be prioritised. Conversely, those who are dealing with more complex issues such as maternal mortality, child oral health, obesity and the social determinants of health and health inequities where there is a lack of hard evidence are less likely to find success.

In summary, this review has shown that evidence is important in the agenda setting process in framing an issue in a way that will gain political support, providing baseline data to evaluate a program against, and to convince Treasury departments (finance) that their investment is worthwhile. However, there is a gap in the literature as to what policy actors should refer to when there is a lack of evidence. What should their approach be when the evidence does not provide data in a way that Treasury departments require? How can personal opinion, knowledge and experience be used in the absence of convincing research facts? Therefore, this thesis will build on the knowledge translation literature that looks at how policy is translated into health policy, by addressing the gaps identified here which relate to how policy actors use alternative methods when confronted with evidence that does not fit the policy development process for the specific health issue they are advocating for. The sub-themes that sit under the main theme of evidence are framing of ideas, beliefs and credibility.

2.2.4 Main theme – Political Context

The political context was mentioned as being influential in one-quarter of the articles in this review (Smith 2007, Bowen et al. 2009, Dionne et al. 2008, Schmidt et al. 2010, Maclennan et al. 2013). The term 'politics' was interpreted broadly. In the first instance, it was explored in terms of a general acknowledgement that an election campaign or change of government can influence the health policy agenda; that public opinion (and the media) can influence a minister's decisions; that understanding policy processes and government structures assists advocacy efforts; that political ideology can affect

the health policy agenda; that fiscal arguments need to be addressed when seeking to change health policy agendas; and that laws and events that occur outside health departments can affect the inclusion or exclusion of specific health issues on the health policy agenda. It was clear from this review that it is necessary to understand what preceded a particular policy or agenda (for example, which political party was in government, their ideology, related laws or policies, or previous policies), and to understand how the current mood of the government and the general public affected change or innovation and acted as an enabler for policy change.

The three main themes explored so far, policy networks, policy entrepreneurs and evidence, were perceived by researchers as softening up the political environment during the agenda setting and policy development processes. However, throughout the articles in this review, 'politics' was often overstated as the reason for health issues not reaching the health policy agenda. Yet there was little explanation as to how and why politics acted as a barrier. The articles that did most to break down this concept were those that used political science theories to guide the design and analysis of the study. The political science theories used in the selected studies for this review are detailed below. Following this, there is a discussion section where the main themes and sub-themes are used to generate a range of synthetic constructs.

2.3 Theoretical literature

This section addresses the second guiding question: What theories underpin empirical research in this area?

As mentioned above, the use of political science theories to guide data collection and analysis in studies on the politics of developing health policy was seen in 12 of the empirical studies included in this review. Most of these researchers selected well known political science theories or frameworks such as multiple streams theory (Kingdon 2011) and/or advocacy coalition framework (Sabatier and Jenkins-Smith 1988) to guide their studies. Shiffman and Smith (2007) combined these theories to develop a framework to research agenda setting in a health policy context. There were also studies that adopted social networking theory, and this was often combined with one of the abovementioned theories. Most of the 12 articles did not describe their broader methodological approach, but those that did referred to social constructivism (Macnaughton et al. 2013), ideation (Lewis 2005, Shiffman and Smith 2007) and/or theories of power relations such as pluralism, Marxist or elitist, and actor–

structural interests (Lewis 2006, Shiffman and Smith 2007, Guldbrandsson and Fossum 2009). These theories will be described and critiqued further in Chapter 4.

2.4 Discussion

Following the CIS method, the next stage was to develop the analysis further with a 'synthesising argument' (Dixon-Woods 2006 p. 5). The aim is to create an argument that goes beyond description and 'integrates evidence from across the studies in the review into a coherent theoretical framework comprising a network of constructs and the relationships between them' (Dixon-Woods et al. 2006). In the next section I present a synthesising argument that positions the main themes and sub-themes within the literature as a whole. In doing so I generate four synthetic constructs, leadership, credibility, ideology and politics, that relate back to the guiding question and assist in identifying gaps in the literature.

2.4.1 Synthetic construct – Leadership

There is a strong emphasis in the literature on factors that support or hinder policy networks as they seek to influence the health policy agenda. However, networks do not act alone and are often competing with other networks to bring about change. Therefore, to navigate the competition and barriers through an often-lengthy process, a policy network relies on the leadership of one or more individuals to ensure political attention is sustained until the policy is endorsed by government. This is described in the literature in general terms as a policy entrepreneurial role (Kingdon 2011). However, the literature offers little insight into the range of policy actors who are prepared to lead a policy network and why they choose to take on this role. Furthermore, while some theoretical articles have explored the skills required by a policy entrepreneur, recent empirical evidence in this area is lacking. Given that this review indicates that the range of policy actors is expanding and public servant roles and governments are changing rapidly, this area needs further consideration.

The other area of leadership that was highlighted in the literature, but not further developed, was at an organizational or institutional level. The main topic of this discussion across a small number of studies was how the apparent outsourcing of decision making to other people or NGOs helped avoid tension for government. In this way, a policy entrepreneur within government can take the lead on a specific health issue that is on the fringes of the health policy agenda without bearing full responsibility for it or any negative feedback against the idea. In addition, once a suitable person or NGO is established

and has sufficient resources, they can take over advocacy efforts, providing a sustainable model for keeping the issue on the health policy agenda. The development of a strong institutional culture was also hinted at in several studies suggesting that a shared vision and agreement on resource distribution was a facilitator for sustaining change. However, no advice was offered on the practical formation of strategies to foster leadership at an institutional level. Further research into this area could strengthen the work of a range of institutions that are seeking to bring about change.

Therefore, throughout the literature a new concept of leadership has emerged that relates both to the work of policy networks and policy entrepreneurs. I define this as the need for a strong leader to bring together the main elements of agenda setting (from collective action and individual perspectives) and sustain them through a variety of strategies which are evident throughout the entire policy development process.

2.4.2 Synthetic construct – Credibility

Another new concept that has emerged but is not well understood is building credibility within the health policy environment. While this is seen as important throughout the literature and essential to gaining and sustaining political attention, there is very limited empirical research that explores this concept. In this review, credibility is linked to three of the main themes – networks, policy entrepreneurs and evidence – and builds momentum to influence the fourth main theme, politics. An individual is seen to influence politics if they possess the skills of a policy entrepreneur and can sell their idea to government. A policy network is seen to influence politics if they create a co-ordinated advocacy campaign and frame the issue (and the solution) in a way that is acceptable to government. However, a potential weakness in the field is the need for a range of examples to demonstrate how individuals, networks and institutions can strategically build credibility to influence 'politics' throughout the entirety of the agenda setting and policy development processes. Therefore, analysis across several policies is required to illuminate this area of interest.

2.4.3 Synthetic construct – Ideology

Another strong emphasis in the literature is the way ideology links many aspects of the agenda setting and policy development processes. Firstly, policy actors within policy networks approach their work with a combination of personal beliefs and/or a set of professional beliefs that affect which policy network(s) they join. These beliefs are discussed in the literature in terms of whether they are

fundamental beliefs that are unlikely to be altered, or more superficial beliefs that, with the right framing of an issue, have the potential to change (Lewis 2006). The framing of issues is important at the level of evidence and it appears that the 'ideas' put forward at this stage have an impact on political support. In addition, the way ideas are framed has the potential to change the level of support for a specific health issue, even if members' fundamental beliefs differ. However, in the literature, the differences in ideological belief systems of policy actors are most often only described in broad terms, for example conservative versus progressive or medical versus social. While these areas are important to the study of public health in general, this review highlights the need to reflect on these issues in more detail by adopting political science theories to provide a more nuanced understanding of why ideology influences health decisions made by governments. In particular, more needs to be known about the underlying assumptions under which policy actors operate and which may act as facilitators or barriers for change in policy.

2.4.4 Synthetic construct – Politics

The findings from this review indicate there is a lack of public health research that adopts a political science approach to inform empirical research. It is widely acknowledged that this is an area that needs to be addressed, with several public health authors highlighting the need for public health researchers to adopt a more theoretical approach to exploring the agenda setting and policy development processes (Breton et al. 2008, Exworthy 2008).

Breton et al. (2008) suggest that 'overall, policy-related articles in the [public health] field still apply few theoretical insights from political science to study the policy process' (p. 110). While using a political science approach has been recognised as potentially useful to the study of the agenda setting and development phases of health policy (Bambra et al. 2005, Oliver 2006, Exworthy 2008, Shiffman 2009, Alvaro et al. 2010, Baum and Sanders 2011, Bernier and Clavier 2011, Kickbusch 2012), neither political science nor public health scholars have produced significant amounts of empirical research in this area. This may suggest that working at a cross-disciplinary level has proven difficult (because of the unfamiliarity of issues, theories and methods) and that researchers from both disciplines are reluctant to act as experts in the other's field. In addition, the partnership between these disciplinary areas is not an obvious one as it might be with law and politics, or public health and psychology. However, the findings from this review support the view that this is an area of cross-

disciplinary research that is worthwhile, especially when the aim of the research is to better understand how complex health issues gain political attention at a policy level.

Therefore, this thesis will build on the small amount of empirical research identified in this review that has adopted a political science approach to inform and guide the research. Specifically, in this thesis I will focus on the politics of developing health policies with a focus on complex health issues.

2.5 Gaps in the literature

This critical interpretive synthesis review has synthesised and critiqued a wide range of topics related to the politics of developing health policy. The review represents the relevant literature from the public health, health policy and political science literature. It has highlighted the areas that have been studied up until 2013, and the gaps in the literature that warrant further study, including:

1. Empirical research that adopts a political science theory to better understand how and why specific health issues (and the associated policy solutions) reach the policy agenda.

2. A detailed exploration of the patterns of involvement and advocacy of networks, specifically how and why policy networks form, function and exert influence, the specific strategies they employ, and how and why the collective action taken facilitates or constrains complex health issues rising on to the health policy agenda.

3. A detailed exploration of how leadership and credibility interact at both an individual and institutional level to facilitate change in the health policy environment.

4. A detailed exploration of how ideas and ideology/beliefs influence the framing of an issue which facilitates or hinders political attention throughout the agenda setting and policy development processes.

2.6 Aims and objectives

Identifying these gaps in the literature led to the development of the aims and objectives for studies 2 and 3 in this thesis. However, before I could develop these it was necessary to identify a specific area of health policy so that specific research aims and objectives could be developed. To do this I took the health issues that were identified in the literature (see Table 1) together with my previous broad

research interests. The result was a focus on child and youth health policy and the social determinants of health and health equity, with the following aims and objectives:

Aim (study 2): To assess the extent to which current Australian child health policy addresses the social determinants of health and health equity

Objective (study 2): To review systematically a selected set of current Australian child health policies

Aim (study 3): To explore policy actors' perceptions on the factors that facilitate or constrain the development of Australian child health policy that focuses on the social determinants health

Objective (study3): Conduct semi-structured interviews with policy actors involved in the development of Australian child health policy

2.7 Chapter summary

In this chapter I have provided a critical interpretive review and synthesis (CIS) of the public health and political science literature that is relevant to the facilitators (and barriers) that influence the inclusion and exclusion of specific health issues on the health policy agenda, the theories that underpin empirical research in this area, and the health issues covered in this area of research.

This process has led to a synthesis of the literature and development of an argument that goes beyond descriptions to provide a theoretical base from which to understand the evidence across the literature. Four synthetic constructs were developed, politics, ideology, leadership, and credibility. Finally, gaps in the literature were identified and these, with the synthetic constructs, were used to form a basis from which to develop the aims and objectives for the remaining two studies in this thesis.

In the following chapters I aim to understand the extent to which current child health policies address the social determinants of health and health equity (Study 2 in Chapter 3) and to adopt a political science approach to explore policy actors' perceptions on the factors that facilitate (or constrain) a social determinants of child health approach gaining legitimacy in Australian health departments (Study 3, Chapter 4).

CHAPTER 3: DOCUMENT ANALYSIS (STUDY 2)

In this chapter I report on study 2, a document analysis study of 17 child health policies selected from Australian health departments. The aim was to provide an in-depth picture of the current state of children's health policy development in Australia with a specific focus on the extent to which these policies addressed the social determinants of health and equity. To do this, an *a priori* coding framework was developed to assess the extent to which health departments address the social determinants of child and youth health and health equity (Wilkinson and Marmot 2003, Carter et al. 2009, Baum 2016).

Firstly, I detail the methods used in this study including the choice of document analysis, policy selection and criteria, coding structure and the theoretical contributions used in the development of the *a priori coding* framework. Next, I present the findings using the following headings: health issues and overall target group, principles and values, health and health equity goals, social gradient, objectives, strategies, social determinants of health (additional coding) and recognition of health inequities in the intended outcomes of strategies. I discuss the findings in relation to the public health literature and highlight that Australian child health policy addresses a wide range of health issues for children aged 0–12 years and to a lesser extent youth aged 12–25 years. I also suggest that while most policies preference medical or behavioural strategies, the small number of strategies that initially appeared to be addressing important social determinants of health, such as early childhood development and healthy settings, often resulted in narrow strategies that reverted to a focus on the individual. I provide several examples to illustrate this point, including the home environment and healthy settings. Finally, I present the conclusions from this study.

Newman et al. (2006) used document analysis in a study of Australian health policy and found it was an effective way to assess the practical uptake of evidence on the social determinants of health and health equity. However, there has been no systematic analysis of Australian child and youth health policies with a social determinants and health equity focus and this study aims to address this gap.

The aims and objectives of study 2 are detailed below:

Aim 2: To assess the extent to which current Australian child health policy addresses the social determinants of health and health equity

Objective 2: To review systematically a selected set of current Australian child health policies

This study has been published in *BMC Public Health:* Phillips, C., M. Fisher, F. E. Baum, C. J. MacDougall, L. A. Newman and McDermott, D.R. (2016) "To what extent do Australian child and youth health policies address the social determinants of health and health equity? A document analysis study." *BMC Public Health* **16**: 512.

3.1 Methods

3.1.1 Choice of document analysis to assess policy documents

Document analysis was selected as the research method to address the aims and objectives of this study. Document analysis has been shown to be an 'important aspect' of the 'quest for the practical uptake' of the social determinants of health (Newman et al. 2006 p. 218). The study of policy documents has been described as one part of 'sense making where the analysis process allows us to reconstruct, sustain, contest and change our sense of social reality' (Patton 2015 p. 498). Other scholars have highlighted the need for policy analysis that allows public health researchers and health departments to reflect on policy outputs, and learn from their successes and failures (Breton et al. 2008). Patton (2015) suggests document analysis is an appropriate method to make sense of policy documents because the systematic nature of the method allows the researcher to deconstruct the text and assess the *status quo*.

3.1.2 Policy selection

The first stage was to select a set of Australian child health policies suitable for inclusion in this study. The aim was to provide a picture of the current state of children's health policy in Australia with a specific focus on the extent to which the selected set of health policies addressed the social determinants of child health and health equity.

The criteria for inclusion were:

a) the title of the policy addressed ‘child/ren/hood’ ‘young people/youth’ or ‘paediatric health’ directly,

b) the title of the policy addressed family/ies directly,

c) the policy was a strategic document outlining a health department’s principles, goals, objectives and strategies for action in a major area of their responsibility for public health or health services,

d) policies identified as whole of government (across portfolios) were only included if specific responsibility was assigned to a health department and/or there were strong links to health policies,

e) the policy was the most up-to-date policy in the area and was published no earlier than 2008.

Health promotion or prevention policies with chapters or extensive sections devoted to children were also included. The rationale was for this was to enable assessment of a small number of broad health policies that had a focus on children although they did not fit the original selection criteria.

The exclusion criteria were policies identified as:

(a) subsidiary to higher-level strategic policies,

b) out-of-date or expired,

c) focused on internal (department or service) operational issues,

d) reporting on outcomes of research or evaluation,

e) advisory only, or

f) purely for public information-giving.

To locate suitable policies, I searched the websites of all Australian health departments at federal, state or territory level. Those matching the selection criteria were listed and downloaded in February 2013 from publicly accessible government websites. At the time of selection, the currency of each document was confirmed by a formal email to the relevant health department, with a follow-up telephone call if necessary. This selection process resulted in the inclusion of 17 policies providing a strategic set of child health policies for analysis (see Table 3). All policies were entered into NVivo data analysis software for analysis.

The selection contains 15 health department policies, one whole of government policy from the ACT, and one Office of Children policy from Tasmania. These two policies were included because they had strong links to departments of health. The *ACT Children's Plan: Vision and building blocks for a child-friendly city 2010–2014* was described as a whole of government policy but had been prepared by ACT Health and the ACT Department of Disability, Housing and Community Services. The Tasmanian policy, *Our children our young people our future 2011–2021*, was developed by the Office for Children, which is embedded in the Department of Health and Human Services.

Table 3: Selected Australian child and youth health policies

Strategic health service plans
1. *Strategic plan 2009–2014.* Child Health & Parenting Service (CHAPS), Tasmania
2. *Supporting families early - SAFE START strategic policy 2009.* New South Wales
3. *Supporting families early – maternal and child health primary health care policy 2009.* New South Wales
4. *Aboriginal family health strategy 2011–2016.* New South Wales
5. *Strategic framework for paediatric health services in Victoria 2009.* Victoria
6. *CAMHS (Child and Adolescent Mental Health Services) in communities 2006.* Victoria
7. *Children, Youth and Women's Health Service (CYWHS) strategic plan 2011–2015.* South Australia
8. *Our children, our future: A framework for child and youth health services in Western Australia 2008–2012.* Western Australia
9. *Our children our young people our future 2011–2021*. Tasmania
Comprehensive and cross-sector approaches to child and youth health and wellbeing
10. *ACT children's plan: Vision and building blocks for a child-friendly city 2010–2014*. Australian Capital Territory
11. *Youth health policy 2011–2016: Healthy bodies, healthy minds, vibrant futures*. New South Wales
Policies that addressed specific childhood health issues
12. *NSW Government plan for preventing overweight and obesity in children, young people & their families 2009–2011.* New South Wales
13. *Keep them safe: A shared approach to child wellbeing 2009–2014*. New South Wales
14. *Guidelines on the management of sexual health issues in children and young people, 2011*. Northern Territory
Broader health policies (with dedicated chapter or section on children's health)
15.*Victorian public health and wellbeing plan 2011–2015* (chapter on early childhood and education). Victoria
16. *Primary prevention plan 2011–2016* (section on children and youth). South Australia
17. *Preventative health – strategic direction 2010–2013* (section on children). Queensland

3.1.3 Coding process and structure

To analyse the selected policies, a coding framework was developed to assess the extent to which each policy sought to set goals for child health equity, acknowledge evidence on the social determinants of health and propose action on the social determinants of health through objectives and strategies.

The coding structure was based on categorical analysis, where the 'categories are constructed before the commencement of the study' (Sarantakos 2005 p. 294). The development was guided by the theoretical contributions of Baum (2016) and Dahlgren and Whitehead (2006a, 2006b), who comprehensively considered the social determinants of child and youth health and health equity (respectively) in Australia and other countries, and made particular reference to the ways in which policy could be improved to facilitate more equitable and sustainable health outcomes for all children. The methods of Carter et al. (2009), who analysed social determinants and health equity in cancer policy, were also adapted and built into the overall coding structure. The methods were applied to analyse the selected policies using NVivo 10 qualitative data analysis software.

This coding framework was developed as part of a broader 3-year project funded by the Australian Research Council that aimed to understand the uptake of evidence on the social determinants of health across all Australian health policies. I was a part of this research team and adapted the framework to apply specifically to child health as part of my PhD. The framework for the ARC project has been published in *Evidence and Policy*: Fisher, M., F. Baum, C. MacDougall, L. Newman and D. McDermott (2015) "A qualitative methodological framework to assess uptake of evidence on social determinants of health in health policy." *Evidence and Policy* 11(4): 491-507.

There are four main categories in the *a priori* coding structure: goals, recognition of evidence on SDH and HE, objectives, and strategies, with these last two categories sharing the same codes (see Table 4). These categories were derived from the public health theories selected for this study and the codes within them were developed as follows. First, for the category of **goals** I drew on Dahlgren and Whitehead (2006a, 2006b) and Baum (2016) to examine how policies addressed health inequities. There are five coding options in this category, which represent the different ways improvements in health or health equity are presented in the goals of policies. During coding, one code was allocated for each health goal identified in the policy text. For the purpose of this study, 'equity groups' were defined as groups of children who are known to be subject to social, economic, locational or cultural disadvantage and who are known to experience worse health outcomes than non-members of that group. Examples are Aboriginal and Torres Strait Islander children, children with disability, LGBTIQ children, asylum seeker and refugee children, children living in regional and remote areas and children in out-of-home care (Australian Child Rights Taskforce 2018).

Next, for the category **recognition of evidence on SDH and HE**, the work of Carter et al. (2009) on the social determinants of health was used to assess how evidence on the social determinants of child health is recognized in policies. There are two codes in this category, with text coded as either 'acknowledging' or 'auditing' the social determinants of health. Carter et al. (2009) describe 'acknowledging' as the social determinants simply being acknowledged in the text while 'auditing' indicates in-depth knowledge of the evidence on the social determinants of health and refers to actions or outcomes which are related to the social determinants of health (Carter et al. 2009 p. 1451).

In the third and fourth categories, **objectives** and **strategies**, there are codes for 11 main domains of activity. To develop these codes, I drew on both the public health literature and a preliminary review of the selected policies, which were continually reviewed throughout the coding process. The coding procedure involved identifying one or more areas covered in each objective or strategy. In addition, the strategies coded under the code *social determinants of health* were given one of ten sub-codes as follows: early childhood development, education, health settings, employment/workplace conditions, housing, urban planning, public transport and regulatory measures. This was considered an important addition to the coding structure because of the focus of this research on the social determinants of child health.

Finally, to assess the intended equity outcomes, each strategy was cross-coded with the same codes used for health goals (described above). The *a priori* coding structure with the four main categories and related codes is shown in Table 4.

Table 4: A priori coding structure for document analysis

Main categories (codes)	**Codes (sections of text can be coded against several codes)**
Goals	Intended gains in health status specified as: • average health • subject to ill health • equity groups • Close the Gap • Across the gradient
Recognition of evidence on SDH & HE	• Acknowledge • Audit

Objectives
Strategies
These two categories coded with the same codes
	• Environmental health
	• Research
	• Policy development and governance
	• Workforce
	• Health Service quality
	• Health service access
	• Collaboration between health services
	• Health promotion and disease prevention
	• Community engagement
	• Cross-sector activity
	• Social determinants of health (other than health service access)
	  • home environment
	  • early childhood development
	  • education
	  • health settings
	  • employment/workplace conditions
	  • housing
	  • urban planning
	  • public transport
	  • regulatory measures
	  • And reducing social inequalities
	Note: Strategies were double coded against intended outcomes for health equity

I coded the policy documents myself, with 20% of policies being cross-coded by my supervisory team. Any disagreements were discussed and resolved at monthly meetings. After analysis of each policy a narrative report was produced using a *pro forma* document that allowed comparison and assessment

of each code across the policy set. In addition, NVivo 10 analysis allowed me to draw out the extent to which the policies, both individually and as a group, set goals on equitable health outcomes for children and proposed action on the social determinants of child health. These results were consolidated into a narrative report that was used as a basis for reporting the findings in this thesis.

3.2 Findings

3.2.1 Health issues and overall targeted age groups

The 17 policies selected for this study covered the following health issues relating to children: general health and wellbeing, obesity/overweight, nutrition, physical activity, sexual health and sexually transmitted infections, child protection, mental health, infant mortality, alcohol/tobacco/illicit drug use, oral health, chronic disease prevention and management including in relation to diabetes and cancer. The policies covered a range of ages from before birth to 25 years, but most focused on the 0–8 or 0–12 age groups. Although some policies stated that they addressed the health of children aged 0–18 year, the focus remained on those aged 0–12 years, with older ones receiving limited attention. There were six policies dedicated to children aged 0–8 years, one dedicated youth health policy and one policy that focused on families and communities. The remaining nine policies stated that they addressed the 0–18 years age range but concentrated on those aged 0–8 years. According to the United Nations, ‘youth’ is defined as those aged 15–24 years, while the Australian Institute of Health and Welfare defines ‘young people’ as aged 12–24 years. In this study, I found limited focus on those aged 12–18 years and very little mention of people aged 18–24 years. More details about each policy can be found in Table 5.

Table 5: Overview of content of 17 child health policies

Policy document #	Main health Issue	Age range covered	Aim of goal/s	Acknowledge or audit	Social gradient	Objectives – main codes	No. of strategies	Strategies – main codes	No. of strategies addressing equity	# SDH codes	Main SDH covered
1 (TAS)	Infant & child health	0–8	Population group (non-equity)	Significant audit and acknowledge	No	1. Promote and prevent (individualised) 2. Health services access	46	1. Promote and prevent (individualised) 2. Health services	3	2	Early childhood development
2 (NSW)	Mental health	0–2	Population group (non-equity)	Significant audit and acknowledge	No	1. Promote and prevent (individualised)	42	1. Cross-sector 2. Health services 3. Health workforce	13	3	Early childhood development
3 (NSW)	Infant mortality	0–2	Population group (non-equity)	Minor acknowledge and audit	No	1. Health services	44	1. Health services 2. Health workforce 3. Health services access	7	0	N/A
4 (NSW)	Family violence	0–8	Population group (equity)	Significant audit and acknowledge	No	1. Health services 2. Cultural awareness 3. Promotion and prevention (individualised)	116	1. Health services 2. Promote and prevent (individualised) 3. Health services access	61	5	Education
5 (VIC)	General health	0–8	Population group (non-equity)	Minor acknowledge	No	1. Health services 2. Health service access	81	1. Health services 2. Health workforce 3. Cross-sector	5	2	Early childhood development
6 (VIC)	Mental health	0–18	Population group (non-equity)	Minor acknowledge	No	1. Health services 2. Health services access	24	1. Health services 2. Health service access 3. Health policy	11	1	Housing
7 (SA)	General health	0–18	Population group (non-equity)	Significant audit and acknowledge	No	1. Health services	23	1. Health services 2. Health workforce 3. Promote and prevent (individualised)	1	0	N/A
8 (WA)	General health	0–18	Population group (non-equity)	Significant acknowledge	Yes	1. Health services 2. Promotion and prevention 3. SDH	155	1. Promotion and prevention 2. Health services 3. SDH	39	20	Early childhood development
9 (TAS)	General health and education	0–8	Population group (non-equity)	Significant acknowledge and audit	No	1. Cross-sector 2. Health services	68	1. Cross-sector 2. Promotion and prevention (individualised)	13	10	Early childhood development Education

							3. SDH				
10 (ACT)	Child friendly city	0–12	Population group (non-equity)	Extensive acknowledge and audit	No	1. Policy and governance 2. Community engagement 3. Cross-sector action	284	1. SDH 2. Cross-sector 3. Policy and governance	59	70	Early childhood development Education Healthy settings Housing Urban planning Employment/workplace conditions
11 (NSW)	Physical, social and emotional wellbeing	12–24	Population group (non-equity)	Extensive acknowledge and audit	No	1. Health services access 2. SDH 3. Health research	45	1. Health service access 2. SDH 3. Health services	3	7	Healthy settings
12 (NSW)	Obesity, physical activity, nutrition	0–18	Population group (non-equity)	Significant acknowledge and audit	No	1. Promotion and prevention (individualised) 2. SDH	60	1. Promotion and prevention (individualised) 2. SDH 3. Cross-sector	4	15	Healthy settings Urban planning Regulation Public transport
13 (NSW)	Child protection	0–12	Population group (non-equity)	Extensive acknowledge and audit	No	1. SDH 2. Promotion and prevention (individualised) 3. Health services	133	1. Policy and governance 2. Health services 3. SDH	60	22	Early childhood development Education
14 (NSW)	Sexual health	12–18	Population group (non-equity)	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A
15 (VIC)	Health promotion and early childhood development	0–12	Population group (non-equity)	Acknowledge and audit	No	N/A	11	1. Promotion and prevention (individualised) 2. Policy and governance 3. SDH	0	1	Healthy settings
16 (SA)	Health promotion	0–3	Population group (non-equity)	Extensive acknowledge and audit	Yes	N/A	48	1. Promotion and prevention (individualised) 2. Health services 3. Health service access	13	5	Education Healthy settings Urban planning
17 (QLD)	General health	0–8	Population group (non-equity)	Minor acknowledge	No	N/A	71	1. Promotion and prevention (individualised) 2. Health workforce 3. Health services	8	14	Early childhood development Healthy settings

3.2.2 Principles and values

A number of guiding principles relating to governments' approaches to child health and healthcare delivery were identified. These included values that espoused a social view of health; an ecological view of the child, including the broader social environment in which children live; and the importance of placing the child (and their families) at the centre of health services.

The following quotes from policies demonstrate these values.

> *NSW Health believes that good health and wellbeing relies on being well in every sense – physically, emotionally, sexually, mentally, socially and spiritually – not just an absence of illness.* (NSW, Policy 11)

> *An ecological view of the child: The child/children are the key concern of early years' health services. However, the opportunity to influence the child's health and wellbeing is totally dependent on influencing those caring for the child and the community in which they live.* (TAS, Policy 1)

> *Child and Youth Focussed and Family Centred: Emphasis on promoting a patient focussed philosophy that recognises children and youth as the most important component of paediatric health care services, and the involvement, support and education of families as fundamental to improving patient health outcomes.* (WA, Policy 8)

> There was some recognition of child and family rights in the principles and values sections of policies, while a few policies addressed reconciliation and equity.

> *These values will be demonstrated through everything we do: Respect for our clients, patients, colleagues and communities; Act with integrity, honesty and accountability; Improve our services and care through innovation, learning, experience and research.* (SA, Policy 7)

> *All children should expect to receive quality services such as health care and education and be safe and protected from exploitation, violence and abuse.* (ACT, Policy 10)

For the NSW Department of Health, this Statement of Commitment means building our cultural competence and working to deliver sustainable health outcomes and contribute to closing the health gap between Aboriginal and non-Aboriginal people. (NSW, Policy 4)

In particular, closing the opportunity gap for children who are vulnerable or financially or socially disadvantaged is a priority. (ACT, Policy 10)

3.2.3 Health and health equity goals

I identified whether the goals of policies suggested improvements in overall child/youth/family health, or for equity or disease-based groups. Most goals (10) were aimed at children or youth in general, for example:

…improve the health and wellbeing of our children (ACT, Policy 10)

…all children in Tasmania have the best start in life (TAS, Policy 1)

Three policies identified health goals for equity or disease-based groups:

…that all Aboriginal people in NSW live safe and healthy lives free of domestic violence. (NSW, Policy 4)

Four policies identified the family environment in some way:

…to engage all families with newborns and to provide support to parents with young children. (NSW, Policy 2)

Acknowledging or auditing evidence on the SDH

All policies acknowledged evidence on the social determinants of health and health equity, although the extent to which they did so varied widely. Across all 17 policies there were 146 items coded as *acknowledging* the social determinants of health and health equity and 98 coded as *auditing* the SDH and health equity. For example, this is a statement acknowledging the SDH:

NSW Health is strongly committed to basing its services, programs and responses to young people on a holistic understanding of young people's health and wellbeing. This means recognising the range of socio-economic and environmental factors that have an

impact on young people's wellbeing. (NSW, Policy 11)

The following is an example of a statement auditing the SDH/HE:

> *The government recognises the importance of ensuring Aboriginal families and children have access to safe, affordable and appropriate housing, noting that one third of Aboriginal households in NSW live in social housing compared to 6 percent of the non-Aboriginal population. Aboriginal people face multiple barriers in the private rental market and most of this housing is unaffordable or unsuitable to meet the needs of large Aboriginal families.* (NSW, Policy 13)

The four policies that did most to acknowledge and audit the social determinants of health and health inequities were *ACT Children's Plan: Vision and building blocks for a child-friendly city 2010–2014* (ACT, Policy 10)*; Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures* (NSW, Policy 11)*; Keep them safe: A shared approach to child wellbeing* (NSW, Policy 13)*;* and *Primary Prevention Plan 2011–2016* (SA, Policy 16) which had an extensive chapter on children.

3.2.4 Social gradient

Much research has stressed that health inequities occur as a gradient (Graham and Power 2004, Dahlgren and Whitehead 2006a, 2006b, CSDH 2008). Two policies acknowledged this evidence, namely the *Primary Prevention Plan 2011–2016* (SA, Policy 16) and *Our children our future: A framework for Child and Youth Health Services* (WA, Policy 8), as shown in the extracts below.

> *What is now more apparent is the potential contribution of early life experiences and opportunities to reducing health inequalities across the life course. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundations.* (SA, Policy 16, section on early childhood)

> *It is important however to recognise that inequalities in health extend across the whole of society, with those at the top of the socioeconomic gradient having the highest level of health, with decreasing health outcomes experienced across the whole of the population, and those at the bottom having the poorest level of health.* (WA, Policy 8)

3.2.5 Objectives

Across all policies I identified 172 objectives of which over half (91) were related to health services, followed by policy and governance (23), social determinants (19), and promotion and prevention (18). Examples are shown in Table 6.

Table 6: Examples of phrases coded under Objectives for each category

Code	***Phrase from policy***
Health services	*Improve child and youth health and wellbeing through the early diagnosis, acute care and ongoing treatment of current key health issues.* (WA, Policy 8)
	To ensure greater reach of programs that successfully provide access and services tailored to the needs of more higher need families. (SA, Policy 16)
Policy and Governance	*The Government and non government sector will build the capacity across the ACT to advocate, promote and protect children's rights.* (ACT, Policy 10)
Social determinants of health	*Early years services must be relatively accessible to all and include strategies to overcome barriers eg. socio-economic disadvantage, cultural and language barriers, access to services in remote areas.* (TAS, Policy 1)
	(to ensure) children and young people meet developmental and educational milestones at school. (NSW, Policy 13)
	All Victorians should all be able benefit from regular supply of and access to nutritious foods. (VIC, Policy 15)
Promotion and prevention	*Improve child and youth health and wellbeing by encouraging self-management and addressing key health-related and risk-taking behaviours.* (WA, Policy 8)
	Increase the health literacy of all Victorians and support people to better manage their own health. (VIC, Policy 15)

3.2.6 Strategies

I found a total of 1478 strategies of which around one-third were related to health service delivery (469), followed by (individualized) promotion and prevention (278), health policy/governance (197), cross-sector strategies (177) and social determinants of health (173). Examples are shown in Table 7.

Table 7: Examples of phrases coded under Strategies for each category

Code	***Phrase from policy***
Health service delivery (service improvement, access)	*…planning for the development of the new Women's and Children's hospital* (ACT, Policy 10)
	Provide intensive mobile youth outreach services for high risk adolescent clients who are difficult to engage and need intensive case management outreach and support. (VIC, Policy 6)
	Implement targeted, quality and intensive home visiting for vulnerable children. (SA, Policy 16)
	Establish an integrated case management response, which includes participation of non-government organisations to provide support to those families who require services from a range of agencies. (NSW, Policy 13)
	Recognise and respond to the needs of young people through existing multidisciplinary care models. (NSW, Policy 11)
	Advocate with clinicians for the use of the pregnancy hand held record. (QLD, Policy 17)
	Expansion of dental health services for Aboriginal and Torres Strait Islander children. (ACT, Policy 10)
Promotion and prevention	*Provide a tailored community education and social marketing initiative that engages parents, families and the broader community in preventative health'* (VIC, Policy 15)
Health policy/governance	*Establish the appropriate governance arrangements to support a collaborative approach to implementing the (child health) agenda.* (TAS, Policy 9)
Cross-sector strategies	*(develop) partnerships between Child, Youth and Women's health programs and Family Centres for the provision of maternal and child health services within the centres.* (ACT, Policy 10)
Social determinants of health	*Support healthy food and fresh produce initiatives as part of community regeneration in social housing areas.* (NSW, Policy 12)

3.2.7 Social determinants of health – additional coding

With only just over 10% of strategies identified as being relevant to the social determinants of health, it is clear that the policies proposed relatively little action on this aspect of child and youth health. However, given that the focus of this research is on the social determinants of health, the strategies identified were further divided into sub-categories (see Table 5, RH column) to enable more detailed exploration of how the social determinants of child and youth health were addressed.

There were 68 examples of strategies addressing early childhood development (ECD). Action in this area centred on the home environment and/or government or community services designed to foster early childhood development. Phrases that were coded under the *home environment* often referred to mental health screening or surveillance of mothers and children, or the need to provide extra support where the capacity of a parent or carer was 'diminished'. For example: *provide mental health screening for all mothers; influence mothers' wellbeing through post-natal depression screening and intervention programs*; *identify where a parent or carer's capacity may be diminished, and their ability to meet the needs of their children may be compromised and they may require additional support*.

Strategies focused on the *home environment* also included services or health promotion activities designed to improve parenting skills or help parents make healthy choices for their children by providing them with information. Fathers were mentioned only eight times, with most sections of text describing the father in a supportive rather than an active role. For example, *'SAFE START acknowledges…the vital role of support systems, especially fathers or partners'.* There were two mentions of supporting fathers with mental illness and two mentions of the 'absence' or 'violence' of the father. The following extracts demonstrate how policies acknowledged the importance of fathers:

> *Fathers are more likely, than in previous generations, to be actively engaged in parenting. Growing numbers of fathers visit child health sites with their child and express interest in parenting groups. Some fathers have sole custody of their child/ren.* (TAS, Policy 1)

> *In contrast, young men were more likely than young women to confide in their father (40% vs 27%) or a male friend (41% vs 31%) for advice regarding sexual health.* (NT, Policy 14)

ECD strategies focused on *Government or community services* referred mostly to increasing the capacity and quality of ECD programs in the community or better targeting them. For example: *work*

with targeted communities, including Aboriginal and Torres Strait Islanders to promote and deliver early childhood programs; *development of four early childhood schools; provide early literacy programs in libraries*; *implementation of 12-hour week for ACT pre-schoolers; fund an additional 10,500 places to ensure a quality preschool program is available for all four year olds; increase ratio of carers to children in long day care services to one carer for every four children under 2.*

There were 34 strategies related to *education*, mostly about primary or secondary schooling with very few related to the transition to tertiary studies. Strategies on *education* referred to providing better quality education and/or keeping young people at school for longer. For example: *provide quality education for all children*; *raise school leaving age to ensure all NSW students have improved opportunities*; *increase to number of Aboriginal student liaison officers to work with an expanded number of Aboriginal communities to develop locally identified solutions to the non-attendance of Aboriginal students and to improve their connection to education*; *support young people to attain a year 12 qualification or equivalent.*

There was also a focus on creating *healthy settings* (26). Half of these strategies referred to individualised health promotion activities within *schools.* For example, *'The government will support primary and secondary students' participation in physical activity and reduced sedentary behavior through the implementation of the Premier's Sporting Challenge'.* Other strategies coded under *healthy settings* focused on *recreation or sporting clubs*, mainly promoting healthy eating options at sporting events, encouraging children and youth to participate in sport, or supporting the development of open spaces and parks for children and youth to play sport in. For example: *ensure participation in sport and recreation by all children; ensure quality places to play through the provision of public sports grounds, open spaces, pools and sport specific facilities; work with Sport and Recreation Services to scope and plan implementation of guidelines for junior sporting clubs' canteens*.

There were two sections of text coded under playgrounds or open spaces and gardens (not related to organized sport and recreation). For example: *Construction of a sensory play space and garden in O'Connor.*

There was one strategy that suggested addressing the broader determinants in a *healthy setting* context by supporting access to fresh fruit and vegetables in local communities:

*Support healthy food and fresh produce initiatives as part of community regeneration in social housing areas. (*NSW Policy 12)

The social determinants of health with least mention in the policies were the structural determinants that are known to have an impact on reducing health inequities, and which relate to the broader context in which children and youth play, live and learn (WHO 2008). The matters referred to in the policies were employment/workplace conditions or flexibility for parents (15), housing (12), urban planning (6), and public transport (3).

Regulation was mentioned only nine times in the 17 policies, with most strategies in this area relating to self-regulation of food labelling and junk food advertising to children. The following quote is a rare example of a statement suggesting direct regulatory action:

*The NSW Government, working with Local Government, will have objectives and measures included in land use planning strategies and policies to support access to fresh foods in local communities. This will involve provisions in planning instruments to protect and maintain significant local food production and agricultural activity (*NSW, Policy 12).

3.2.8 Recognition of health inequities in the intended outcomes of strategies

The intended health outcomes of strategies were mentioned 1067 times. Just over half (605) of these were directed toward children in general, about one-third toward equity groups of children (305), and most of the remaining strategies (132) toward improving average health of the whole population. A small number of strategies was coded as intended to close a health gap, and most of these related to the inequitable health outcomes between Indigenous and non-Indigenous Australians (21). *Closing the gap* is a strategy endorsed by the federal government in 2008 that aims to reduce Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes in 25 years.

The equity groups recognized most often in policy strategies were Aboriginal and Torres Strait Islander children and children in out-of-home care and/or the child protection system. Other equity groups that were recognized, but only rarely, were children with a disability, culturally and linguistically diverse children, children of teenage parents, children living in rural/remote areas and refugee children.

3.4 Discussion

In this section, I will relate the findings from the document analysis to the public health literature. As mentioned above, the coding structure for analysis was designed to identify the *status quo* in Australian child/youth health in relation to the extent to which health policies acknowledge and direct action on evidence related to the social determinants of health.

The analysis shows that Australian child and youth health policies are addressing a wide range of health issues for children (0–12 years) and, to a lesser extent, youth (12–25 years). However, the policy solutions being proposed predominantly lie in provision of health services or access to them, with limited scope for action on the broader social determinants of health. There are some exceptions, such as the *ACT Children's Plan* (Policy 10), but in general when a social determinants approach is adopted there was a tendency to take a narrow view of the evidence or to acknowledge the evidence then revert to medical or behavioural strategies. An example of this is seen in the way some early childhood strategies adopted a narrow view of the evidence about the home environment by focusing on mothers' mental health. Thus, policies tended to take a biomedical approach to the issue, opting for screening and surveillance strategies and not adequately addressing other important determinants of health that are known to improve the home environment, such as adequate and affordable housing, income support and social connectedness (Baum 2016).

This critique has been raised before, with a recent study on infant mental health finding that 'although there is recognition that the broader social context plays an important role in early childhood development, the problematisation of mothering as risk shifts the focus to the individual capacity to promote healthy attachment and development rather than a focus which encompasses systems and social conditions that support healthy relationships' (Lawless 2010 p. 107). In this way, there appears to be an element of victim blaming, placing the responsibility of raising a child in the hands of the mother alone. Keleher and Reiger (2004) in their review of child health policy in Victoria also found 'tensions' between a medical 'surveillance' of mothers and children and a social determinants approach, with the former dominating.

In addition, the policy analysis revealed a policy silence in relation to fathers, who were rarely mentioned and only seen in a supportive role rather than a central role. There was some mention of fathers' mental health but only a few instances where fathers were portrayed as vital to parenting. In her study on infant

mental health, Lawless also found that 'beyond a "fathers are important" stance, there is little discussion of how father figures can support infant mental health and healthy children more generally' (Lawless 2010 p. 106).

The policies that focused on healthy settings showed promise of moving towards a social determinants of health approach, but when actions were considered they tended to opt for social marketing and educational health promotion activities, thus focusing on individual behaviour change rather than broader social change. While the Ottawa Charter (WHO 1986) has long advocated for a healthy settings approach, the evidence about this approach has been translated into different levels of action in policy and health promotion activities. Whitelaw et al. (2001) categorized these responses into passive, active, vehicle and organic models. The passive model focuses on education and informing the individual; the active model seeks to change the environment but still places responsibility on the individual to change; the vehicle model is based around setting goals to inspire behavioural change; and the organic model places the problem within the system and assumes that that if you change the system using community empowerment principles then the overall health of the population will improve (Whitelaw et al. 2001).

The data suggest that in terms of Whitelaw et al.'s categories, the majority of healthy settings models assessed in this study fit into the passive model and moving towards the active model. They either use traditional means of education to deliver an individualised health promotion message to a captive audience (for example, in schools) or they take a slightly broader view and try to adjust the environment to encourage people to change their behaviour. The exception was the *ACT Children's Plan* (Policy 10), which could be categorized under the active model with elements of the organic model. This policy focused on the health and wellbeing of children at a broader determinants level, implying that the health and wellbeing of children would be better if the environment and daily conditions in which they lived were improved.

Overall, the analysis of this suite of Australian child health policies suggests that the social environment in which children and youth live is either currently considered outside the scope of health departments or is not seen as a priority. The reasons for this will be explored (using a range of theories – including neo-liberalism) in the following two chapters.

3.5 Conclusion

In conclusion, the Australian child/youth health policies studied addressed health inequities to some extent, with the best examples being in Aboriginal or child protection policies, and whole of government policies with strong links to health departments. However, within the strategies there appeared to be limited scope for action on the social determinants of child and youth health by Australian health departments. While all policies acknowledged or audited the evidence on the social determinants of health at the beginning of the policy, only 10% of strategies committed to action in this area. With some exceptions, upon closer examination the strategies that initially appeared to be addressing important social determinants of health, such as early childhood development and healthy settings, often resulted in narrow strategies that placed the focus on the individual.

Most strategies identified in this study were concerned with improving health service delivery and access. Although there was some focus on promotion and prevention, most strategies reflected the dominant medical or (individualized) behavioural models of health. While access to healthcare is an important determinant of child and youth health, the evidence suggests that health departments should not limit their actions on the social determinants of health to this strategy alone, but broaden their scope to include work with other sectors to address structural determinants of health that are known to reduce child and youth health inequities.

The strengths and limitations of this study are presented in Chapter 5 (sections 5.6 and 5.7)

3.6 Chapter summary

In this chapter I have presented a document analysis study that provides an in-depth picture of the current state of children's health policy development in Australia with a specific focus on the extent to which the selected set of policies addressed the social determinants of health and equity. Through this process I highlighted the limited action taken to address the social determinants of health and health equity by Australian health departments. To date, there have been no systematic analyses of Australian child/youth health policies with a social determinants and health equity focus and this study addresses this gap. In the following chapter I adopt a political science approach to explore policy actors' perceptions on the factors that facilitate (or constrain) a social determinants of health approach gaining legitimacy in Australian health departments.

CHAPTER 4: FOUR POLICY CASE STUDIES (STUDY 3)

In this chapter, I report on study 3 where I conducted four policy case studies using 27 semi-structured interviews with policy actors directly involved in the development of Australian child health policies. To do this, I use a range of political science theories and frameworks to guide design of the study (Sabatier and Jenkins-Smith 1999, Lewis 2005, Shiffman and Smith 2007, Kingdon 2011), with the Shiffman and Smith (2007) framework predominantly used for analysis. The aim was to understand policy actors' perceptions on the factors that facilitated (or constrained) the social determinants of child health gaining legitimacy in Australian health departments.

Firstly, I detail my research approach in terms of my philosophy on the generation and interpretation of knowledge, including a social constructivist perspective. Next, the theoretical background for this study is outlined, including Kingdon's multiple streams theory (2011), the Advocacy Coalition Framework (Sabatier 1988), Lewis's critical framework for health policy (2005), and Shiffman and Smith (2007). I then summarise how a complementary approach to using these theories in the design of this study was useful (Cairney 2013).

In the next section, I discuss my choice of a qualitative methodology for this study, followed by an outline of the methods, including policy selection, recruitment of policy actors directly involved in the development of the selected policy, sampling, the choice of telephone interviews, ethical considerations and reflexivity and the semi-structured interview schedule, showing how the political science theories informed the data collection tool.

Next, the process of data analysis is described including familiarisation and use of the framework to guide this process. I present the findings for each case separately under the following headings: power of actors, power of ideas, power of political context, power of issue characteristics, discussion, and conclusions.

Finally, I present a table which was guided by the Shiffman and Smith (2007) framework to provide a comprehensive picture of the data across cases, highlighting key factors identified throughout this study and the strategies employed by policy actors to advance a social determinants of child health approach in child health policy in Australia.

The aims and objectives of study 3 are as follows:

Aim 3: To explore policy actors' perceptions of the factors that facilitate the development of Australian child health policies that focus on the social determinants of health

Objective 3: Conduct semi-structured interviews with policy actors involved in the development of Australian child health policy.

4.1 Methodology

Patton (2015) suggests that each research project requires a unique set of philosophical and theoretical traditions to address a specific question and guide the design of appropriate methods. Therefore, in this section I outline the methodological approach and describe the theoretical framework used to guide this study. To address the aim and objective outlined above, I adopted a social constructivist approach to inform my understanding of the generation of knowledge. I also employed a range of political science theories, namely Kingdon's (2011) multiple streams theory, the Advocacy Coalition Framework (ACF) of Sabatier (1988), Lewis's (2005) theories on power and ideation, and adapted the Shiffman and Smith (2007) framework which embeds these theories into a practical framework with which to address the agenda setting and policy development processes in the Australian health policy environment.

4.1.1 Social constructivism

Social constructivism is a philosophical perspective used in the social sciences to explore the generation of knowledge in relation to the context with which reality is constructed (Berger and Luckman 1966). The two main concepts associated with this perspective – reality and knowledge – are embedded in the social interactions and traditions of everyday life, including personal and professional life. Berger and Luckman (1966) define *reality* as 'a quality appertaining to phenomena that we recognize as having a being independent of our own volition (we cannot 'wish them away'), and 'knowledge' as the certainty that phenomena are real and that they possess specific characteristics' (p. 13). Therefore, adopting this perspective in research allows the exploration of people's experiences of their own reality in the context

that this knowledge is formed (Berger and Luckman 1966). Thus, a researcher who adopts this perspective acknowledges that people's reality, or their perception of the world, is socially constructed according to the specific set of circumstances within which they are situated. Therefore, the knowledge generated from a research project that seeks to understand the world within which people operate must acknowledge that meaning is constructed in a variety of different ways by a variety of different people (Patton 2015). Therefore, a social constructivist approach sets a research environment wherein it is possible to privilege a range of points of view and facilitates the study of networks where the creation of human knowledge is seen as a collective response to the environment within which policy actors work (Hay 2016).

Patton (2015) suggests that this approach allows the researcher to 'capture diverse understandings and multiple realities about people's definitions and experiences of a situation' (p. 122). According to Shiffman and Smith (2007), a social constructivist approach is appropriate when exploring health policy agendas because it 'recognises that material influences alone cannot explain all political behaviour and that people interpret the world around them very differently' (p. 1371). Macnaughton et al. (2013) put forward a social constructivist view in opposition to those who posit that a step-by-step linear approach to getting evidence into health policy is valid, stating that 'such problems are by nature not objectively apparent, but are usually multi-faceted in nature and thus amenable to being conceptualized in different ways' (p. 101).

A social constructivist approach to research acknowledges the context within which meaning is constructed, thus taking into account the contested and complex nature of working inside or outside government to bring about change in policy. This approach was appropriate for study 3 because it allowed me to understand 'how power differentials affect and shape social constructions and perceptions of reality' (Lincoln and Guba 2013, p. 47). The concept of 'power' is embedded in each of the political science theories described below. A social constructivist perspective led me to a qualitative methodology because the methods involved allowed me to privilege the reality of policy actors working within Australian health departments, and to better understand the 'specific characteristics' of the environment in which they are trying to bring about change (Berger and Luckman 1966, p. 13). This approach may be seen as counter intuitive to a political science approach which is often associated with a more positivist approach that claims 'causality' when applying political science frameworks (Sabatier 1988). However, this is not the intention in this thesis, rather, a social constructivist approach is seen as a way to approach this research with a public health lens in order to better understand the real world of policy making. And, to draw out power relations in this environment as related to agenda setting and policy development process. This debate again highlights the challenge of conducting research across two disciplines – public health and political science.

4.2 Political science theories and frameworks

In this thesis, I focus on the first two stages of the policy process, agenda setting and policy formulation, which lead to the creation of published, strategic level health policy documents. In this section I briefly outline the political science theories selected to guide study 3.

4.2.1 The policy process

At the start, it is important to provide a brief background on how the policy making process has been viewed over time by political scientists. In the academic literature, variations on how the policy process works fall into four categories, rational, incremental, mixed scanning and 'garbage can' theories. Policy making is therefore considered a complex and messy process that requires in-depth study to understand it. Each political science theory below espouses a different approach to how the policy process works.

4.2.2 Kingdon's multiple streams

When examining the agenda setting and policy development processes in the USA during the 1980s, Kingdon (2011) devised a multiple streams approach based on the garbage can model but with a more sophisticated iteration. This theory focuses both on the active participants (policy actors and policy entrepreneurs) and the processes (or streams) that bring issues onto the policy agenda, namely problems, policies and politics. While these streams mostly act independently of each other, Kingdon (2011) proposes they come together at critical times to form windows of opportunity for policy change. He focuses on the first two stages of policy development (a) agenda setting, which refers to setting the policy agenda, and (b) the specification of alternatives (policy development process) from which a choice (about a policy proposal) is made (Kingdon 2011).

In Kingdon's theory, the *political* stream considers how national mood, interest groups, government elections and government structure influence the policy process (Kingdon 2011). This suggests that the political context within which a policy is developed is important. In Kingdon's view, factors such as public opinion (or national mood) have a key influence over the policy agenda, with politicians and other policy actors continually attempting to sense this mood to maintain the *status quo* or bring about change (Kingdon 2011). The policy actors involved in the agenda setting and policy development processes have been identified as politicians, public servants, advocates, journalists, consultants, academics and the general public (Kingdon 2011). Lewis (2005) suggests that different actors have varying levels of influence, and notes that policy actors from both inside and outside government are important. In Kingdon's view, organised political forces (such as interest groups, academics etc.) are important factors in bringing about change, especially if they are all working together to deliver a consistent message (Kingdon 2011). The political stream is relevant to this study because it provides a theoretical framework with which to understand the political context within which child health policies are developed in Australia. In particular, it allows exploration of how policy actors understand the political climate within which they are working and whether it influenced the facilitation of a social determinants approach during the development of child health policies.

Kingdon (2011) considers that the *problem definition* stream examines how particular issues on the policy agenda are given priority while others are not. He suggests that the way policy actors present a problem to government may influence whether a policy proposal reaches the policy agenda and may

also affect the type of action taken to improve health outcomes in a given policy document. In Kingdon's view there is usually a specific indicator (e.g. research statistics), event (e.g. disease epidemic), or feedback from the community (e.g. demands for more hospital beds) that draws attention to a problem. Kingdon also highlights the special role budgets play in allowing only certain policy solutions to be acted on once a problem is on the policy agenda. This suggests that treasury department priorities are an important consideration for policy actors when they define a particular problem to be addressed in policy, and when policy actors consider how policy strategies will be implemented.

The *policy* stream considers the ways in which an idea develops and is then formulated into a written policy document. This process is like a 'primeval soup' where 'a policy community made up of specialists from inside and outside government interact to formulate a policy solution that must survive the array of arguments, constraints and value systems throughout the policy development process before being seriously considered by governments for policy action' (Kingdon 2011, p. 116).

In Kingdon's (2011) view, the three streams converge to create a 'window of opportunity' for policy change and innovation, and while these opportunities vary in predictability, they always happen at a critical time. For the three streams to converge, 'a problem is recognised, a solution is developed and available in the policy community, and, a political change makes it the right time for policy change' (Kingdon 2011, p. 65).

The policy entrepreneur is an important figure in Kingdon's theory (2011) especially in terms of moving issues or solutions from ideas to action. Kingdon defines a policy entrepreneur as a person from 'in or out of government, in an elected or appointed position, in an interest group or research organization' (p. 122). In Kingdon's view, a policy entrepreneur's defining characteristics are 'much the same as a business entrepreneur, with their willingness to invest resources – time, energy, reputation, and sometimes money – in hope of future return' (Kingdon, 2011, p. 122). This definition of a policy entrepreneur has been criticised for being over simplified, with some scholars expanding the range of qualities policy entrepreneurs must possess which include the ability to develop and use good networks and understand the local context with regard to what is already in place and what it is possible to change (Mintrom and Norman 2009). Cairney (2018) adds to this discussion by suggesting that policy entrepreneurs adopt several main strategies to influence the policy agenda namely creating a dialogue that fits with the language of the specific policy context, building trust in this message, and ensuring

that the proposed 'solution' is a possibility, and the 'timing' is right before the message is released (p. 211). This suggests that policy entrepreneurs from inside or outside of government play a key role in recognizing and acting on windows of opportunity for change.

Kingdon's theory (2011) leads back to a social constructivist approach because in his view, policy actors are seen as key drivers of policy innovation and change. Thus, they play a role in developing ideas and seizing opportunities to pursue new policy approaches. *Argumentation* is a concept used by Kingdon (2011) to describe the way policy actors 'argue, evaluate and problem solve' to get an idea (or proposal) on the agenda, thus 'wielding power, influence, pressure and strategy' within the policy community (Kingdon 2011, p. 125). These concepts are relevant to this thesis and will be explored further through empirical research.

4.2.3 Advocacy Coalition Framework

Sabatier's Advocacy Coalition Framework (ACF) was developed in an attempt to analyse the complexities of public policy making and the ways in which policy agendas change over a specific period of time (Sabatier 1988). The theory focuses on understanding subsystems (or advocacy coalitions), which relate to the interaction between a group of policy actors inside and outside institutions who are working on a particular policy issue and operating under a belief system that involves both personal and professional understandings of the issue (p.132). According to Sabatier (1988), the ACF assumes that people who are actively involved in the policy development process are politically oriented and have a set of beliefs they seek to convert into policy action (p. 131). However, it is not assumed that policy actors are merely in the policy making environment for their own self-interest; rather they hold a core set of beliefs (based on research and professional experience) which align with one or more coalition groups including deep core beliefs, policy core beliefs and secondary aspects (Sabatier 1988). Sabatier (1988) assumes that subsystems can be disrupted by external events (such as a global recession, environmental crisis or demographic changes). However, it is noted that although policy actors may not be able to control these aspects, they can use their power within the system to manipulate how these events are perceived in society (Sabatier 1988).

The ACF is a useful theory in this thesis for drawing out the way policy coalitions work as they progress through the policy making process. It can be used to aid understanding the of way coalitions begin, and how they change as a policy decision reaches the end of the policy formulation process. Several authors

have critiqued the ACF, suggesting that the singularity of the description of coalitions does not address the real complexities of policy networks in a real world policy development process, suggesting that this model is most useful when combined with other theories (Larsen et al. 2006, Breton et al. 2008). The ACF is useful for this thesis because it addresses the power and belief systems associated with policy networks and addresses a gap in the other political science theories selected to guide this thesis.

4.2.4 Lewis's critical framework

Lewis (2005) developed a critical framework designed to analyse the political factors that influence the development of health policy in Australia. In Lewis's (2005) view, the interaction between policy actors, the formal structures with which they work and the policy processes they follow are important factors to study when trying to understand why certain issues get onto the Australian health department policy agenda (Lewis 2005). A core concept in Lewis's framework that will be used in this study is ideation. This concept adds depth, and an Australian perspective, to Kingdon's (2011) problem definition stream. Ideation refers to the way in which policy actors formulate 'stories' or 'arguments' to push an item onto the policy agenda. In Lewis's (2005) view, policy making is a discursive activity and argumentation and manipulation are skills that are useful to policy actors because the more powerful the storyline they create, the more likely it is that a policy idea or proposal will move onto the health policy agenda (Lewis 2005). The notion that discourse is important is echoed by Bacchi, who asks 'what is the problem represented to be?' and suggests that the ways health policymakers define health issues as problems are central to the way particular policy 'solutions' are adopted or overlooked (Bacchi 2009). Cairney (2009) also discusses the importance of policy narratives in understanding how a particular policy development occurs and uses the case of tobacco policy development in the UK to illustrate how a policy narrative can change over time.

From Lewis's (2005) perspective there are two types of ideation: (a) *surface ideation*, which is comparable to Kingdon's policy stream, where policy communities and actors interact to discuss possible policy solutions; and (b) *deep structure ideation*, which refers to 'a fundamental set of ideas, associated beliefs, values and perspectives that determine problem recognition and definition, shape the policy discourse, and constrain possible policy proposals and strategies' (p. 98). Alvaro et al. (2010) also suggest that ideology is a factor in determining whether governments take action to develop equitable health policies. Lewis (2005) argues that bringing about change at the deep ideation level is

difficult and alternative approaches (including a social determinants approach) are mostly only successful in making changes at a surface level, thus only bringing about temporary change. To use ideation in policy analysis, Lewis (2005) describes three main filters that can be applied to policy to describe different combinations of change at the surface and deep structure levels. These are *impermeability*, which refers to instances where no change occurs at either the deep structure or surface level of ideation; *incorporation*, which refers to change that occurs at the surface level only while deep structure ideation remains unchanged; and *transformation* which refers to change that occurs at a deep structure level, where there is a 'paradigm shift' and change occurs at a policy level (p. 108).

Lewis (2005) also argues that ‘a feature of health policy in wealthy nations is the role professions play as powerful institutions, interests and experts’ (p. 174). For example, she suggests that the medical profession in Australia is not just a powerful interest group but can be represented in different ways including as ‘individual collegial networks, as special partners with the state, as embedded resources of expertise and knowledge, and as an authoritative voice that shapes how health is understood within society’ (Lewis 2005, p. 174). In this thesis, the concept of ideation will be used to extend the work of Kingdon (2011) and Sabatier (1988) on networks and interests groups, and illuminate the power struggles policy actors may face as they seek to influence the agenda setting and policy development processes.

4.2.5 Shiffman and Smith framework

Shiffman and Smith (2007) developed a framework designed to analyse the question ‘why do some global health initiatives receive political priority whereas others do not?’ (p. 1370). The Shiffman and Smith (2007) framework focuses on the power associated with collective action and advocacy efforts that seek to bring about change.

The framework is divided into four main categories (Table 8) (Shiffman and Smith 2007, p. 1371):

1) the power of actors connected to the issue;
2) the power of the ideas used to define and describe the issue;
3) the power of political contexts to inhibit or enhance political support;
4) the power of some characteristics of the issue.

Each category is associated with a range of factors or questions that assist in drawing out the narrative and lessons learned from each case (Shiffman and Smith 2007, p. 1371).

In relation to this study, the Shiffman and Smith framework (2007) is apt because it embeds several well-established political science theories described above into a common framework (outlined above), which is especially useful during the analysis of data. The framework fits well with this study because it adopts both a social constructivist view and a political science approach but does not claim causality from the findings, rather aiming to 'examine the content of the debates' during the agenda setting and policy development processes and seeking to draw out the perspective of 'how they were understood by the participants themselves to assess the effects the debates had on political support for an initiative' (Shiffman and Smith 2007, p. 1371). According to Shiffman and Smith (2007), the framework 'does not require a case to fit perfectly within the parameters, however, the closer a case aligns with this framework the more likely an issue will receive political priority in the policy environment' (p. 1371). This framework will be adapted to suit the state/territory level policy environment in Australia and be used as the main political science contribution to guide analysis in this study. The adaptation and application of this framework will be discussed further in section 4.4.3.

Table 8: Shiffman and Smith framework

Factor	**Description**	**Factors shaping political priority**
1. Actor power	The strength of the individuals and organizations concerned with the issue	1. Policy community cohesion: the degree of coalescence among the network of individuals and organizations that are centrally involved with the issue at the global level 2. Leadership: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause 3. Guiding institutions: the effectiveness of organizations or coordinating mechanisms with a mandate to lead the initiative 4. Civil society mobilization: the extent to which grassroots organizations have mobilised to press international and national political authorities to address the issue at the global level
2. Ideas	The ways in which those involved with the issue understand and portray it	5. Internal frame: the degree to which the policy community agrees on the definition of, causes of, and solutions to the problem 6. External frame: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
3. Political contexts	The environments in which actors operate	7. Policy windows: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decisionmakers 8. Global governance structure: the degree to which norms and institutions operating in a sector provide a platform for effective collective action
4. Issue characteristics	Feature of the problem	9. Credible indicators: clear measures that show the severity of the problem and that can be used to monitor progress 10. Severity: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11. Effective interventions: the extent to which proposed means of addressing the problem are clearly explained, cost effective,

		backed by scientific evidence, simple to implement, and inexpensive

Source: Shiffman and Smith (2007, p. 1371)

4.2.6 Summary

As mentioned above, I used three well established political science theories and a recently developed framework to guide the design of this study. However, it should be noted that while I drew on concepts from these political science theories throughout this thesis I did not comprehensively apply them as per a scholar in the discipline of political science might do. Instead, I used the Shiffman & Smith (2007) framework, which has a range of these concepts embedded within it, to guide the analysis of interviews with policy actors on the development of specific policies.

The Shiffman and Smith (2007) framework consolidates all these perspectives but provides a greater focus on how power is associated with agenda setting processes, especially about how ideas are used to frame the issue, how policy actors and organizations work to drive health issues on to the health policy agenda, how the political context is an important facilitator for change, and how specific technical factors associated with a particular health agenda can be a barrier or facilitator for action at a policy level.

4.3 Methods

Methods are the steps and procedures that the researcher follows for the collection and analysis of data (Saks and Allsop 2007). In this study, the choice of qualitative methods was appropriate for the collection of data through interviews with policy actors involved in the development of child health policy in Australia.

4.3.1 Selection of qualitative methodology

I employed a qualitative methodology to address the aims and objectives in this study. Qualitative research focuses on text or words and uses small sample sizes with the aim of illuminating meaning and providing an in-depth understanding of a particular problem, situation or phenomenon (Patton

2015). This type of research facilitates the collection of rich data and acknowledges participants' subjective meaning and the complexity of the environment in which they are located (Saks and Allsop 2007). This is relevant to my research because I am interested in the subjective perspectives of policy actors from within and outside government. Furthermore, I seek to understand both 'how' and 'why' the social determinants of health are reaching the Australian health policy agenda. Therefore, this methodology provides the best way to address the aims and objectives of this study. A qualitative methodology is appropriate for this study because 'rather than gaining absolute truths…it is about gaining understanding how some differently positioned actors talk about their experiences and the meanings they associate with particular events, actions and claims' (Saks and Allsop 2007, p. 26). Baum (2016) suggests that qualitative research is particularly useful when seeking to explain, in some depth, the economic, political, social and cultural factors that influence health and disease (p. 181).

4.3.2 Selection of policies

I selected four individual policies from those used in study 2 of this thesis that demonstrated relatively good practice on the social determinants of child health and health equity. Policy selection was based on the following criteria:

a) Relatively good practice was judged on a variety of elements including those that did most to address health equity, acknowledge or audit the SDH, and the types of SDH that were covered.

b) the relevant Australian health department Directors responsible for the selected policies agreed to participate, thus providing permission for staff to be interviewed

c) the policies selected allowed coverage of a range of policy styles.

Details of the selected policies are outlined in Table 9.

Table 9: Four selected Australian child/youth health policies

State	Department responsible	Policy name
NSW	Health Department	Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures
ACT	ACT Department of Health & Department of Disability and Human Services	ACT Children's Plan: Vision and building blocks for a child-friendly city 2010-2014
WA	Health Department (HS)	Our children our future: A framework for Child and Youth Health Services in Western Australia 2008–2012
VIC	Department of Health	Public health and wellbeing plan (chapter on early childhood) 2011-2015

4.3.3 Recruitment

The next stage was to recruit participants who were directly involved in the development of each policy. A letter of introduction was sent by my principal supervisor to the most senior person in the Department of Health of each chosen jurisdiction. The letter described the study, the time commitment for participants and the interview process. It also requested official permission from the Department for the staff in question to be given permission to participate. If this person agreed they were also asked to recommend a key contact so I could begin recruiting participants. All jurisdictions approached (WA, VIC, ACT, NSW) agreed to take part and provided the name of a staff member who could be contacted from the committee responsible for the development of each policy. This person became my key contact for that jurisdiction, and I contacted them by telephone to introduce myself and discuss the recruitment process. Each key contact gave me a list of names and email addresses of potential participants and I emailed these people directly with an introductory email, information sheet and consent form, asking if they would be willing to participate in the study. The main criteria for inclusion as a study participant was that participants held, at a relevant time, a senior position (within or outside government) and were directly involved in the policy's development.

4.3.4 Sampling

After the initial purposeful sampling of participants through the key contacts, I needed more participants and employed a snowball sampling technique to recruit more policy actors into the study. This type of sampling is used to locate 'information rich cases from which one can learn a great deal about the focus of inquiry and which therefore are worthy of in-depth study' (Patton 2015, p. 309). At the end of each interview I asked participants who else they thought was involved in the development of the policy and who I should approach next. This process continued until I was satisfied that all the main actors involved were represented or that I had reached data saturation. Saks and Allsop (2007) describe theoretical saturation as 'satisfied when no new information is generated by subsequent interviews, and when the data reflects a conceptual richness that both accounts for 'variations' in the data and allows for detailed description of the informants experience' (p. 233).

After following up all the leads provided to me, 49 recruitment packs were dispatched, and 27 policy actors agreed to participate. Those who were approached but declined to participate provided the following explanations: too busy, did not feel they had enough involvement in the development of the policy, or did not feel they could speak openly about the topic while employed by an Australian health

department. Some people who did not agree provided the name of a colleague whom they believed had been more involved and therefore would be more appropriate. A small number of people did not respond at all. This may have been because they had moved into other employment and although efforts were made to contact them, these were not always successful.

The sample size for each case study varied from six to eight participants. Table 10 shows the number of participants in each jurisdiction, the designated names used to identify quotes in the findings, and whether they worked inside or outside government at the time of policy development. Overall, there were 27 semi-structured telephone interviews conducted for this study.

Table 10: Policy actors interviewed across cases

State (Jurisdiction)	Designated participant name	Role – inside/outside government
ACT	Participant 1	Inside government
	Participant 2	Outside government
	Participant 3	Outside government
	Participant 4	Outside government
	Participant 5	Inside government
	Participant 6	Inside government
NSW	Participant 7	Inside government
	Participant 8	Inside government
	Participant 9	Outside government
	Participant 10	Inside government
	Participant 11	Outside government
	Participant 12	Inside government
	Participant 13	Outside government
	Participant 14	Inside government
WA	Participant 15	Outside government
	Participant 16	Outside government
	Participant 17	Inside government
	Participant 18	Outside government
	Participant 19	Inside government
	Participant 20	Inside government
VIC	Participant 21	Inside government
	Participant 22	Inside government
	Participant 23	Inside government
	Participant 24	Inside government
	Participant 25	Inside government
	Participant 26	Inside government
	Participant 27	Inside government

4.3.5 Semi-structured telephone interviews

According to Yin (2014), in-depth interviews are one of the most important sources of case study information. Baum (2016) describes the in-depth interview as a 'powerful way of getting detailed pictures of how people experience and explain their worlds' (p. 7). Signal et al. (2018) found that the benefits of interviewing policy actors include 'access to specialist knowledge of the policy process which cannot be obtained by other methods…. including insights into the ways policy-makers need, understand and use information, including research findings' (p. 192).

Traditionally, telephone interviews have not been used in qualitative research because of concerns about the interaction between the researcher and participant including reading non-verbal cues and body language (Irvine et al. 2012). Rather, telephone interviews are more likely to be selected for quantitative research where the respondent is required to provide short and succinct answers (Sturges and Hanrahan 2004). However, recent comparisons between face-to-face and telephone interviews in one research project suggest that the decision to conduct telephone interviews can be justified in certain research situations, and in these situations the method used makes little difference to the quality of interview data (Sturges and Hanrahan 2004, Irvine et al. 2012). Sturges and Hanrahan (2004) suggest that one positive aspect of using telephone interviews is that a 'wider variety of respondents can be included' (p. 115). Early in the planning process for this thesis, I decided to conduct interviews by telephone. This was mainly because of financial restrictions on travelling interstate and with the understanding that this method provided flexibility for the schedules of senior level participants such as Commissioners or Head of Departments. This approach meant that policy actors could commit to a time, but, where necessary, I could be flexible about last minute changes to their schedules. This occurred several times because of parliamentary activities or other important meetings that arose. This approach was also deemed appropriate because the policy actors and I were both used to working within professional environments (inside and outside government) where telephone conferences are a daily occurrence. Throughout the interview process the participants and I appeared to be comfortable with this style of interview, and to my knowledge this did not restrict their ability to respond to the questions or restrict the flow of the conversation. Sturges and Hanrahan (2004) suggest that in telephone interviews it is important to take the time to build rapport and to ensure that participants are comfortable in seeking clarification from the interviewer as often as necessary. I was aware of the need to balance establishing rapport with ensuring that we started the interview as quickly as possible,

because many participants had fitted me into their already overcrowded schedules. In all instances I felt that this goal was achieved, and that participants were able to seek clarification when they did not understand a question or needed more information before responding.

Interviews were conducted between February and June 2014. The duration of interviews ranged from 45 to 90 minutes and each interview was recorded and then transcribed in full by an external contractor. At the end of the interview each participant was asked whether they would like to review their transcript, with 14 out of 27 wishing to do so, returning them either unchanged or with minor amendments to make the language flow better without altering the meaning.

4.3.6 Ethical considerations

This research was approved by the Flinders University Social and Behavioural Research Ethics Committee. As mentioned above, once the senior member of the health department in each jurisdiction agreed in writing to be involved in the study, participants were approached with information about the study and an invitation to participate. At this stage potential participants were made aware that they were free to choose whether to participate, they could withdraw at any time without penalty and that their decision would remain confidential. There was the potential that a participant could be identified by association with a policy and/or a jurisdiction, so they were informed that while data collected from interviews would be treated with strict confidence and every attempt would be made to make publications that arose from the research anonymous, this could not be wholly guaranteed. Once each interview was completed the participant was offered the opportunity to review their transcript and delete or amend passages as they saw fit. Each participant gave consent to participate in the study prior to the interview either verbally on the telephone, by email or on the consent form provided. After the interview process was complete all participants were sent a letter or email to thank them for their participation. Participants were also invited to attend a knowledge exchange session held in Canberra in April 2015, where I presented the initial findings from this study.

4.3.7 Reflexivity

This research acknowledges ‘reflexivity’ as a process whereby ‘we own our own perspective and take seriously the responsibility to communicate authentically the perspectives of those we encounter during our inquiry’ (Patton 2015 p. 65). Therefore, it is appropriate to acknowledge the specific set of characteristics I bring to this research. My educational and professional background is in music,

education, communications and public health. My main research interests are the political and social determinants of health, media, and nutrition, with a specific interest in the population group children. I have taught Public Health topics at Bachelor's and Master's level in various university settings and have worked on a range of related projects as a research assistant.

I have worked extensively in the not-for-profit sector but have not held a government (public servant) position. However, I have dealt with government departments on many occasions through funding applications, contracts, and at conferences. Therefore, while my professional experience provided some insight into the context within which participants for this study were working, I did not fully understand the context within which they were making decisions or disclosing situations to me in interviews.

In addition, although I am not aligned to a particular political party I actively participate in debates about current affairs at a professional and personal level and my opinions fall onto the Left side of politics in Australia. Therefore, while I endeavoured to be politically neutral and professional during interviews I need to acknowledge that I may have influenced participants' answers by the way I delivered questions or how I interpreted their responses in the findings.

To counteract these potential biases, throughout this study I ensured that my supervisory team were involved in the development of data collection tools and analysis of findings. I also presented the findings in a manner that describes the political context within which my participants were working, with an in-depth description of policy actors' accounts and a wide range of quotes to ensure that my thesis 'illuminates the subjective meanings, actions, and context of those being researched' (Popay et al.1998 p. 345). To increase data quality I describe in detail the public health and political science theories I used to guide the design and analysis for this study and triangulated the findings with both the public health and political science academic literature (Popay et al. 1998). As this study is related to advocating for policy change in the Australia health policy environment I am careful not to claim that the findings are generalisable, rather to suggest implications for future advocacy efforts (Popay et al. 1998).

4.3.8 Semi-structured interview schedule

The semi-structured interviews were guided by a set of questions, with supplementary questions if needed. The interview schedule was divided into six main sections and outlined the initial decision to

develop the policy (agenda setting), b) the policy development process, c) general concepts surrounding the social determinants of health and health inequities, d) the policy now, e) personal views and values, and f) follow up questions. See Table 11 for the full interview schedule.

Table 11: Semi-structured interview schedule

Preamble:
Evidence is now widely available showing that socioeconomic factors such as income, education, employment and housing, and sociocultural factors such as gender, race, family and social relationships influence health outcomes. Social advantages in these areas in early childhood, middle childhood and youth appear to be protective of good health, while disadvantages contribute to poor health. Unequal distribution of social advantages and disadvantages contribute to health inequalities between groups and, indeed, across the whole social spectrum. This study is concerned with the political factors and policy development processes within the Australian health policy environment that influence the extent to which evidence on the social determinants of health is translated into policies that address child and youth health.

Questions: Supplementary questions (if required) shown as dot points under each main question.	**Theoretical perspective**
The initial decision to develop the policy…for example, ACT Children's Plan	
1. Looking back, how did the original decision to develop this policy come about? • Were there any particular groups or individuals who were particularly influential in arguing the need for this policy? Who were they? • Did the ideas come out of any previous event or pre-existing process? • Did you have any particular role in that? What was it?	Kingdon (2011) – Problem stream & policy entrepreneurs & policy networks Shiffman & Smith (2007) Category 1, 2, 3 ACF (1988) – Policy coalitions Lewis - ideation
2. Were there particular issues being discussed at the time which prompted development of the policy? • Was there a particular problem it was intended to address? • Were there any particular State, national or international reports or research evidence which motivated the decision to develop the policy? • In regard to the section on children/youth, was there any particular research evidence drawn on? And what was the problem it sought to address?	Kingdon (2011) – Problem stream Shiffman & Smith (2007) Category 1 & 4
3. What were the general circumstances of the state/territory government at the time the policy was initiated? • Were there any particular things about government at the time, or the Health Minister, which made this a good time (or a difficult time) to develop this policy?	Kingdon (2011) – Political stream and windows of opportunity Shiffman & Smith (2007) Category 1 & 3
4. Was the initial decision to develop this policy influenced by existing State policies, or national policies?	Kingdon (2011) – Political stream Shiffman & Smith (2007) Category 1 & 3
5. Do you think an understanding of SDH was a significant factor in the decision to develop the policy, and if so why? • How did that happen? Was there any particular individual or group who advocated for that perspective? • Was there a particular group that advocated for children/youth and the determinants of health that affect them most?	Kingdon (2011) – Problem and policy stream & policy entrepreneurs & policy networks Shiffman & Smith (2007) Category 1, 2, 4 ACF (1988) – Policy coalitions Lewis (2005)– ideation and argumentation
The policy development process…	
6. What was the formal structure set up to develop the policy? • Who were the people or organizations directly involved?	Kingdon (2011) – Political stream & policy entrepreneurs and policy networks

• Was there a community consultation process? How did it work? • Was there a particular group or person representing the interests of children/youth? • What was your involvement?	Shiffman & Smith (2007) Category 1, 2,3 ACF (1988) – Policy networks
7. Were any individuals or groups particularly influential in the process? • Who were they? • What was the nature of that influence? • Did different people or groups exercise influence at different stages in the process? • What role did the (Premier or…) Health Minister (or other politicians) or their staff play during development of the policy?	Kingdon (2011) – Policy entrepreneurs and policy networks Shiffman & Smith (2007) Category 1 ACF (1988) – Policy networks
8. Did the people or groups involved put forward different or competing perspectives on 'what to do', or were they mostly 'on the same page'? • Did people from within and outside government bring different ideas or attitudes to the process? How so? • If there were conflicting views, what were they and how were they resolved or overcome?	Kingdon (2011) – Policy entrepreneurs and policy networks Shiffman & Smith Category 1, 2 ACF (1988) – Policy networks
9. Was there any significant commentary or even criticism coming from the wider community or the media about the policy during its development? • (If so…) Do you think this influenced the process or the outcome?	Shiffman & Smith (2007) Category 1, 3
10. In your view, what values or ideology shaped development of this policy?	Kingdon (2011) – political stream Shiffman and Smith (2007) – Category 2 ACF (1988) – belief systems Lewis (2005) - ideation
11. In your view, were there any issues or actions that should have been addressed in the policy, but were left out, or overlooked? (especially in regards to children/youth) And if so, why?	Kingdon (2011) – Problem and policy stream Shiffman & Smith (2007) – Category 2 and 4
12. How did an understanding of SDH, or particular pieces of evidence about SDH, come into the policy development process? • Was there any particular person or group who brought that perspective? • Did any particular documents figure prominently?	Kingdon (2011) – Problem and policy stream Shiffman & Smith (2007) Category 1, 2, 4
Preamble: *Evidence on health inequities in Australia and elsewhere shows that health outcomes often take the form of a gradient across the socioeconomic spectrum (show example). Other evidence highlights health gaps between population groups.* 13. Did an understanding of health inequity play a particular part in the development of this policy, and if so, was that more in terms of a gradient or a gap? • Did particular evidence play an important role here? • Was there any particular person or group who brought that perspective? • If evidence on a health gradient was important, how was reflected in the policy?	Kingdon (2011) – Problem stream & policy entrepreneurs and policy networks Shiffman & Smith (2007) Category 1, 2, 3 ACF (1988) – Policy networks Lewis (2005) - ideation
Preamble: *In our view it is not uncommon that health policies recognise social determinants of health, but still implement strategies mostly focused on medical care, or encouraging individuals to change their behaviour (e.g. diet or exercise).* 14. Do you think there was any 'tension' in the development of this policy between acting on SDH, and delivering better or more medical care, or programs to motivate behaviour change? If so, how was that expressed? By who? • Why do you this particular policy was able to include a range of strategies to address SDH, while other health policies have not done that? • **OR:** Why do you this particular policy was able to get beyond strategies on health care and lifestyle change and include a range of strategies to address SDH?	Kingdon (2011) – Problem stream & policy entrepreneurs and policy networks Shiffman & Smith (2007) Category 1, 2, 3, 4 ACF (1988) – Policy networks and belief systems Lewis (2005) - ideation
Preamble: *The evidence on SDH leads quite readily to the conclusion that (ideally) action is required across a range of policy areas outside the health sector.* 15. Was the idea of collaboration between sectors of government seen as important in how the policy would be implemented? If so, how was that reflected in the policy development process?	Kingdon (2011) – Policy stream Shiffman & Smith (2007) Category 1, 3
The policy now…	
16. Thinking about the [*name of policy*] now, how do you think it is progressing?	Kingdon (2011) – Policy stream Shiffman & Smith (2007)

• In broad terms what sort of impacts has implementation of the policy had so far? • Were these as intended? And/or what sort of impact has it had?	Category 3, 4
Preamble: *Finally, just a couple of questions about your own perspectives and values.* 17. In terms of your own understanding of social determinants of health, how have you have acquired that understanding? • Has it changed over time or through different positions you've held? • What difference does this understanding make to your work? 18. To what extent is a value of *equity* or *fairness* important to you? • *[If they say it is important]* Where did that come from? • *[If they say it is important]* What difference does this make to your work?	Lewis (2005) – ideation ACF (1988)– belief systems
19. Do you have anything else that comes to mind that you would like to raise at this point?	
Follow up…	
• Are there any particular documents, or speeches we should look at to further understand the development, implementation or evaluation of this policy? • Who else would you recommend we talk to about development of the policy • Would you like the opportunity to review a transcript of your interview? To make sure it says what you would like it to say? Thanks again for taking the time to be part of this study, your time is much appreciated	

4.4 Analysis

Analysis of data collected through qualitative methods involves a number of stages including familiarisation, coding, and thick description, and in this case using a political science framework to guide this process. The following section outlines how I conducted the analysis in this study.

4.4.1 Familiarisation

The first stage of analysis was to become familiar with the transcripts before formal analysis began. This is similar to the concept of 'familiarisation' where before the researcher begins 'the process of sifting and sorting the data', they must 'become familiar with the range and diversity of the data, and must gain an overview of the body of material collected' (Ritchie and Spencer 1994, p. 178). To do this I read each set of interviews several times and took detailed notes.

4.4.2 Coding framework and thick description

Secondly, drawing on the related theories, a coding framework that included a set of questions (see table 12) was set up in NVivo 10 to analyse each set of interviews. This was a deductive process where I used pre-determined theoretical concepts to examine the data (Patton 2015). Patton (2015) suggests that at this stage each case should be written up to give a 'thick description, or story, in a highly readable format' (Patton 2015, p. 450). Therefore, after coding all interviews in each case study, I wrote up four separate case study reports guided by the theoretical framework under the following headings: problem definition and ideation; policy options; political context; policy processes; windows of opportunity; key individuals and policy entrepreneurs; networks; institutions and interest groups. These reports provided

a thick description of the story for each case study and were used as a basis on which to conduct further analysis. Throughout this process my supervisors were involved in reading at least 20% of the transcripts and at monthly meetings the findings and reports were discussed. Any issues, discrepancies or differences in interpretation were discussed and resolved. The coding structure including the embedded political science theories is shown in Table 12.

Table 12: Coding framework for case study analysis

Main Code	Sub-code	Embedded political science theories Note: where there is possible overlap the main political science theory has been listed
Problem definition & ideation	What is the problem (health issue)? How was the problem framed? Did ideas play a role? How did policy actors use argumentation to get across their understanding of the issue? What evidence did policy actors use to frame the issue? What alternative methods did policy actors use when there was a lack of evidence?	Kingdon (2011) – problem stream Shiffman & Smith (2007) – Category 2 & 4 Lewis (2005) – ideation
Policy options	What policy solutions were put forward to address the issue? What was the source of chosen option? ie evidence, professional or personal beliefs What factors limited the scope of policy options ie medical dominance?	Kingdon (2011) – policy stream
Political context	How did the government influence the process? (including MPs) How did government culture influence the process? (including bureaucrats) How did public opinion, media electoral cycle influence the process? How did the current political situation (ie events or other policies) influence the process? In what ways did policy actors understanding of the political environment influence the process?	Kingdon (2011) – political stream Shiffman & Smith (2007) – Category 3
Policy processes	What are the lessons for 'effective' policy processes? How do policy processes set limits on the 'agenda'?	Kingdon (2011)– policy stream
Windows of opportunity	In what ways did problem definition, policy options and politics align for success?	Kingdon (2011) – Windows of opportunity
Key individuals and policy entrepreneurs	How did policy actors influence the process? Who were the key individuals that influenced the process? What role did policy entrepreneurs play? What influence does a policy entrepreneur exert including credibility, professional position, timing?	Kingdon (2011) – Policy entrepreneurs Shiffman & Smith (2007) – Category 1
Networks, Institutions and interest groups	How did a strong network facilitate change? How did leadership affect the policy network? Did institutions support the policy network's advocacy efforts? How did the policy network gain credibility?	Kingdon (2011) – political stream ACF (1988) Lewis (2005) – ideation and beliefs

4.4.3 Political science framework (Shiffman and Smith 2007) to guide final analysis

The final stage of analysis was to further analyse the data and to write up the findings using the Shiffman and Smith (2007) framework. The framework allowed me to incorporate all the political science theories described above in a common framework. The approach of Shiffman and Smith (2007) was adapted to address state and federal policy agendas rather than global initiatives (see Table 13).

Table 13: Adaptation of Shiffman and Smith (2007) framework

Element	**Main question**	**Factors shaping political priority**
1. Actor Power	What is the strength of the individuals and organizations concerned with addressing the social determinants of child/youth health at a state/territory policy level?	1. Is the child/youth health policy community cohesive? What is the degree of coalescence on the social determinants of health and health equity among the network of individuals and organizations that are centrally involved with the child/youth health policy at the state policy level (both inside and outside government)? 2. Leadership: are there capable individuals uniting the policy child/health policy community, especially in relation to the social determinants of health and health equity? and are they acknowledged as particularly strong champions for the cause? 3. Guiding institutions: are there effective organizations (outside of government) or coordinating mechanisms (within or outside of government) with a mandate to lead the development of child/health policy that addressed the social determinants of health? 4. Civil society mobilisation: are there grassroots organizations that are mobilising the media and political authorities to address the social determinants of child youth health at a state and federal level?
2. Ideas	In what ways do those involved with the state/territory child/youth health policy understand and portray the social determinants of health and health equity?	5. Internal frame: to what degree does the policy community agree on the definition, causes of, and solution to the problem 6. External frame: is there evidence that public portrayals of the social determinants of health and health equity resonate with external audiences, especially the political leaders who control resources
3. Political contexts	What are the environments in which actors operate?	7. Policy windows: is there evidence of political moments when political conditions and public opinion align favourably for the social determinants of health, presenting opportunities for advocates to influence decisionmakers? 8. State and federal governance structure: to what degree do norms and institutions operating in the child/health policy space provide a platform for effective collective action on the social determinants of health and health equity?
4. Issue characteristics	What are the specific features that influence the development state/territory child health policy with a focus on the SDH?	9. Credible indicators: are there clear measures that show the severity of child/youth health equity that can be used to monitor progress? 10. Severity: is the size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11. Effective interventions: Are proposed means of addressing the social determinants of health clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive

At this stage I was very familiar with the story of each case study and I applied this framework by sorting the data and initial coding into the four main categories. I then worked through each case addressing the main criteria (factors) that Shiffman and Smith (2007) suggest shape political priority. This resulted in the final write up of the findings which are presented below. Each policy case study is presented separately and is accompanied by a discussion that triangulates the findings with the public health literature and draws out the specific political science theory that is most relevant to the case.

4.5 Findings

4.5.1 Recap of Shiffman and Smith (2007) framework

Findings from each case are presented using the Shiffman and Smith framework (2007, p. 1371) which is summarised briefly below.

1. Power of actors

The first element of the framework is actor power which addresses the force of the 'individuals' and 'organizations' concerned with addressing the social determinants of child/youth health at a policy level (Shiffman and Smith 2007, p. 1371). Central factors include policy actors who are linked by their concern for the issue, specifically leaders who act as 'champions' for the cause and have credibility within the collective, and institutions and civil society mobilisation that add strength to advocacy efforts (Shiffman and Smith 2007, p. 1371).

2. Power of ideas

In the second element ideas are described as the ways in which those involved with the development of child and youth policy understand and portray the social determinants of health and health equity. This relates to how policy actors frame the issue to gain support, and how these ideas 'resonate' in a variety of ways with those who make decisions about which policies to develop, the content that is included, and how government resources are allocated (Shiffman and Smith 2007, p. 1371).

3. Political context

The third element refers to the 'environments in which actors operate', including moments when political conditions and public opinion align favourably for a social determinants of health approach, presenting opportunities for advocates to influence decision makers; and when federal and state governance

structures operating in the child health policy space provide a platform for effective collective action on the social determinants of health and health equity (Shiffman and Smith 2007, p. 1372).

4. Issue characteristics

The fourth element is the identification of the specific features that produce measurable indicators, assessing the 'severity of the issue' in comparison with other issues and suggesting effective interventions that are acceptable to government (Shiffman and Smith 2007, p. 1372).

4.5.2 Case study A: ACT Children's Plan: Vision and building blocks for a child-friendly city

'A step in the right direction…'

This case study draws on interviews with six policy actors, three from within government and three from outside government in the Australian Capital Territory.

4.5.2.1 Power of actors

Cohesive policy community level – several layers of support

Throughout the development of the ACT Children's Plan (2010) there was a policy community within government comprised of policy actors who were members of an existing interdepartmental committee (IDC) *…'including treasury, chief ministers, education, health etc.'* (Participant 1, inside government). Their brief was to oversee the development and implementation of the policy. However, although this group was seen as important within the structure of government and it potentially affected how children's health and wellbeing was addressed overall in the ACT, there was some tension regarding the effectiveness and/or influence of this group during the development of the ACT Children's Plan. The majority of participants did not see the IDC as driving the agenda for the policy, rather they would *'oversee drafts and say 'yeah that's nice' or 'that's not nice'… it was more rhetoric than reality to some extent'* (Participant 4, outside government). In this way they reviewed the progress of policy development but did not drive the agenda.

The driving force behind a social determinants of health approach was co-ordinated by a policy actor within government who took the lead and gathered a core group of policy actors who were known to be advocates for a child rights and social determinants approaches. This group of policy actors included a

senior bureaucrat (inside government), academic (outside government), paediatrician (outside government) and commissioner (outside government). This group worked together (informally) to build momentum for the adoption of a social determinants approach. Although several of these policy actors were also members of the IDC it was the work they did outside the official meetings that placed them in a position to influence the development of this policy.

Key policy actor uses credibility and strong communication skills to convince others

An academic who was part of the core group had been working on setting a social determinants of health agenda for children in the ACT for many years. In the lead up to decisions about the content of the ACT Children's Plan the academic presented at a regular government forum (across departments) and outlined how a child rights framework could frame a social determinants approach in policy. This forum was seen by most participants as particularly influential in shaping how the ACT Children's Plan was developed. At the forum the idea of a UNICEF *'child friendly city'* was introduced, with the basic message that *'if we concentrate on making the whole city more child friendly…we can create environments where children are free to grow up feeling safe and secure and playfully explore their neighbourhoods…and as part of that we can ensure that they have social support, basic services, clean air and water and trust in adults that their voices will be heard'* (Participant 2, outside government).

Commissioner role emphasises Child Rights

This framing of the issue also had traction in the ACT community because the Children and Young People's Commissioner had also been advocating for this approach. The Commissioner position was created in the ACT under the *Human Rights Commission Act in 2004.* The Commissioner and his staff were seen as very supportive during the development of this policy.

Community consultation – children's voices heard

Part of the specifications for the UNICEF child friendly cities approach is that children are consulted. The following statement demonstrates this requirement:

> *The UNICEF model [which] requires opportunities for children to influence decisions about their lives and their community and to actively participate in their communities.* (Participant 2, outside government)

Therefore, this became part of an extensive mobilisation of civil society in this case. The consultation involved surveying children, families and professionals who worked with children. Participants filled in surveys individually, in pairs, in friendship groups or class groups at school, child care or playgroups or in targeted and facilitated consultations. There were 725 responses, with open-ended questions and sections for drawings or quotes. Overall the consultation was seen by participants as a valuable way to hear the voices of children and those working with children. One policy actor said *'their contributions to our thinking and understanding of the issue were vital to the success of the policy'* (Participant 1, inside government).

Political leadership

Throughout the agenda setting phase the ACT Chief Minister Katy Gallagher was seen as a champion for policy related to 'children'. Her credibility was evident in interviewee responses and had been developed while holding portfolios in education, youth and family services; women; industrial relations; health, disability and community services; children and young people. Participants believed she understood the importance of both a child rights and social determinants approach when developing health policy.

> *We were very fortunate in having a Health Minister who was – who is now the Chief Minister – who was very committed to children and wanted to see it (this policy) happen. As a group we'd wanted things but you really needed the political motivation to move it ahead.* (Participant 3, outside government)

In the context of this interview 'motivation' referred to a politician who through her previous portfolio experience had a particular interest in seeing children in the ACT thrive and understood that addressing child health from a social perspective was the best way to ensure this happened.

In addition, the Minister for Children and Young People, Ms Joy Burch, was very supportive. Minister Burch and her staff were involved in the approval process and the Minister was present at the launch of the 2010 ACT Children's Plan, issuing a media release, tabling the policy and making a speech in parliament at this time (22nd June 2010). Again, participants felt these commitments demonstrated considerable political leadership and support for this policy in the ACT.

See Figure 2 for the power of actors and the different levels of influence in the ACT.

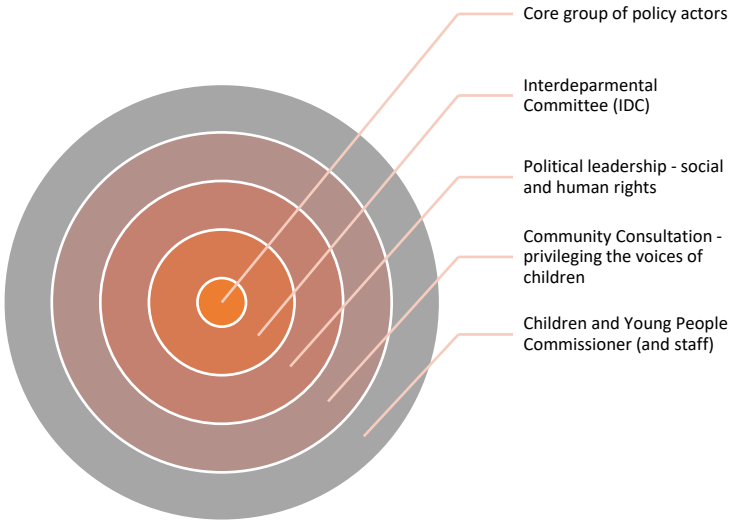

Figure 2: Power of actors – different levels of influence in ACT

4.5.2.2 Power of ideas

An emphasis on 'the social' in policy development

According to participants, the broader policy environment in Canberra helped frame the issue, placing a social approach at the core of the ACT Children's Plan (2010). The political history is that in the 2001 ACT election, the Australian Labor Party government with the support of the Greens defeated the Liberal government of eight years. They immediately began work on The Canberra Social Plan, and this policy gave the directive to develop a plan within the ACT for the demographic group 'children'.

> *At that stage there was no sort of strategic plan for any of the sort of broad demographic groups across Canberra. So, there was a very thorough process to develop a Canberra social plan and then some different sub-plans that sat underneath that demographic plan. So, the ACT Children's Plan was one, there was a young people's plan, women's plan, multicultural strategy.* (Participant 1, inside government)

Labor/Greens ideology

Some participants saw the Greens' influence as a facilitator for moving the child friendly cities approach onto the policy agenda.

> *Needless to say the Greens had more of a sort of flavour of involving children and sort of more social justice, social equity kind of things. It wasn't their initiative; I'm not saying in any way it was the Greens that made the Labor Party do it but I think the Green's presence made things like a child friendly children's plan probably more palatable, I suppose.* (Participant 4, outside government)

In the context of this interview 'palatable' is referred to in terms of the Greens influence in supporting a human rights approach to policy development in the ACT, thus creating a context within which a child friendly city approach would be accepted. Some participants also drew attention to how the change in government in 2001 softened up the agenda to facilitate a social determinants approach.

> *When I first came to Canberra I worked in a youth area when it was a Liberal government and it was incredibly challenging and very difficult and so anything with social had to be removed – when they first came in all of the documents…..all the documents had to be almost rewritten so that social disadvantage was removed from it, so I think to have that sort of – the political frame (ie Labor during the development of this policy) that's supportive of equity and social justice and stuff certainly makes the work easier to talk about the social determinants of health.* (Participant 1, inside government)

A child rights approach acceptable to government

The core group of policy actors mentioned above were strong advocates for a social determinants of health approach, and according to participants, the UNICEF framework was considered a successful policy option for several reasons:

a) It was evidence based and it was hard to argue against UNICEF because they were recognised by most policy actors (inside and outside government) as an authoritative voice in children's health and wellbeing.

I think people were pretty excited about being aligned to the UNICEF child friendly cities idea…I think it had credence…and I think people were excited that this gave us a platform, the UNICEF principles added value, for want of a better word. I think also it put it at an International level, and meant that we couldn't just let it sit there, we were accountable. (Participant 6, inside government)

b) The child friendly cities approach was considered a way of framing the issue in a way the government could accommodate and it facilitated cross-sectorial action, without excluding or boxing people in.

Well the Child Friendly Cities framework sat behind it and the children's plan I think was a bit of a watershed moment for policy in the ACT government because traditionally we would be used to having policies that have a list of objectives and then a range of activities and who was responsible for those and how they'd be delivered. Based on the Child Friendly Cities framework, this was very much more an aspirational plan about what we'd like the future state to look like. There were a range of signposts of success that are included in the plan that would help guide some of the things that might be evident if we were to work towards a child friendly city but the plan didn't limit people's actions or activities in relation to those signposts, which I think was really important. (Participant 5, inside government)

c) The UNICEF framework was an easy concept to understand.

So trying to find a vision that was going to be an easy one for people to get and understand, it fed into our sort of human rights context that we actually had here. It was tangible and not jargonistic – it was really, for me at the time, quite fortuitous that the concept of child friendliness was really, I thought, quite a simple concept with complexity that sat underneath. (Participant 1, inside government)

In summary, this framing of the problem and agreed solution resonated with politicians and the broader community. This was particularly evident at the launch of the ACT Children's Plan in 2010, where politicians, bureaucrats and community members (including children) were present.

4.5.2.3 Political context

Government investment in research to understand the issue

During the development of the ACT Children's Plan (2010), the ACT government made a significant investment in research, producing a document that was designed to provide baseline data for the policy titled *'A picture of ACT's children and young people'*. This was the *'first ever ACT snapshot of how children and young people, families and their communities were faring against key health, wellbeing, learning, and development outcomes'* (Participant 5, inside government). This process is still being supported by the ACT government with the most recent report being released in 2016.

Participant 5 explained the importance of this type of evidence at a political level:

> *The other thing I think that's really important is that it was the first plan to report to government through an outcomes-based framework as opposed to an activity report. The report against the ACT Children's Plan is called a Picture of ACT's Children and Young People. When we developed that it had a number of purposes. One was obviously to satisfy our obligations to report to government, so it ticks that box, but it was also in my mind about building capacity in policy and program development areas for people to be using data more effectively in decision making. What the report seeks to do is identify some of those real headline indicators that are really important measures of the progress of children and young people and to outline, I guess in quite a user friendly format, why we measure those, why it's important and what it actually means and then to track ACT's progress over time.* (Participant 5, inside government)

Whole of government approach

A key factor in facilitating a social determinants approach was the shift towards a whole of government response to address the issue of child health in the ACT. Policy actors saw this factor as *'a game changer'* in terms of addressing the social determinants of health. One policy actor said that the structural changes in government between 2004 and 2010 were vital to the way in which child health was seen across government.

> *I think the main shift that I saw between 2004 to 2010 was the articulation of a whole of government approach to children and young people and that shift was made available because government itself was very focused on whole of government approaches to a range of different policy and service delivery areas.* (Participant 6, inside government)

Young government – willing to try new things

Several policy actors reflected on the political mood being conducive to change at the time the ACT Children's Plan was being developed. Policy actors referred specifically to the ACT being a small government and that the Territory had only recently become self governing. There was a sense that this young government '*were a bit enthusiastic, they wanted to show they were doing good things'* (Participant 3, outside government).

A summary of political and policy events related to this case is shown in Table 14.

Table 14: ACT political context timeline

2001
Labor/Greens government formed defeating Liberal government (of 8 years)
2004
Canberra Social Plan 2004–2014 launched
ACT Children's Plan (original) 2004–2014 launched
2005
ACT Human Rights Act 2005 – Children and Young People Commissioner position created
2006
ALP Minister Katy Gallagher – takes on health portfolio
2007
ALP Minister Katy Gallagher – takes on Children and Young People portfolio
In-house government community forum – presentation by academic – child friendly cities
2009
Directive comes from government to refresh or revisit the ACT Children's Plan to align with the new Young People's Plan
Minister Joy Burch is elected and takes on Children and Young People portfolio
First Australian Early Development Instrument (2009) released
2010
ACT Children's Plan 2010–2014 launched (unit of analysis for this study)
2011
ALP Minister Katy Gallagher becomes Chief Minister in ACT
A Picture of ACT's Children and Young People policy (first released)
2014
ACT Children's Plan policy – to be revisited and consultation underway

4.5.2.4 Issue characteristics

Investment in research

A powerful idea generating political attention was child vulnerability. While the policy was being developed, new research (AEDI 2009) emerged highlighting that 'children' in the ACT were not doing as well as the government had once thought.

> *There were very serious problems, social problems, for children and families in the ACT and probably some of the more significant parts of this were some fairly high profiles of inquests and a number of child protection enquiries and these brought to people's attention*

> *the fact that more needed to be done for children living in the ACT.* (Participant 3, outside government)

Some participants saw this as 'critical' to how the health of children in the ACT was seen across Australia, explaining that prior to this, although people knew there were

> *…pockets of disadvantage in the ACT* (there were) *assumptions on how children were faring based on the socioeconomic status of a particular area and sometimes there's a correlation but often there are results that can be surprising and different to what you expect. What was critical at demonstrating this for the ACT was that developmental vulnerability can, and does, occur across all socioeconomic spectrums and that there is a socioeconomic gradient.* (Participant 5, inside government)

Problem magnified

Once this evidence was presented to government policy actors felt that the framing of the issue shifted and *'magnified the problem'* which meant the government was forced to act, as one participant suggested, *'specifically treasury departments…who have significant sway at the end of the day'* (Participant 4, outside government).

The severity of the issue was reinforced by several policy actors who spoke about recent 'high profile' child protection cases. The following quote highlights this point:

> *I speak about social determinants of children's health every opportunity I have and I guess I do have a number of opportunities. It's a terrible thing to say but working predominantly in child abuse you are in a strong position to continue to point out that a lot of these terrible outcomes are results of the circumstances of these children's lives.* (Participant 3, outside government)

A solution that resonates with politicians but is not necessarily easy or cost effective to implement

Finally, as mentioned above, the UNICEF Child Friendly Cities Framework had credibility within government. However, adopting this framework did not fit as neatly into government structures as the core group of policy had initially hoped. The main conflict was the UNICEF framework specified constantly evolving strategies while government wanted concrete strategies that fitted within their budget at that specific point in time. When the draft policy was sent to UNICEF for comment they provided the following feedback.

> *UNICEF had concerns - they absolutely supported and endorsed the document but they were quite concerned that there was a tendency for governments to then have like a rubber stamp approach to the concept of child friendliness and so they wanted to really – for me to re-craft the wording of it so that it was seen as a continuous process and ambition and goal that you would strive for, not that it was just you become child friendly and you get accredited. So, if you actually have a look on page three of the plan there's a little text box there which UNICEF was really pleased with the inclusion, that 'rather than a permanent label or brand child friendliness is, above all, a constant ambition that a city continuously endeavours to achieve'. So a lot of the wording of it was about rather than that 'we are a child friendly city' that we were 'becoming a child friendly city' so it's constantly aspirational. So the challenge for me then in the policy context and trying to get it through the political processes of approval and acceptance.* (Participant 1, inside government)

While changing the style of writing to suit UNICEF's requirements, policy actors reported feeling quite 'vulnerable' as they worked with government to ensure the language worked. Finally, they came up with a compromise of calling strategies 'signposts of success'. The following quote shows the effort made to get the language right.

> *What we identified was 'signposts of success' which replaced strategies. So if, for example, we want to improve opportunities for children's participation, if we were looking at some of the signposts of success, if we had more of those things happening in those dot points then we knew we were heading in the right direction towards becoming more child friendly city.* (Participant 1, inside government)

While most participants believed the policy was a success, the final version of the plan also had its critics, with several policy actors outside government commenting that the plan had not gone far enough along the child friendly city route. The next comment highlights the filtering process that is evident as an idea goes through the policy development process, and the difficult job policy actors face as they balance what they send to decision makers to get a policy through the approval process and further towards implementation.

> *This plan didn't go so far down the child friendly city route as I would have liked…certainly the people involved in the development spoke to UNICEF and got a sense of what was required to do this, and managed to get government to commit to some actions that would improve the health and wellbeing of children in the ACT, but there is still a way to go but, I suppose, it is a step in the right direction*… (Participant 2, outside government)

4.5.2.5 Discussion

This case study demonstrates a positive case for the social determinants of health reaching the health policy agenda. There are several factors that facilitated this success including a supportive political environment, evidence that drew attention to child vulnerability, and a solution – child friendly cities – that was acceptable to government. A significant finding from this research was the different levels of leadership that operated over many years to prepare the policy environment for acceptance of a social determinants approach. This included leadership from politicians who were prepared to emphasise the 'social' and put a 'human rights' approach at the forefront of all government policy, with a specific focus on children. However much of the groundwork was done by a core group of policy actors who were working behind the scenes to bring about change. As stated by Kingdon (2011), once this group sensed that the political environment was favourable they worked together across the problem and policy stream to bring their 'pet solution' to the table. Shiffman and Smith (2007) define leadership as 'the presence of individuals capable of uniting the policy community and being acknowledged as particularly strong champions for the cause' (p. 1373). This case involved a range of individuals who possessed these qualities, and although not one individual stood out as a single policy entrepreneur, it was the co-ordinated effort that brought success at a policy level. While the formal structure that was set up to develop the policy was supportive the IDC did not appear to drive the agenda.

In this way, this case provides a variation on classic Advocacy Coalition Network theory (Sabatier 1988), where instead of competing policy networks with differing membership, there was an inner and outer circle of influence, with the key individuals at the centre and the IDC at the next layer (see Figure 2, p. 96). Politicians played a supportive role on the next layer. In addition, the key group of individuals were instrumental in mobilising the community and children through community consultations, which added another layer of support at the outer level.

This finding reflects the range of definitions of a policy network in the political science literature and perhaps suggests that to distinguish between cases, there is a need look towards the function of a policy network within the context of governing in modern politics (Borzel 1998). In doing so, the group of policy actors in this case could be defined as a policy network because they formed a 'web of relatively stable and ongoing relationships which mobilize and pool dispersed resources so that collective (or parallel) action can be orchestrated towards the solution of a common policy' (p. 260). The newly established government in the ACT was relatively progressive and small when compared with other jurisdictions and operated under 'predominantly informal interactions' where policy actors knew each other across departments. In this context, therefore, the policy actors were able to 'strive to solve problems of collective action on a central, non-hierarchical level' (Borzel 1998, p. 260).

Recent Australian research suggests that one barrier to gaining political attention for a social determinants approach is if policy actors are not able to promote the idea to government and/or they do not have a policy solution that facilitates government action (Carey and Crammond 2015). However, in this case the academic, paediatrician and commissioner had the skills to promote the idea of child friendly cities and had been doing so for a number of years. In addition, a senior bureaucrat who understood the policy process within government sensed the political mood was ready for change and could see that this solution would fit into the new cross-government structure in the ACT. Thus, as in Kingdon's (2011) multiple streams theory, the three streams aligned, and a window of opportunity opened facilitating change at a policy level.

However, it is arguable whether all those involved in the decision-making process and those on the IDC would have associated the child friendly framework specifically with a social determinants of health approach. Rather, the findings suggest that this strategy was cleverly constructed by those who were knowledgeable in this area, and understood that to gain political attention and convince cross-

department colleagues that this was the best way forward they had to make the agenda easy to understand and able to fit into the existing structures of government. Thus, as per recent political science debates about the vagueness of the definition of the social determinants of health (Cairney et al. 2019), in this case study, the child friendly cities approach produced a more concrete definition, for which those outside of the social determinants advocacy movement could understand.

As mentioned above, a 'social' approach to policy development and the acknowledgement of children's rights was a facilitator for applying a social determinants approach in the development of the ACT Children's Plan. This aligns with public health research that suggests that political ideology of a government influences the adoption of a social determinants approach (Alvaro et al. 2010, Baum et al. 2016). It also fits well with political science theories that posit that decision makers in the policy environment act within a core set of beliefs (Sabatier 1988, Lewis 2005). Lewis (2005) refers to this as *deep structure ideation*, defined as 'a fundamental set of ideas, associated beliefs, values and perspectives that determine problem recognition and definition, shape the policy discourse, and constrain possible policy proposals and strategies' (p. 98). This case, therefore, is contrary to research that finds the social determinants of health to be at the surface level of ideation and places it a deeper level where there is a paradigm shift and change occurs (Lewis 2005). This analysis suggests that there were several explanations for this change. First, there was a federal Labor government that placed an emphasis on early child development as an important determinant of health. Although there are contested agendas between the federal and state/territory governments over responsibility for health and other issues, it is generally accepted that the states/territories follow the federal government's lead on highlighted agendas (Duckett and Willcox 2011). Secondly, the ACT had not been self-governing for long and during the period leading up to the development of the policy the mood was conducive to alternative ideas being heard. Finally, the ACT was the first jurisdiction to enact a *Human Rights Act in 2004*, and the Children's Commissioner advocated for the merits of this approach as a way to address the social determinants of health. A recent Australian study also found that a human rights approach facilitated a social determinants approach when developing the National Aboriginal and Torres Strait Islander Health Plan (Fisher et al. 2019).

Health equity was also at the forefront of decision makers' minds during this time because 'shocking facts' about child vulnerability in Australia (Australian Child Rights Taskforce 2018) and specifically in

the ACT (AIHW 2016) were being presented to government. These provided ‘credible measures’ about the extent of the problem (Shiffman and Smith 2007) and further strengthened advocacy for a social determinants approach. This aligns with Bowen et al. (2009) who found that ‘killer facts’ were a facilitator for stimulating change in the Australian health policy environment (p. 5). However, while the core policy actors in this case were aware of the importance of addressing the ‘upstream’ determinants before children’s health reached an acute stage, the need for startling statistics to prompt a budgetary response in government poses many issues for those advocating for a social determinants approach. Firstly, it reinforces a focus on a medical approach where ‘downstream’ issues are given priority and governments wait to treat sick children (Heymann and McNeill 2013). Secondly, it makes it difficult for advocates to suggest that governments take action across the social gradient where statistics on vulnerability may vary. The WHO (2008) suggests that societies that invest ‘upstream’ have the best health status and lowest levels of health inequities. Therefore, while advocates need to present data that shocks government into action, they also need to continue to advocate for ‘upstream’ approaches to reduce these health inequities in the first place. This may prove difficult in a reactionary policy environment with competing agendas.

4.5.2.6 Conclusions

In conclusion, this case was a particularly strong example of actor power, especially the factors associated with policy cohesion, leadership and community mobilisation. A core group of policy actors collectively led the way to move social determinants onto the ACT health policy agenda and in so doing demonstrated leadership skills, including good argumentation skills, and the ability to build credibility in a strategic manner (Sabatier 1988, Lewis 2005, Carey and Crammond 2015). This was backed up by a supportive IDC and considerable political support. A cohesive policy community mobilised the wider community and used their knowledge of government processes to frame the agenda in a way they knew would fit government structures and ideology. The role of the Children’s Commissioner in the ACT acted as a powerful institution and UNICEF’s presence provided the credibility that was needed to convince decision makers within government (Lewis 2005, Shiffman and Smith 2007). The framing of ideas was also an area of strength in this case and was set up by a Labor/Greens government who put a social approach first in policy development. This was followed by the UNICEF Child Friendly Cities approach that framed the social determinants of health and health equity within a child rights framework. It also framed the social determinants of health in a way that was easy to understand, worked well across

sectors, and had credibility within the broader ACT policy community. There were some favourable political factors in the ACT that facilitated a social determinants approach including a long-term Labor/Greens government providing both political stability and the opportunity for sustained and iterative policy development. This young progressive government was open to new policy solutions, including a whole of government (and in this case with strong links to the health department) response to child health and investment in research that would create measurable policy outcomes. There were some credible indicators that gained political attention during the development of the ACT Children's Plan, with research (Australian Department of Education and Training 2016) pointing to child vulnerability across the social gradient and the severity of the matter being demonstrated by high profile child protection cases in the ACT. The UNICEF Child Friendly Cities initiative was considered an effective intervention that was easy to understand and, although some did not consider the policy to go far enough it set the foundation for further action on the social determinants of health in the future. This case provides a positive case for addressing the social determinants of health in the Australian child health policy environment.

See Table 18 (p. 148) for a summary of the key factors highlighted in this study and the strategies employed by policy actors in Australian health departments to advance a social determinants of health agenda in child health policy.

4.5.3 Case study B: NSW Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures

'It was the voices of the young people that broadened the agenda'

This case study draws on interviews with eight policy actors, six from inside government, and two from outside government.

4.5.3.1 Power of actors

Guiding institution – independent of government

The advisory group developing the NSW Youth Health Plan was steered by the New South Wales Centre for the Advancement of Adolescent Health (CAAH), an institution outside of but funded by the government set up with a view to provide strategic advice and research on youth health issues. The

advisory group included CAAH staff, academics, senior bureaucrats, community youth workers, and youth representatives.

> *We were funded by the Department of Health. We were part of New South Wales Health which, you know, is state government, but we were housed and managed separately.* (Participant 7, inside government)

Policy entrepreneur – classic style

While CAAH was commissioned to write the NSW Youth Health Plan, most participants credited a senior bureaucrat within government for getting the policy onto the health agenda. This person had been working across various portfolios for over 20 years and in Kingdon's (2011) terms would be considered a policy entrepreneur.

> *I think we were very lucky having within government a person who was responsible for youth health alongside many other portfolio areas…I think this person sowed the seeds…and was committed to assisting us to do this and became a champion for it happening and I think this also assisted in leveraging the support that was needed to do that...this person would certainly been a champion within government.* (Participant 8, inside government)

Most participants perceived the policy entrepreneur to be largely responsible for establishing CAAH in the first place.

> *So basically, that was a structure that was created because there are always limitations and pressures within the Department… so the safest thing to do is actually develop a structure outside the Department, still within the health system but outside the Department, that can provide policy advice, support, research and so on without appearing to be kind of influenced by the Department…this KPI in fact was something that happened as a result of the last iteration of the NSW Youth Health Plan some 12 years ago.* (Participant 10, inside government)

This style of leadership can be explained using Kingdon's multiple streams theory where policy entrepreneurs have credibility within government and are able to use their marketing skills to sell an

idea (2011). Kingdon (2011) suggests that policy entrepreneurs have the ability to network and bring others on board to drive a specific policy agenda. These skills enable policy entrepreneurs to understand and manipulate the politics that surround the framing of an issue, including the development of objectives and strategies that they believe will survive the policy approval process (Kingdon 2011, p. 181). Therefore, a strategic move made by a policy entrepreneur to facilitate change at a policy level resulted in the establishment of an independent institution that employed staff who were advocates for the social determinants approach and were determined to tackle issues that would improve the health and wellbeing of young adults in NSW. The Director of CAAH and the policy entrepreneur were in constant communication which further strengthened the social determinants agenda as the NSW Youth Health Plan was being developed.

Community consultation

Once the youth health policy was on the agenda, CAAH and the policy entrepreneur mobilised civil society by leading an extensive community consultation involving 20 young people and 120 adults from youth health services, other government agencies, youth NGOs, other Department branches and other peak organizations. Participants explained how the ideas that came from this forum informed the policy:

> *We used an appreciative enquiry planning process to look at how to develop the main goals of the policy. So by lunchtime each table had come up with their three top sparkling ideas for creating a better future for young people and then these ideas were drawn on yellow stars and blue tacked to the wall….then at lunchtime everyone was given dots to vote and we ended up with the top twelve sparkling ideas after lunch, which we distributed to twelve tables and invited people to work on the sparkling idea that sort of interested them most and then that was fleshed out. They literally became the priorities in the policy…so probably the biggest influence was that consultation forum because literally the sparkling ideas – 12 of them there are – became the 12 priorities in the policy, and I guess that's why the sector's so supportive of it. We also held an online consult with a group of about 20 more young people over a month and posed questions every week and the young people would answer them. As part of that young people suggested the name for the policy and then the final choice came from the reference group voting from what the young people suggested.* (Participant 7, inside government)

Shiffman and Smith (2007) argue that an issue that is backed by civil society is more likely to reach the agenda. This case demonstrates how the voices of young people helped shape the scope of the policy. Research suggests that children and youth should be afforded the right to be involved in developing policy that affects them, and that such participation benefits not only the individual but society as a whole (UNICEF 2011). Other researchers also promote citizen involvement when developing policy as a way to make policy more relevant to the population group it is intended to assist (Whitehead and Popay 2010). However, as will be discussed below, the framing of the issue for this policy was complex and competing agendas were evident through different stages of the policy development process. The power of actors and the different levels of influence in NSW are shown in Figure 3.

Figure 3: Power of actors – different levels of influence in NSW

4.5.3.2 Power of ideas

Pitching an idea and solution that resonates with government

Access to youth health services was now firmly on the health policy agenda and the next stage was to suggest a solution that resonated with government. A powerful idea triggering attention from the NSW Health Department at this time was access to youth health services. While policy actors felt the broader

determinants of health should be at the centre of policy development, they knew that this approach would encounter resistance, so their pragmatic response was to compromise. A policy actor explains how decision makers were prepared to listen to this framing of the issue.

> *The drive and the interest [within the department] was more around services and creating more youth friendly services, so increasing the provision and improving service provision…I can't say that at that point of deciding to make the policy there was a particular sort of drive [within government] to look at the broader social determinants… in fact at the time there was a push within government for youth health services to become more and more clinical.* (Participant 7, inside government)

Youth voice broadens the agenda

As mentioned above, an interesting development in this case occurred when the community consultation led to a brief opportunity to frame the issue from a broader social determinants perspective. Several participants commented on how the input of young people shifted the focus.

> *They [young people] wanted to talk about education and health, housing and personal safety, employment and training, transport and technology… because they are the social determinants of health.* (Participant 12, inside government)

The social determinants of health that participants recalled being raised during the consultation were family support; linking health to educational support and attainment; creating healthy settings; regulating tobacco and alcohol; making fresh fruit and vegetables available and accessible to youth; addressing working conditions and flexibility for youth engaged in part-time employment; regulating the advertising of alcohol and unhealthy food; health promotion; positive media representation of youth; including young people in decisions about their health and wellbeing; recognizing that educators, religious leaders and politicians have an influence on youth health; that urban planning and communities are important; and that safe and affordable accommodation is essential.

The quote below highlights the optimistic mood of policy actors involved in the community forum when they could see a window of opportunity open to include the broader determinants of health in the policy:

> *It's definitely the voices of young people that help broaden out the scope of the policy.* (Participant 7, inside government)

However, after a change of government and once the policy was tabled for approval at a higher level of government, policy actors reported some 'heated discussion' about the 'scope' of the health department. At this stage, CAAH were told that there were many strategies included in the policy that the health department could not act on and that they needed to re-write the policy in '*ways that are proportionate to what can be done'.* (Participant 14, inside government)

A senior policy actor explained:

> *We were very much told at the time 'look, this is a policy for health for NSW Health; it's not a whole of government policy and so anything that is about a different government department' – so that is about education, police, whatever, even community services – 'is basically out of scope.* (Participant 7, inside government)

This complicated and slowed down the policy process. Senior bureaucrats within government were now given the task of making the final draft fit a specific set of criteria from the NSW Health Department. A senior bureaucrat explained the process:

> *That was perhaps the most contentious part of the whole process…the difficulty was that even mentioning some areas of social determinants of health within a policy can be given to indicate that the system, a health system, is going to be doing something about them….and ultimately the resources are limited so we did have to choose a way forward…* (Participant 12, inside government)

Considering the work that had been done in the community forum and the resulting inclusion of the broader determinants of health, policy actors found this process 'frustrating' and 'upsetting'. However, several experienced policy actors suggested that 'this tension was always there' when trying to take action on the social determinants of health. The following quote highlights a senior policy actor's view on this matter.

> *The reality, however, is that we don't run in Australia health systems, we run departments of ill health and that means that it's still the medical stuff that gets given*

priority, so the waiting list is what drives politicians, you know, no matter what they say. I'm not disputing that many of them sort of agree with the social determinants, it's just that on a day to day basis it's not what they get clobbered about, what they get, you know, hit over the head by the media, by the shock jocks, by whoever, is 'well, what are you going to do about this person who needs a hip replacement? What are you going to do about this miracle cancer drug that America has already endorsed but we haven't?' So this is the reality that we, those of us who wanted to change these things, had to fight and it was a constant battle and we are bruised every day and I'd say 99 percent of the time we lost. We didn't lose the ideological battle, we just lost the money battle, which is – you know…I don't know what to make of that. Maybe at some point in time we'll win more. We've won the ideological battle but, yeah, it hasn't resulted in a huge change in the way health systems are run. (Participant 10, inside government)

This finding reflects issues seen in study 2 of this thesis and it highlights the dominance of a medical approach in Australian health departments. According to Lewis's (2005) theory on ideation, this case study falls into the middle category of 'incorporation', which refers to change that occurs at the surface level only while deep structure ideation remains unchanged. In summary, a compromise was made and the framing shifted back to action on access to health services, with the broader determinants of health being acknowledged in the background, or appendix, of the policy. The following quote demonstrates how this occurred:

By the way, one thing that's probably quite relevant is appendix three, which is on page 31, it is on working together for young people's health and wellbeing. I wrote this section. I didn't write a lot of the policy, by the way, I sort of wrote the summaries of services and this appendix three, but I wrote this mainly because these were basically the ideas I had to chop out and this was my way of proposing to get them back in, so that they're at least acknowledged, even if it was stuck in as an appendix…it was created after the draft was circulated so it was while we were grappling with the issue of the scope being defined and having to chop – not necessarily chop bits out but stuff we wanted to put in we weren't allowed to put in. (Participant 7, inside government)

Kingdon's multiple streams theory (2011) suggests that policy making is complex and this case study highlights the point, showing that the way a problem is framed can change at different stages throughout the policy development process.

4.5.3.3 Political context

Political support – bipartisan

From a political perspective the timing of the development of the NSW Youth Health Policy (2010) was not ideal. At the time the policy was to be launched a state election was due, with a potential change of government after 16 years of Labor to a government headed by the Liberal party. However, because of the policy entrepreneur's argumentation skills and political connections it appeared that bipartisan support for the policy was achieved at a surface level. The following quote demonstrates the political history and relationship building that bridged the divide between political parties and brought success for a long-standing advocacy campaign to get youth health onto the NSW health policy agenda:

> *In fact, we had a youth friendly minister by the name of Carmel Tebbutt, the Labor Minister for Health. We had a very close and good relationship with her and it was her initiative in fact to publicly launch the policy rather than just have it dribble into parliament and she launched it at the very, very end of her tenure; the government literally fell over immediately after that so we were quite fortunate to have her do that. Then the incoming minister, Jillian Skinner, also a very youth health friendly minister who'd been a Director of the Office of Youth Affairs ten years previously… she said that she would endorse this. She liked it and has been quite comfortable with us getting on and looking at how to implement this new policy that was in fact given birth during the Labor reign.* (Participant 10, inside government)

Medical academia builds momentum to address youth health

This finding again demonstrates one of the classic qualities of a policy entrepreneur (Kingdon 2011) where the person has a 'claim to a hearing' with those in senior decision-making positions within government. In addition, during this time there was a movement in medical academia internationally and in Australia about the need to address adolescent health. Several participants mentioned the significance of how these publications placed pressure on politicians to take some action in this area.

> *…because looking internationally probably the most significant thing that had happened as a profile raising activity was the Lancet taking on the publication of a series of articles. It was really a bit of a game changer to have the Lancet publishing a range of articles arguing the importance of adolescent medicine and adolescent health…just moving towards an acceptance that if there's not an investment in the health of young people then we're actually burdening the adult health system unnecessarily. The notion of continuity of issues from adolescent into adult life and all the implications of that I think was starting to be heard and understood a little better.* (Participant 8, inside government)

This renewed energy for youth health in NSW resulted in the creation of a Chair of Adolescent Medicine at the University of Sydney. CAAH staff were *'very active in negotiating this position (which was funded by the medical foundation of the Sydney Medical School) because they 'felt that in adolescent medicine there was a lack of research and empirical evidence for what people were doing'* (Participant 9, outside government).

At the time NSW was the only state in Australia to have created such a position, and, as a key member of the advisory board steering the development of the NSW Youth Health Policy, this person bought significant influence to the campaign.

> *…the Chair of Adolescent Medicine at the University of Sydney…representing what you might call academic adolescent medicine and this was the inaugural position of that chair so that was the first time there was a clear academic involvement from a university perspective, and there's very few of these positions that represent youth around the world.* (Participant 9, outside government)

Window of opportunity – half open

Overall, policy actors felt that the political context at the time of policy development had shifted to open a window of opportunity to address access to youth health services. Although they struggled to tackle the broader determinants of health in the policy, many agreed that the policy pushed the boundaries within the political context in NSW to

> *…at least acknowledge the broader influences that are impacting on health and wellbeing and the responsibilities of other sectors of the community, of society, to a person…without going into too much depth or detail they've said that there are these broader responsibilities, broader issues that need to be addressed.* (Participant 13, outside government)

The following quote summarises policy actors' perceptions of the challenges faced when developing the policy: *'I guess, we had enough influence in the system to be able to push it a bit but we didn't have enough to challenge it totally'* (Participant 7, inside government).

A summary of political and policy events related to this case is shown in Table 15.

Table 15: NSW political context timeline

1995
Labor government formed, defeating Liberal government (of 8 years)
1998
NSW Youth Health Policy (original) launched
NSW CAAH established
2009
NSW CAAH – community consultation and literature review
2011
NSW Youth Health Policy launched
Liberal government formed, defeating Labor government (of 16 years)

4.5.3.4 Issue characteristics

Health equity and lack of access to health care were highlighted as important factors in triggering policy action in this case study, especially the CAAH access study series titled *Mapping out how to promote resilience in young people at risk across different service spectrums including prevention and treatment* (Booth et al. 2002, Kang et al. 2005). However, most people commented that in comparison with early childhood development, there was relatively little research on the current state of youth health within Australian and NSW. Participants also noted that although there was a need for data to support youth health policy development, however, they had little confidence that this type of research would be funded. A statement released by the Australian Research Alliance for Children and Youth (ARACY 2010) highlighted the lack of measurable data for this age group: 'ARACY is also calling for

the introduction of internationally comparable 'middle years' measures, so we know how children in the middle years are faring, emotionally and socially. In Australia, there is basically no comparable data available on peer, family and behavioural issues for children in this age group' (p. 1).

One omission from this case study was a policy solution that included the broader determinants of health. Again, while policy actors could name successful programs that adopted a social determinants approach in the youth health policy environment (mostly from the 1980s), at the time the policy was being developed they did not think these solutions would fit into the scope of the health department. A policy actor explains the extent of their knowledge on this topic, and some of the political history.

> *…you see we know what works…we were, in the early 1980s, blown over by the advent of a service called The Door, a youth centre in New York; it was created for homeless kids in Manhattan but it was a multi-sector initiative. It was all done on a pro bono basis for those kids and they were provided with education, creative activity, health care, social welfare, legal advice, family support etc. Basically, addressing the Ottawa Charter to address the social determinants...it was an amazing model. It was like the one-stop shop model that was taken up in Australia, in Shopfront in South Australia and in other places, and it was the inspiration for establishing Cellblock Youth Health Service in Sydney; in other words bringing the creative arts alongside a whole lot of other things….the Ottawa Charter had a very, very respectful recognition of the determinants of health in the socioeconomic context that people live in, and that is important for youth health and wellbeing. What we saw happening towards the end of the '80s and in the '90s was that health care funding – funding for young people became more siloed, that people started to sort of seek money for pregnancy prevention or drug and alcohol and the notion of joined up services became less de rigueur. Then we lost funding in the early '90s for non-government organizations, so the fledgling Association for Adolescent Health in Australia, which had strong branches in every state in the country, basically was defunded federally and then fell over one by one, leaving only the New South Wales group which was recently liquidated, but a very, very strong NGO sector and a very strong representation of the Ottawa Charter in the '80s was dissipated.* (Participant 11, outside government)

4.5.3.5 Discussion

The findings from the case study demonstrate an advocacy campaign that facilitated the placing of youth health onto the NSW health policy agenda and a pragmatic approach to getting the social determinants of health into the policy. In this case study, advocates gained political priority for access to youth health care and while this was recognised as an important determinant of youth health, policy actors were clearly frustrated by the dominance of a biomedical approach within the NSW Health Department in which the broader determinants of youth health were defined as 'out of scope'.

Study 2 in this thesis provided evidence to suggest this occurred across all child health policies in Australia. However, while this case study does not shed light on a policy that succeeded in fully embracing a social determinants of health approach, it does highlight the strategic steps taken by a policy entrepreneur and a cohesive policy community to build a strong foundation for action on the broader determinants of youth health in the future. Another Australian study also concluded that starting with 'a discrete' solution that fits within a departmentalised system can build trust and therefore open up opportunities to influence future policy agendas (Carey and Crammond 2015).

This case study provides an example of a classic policy entrepreneur where an individual acted as 'champion' for a social determinants approach to youth health (Kingdon 2011). As a leader who had been working in government for over 20 years, he had credibility within the policy community. However, this case also extends Kingdon's theory, because the policy entrepreneur did not work in isolation but rather gathered support and resources to build a platform from which to facilitate change and work towards changing the dominant approach of the NSW Health Department. This required argumentation skills, persistence and the capacity to build good relationships at both bureaucratic and political levels (Lewis 2005, Kingdon 2011). The foresight of a policy entrepreneur in setting up an institution outside of government was a key element in gaining political priority for a clinical approach that also included 'access to health care'. This is consistent with the results of a study that highlighted institutional support (outside of government) as a key facilitator for change (Larsen et al. 2006). However, in Larsen et al.'s study it was a Member of Parliament, not a public servant, who wielded power within government to establishment an NGO to divert decision making away from government. It is arguable whether the policy entrepreneur (in NSW) had enough power at this level to bring about change at a political level. Thus, a potential weakness in this case was that while bureaucrats

understood the social determinants of health, they failed to communicate to the Ministers involved that their version of a ‘youth friendly’ health policy involved applying a social determinants of health approach.

The strategy to consult youth about a policy that addressed their health was considered to broaden the scope of the policy and had the potential to bring about change. This process acknowledged ‘that young people’s knowledge of the concerns of their constituency gives them unique insights that can inform the design of youth-related policies’. Furthermore that ‘with the tools and the empowerment to participate in policymaking, young people can make contributions leading to strategies that are more responsive to their needs, and their participation leads to policy frameworks that have greater legitimacy’ (United Nations 2016, p. 13). While the community consultation process was successfully conducted in this case study, it appeared to have had only a limited influence on the final framing of the issue. Therefore, while a policy silence on youth health was successfully addressed in this case, further advocacy efforts that ensure the voices of youth are heard by politicians and high-level decision makers may advance a policy agenda that prioritises the broader social determinants of youth health.

The omission of measurable indicators that associated the outputs of policy with the broader social determinants of youth health was a barrier in this case study. As suggested by Shiffman and Smith (2007), ‘different frames appeal to different audiences’ and the collection of meaningful data may provide alternative ways of framing an issue (p. 1374). Advocates in the early childhood policy environment have had some success when using ‘economic frames’ to get the early childhood development as a determinant of health onto the health policy agenda, and perhaps youth health advocates can learn from these efforts.

4.5.3.6 Conclusions

This case was particularly strong on actor power, specifically the leadership, cohesive policy network, and independent institution (outside of government) that exerted influence, academic investment and operationalized community mobilization, which assisted in gaining some political priority for youth health and to some degree, a social determinants approach. The framing of the issue went through a series of iterations and began with a pragmatic attempt to set the internal framing as ‘access to health services’. However, a significant finding was that community consultation with young people and

professionals from the sector briefly broadened the agenda to include the social determinants of health. While the prevailing organizational culture within the health department did not support this frame, advocates were satisfied that they had shifted the focus to some degree and while the window of opportunity was only half open for a social determinants approach, they were preparing the agenda for future advocacy efforts. The political context was contested in this case because while there appeared to be bipartisan support for a 'youth' health policy and equitable access to health received some political attention, the broader determinants of health remained at a surface level of ideation, being deemed as outside the scope of the health department (Lewis 2005). Thus, the political leadership required to facilitate a broader determinants approach did not emerge. The health and wellbeing of youth is not well supported in Australia and this case highlights the need for measurable indicators to assess the health and wellbeing of youth as a specific population, especially when suggesting that this demographic group needs specific policy attention. In addition, advocates felt that at the time of development the scope of the health department would not extend beyond 'access' to healthcare, and in a pragmatic attempt did not attempt to suggest solutions that were known to address the broader determinants of health. Overall this case highlights a positive development in addressing access to youth health services in Australia. The findings provide several factors that may improve advocacy efforts to address the broader determinants in the future.

See Table 18 (p. 148) for a summary of the key factors highlighted in this study and the strategies employed by policy actors in Australian health departments to advance a social determinants of health agenda in child health policy.

4.5.4 Case study C: Our children our future: A framework for child and youth health services in Western Australia 2008–2012

'I also think the social determinants went down the line quite early because of the leadership of the two paediatricians'.

This case study draws on interviews with six policy actors, three from within government and three from outside government in Western Australia.

4.5.4.1 Power of actors

Medical policy entrepreneurs unite policy community

The policy community steering the development of *Our Children, Our Future: A Framework for Child and Youth Health* was comprised of two paediatricians (co-leads) selected by the Commissioner for Health and confirmed by the Minister of Health Jim McGinty; a Policy Officer selected by the co-leads; and an advisory committee selected by the co-leads with representation from a cross-section of sectors including nurses, social workers, adolescent health service workers, bureaucrats from the health department, academics and a community representative. The co-leads were seen as 'champions' for a social determinants of health approach in a policy where the original focus was clinical. As described by Kingdon's multiple streams theory (2011), these two individuals acted as policy entrepreneurs during the agenda setting and policy formulation processes and employed several strategies to lay the foundations for a social determinants approach.

Firstly, they communicated early on to Ministers and high-level decision makers about the need to change the child and youth health network from a clinical network to a health network. Health networks had emerged in WA as part health reforms that were recommended in the Reid report (Reid et al. 2004).

> *One of the first things we did was actually say 'well, we don't want to be a clinical network, we want to be a health network' so we drove that change from the start… we said we want to look at the health agenda for children and youth with a broader remit...* (Participant 16, outside government)

The co-leads reported 'no resistance' to this request, which suggested that high level decision makers afforded them considerable trust and power within the policy development process. Recent research suggests that having a medical degree in Australia 'provides a useful entrée into health policy networks, providing personal and positional resources' (Lewis 2006, p. 2134). The comment below demonstrates how this occurred in this case study:

> *There was widespread support. I think that a lot of people saw that here was an opportunity where people who controlled a lot of the money – ie clinicians – actually had a broad view of what should happen in child health.* (Participant 15, outside government)

Secondly, the co-leads hand-picked an advisory committee that included a broad range of professionals working in child and youth health who were known to be advocates for a social determinants approach.

> *We made sure there was a good smattering of people who had a public health interest and we had some pretty useful individuals around the table who were able to drive a social determinants agenda…people like Fiona Stanley were obviously very important.* (Participant 16, outside government)

Finally, the co-leads were instrumental in employing a policy officer who held a Master of Public Health degree to research and write the policy.

> *The key person who was a driver, was in fact our project officer who came from a research and policy background and had a Masters of Public Health, so the social determinants of health were core business for her. So, having a project officer who had a lot of that knowledge, that training already, she was very much able to help us, guide us and actually put the words down that made it significant.* (Participant 16, outside government)

This case highlights the power of two policy entrepreneurs who used their influence within government to advocate for a social determinants approach. With strong leadership and a cohesive policy community, at this stage the agenda was *'very open to discussing things beyond, I suppose, a hospital focus'* (Participant 15, outside government).

One of the omissions in this case study was a broad community consultation, with just one community representative on the advisory board. Policy actors who were involved in writing the policy suggested that the timeline did not allow for an extensive community consultation so a volunteer from the Telethon Kids Foundation was included in the advisory group. Contrary to recommendations by Australian Child Rights Taskforce (2018), this case did not privilege the voices of children or youth or mobilise support for the policy outside of the political or bureaucratic process (Shiffman and Smith 2007).

The power of actors and the different levels of influence in WA are shown in Figure 4.

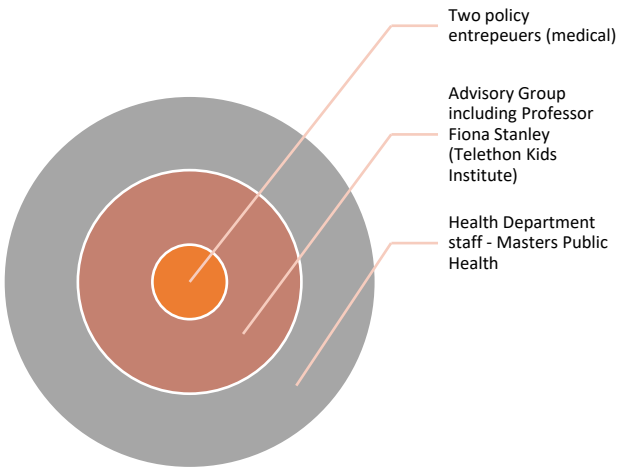

Figure 4: Power of actors – different levels of influence in WA

4.5.4.2 Power of ideas

A SDH approach to improve child health equity was well understood

There was consensus across participants that those developing the WA *Our Children, Our Future: A Framework for Child and Youth Health* understood and were conversant with the social determinants of health and health equity. With much discussion about health equity, the social determinants of health were framed as a 'natural fit' and 'essential' when addressing health issues for this demographic.

> *I think equity was probably the most important concept that drove the development of this policy with an understanding that all children and youth deserve an opportunity to achieve their potential and we know that comes back to the social determinants of health…you know when you're dealing with complex systems you need complex solutions. If you're dealing with drug and alcohol issues for youth, you need to address justice, education, family support, you know, the social determinants of health, so ultimately once you start down this track it's a relatively more natural step to start going down those broad agendas.* (Participant 16, outside government)

Ambiguous policy format

Interestingly, while there was a level of agreement about the framing of a social determinants agenda across all levels of decision making, policy actors raised concern about the intended use of the

document. Part of the brief given to the co-leads and the advisory group was to develop a framework to guide future development of child and youth health policy in WA. This quote illustrates this point:

> *Well, it was not a policy as such, it was a framework. It was a descriptor of what is and what perhaps directions should be. A policy is something which is normally used to point to a direction but also is agreed by organizations for allocation of resources to take action and the framework was not that… the framework was created because there was a need to articulate some key elements of the nature of the services in WA and it described what was but also gave strategies and indicators of what we should basically be bringing together, it was a set of directions and themes.* (Participant 19, inside government)

With this in mind, several participants expressed concerned that the document was merely rhetorical and would not lead to actual changes in child and youth health, and the following quote demonstrates that some of these concerns were warranted:

> *It [the framework] has not, to my mind, led to very many program changes. I think it has informed people, has informed thinking in child health, but it's been limited in its impact on programs*. (Participant 15, outside government)

Limited resources of the health department

The discussions around the format of the document moved quickly to funding arrangements and the limited resources of the health department. This included a general understanding that the social determinants of health were not priority items for funding allocations in the health department.

> *Look, I think implementation is a huge tension. Ultimately once you start diving into this area around social determinants you get well beyond what is, I suppose, governable by health.* (Participant 16, outside government)

> *I don't recall any significant criticism about the content, even when we got to the State Health Executive Forum people, they were just concerned about whether we should endorse the policy when by that stage they didn't have a lot of money.* (Participant 15, outside government)

Divergent views and compromise

Therefore, while the internal framing of the issue was cohesive, there were barriers associated with the external framing of the issue. While some policy actors accepted the development of a 'framework' as a step in the right direction towards getting social determinants onto the WA health policy agenda, others perceived this as a strategy by government to acknowledge the evidence on the social determinants of health while taking limited or no action. The next quote summarises how some policy actors perceived the framing and function of the document.

> *For them [the WA Health Department] it's a much easier thing to talk social determinants than change them and drive them.* (Participant 16, outside government)

4.5.4.3 Political context

Influence of federal agenda

With a stable Labor government in WA and an incoming Labor government at a federal level most participants felt the time was right to challenge the political mood to look at new policy solutions.

> *It was a Labor government. The Health Minister was quite a strong minister, Jim McGinty, who has broad interests in investments in the community…he clearly wanted to stop children from falling through the cracks, so that was really very important.* (Participant 18, outside government)

Medical profession interacted with politicians to gain priority for a social determinants approach

Alongside a positive political mood at the time the policy was being developed, participants credited the positive interaction between the medical profession and politicians as a factor that set the agenda for a social determinants approach to be considered as part of this policy.

> *…I think this network was probably a little more forward thinking in realising that to influence children's health and outcomes we needed a broader population health approach…I also think it went down a line quite early because of the leadership of the two paediatricians who were able to interact with politicians at a higher level than most of us could…* (Participant 17, inside government)

The co-leads in this case study held many of the qualities of Kingdon's policy entrepreneurs, specifically in the way they had a voice that was heard in appropriate circles (Kingdon 2011).

Paediatrics provides training for SDH understanding

The unique part about this case study was the way the co-leads used their voice and professional power to push back against the clinical agenda within which they worked. In the quotes below, they demonstrate their perspective on this situation and show how they perceived the work of paediatricians to be attuned to the social determinants of health approach, especially when compared with those working in acute clinical areas.

> *Look, the social determinants of health wasn't something that was completely alien to medical training back in the '80s. I think there was some acknowledgement of it, depending on the specialty and things that you were coming through. I've gone well beyond a sort of highly clinical focus in my field. It's very easy as a consultant specialist to have a very narrow focus so you can become an expert in a very narrow area and be very good at it, and we need people like that. But there's no question doing paediatrics it's something that is part of fairly much of your routine, day to day care*. (Participant 16, outside government)

> *I see the social determinants of health as a core part of my training forty years ago. I think it has always been part of my view of child health. Look, it's held to various degrees I think by all paediatricians. Some people say 'we can't change that so we're not going to spend a lot of time and resources trying to' but I think you'll find most paediatricians are very, very aware that child health is influenced by lots of different factors which are not strictly medical factors. As paediatricians we try to bring in all of the social influences into our work.* (Participant 15, outside government)

Research suggests that the medical profession has influence over the health policy agenda (Lewis 2006) and this case provides an example of two paediatricians who exerted their power to influence the health policy agenda, specifically to ensure a social determinants approach was considered. However, while they had significant influence during the agenda setting and policy development phases it is less clear as to whether they were able to influence the resources allocated to support the 'policy' document they developed. A summary of political and policy events related to this case is shown in Table 16.

Table 16: WA political context timeline

2001
Labor defeated Liberal party in WA election
2003–2008
Health Minister – Jim McGinty
2004
The Reid report (released) – the health reform committee
2005
State election – Labor re-elected in WA
2007
Federal election – Labor defeated Liberal (after 12 years in office)
2008
WA Our Children Our Future – A strategic framework for child and youth health services in Western Australia 2008–2012 (released)
2009
COAG – Investing in the Early Years – A National Early Childhood Development Strategy (released)
2010
Federal election - Labor re-elected

4.5.4.4 Issue characteristics

Demographic group 'children' prepares agenda for an SDH approach

As in the other case studies, the demographic group 'children' seemed to prepare the agenda for a social determinant approach being adopted. As one of the co-leads put it... *'(for children) things lead very quickly to a broad consideration of the social determinants of health'.* (Participant 15, outside government)

Interestingly, although young people were named in the title of this policy, other than the recommendation in the Reid report (Reid et al. 2004), there was little mention across the interviews of statistics on youth health that inspired action. As seen in study 2 of this thesis, the integration of youth health into either a childhood agenda or an adult agenda and not seeing this demographic group as needing specific attention is common in the Australian health policy environment.

Commonwealth agenda links

Most participants interviewed for this case study agreed that the early childhood agenda of the Australian federal government was a factor that influenced the agenda setting and policy development stages in WA.

> *This was occurring at the same time that there was the National Early Years Strategy which was being led by the Commonwealth government so there was an opportunity here to show how the work that was occurring in WA articulated with the directions being set through the Council of Australian Government (COAG).* (Participant 19, inside government)

Credible academic influences understanding of SDH and health equity in WA

Across all interviews, policy actors described a named academic and their institution as being largely responsible for the dissemination of research on the social determinants of child and youth health and health inequities over the past 20 years in Western Australia.

> *In Perth I guess there is this emphasis on population health and social determinants and a lot of that has been generated by Fiona Stanley and the Telethon Kids Institute.* (Participant 17, inside government)

The perspective conveyed by participants was that there was general understanding of the evidence in WA but the politics of the health department blocked policy action in this area.

Lack of measurable indicators – cut at approval

As mentioned above, the policy under examination (*Our Children, Our Future: A Framework for Child and Youth Health*) included objectives and strategies that were to guide future policy efforts. However, there were no indicators to measure possible outcomes. While this is not surprising when writing a document that has no funding attached to it, several policy actors provided insight into this part of the policy formulation process. They suggested that there had originally been measurable indicators included in the policy, but these were removed at the final approval stage. This suggests that a barrier

to applying a SDH approach in child health policy can come late in the policy development process. The following quote emphasises this point:

> *There was one section; it just hit me, the indicators. So, we had some key indicators about – in fact there was a whole chapter on the indicators and outcomes that you would hope to achieve from this and they [were] cut out.* (Participant 17, inside government)

This finding highlights the resistance within the WA health department to commit the amount of resources needed to take action on the suggested strategies in the policy. It may also indicate an initial intention to implement the policy but a change of heart at the end of the policy development process. As suggested by another policy actor *'I'm not sure why they cut this section out but I think it would have been mainly political'* (Participant 17, inside government) or as another policy actor put it *'I think they probably just ran out of money'* (Participant 18, outside government). These factors indicate a flaw in this campaign, as described by Shiffman and Smith (2007), where complex health issues such as the social determinants of health are less likely to attract government resources.

4.5.4.5 Discussion

This case study provided insight into the development of a policy which involved credible leadership from the medical profession and a united policy community, both with a strong commitment to applying a SDH agenda in Australian child health policy. The co-leads were clearly policy entrepreneurs, but as concluded in study 1 in this chapter, this case provided a variation to Kingdon's (2011) classic description of this role. For example, these policy entrepreneurs were not operating from within a traditional political or bureaucratic role but had been bought into government from a clinical environment. Furthermore, they were most influential during the agenda setting phase and played a more supportive role later, allowing others more experienced in the policy development process to take the lead on writing the policy. While they were prepared to use their position (and power) to advocate for a social determinants approach they were not immune from government actions that acknowledged but did not act on the social determinants of health at the end of the policy development process.

In this case, the Australian federal government's early childhood agenda softened up the agenda for a social determinants approach and was a particularly important part of the explanation for gaining the support of the medical profession. The co-leads were clear that a social determinants of health

approach is part of a ‘deep core belief’ for paediatricians and they were keen to see those beliefs reflected in the policy (Sabatier 1988). Social justice, health inequities across the social gradient, and early intervention for children and families were clear motivators to bring about change. Kingdon (2011) suggests that policy entrepreneurs have a voice with high level decision makers and the co-leads confirmed this when there was no opposition to suggested changes so the ‘policy’ incorporated a broader approach to child health.

However, the policy process was relatively new to them, and while they were the link to trust from high level decision makers, they were also willing to trust those that had experience working within the policy development process and saw particular benefit in having members with public health training on the advisory group. This suggests that even when members of the medical profession are willing to act as ‘champions’ for the social determinants of health agenda (Shiffman and Smith 2007), they may not know how to operationalise this approach. Therefore, public health advocates who work in government and understand the policy development process and government structures have the potential to guide the medical profession, and if qualified, may be trusted to do so. Advocates should consider building links between these professions because this may tip the balance of power and potentially advance a social determinants agenda in Australian health departments.

This finding is significant in relation to the public health literature because it contradicts the commonly held view that the medical profession is unlikely to promote a social determinants of health approach ahead of a clinical approach (Lewis 2005, Baum 2016). On the contrary, the findings from this case suggest that in specific circumstances the medical profession is prepared to advocate for a SDH approach and wield their power within the health system to do so. Therefore, the inclusion of the medical profession in policy making activities is seen as a positive in this case study.

Therefore, this case study provides an impetus for future research to explore a more nuanced understanding of why the medical profession is not generally perceived in the literature as supportive of a SDH agenda when lobbying governments for health resources (Baum 2016). This discussion is similar to the debate about the term ‘political will’, which is often stated in the public health literature as the reason why the social determinants of health do not reach the health policy agenda, and in this research I am attempting to unpack this debate by adopting a political science perspective. A similar unpacking of the social determinants versus biomedical debate may lead advocates to identify more

strategic solutions as they seek bring about change. Others have begun to question the suggestion that the social determinants of health concept is not understood in government and other professional circles. For example, a recent study concluded that evidence on the social determinants is largely accepted but the way policy actors put it forth as a problem is not nuanced enough to fit into various structures within government (Carey and Crammond 2015). This notion aligns with theories on argumentation which suggest advocates need to be able to create a narrative that speaks to the specific audience they are trying to convince (Lewis 2005, Kingdon 2011). Therefore, a recommendation drawn from this case study is for public health professionals to conduct further research into how to communicate the social determinants of health in a way that speaks to the medical professional, because this group of professionals may hold the balance of power to gain political support for this agenda.

The definition of a 'policy' was a clear theme in this case study. As stated in section 1.2 of this thesis, I define child health policy as published, strategic level, health sector policy that describes the actions government intends to take to improve child and youth health at a population level and which shows a commitment to implementing the recommended activities. Therefore, in this case, the government facilitated the writing of a document that included all the elements of 'a policy' but which was named a 'framework'. The word 'framework' was used to describe the intention of government without full commitment or the allocation of appropriate resources. This raises questions about why a government would invest large amounts of human resources, time and energy in this type of document. It was clear that policy actors felt a sense of achievement in having advanced the social determinants agenda with this document, but there was a perception that they would not have achieved this in a traditional 'policy' that had funding attached to implementation. Therefore, the commitment can be seen as the social determinants being acknowledged in this document but not audited, resulting in limited change (Carter et al. 2009). In future advocacy efforts policy actors should be wary of the terminology used to describe a policy document, because it may provide some insight into the likelihood of a social determinants agenda being actioned and funded through to implementation.

4.5.4.6 Conclusions

This case study showed strength in the areas of policy community cohesion and leadership but was weaker in the areas of guiding institutions and civil society mobilisation. The co-leads for this policy

demonstrated a sophisticated understanding of health equity and a strong commitment to a social determinants approach in policy. Their influence with high level decision makers and their ability to co-ordinate and form trust within the health department was a facilitator for change. In addition, the internal framing and ideas about the social determinants of health and health equity were well established, especially access to health services as a determinant of health. However, the ambiguous definition of a 'policy' presented a potential barrier to action on the social determinants of health. Thus, there was divergence in opinion as to whether the title 'framework' was a smokescreen allowing the government to acknowledge the evidence on the social determinants of health but take limited action. The political context was perceived as strong in this case because of a stable Labor government and a Health Minister who was looking for new policy solutions. Political priority for a social determinants approach was softened up by the positive interaction between the medical profession and politicians. The presence of a prominent academic and institution in WA and the Australian federal government's early child development agenda were also seen as facilitators for a social determinants of health agenda. There was a wealth of research from the Telethon Kids Institute that emphasised health equity and the social determinants of health, but the policy did not include indicators that would measure progress. The findings suggest that the original intention of the policy community was to include indicators and they were outlined in the first draft but removed in the final stages of the approval process. The data did not indicate 'why' this had happened but there was speculation that it was because of a reluctance from government to commit to action on the social determinants of health, and instead suggest only 'a direction' for future action.

See Table 18 (p. 148) for a summary of the key factors highlighted in this study and the strategies employed by policy actors in Australian health departments to advance a social determinants of health agenda in child health policy.

4.5.5 Case D: Victorian Public Health and Wellbeing Plan (2011)

'The SDH were a factor but in terms of how upstream we went we didn't – we probably didn't go, you know, that far upstream'.

This case study draws on interviews with seven policy actors from inside government in Victoria.

4.5.5.1 Power of actors

A strong, cohesive and qualified policy community

The policy community developing the Victorian *Public Health and Wellbeing Plan* (2011) was comprised of policy actors from across government, academia and not for profit organizations. No policy entrepreneur could be singled out but there was a strong policy community with a high level of public health training and understanding of a social determinants approach. Several strong leaders within government worked strategically to create a team to work in this policy space who were motivated and qualified to drive the social determinants of health agenda forward. The following quote exemplifies this leadership style.

> *I think getting a social determinants approach onto the agenda took some very, very tough policy leadership. I'm going to be really honest. In Victoria we had a few very strong senior policy people in public health and it was a great team to be part of. The team was hand picked and people were brought in from interstate and we had quite a few of us who were very passionate around a very different view for policy in this state and we stewarded that and it made very good sense.* (Participant 21, inside government)

Qualified policy actors in government who understood how to market SDH to politicians

Several policy actors expressed the view that the advocacy campaign for a social determinants approach was strengthened by the cohesive nature of the policy community that understood the best way to market SDH to high-level decision makers because, they suggested, they knew how the policy process worked.

> *So, building a policy narrative is really important. Not a narrative that beats people over the head. Not a narrative that actually just, you know 'go determinants; go determinants'. No, a narrative that shows how it can be done differently, that is compelling and that ticks all the boxes for everyone, whether you're dealing with Treasury and economists to whether you're dealing with the secretary of the Department of Health to whether you're dealing with the Cabinet ministers, you have to have a robust policy narrative so when you're asked by anyone – and I've been asked millions of times – 'what about people that most need this?' 'Well people that most need this are well served'. This is the best*

bang for a health dollar one can get, I believe, from an equity point of view. (Participant 21, inside government)

Efforts were supported by legislative requirement for public health

In Victoria, the efforts of the policy community were supported by a long-term political commitment with a legislative requirement to address the social determinants of health. This document is called the *Public Health Act 2008*. The details and role of the *Public Health Act 2008* in relation to this case will be discussed below, under factor 3 – political contexts.

Political leaders

Throughout the development of the *Victorian Health and Wellbeing Plan* (2011) the Health Minister, David Davis, was seen as a 'champion' for prevention, as shown by participants in their perception of his commitment in this policy area:

This policy agenda has been strongly supported by the Minister for Health who is a very powerful champion of prevention and public health and that's been quite extraordinary political leadership, unprecedented in my experience. (Participant 24, inside government)

In addition, MP Martin Dixon was also considered supportive by participants, and his experience with health promoting schools was seen as particularly beneficial for the chapter on early childhood and education settings.

Then I think the other thing which helped us in the children's space was there was a parliamentary enquiry into health promoting schools which had been tabled in parliament in September 2010 and gained a lot of support and MP Martin Dixon, who is now the Minister for Education, was part of that, so the political landscape to support health promotion was quite good. So, not only did we have a Health Minister wanting to champion for prevention, but the Minister for Education also had a history in being involved in looking at health promoting schools and early childhood settings and knew the evidence and the possibility that this might help. (Participant 22, inside government)

Health and education – collaboration and commitment

During the development of the *Victorian Public Health and Wellbeing Plan* (2011) there was cross-sector interaction between health and education, and this partnership was viewed as 'critical' to the success of the early childhood and education settings chapter. Policy actors believed that the Health Department took this partnership seriously, because it funded one of its staff to work half time in Education. A senior policy actor describes how this occurred and the perceived value of investing in cross departmental relationships.

> *This move is one of the best decisions we [health] have ever made because we now have someone over there [in education] that can initiate change in that system, as well as our system… so in terms of forging ahead big policy change around the social determinants of health…we now have a resource in both departments… and it's been a very fruitful collaboration which means we have arrived at a point that I don't think the two departments in Victoria have ever been at before*. (Participant 23, inside government)

In particular, the collaboration across sectors was seen as essential to translating the 'policy lingo' between departments and it was a real positive for the drive to include a SDH agenda in the *Victorian Public Health and Wellbeing Plan* (2011). The quote below highlights how a policy actor working in health found this partnership valuable:

> *So, for me it has been so worthwhile because having a person who can operate across both sectors and translate things for me so I understand it in health terms, that's been really, really valuable.* (Participant 22, inside government)

Lack of commitment to community consultation

A weakness in this case was a lack of community consultation. Instead, the case relied on actor power that included dependence on the expertise of the public servants and the ability of a cohesive policy community to market the SDH within government and gain support from a range of politicians. The power of actors and the different levels of influence in Victoria are shown in Figure 5.

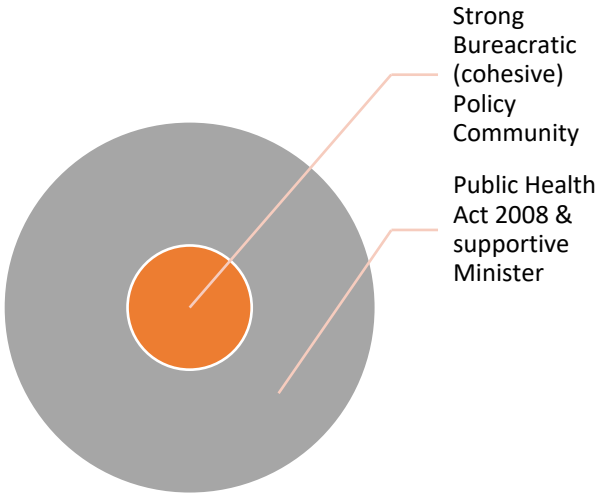

Figure 5: Power of actors – different levels of influence in Victoria

4.5.5.2 Power of ideas

Framing changed throughout the policy development process

This case provides an example of how the policy process is messy and complex and that there are often several competing agendas at play. Specifically, this case demonstrates how policy actors interacted with a range of competing agendas to reach a solution that resonated with government. To do this they adopted a range of strategies to drive their preferred policy solution, but at times these efforts were constrained by the policy environment within which they worked. Therefore, compromises were made, with the outcomes being less effective than originally planned.

In this case, the SDH approach was initially framed within a Healthy Cities framework (WHO 1995) in which a social determinants approach is embedded. As mentioned above, political attention for this policy solution was considered to have been achieved in Victoria because of the re-issuing of the *Public Health and Wellbeing Act 2008* which for the first time included the SDH. However, part way through the policy development process it became evident that Australian federal government funds from the National Partnership Agreement on Preventative Health (NPAPH) would be used to implement the policy. This changed the focus in Victoria at the time because the NPAPH was designed to tackle rising rates of chronic disease in Australia and came with an agenda that focused on individualised behavioural change. The policy actors knew that the initial framing of the Healthy Cities approach would now not pass the policy approval process. In this way, they became aware (from a political perspective) that they needed to frame the issue, and the solution, in a way that would 'resonate' with government

(Shiffman and Smith 2007). This led to discussion about how policy actors would have to adapt the framing of a social determinants approach to fit in with an individualised view of health.

> *…it [the policy] very much reflects an individual responsibility sort of orientation as opposed to a social determinants approach. I guess when you are making policy in this environment the challenge is to find the right balance between the conservative individual responsibility lifestyle sort of world view by linking it to economic growth and choices, or a more collective left response which puts the social before the economic…for this policy, to fit the ideology, there was a real need to be able to articulate the importance of environmental conditions to helping individual people achieve their individualistic goals, while still trying to couch it in some sort of environmental framework.* (Participant 26, inside government)

Therefore, although there were significant legislative strategies in place to legitimise a social determinants agenda in Victoria, a competing agenda of individualised behavioural change designed to tackle chronic disease was coming from the federal government (COAG 2008). This funding created mixed feeling amongst policy actors:

> *...it corresponded with a rather large injection of funding into all the states through the National Partnership Agreement on Preventive Health that was led by the federal government and it disbursed funding to all the states and territories to address the risk factors for chronic disease…so this was happening at the time that the State Public Health and Wellbeing Plan...so although we had to change our approach a bit on the settings stuff for the first time in prevention there was quite a bit of finance that became available.* (Participant 24, inside government)

Therefore, they adapted the language to focus on individual, rather than collective, responsibility by focusing on supportive environments with core strategies designed to support individuals to change their behaviour. Policy actors believed this narrowed the original intention of the original framing of the SDH in the Healthy Cities approach:

> *I mean that was a real stretch to get the original Healthy Cities language into early negotiations around the NPAPH funding…but, I suppose, for us when we were looking at*

> *how to fit this in with the available prevention and health promotion money…we just chose to take a very strong approach on supportive environments for health, which kind of morphed into looking at healthy schools and healthy early child services to fit in with the funding model. In that sense I would say that we did very much think about the broader social determinants of health, they were a factor, but in terms of how upstream we went we probably didn't go, you know, that far upstream.* (Participant 22, inside government)

Many of the policy actors interviewed in this case study expressed disappointment about the dilution of the SDH in the *Victorian Public Health and Wellbeing Plan* (2011) but understood the complexities of the political agenda in health, especially the need for politicians to gain attention.

> *...the style of healthy settings that we ended up with I suppose was good for maintaining ongoing political support through media events and opportunities...Like everyone loves a photo of a politician playing with healthy kids playing in a park or school or something…* (Participant 23, inside government)

With competing agendas at the forefront of this case study, policy actors expressed both success and failure in making progress toward getting the social determinants onto the health policy agenda. While the internal frame was cohesive, the external frame (funding) disrupted this cohesion and policy actors felt the need to adapt to fit within the scope of the health policy environment wherein they were working.

4.5.5.3 Political context

Re-issue of the Victorian Public Health Act 2008 opens window of opportunity for a social determinants approach

Prior to the development of the policy there was a clear window of opportunity that opened to advance a social determinants approach. The 1958 *Victorian Public Health and Wellbeing Act* was re-issued in 2008. According to participants, *'The Act now reflected modern legislation that included a really good social model of health for Victoria...there is now seriousness credibility for public health'.* There was also a legislative requirement within the *Victorian Public Health and Wellbeing Act* (2008) that the state government had to write a *Public Health and Wellbeing Plan* and update it every four years. If a new government was elected during this time, the Health Minister had to ensure the policy was updated

within 12 months. The *Victorian Public Health and Wellbeing Plan 2011*, the focus of this case study, was the first iteration of this policy.

A compromising agenda – with funding attached

At around the same time as the *Victorian Public Health and Wellbeing Plan* (2011) was being developed, there was a change of federal government from Liberal to Labor. The newly elected government established the NPAPH through COAG and made a commitment of $872 million in funding over six years to the states and territories. This document was signed by the Honourable John Brumby (Labor Premier of Victoria) in December 2008 and it provided direction and funds for states and territories to make *'efforts in preventing the lifestyle risks that cause chronic disease'* (COAG 2008). However, as discussed above, while the window of opportunity was open for a SDH agenda in Victoria through the re-issued *Victorian and Public Health and Wellbeing Act (2008)*, the NPAPH agenda limited the degree to which policy actors could develop strategies that took action on the broader determinants of health.

Change of government and ideology

Towards the end of the policy development process, twelve months before the release of the 2011 *Victorian Public Health and Wellbeing Plan*, there was an unexpected change in government in Victoria.

> *Yeah so there had been a Labor government up until November 2010 and then a Liberal government was elected somewhat unexpectedly and so when the plan was released in September 2011 it was a Liberal government which was in its early stages of government.* (Participant 25, inside government)

Policy actors involved in the approval process for the *Public Health and Wellbeing Plan* (2011) experienced some hurdles during the change of government, and they attributed some of these issues to the change in political ideology:

> *Also, there was a change of government and there were a lot of hurdles in the way of the initial draft. The earlier version, which was developed during the final days of the then Labor state government, had much more of a focus on determinants than what ended up being produced because we changed ideologies and went more towards, you know, the*

conservative individual responsibility lifestyle sort of world view. (Participant 27, inside government)

This exemplifies Shiffman and Smith's (2007) argument. The political conditions were initially favourable for a social determinants of health approach but as the policy development process progressed the agenda was constrained, resulting in a narrow view of 'prevention'. While this reduced opportunities to take action on the broader social determinants of health in this iteration of the *Public Health and Wellbeing Plan* (2011), policy actors were well supported by legislation in Victoria to continue advocating for improved policy action on the social determinants of health in the future. A summary of political and policy events related to this case is shown in Table 17.

Table 17: Victoria political context timeline

1958
Health Act 1958 (Victoria)
1999
Labor government defeated Liberal government
2008
Public Health and Wellbeing Act 2008 (Victoria) completed
2009
National Preventative Partnership Agreement on Preventative Health – between the Commonwealth and states/territories
2010
Public Health and Wellbeing Act 2008 (Victoria) took effect
2011
Victorian Public Health and Wellbeing Plan - launched

4.5.5.4 Issue characteristics

Risk factors associated with chronic disease – complex agendas

The issue that gained political attention and funding in this case was the rising level of chronic disease in Australia. The statistics (at the time) showed that one-third of the Australian population was living with at least one chronic disease and 9 in 10 deaths had chronic disease as an underlying cause (Baker et al. 2017). Furthermore, 15 per cent of children and youth (aged 0–24 years) were living with a chronic disease (AIHW 2012). The economic cost to the health system was a concern for the Australian

government (AIHW 2012). The data suggested that the risk factors associated with chronic diseases that were often targeted in Australian health policy were poor nutrition and a lack of physical activity, and the policy solutions suggested were often lifestyle related. This was clearly the case in the *Victorian Public Health and Wellbeing Plan* (2011). The quote below demonstrates the dominance of a lifestyle approach and the compromises that were made to accommodate the Australian federal government's agenda.

> *That was a very complex pathway and really quite messy, but that's the business of policy. I think that we saw the first iteration of the Victoria Public Health and Wellbeing Plan (2011) as a really good opportunity to address the broader determinants. But, then we had this national partnership agreement of preventive health funding coming into the state. In the early days we tried to challenge the lifestyle agenda that came with it…we did fight quite hard for some flexibility around the national partnership agreement indicators that were focused on lifestyle modification, we tried to open up the agenda and say let's look at this much more broadly, we fed that back to the Commonwealth…you know, and said 'health is determined in so many ways'. But, in the end, how do you leverage very, very strong parameters of health funding around chronic disease into something that would be a little bit more revolutionary?* (Participant 21, inside government)

4.5.5.5 Discussion

This case study demonstrates that although there were significant strategies in place to facilitate the adoption of a social determinants approach in this state level policy, the competing agenda of individualised behavioural change at a federal level received political priority. The case study highlights the contradictory and complex nature of formulating policy that focuses on prevention within the Australia health policy environment and the influence of Australian federalism. The *Victorian Public Health Act* (2008) clearly facilitated a culture of change, placing 'prevention' and 'the social determinants of health' on the Victorian policy agenda. However, when developing the resulting policy to implement this change, policy actors' advocacy efforts were hindered by a range of political factors that limited the social determinants of health agenda. This can be attributed to the two different definitions of 'prevention' in Victoria, the social determinants of health approach at a state level and

the individual behavioural approach at a federal level. While it is not surprising that the federal agenda with funding attached became dominant, the strategies employed at a state level to counteract this agenda are worthy of consideration.

The strategic move in Victoria to build a team drawn from across Australia with high level experience and qualifications in public health, specifically the social determinants of health, was clearly a facilitator for change. Policy actors were well equipped to advocate for a social determinants approach, and translate the evidence for other departments. The decision to adopt a 'healthy settings approach' was used to set up a policy environment that focused on people's daily living conditions, consistent with a social determinants approach (Baum 2016). Policy actors argued that this framework enabled advocates to retain some core social determinants principles even when working within an individualist behavioural paradigm. This led to discussions about the need to adapt the language used to apply a social determinants of health approach when working within this jurisdiction. The political science theories used in this thesis describe 'ideas' and 'framing' as important factors for gaining political priority for specific health policy agendas (Sabatier 1988, Kingdon 2011). Lewis (2005) and Kingdon (2011) specifically identify argumentation or storytelling as a way to move an issue onto the agenda. In this case study, there was a perception that using language directly associated with a social determinants approach would hinder advocacy efforts. However, there was a sense that if the policy community could translate some core concepts into a more individualist approach then they would be successful in applying elements of a SDH approach. It should be noted that this approach appeared to be intuitive to some people and counterintuitive to others because while some policy actors felt disillusioned, others accepted the challenge as part of the work of a policy actor working within government. Cairney (2007) suggests that a similar narrative was present in the development of tobacco policy in the UK in the 1970's, where, although the evidence on the harms of smoking was gaining broad support, an economic argument and emphasis on individual choice remained dominant. Kingdon's theory (2011) on policy entrepreneurs and Lewis's theory on argumentation do little to illuminate the subtleties of this style of advocacy. Therefore, this is an area worthy of further study, and may improve collective efforts in applying a SDH approach in Australian health departments in the future, especially when the dominant focus is on individualised behavioural change.

4.5.5.6 Conclusions

This case study presents a long-term vision to increase attention given to preventative health in Victoria to match the acute care system, with the aim of a social determinants of health approach becoming commonplace across departments in Victoria. Actor power was strong, with a cohesive and knowledgeable policy community that was prepared and qualified to negotiate policy change. The policy community had the support of the Ministers for Health and Education, who were known to understand and support 'prevention' across the state. There was limited community consultation, and this weakened advocacy efforts especially at the end of the policy development process. The internal frame in this case was initially quite broad, and based on a Healthy Cities model, but external factors limited this agenda. While the federal agenda to improve prevention efforts was welcome, especially with its attached funds, the accompanying agenda also placed constraints on addressing the broad determinants of health. Rather, the policy community had to change its language on health settings to fit into an individualised behavioural approach that included a narrow view of the evidence about the Healthy Cities approach. A window of opportunity opened when the *Victorian Public Health and Wellbeing Act* (2008) was enacted, reflecting a more balanced prevention agenda that included a social determinants approach. This legislation secured a policy space for 'prevention' in Victoria and held politicians to account, but a competing 'individualist' agenda from the federal government resulted in a narrow view of healthy settings being adopted, especially with funds for implementation coming from the federal government. In this case, there were credible indicators associated with chronic disease that raised the profile of prevention across the state, and the importance of the issue was revealed by specific statistics on low levels of healthy eating and physical activity. However, with regard to effective interventions, this case highlights an emphasis on lifestyle and behaviour rather than the broader determinants of health that are known to improve health across the social gradient. While policy actors in this case study showed frustration, many were resigned to the culture within Australian health departments that limited the scope for a social determinants of health approach.

See Table 18 (p. 148) for a summary of the key factors highlighted in this study and the strategies employed by policy actors in Australian health departments to advance a social determinants of health agenda in child health policy.

4.6 Summary across cases – ACT, NSW, WA & VIC

In this study, a political science lens was used to explore policy actors' perceptions about the development of Australian child health policy focused on the social determinants of health. The Shiffman and Smith (2007) framework was used to bring together multiple political science theories. In addition, it provided a comprehensive and easy to use format that enabled a systematic unpacking of the political factors that facilitated or constrained change at a policy level.

Guided by Shiffman and Smith (2007), Table 18 provides a comprehensive picture of the data from study 3 across cases, highlighting the key factors identified in this study and the strategies employed by policy actors to advance a social determinants of child health approach in Australian health departments. Although these findings are not generalisable, policy lessons learned from this study may assist in future advocacy efforts in this area. Included in the table is a summary of how Kingdon's multiple streams theory (2011) and Lewis's (2005) theory on ideation relate to the data collected.

Table 18: Key factors and strategies employed by policy actors in Australian health departments to advance a social determinants of health agenda in child health policy

	Case A (ACT)	**Case B** (NSW)	**Case C** (WA)	**Case D** (VIC)
Factor 1 Actor Power				
Policy Community Cohesion including leadership (Shiffman and Smith 2007)	> Core Group of individuals from inside and outside government – Senior policy actor, paediatrician, academic, Children & Young People's Commissioner > Political champions – ACT Chief Minister Katy Gallagher Minister for Children & Young People Joy Burch > Supportive Interdepartmental Committee	> Policy entrepreneur – senior policy actor within government > Director of CAAH > Supportive advisory group	> 2 medical policy entrepreneurs 'champions' for SDH > Supportive advisory group (hand selected by medical entrepreneurs to include SDH advocates) e.g. Professor Fiona Stanley > Supportive Health Minister – Jim McGinty > Health Department staff – Master of Public Health	> Range of policy actors across government, academia, and NGOs > Some leaders within government recruited because of SDH expertise/qualifications > Both the ALP Health Minister and Liberal Health Ministers were seen as supportive with incoming Liberal MP David Davis named as a champion for prevention. Liberal MP Education Minister Martin Dixon was also mentioned for his work on health promoting schools
Guiding Institution (Shiffman and Smith 2007)	> UNICEF – child rights > Children and Young People's Commissioner (and staff)	> Centre for the Advancement of Adolescent Health (CAAH)	> Very limited Although not an official connection, Telethon Kids Institute perceived as an authority on child health in WA	None
Civil Society Mobilisation (Shiffman and Smith 2007)	> Extensive consultation with children/parents/professionals who worked with children	> Extensive consultation with young people/youth sector/government workers/ NGOs/academics etc.	> Very limited – one adult community member on advisory group	None
Factor 2 Ideas				
Internal Frame (How did policy actors frame the problem and solution?) (Shiffman and Smith 2007)	> Child vulnerability > Child rights (UNICEF) > Child Friendly Cities – embedded the SDH and HE	> Youth health equity > Access to youth health services > Policy actors constrained by neoliberal policy measures in NSW Health Department > Community consultation tried to broaden agenda with some success	> Child health equity > Child health cannot be addressed through clinical care alone > SDH are central to the work of paediatricians	>Health equity >Strengthening the prevention system across Victoria > Initially healthy cities approach, then because of neoliberal policy context, reframed to healthy settings that appeared to be more likely to be accepted by government > Funding from NPAPH was attached to policy

				> NPAPH agenda to address risk factors for chronic disease – esp. physical activity and healthy settings including a focus on individual responsibility and behaviour change strategies > In response reframed solution to fit into Whitelaw et al.'s (2001) 'passive model'
External Frame (why did the problem and solution resonated with politicians?) (Shiffman and Smith 2007)	> ALP/Greens political ideology > An emphasis on social aspects of child health > Human Rights Act (2004) > Child friendly cities: - UNICEF evidence based and credible - cross sector action - easy to understand	> Originally ALP policy, but Liberals elected near end of process and policy actors achieved bipartisan support for youth health policy > Previous policy silence, 12-year gap between policies > Medical academia momentum to address youth health	> 'Children' as a demographic prepared agenda for a SDH approach > Long term state Labor government/incoming federal Labor government > Health reform in WA (Reid Report 2004) > Federal Early Childhood Development policy agenda > Medical policy entrepreneurs' power to convince high level decision makers to incorporate SDH, not just clinical	> Risk factors associated with chronic disease – coming from federal government >Due to the re-issuing of the *Public Health and Wellbeing Act* 2008 there was a legislative requirement to write a state Public Health and Wellbeing Plan, with an update every four years.
Ideation (Lewis 2005) ***impermeability incorporation transformation***	> Transformation	> Incorporation	> Incorporation	> Incorporation
Factor 3 Political Contexts				
Policy Windows (incorporates Kingdon's MS theory 2011)	**> Political:** Long term political support including the development of the Canberra Social Plan, which focused on the 'social' and recognized the need for a plan in the ACT for the demographic 'children'. Because of ACT *Human Rights Act* (2004) child rights were at the forefront of policy development in the ACT **> Problem:** Research that highlighted health inequities across the social gradient for children in the ACT, and	**> Political:** Political and institutional support for youth health policy – PE & CAAH successfully advocated to get youth health onto political agenda (even with an upcoming change of government) **> Problem:** Began as health service access for youth moving to a broader definition to include the structural determinants of youth health. **> Policy:** Community consultation – broadened the scope of the health department to include some of the more structural determinants of health	**> Politics:** Supportive Labor politicians, health reform in WA and the influence of the National Early Years Strategy **> Problem:** Child health and health equity, and the need for a broader focus than just clinical **> Policy:** Medical entrepreneurs used power to push a SDH approach, and employed a policy officer with a Master of Public Health to write the policy	**> Political:** Victorian *Public Health and Wellbeing Act* 2008 – the reissuing of this Act stimulated a contemporary, bipartisan, and long-term, approach to public health (and addressing the SDH) in Victoria. This resulted in the directive to develop the VIC PHWB Plan. **> Problem definition:** Health equity and improving prevention across Australia which moved to risk factors associated with chronic disease **> Policy Options:** A passive model of healthy settings accompanied by funding

	framing the problem within a child's rights framework **> Policy:** UNICEF child friendly cities framework - providing a credible and easy to understand framework to underpin a SDH approach (UNICEF).			from NPHPA which had a mandate to focus on individual responsibility and behavioural change strategies
Governance structure (Shiffman and Smith 2007)	> Young government > Small government/population > Whole of government approach > Out-comes based reporting	> CAAH – institution outside government helped divert decisions away from health department > NSW Health Department, siloed	WA Health Department, siloed Neoliberal policy measures – much SDH seen as outside health department responsibility	> Bipartisan support because of legislative requirement to address the SDH – *Public Health and Wellbeing Act* (2008) > Cross departmental commitment – a funded position (0.5) from health to work in education
Factor 4 Issue Characteristics				
Credible indicators (Shiffman and Smith 2007)	> UNICEF *Listen to the Children* Report (2011) > Picture of ACT's Children and Young People > AEDI Report (2009)	> Access report prepared by CAAH – inequities for youth health care services	Credible indicators to measure policy outputs originally included but deleted at the final approval stage	Victorian Population Health Survey, Chief Health Officer's Report, State of Victoria's Children
Severity (Shiffman and Smith 2007)	> High profile child abuse cases	> None – at the time of this study there were no data measuring youth health in Australia	No specific data but Telethon Kids Institute perceived as an authority on child health in WA, and because of this all policy actors reported knowing about the evidence on social determinants of child health and health equity	Risk factors associated with chronic disease (AIHW 2012)
Effective Interventions (Shiffman and Smith 2007)	> Child Friendly Cities – some issues during final stages of approval – did not fit perfectly with government protocol	> Many of the SDH included were not strategies, rather placed in the Appendix	> Ambiguous policy format - A Framework – not a policy – no funding attached – acknowledgement of evidence but limited action	> The definition of prevention was constrained by neoliberal policy environment which predominantly focused on individual responsibility for health, with the SDH being perceived as a second priority for VIC Department of Health

4.7 Chapter summary

In this chapter I have presented four policy case studies that provide a deeper understanding of policy actors' perceptions on the factors that facilitate or constrain the social determinants of health being applied in the Australia child health policy environment. The policies I focused on were the ACT Children's Plan: Vision and building blocks for a child-friendly city (2010–2014); NSW Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures; Our children our future: A framework for Child and Youth Health Services in Western Australia 2008–2012; Victorian Public Health and Wellbeing Plan (2011) (chapter on early childhood). I conducted 27 semi-structured interviews with policy actors inside and outside government who were directly involved in the development of these policies. I used a range of political science theories and frameworks to guide design of the study (Sabatier 1988, Lewis 2005, Shiffman and Smith 2007, Kingdon 2011), with the Shiffman and Smith (2007) framework predominantly used for analysis.

This study adds to limited amount of empirical cross-disciplinary research that has been used to understand how health issues rise and fall from the policy agenda. In the next chapter I discuss the findings from all three studies in this thesis.

CHAPTER 5: OVERALL DISCUSSION

5.1 Introduction

In this thesis I addressed three aims:

Aim 1: To explore and synthesise academic literature that explores the politics of developing health policy, specifically the agenda setting and the policy development processes.

Objective 1: To review systematically and synthesise research that explores this topic across two discipline – public health and political science

Aim 2: To assess the extent to which current Australian child health policy addresses the social determinants of health and health equity

Objective 2: To review systematically a selected set of current Australian child health policies

Aim 3: To explore policy actors' perceptions on the factors that facilitate or constrain the development of Australian child health policies that focus on the social determinants of health

Objective 3: To conduct semi-structured interviews with policy actors involved in the development of Australian child health policy.

To meet these aims, I conducted three studies: a critical interpretive synthesis of the current literature on the topic (study 1), document analysis of 17 Australian child health policies (study 2); and four policy cases studies involving 27 interviews with policy actors directly involved in the development of Australian child health policies that, to varying degrees, addressed the SDH and health equity (study 3).

In this chapter I discuss the findings from all three studies. The chapter is divided into four sections. Firstly, to better understand the circumstances that facilitate or constrain policy action on the social determinants of child health, I further develop the four synthetic constructs from study 1, namely politics, ideology, leadership and credibility. After describing each construct, I discuss my interpretation in relation to the broader literature and illustrate how they can be seen in policy making in Australian health

departments, with examples from studies 2 and 3. Secondly, I identify and discuss four policy development tactics that emerged from the data where policy actors constructed storylines to promote SDH to Australian health departments in different ways. These are extension, selective, adaptive and divergent tactics. Thirdly, I present a policy formulation model that illustrates how the synthetic constructs, policy development tactics and associated storylines operate in the Australian child health policy environment. The chapter concludes with my methodological reflections and discussion of the strengths and weaknesses of this thesis.

5.2 Further development of synthetic constructs: politics, ideology, leadership and credibility

In this section, I further develop the four synthetic constructs from study 1. Each construct is described, my interpretation is related to the broader literature and I illustrate how each one operates in Australian health departments, with examples from studies 2 and 3.

5.2.1 The construct of politics

As identified in study 1, an increasing amount of public health literature suggests that political will acts as a barrier to applying a SDH approach in policy (Bambra et al. 2005, Irwin et al. 2007, Baum et al. 2013, De Leeuw et al. 2014). However, few public health scholars have conducted research from a political science perspective to explore this issue. Therefore, the term 'political will' is often described in a broad manner offering little insight into the agenda setting or policy development processes. By synthesising the literature from the public health and political science literature and adopting a political science perspective, I found that the term ‘political will’ is underpinned by other concepts, including ideology, leadership and credibility. Therefore, the construct of politics is used to describe the overarching collective activity relating to setting the agenda and formulating policy in the Australian child health policy environment. This is illustrated in Figure 6 on page 169 where the construct of politics is shown as the outer layer of the agenda setting and policy formulation model.

The construct of politics relevant to this thesis can be described thus:

The construct of politics within the Australian child health policy environment is a dynamic process that involves a range of policy actors, policy networks and institutions from inside and outside government interacting with the neoliberal political context within which they work. It involves policy actors using evidence, professional experience, knowledge and beliefs to develop tactics where policy actors construct storylines to sell the social determinants of child health to the health department in different

ways. These actions result in collective efforts which are applied throughout the agenda setting and policy development processes in an attempt to legitimise a SDH agenda in Australian health departments.

The political science theories used in this thesis (Sabatier 1988, Lewis 2005, Shiffman and Smith 2007, Kingdon 2011) are synthesised in this description, but my original contribution can be seen in identifying, describing and categorising the range of tactics and associated storylines that were used in the development of current Australian child health policy. These categories (and examples) will be presented and discussed in detail in section 5.3. My other significant contribution was to apply a political science framework to gain a deeper understanding of how the constructs of ideology, leadership and credibility interacted with the construct of politics (as described above) to understand why these tactics and storylines were used by policy actors when trying to apply an agenda that was contrary to the preferred agenda in Australian health departments.

5.2.2 The construct of ideology

The findings from this thesis suggest that the construct of ideology is co-constitutive throughout the entire agenda setting and policy development processes. Specifically, this concept is currently manifested in the neoliberal governance approaches within which Australian child health policies are developed. This is apparent in the findings from study 2, which showed that while most Australian child health policies acknowledged the importance of evidence that suggested a SDH approach was the best way to improve the health of all children, only 10% of strategies addressed the SDH. This may suggest that the economic rational perspective associated with a neoliberal governance style limits the space within Australian health departments to take action on the evidence about the SDH (Battin 2017).

Several scholars have written about how a neoliberal policy context influences the development of health policy in developed countries (Bambra et al. 2005, Germov 2005, Alvaro et al. 2010, Baum et al. 2016, Battin 2017). Throughout the public health and political science literature the term neoliberalism has generally been used to describe political ideology that prioritises economic factors when distributing resources in a capitalist society (Bryant 2009). This debate is particularly relevant to this thesis because, according to Battin (2017), neoliberalism has affected the way in which Australian governments shape the policy landscape on behalf of children and their families.

Bryant et al. (2011) suggest that those advocating for a policy agenda that addresses social issues are

particularly affected when neoliberalism is dominant in health policy because there is a reduced capacity for a focus on the redistribution of resources to reduce health inequities, and the expectation that individual rather than collective responses will improve health. Furthermore, Bambra et al. (2005) claim that a neoliberal style of governance in health suggests that health inequities may be seen as an inevitable part of society, while a social democratic style of governance would see tackling health inequities as part of the responsibility of a 'modern state and a humane society' (p. 188). Benoit et al. (2010) argue that the implications of a neoliberal ideology in Australia are manifested in 'extensive neoliberal health reforms' in the governance of health, designed to 'increase efficiency and effectiveness and at the same time expand public choice in health care governance' (p. 476).

Battin (2017) argues that the rise of a neoliberal policy context in Australia in the 1980s constrained political parties that were traditionally more socially progressive by forcing them to 'depoliticise' any progressive policies in a policy framework couched in a neoliberal economically rational, individualist way. It is argued that this resulted in the ALP not having a clear policy narrative between 2007 and 2013 and therefore not offering an alternative view to the dominant conservative force in Australia, the Liberal–National Party coalition. MacDougall (2009) suggests that, for children, a neoliberal political context has resulted in a two-tier policy environment where, depending on level of income, families can either access public services and/or pay for private services in health, education and childcare. Therefore, as Raphael (2015) explains, 'in Liberal welfare states such as Australia it is less likely for a social determinants of health approach to be adopted because the government favours the unimpeded operation of the capitalist economic system and reifies individual initiatives at the expense of government intervention into the operation of the economic system' (p. 381).

Drawing on the literature and the data from this thesis, I describe the construct of ideology as *a series of political and ideological boundaries which result in underlying assumptions (in which there are similarities and variations in each state and territory in Australia) that constrain or facilitate the possibilities of a social determinants approach being applied in child health policy in Australian health departments.*

This discussion extends Shiffman and Smith's (2007) theory that power is present in the political context (or environment) within which policy actors operate. In particular, drawing on the findings from study 3 of this thesis, I suggest that policy actors engage with the neoliberal style of governance in Australian health departments by developing tactics and storylines to navigate the political and ideological

boundaries within which they operate. Thus, while policy actors have little power to change these boundaries or to change the policy landscape, they construct a storyline to navigate them. In accordance with Shiffman and Smith's (2007) framework, and Kingdon's (2011) multiple streams theory, the data from this thesis suggest that by doing this, a window of opportunity is opened for a SDH agenda to be legitimised in Australian health departments.

The construct of ideology sits on the second layer of the agenda setting and policy formulation model (see Figure 6) indicating that ideology and its underlying assumptions are a key consideration for policy actors when developing tactics and associated storylines to frame the SDH in a way that either fits within the scope of, or pushes the boundaries of the particular policy context within each jurisdiction. The categories and examples of tactics and storylines from this thesis will be discussed further in section 5.3.

5.2.3 The construct of leadership

The findings from this thesis suggest that individuals or groups of policy actors and/or institutions play an integral part in advocating for a social determinants approach throughout the agenda setting and policy development processes. However, leadership, is key to sustaining these collective efforts through a variety of strategies that are evident at different times throughout the entire child health policy development process. In study 3, leaders included a core group of individuals from inside and outside government (ACT); a classic policy entrepreneur (Kingdon 2011) (NSW); two medical policy entrepreneurs (WA); and a policy community within government (VIC). This analysis is consistent with a range of political science theories on policy entrepreneurs, policy networks (coalitions), political champions and guiding institutions (Sabatier and Jenkins-Smith 1999, Shiffman and Smith 2007, Kingdon 2011). However, this construct extends Kingdon's (2011) theory on policy entrepreneurs because findings suggest that there was not a single policy entrepreneur or a policy network that worked in a predictable manner, rather there were leaders from a wide range of levels and professions who worked inside and outside the formal structures of government to advocate for the application of a social determinants approach in child health policy. Furthermore, leaders were influential at different times throughout the policy development process. For example, in the policy case study in WA two medical entrepreneurs were most influential during the agenda setting phase and at the beginning of the policy development process, while later in the process they handed over to other policy actors to drive the policy writing process.

The data suggest that when advocating for a social determinants of health approach a leader is integral to bringing policy networks together to develop tactics and create associated storylines that navigate the neoliberal policy context in Australia. In addition, the construct of leadership is intrinsically linked to credibility, which is discussed next.

5.2.4 The construct of credibility

The findings from study 1 suggest that credibility is an important part of building momentum when seeking to apply a social determinants approach in child health policy, especially as this approach is not currently considered core business in Australian health departments. However, there is a lack of real-world policy examples from the health policy domain to demonstrate how individuals, networks and institutions strategically build credibility to interact with politics and legitimise this agenda throughout the entirety of the agenda setting and policy development processes.

In this thesis, I describe the construct of credibility *as a set of ideals and skills that policy actors build up throughout their career; the respect and cohesion of a policy network (either at a formal or reputational level); and a set of values and principles that institutions build up over a number of years (and are known for widely). These attributes can be drawn on to elevate an agenda to a level where it is seriously considered by the relevant health department. In this way, credibility can be described as the systematic actions taken by policy actors to gain legitimacy for their preferred solution to improve child health.*

When related to policy formulation, legitimacy refers to the decisions that lead to the outputs of policies (Heink et al. 2015). Specifically, legitimacy is used by a government to decide whether it can justify these outputs within the specific set of political and ideology boundaries it operates under, and whether they will receive public support (Heink et al. 2015). The data from this thesis suggest that in Australian health departments medical and behavioural strategies have legitimacy within Australian child health policy, but there is limited legitimacy for reducing health inequities by addressing the social determinants of health. Therefore, an essential part of progressing a SDH agenda is building credibility, especially when the political and ideological boundaries are contrary to this agenda.

In the case studies discussed in Chapter 4, credibility was built through individual (policy entrepreneurs) and collective efforts (policy networks and guiding institutions) to market a SDH agenda to colleagues inside and outside of government, politicians and the community. To do this, policy actors developed a

range of policy development tactics and constructed storylines to promote the SDH in different ways. For many of those interviewed, building credibility for a SDH agenda had become part of their professional identity. They built their credibility through professional careers that had a focus on children's health and wellbeing through their advanced knowledge of the topic (evidence), their advanced communication, organization and networking skills, and their ability to work cohesively with a range of policy actors from different professions.

In NSW, a policy entrepreneur who had been working in government for many years had built credibility for a SDH agenda within government through a number of different departments and was able to influence high-level decision makers to establish an independent institution outside of but funded by government to campaign for youth health. In turn, this raised the profile of youth health in NSW and resulted in a range of research outputs supporting a SDH agenda in policy for this demographic group. The credibility of the policy entrepreneur and the values and principles associated with the institution meant that, together, they were able to influence the development of a new health policy for youth. As part of this process, the institution built further legitimacy for a SDH approach within the health department by conducting a comprehensive community consultation with young people and the youth sector. Together they were also instrumental in engaging academics on the topic which led to building more legitimacy for a SDH agenda for youth in NSW.

Other scholars have suggested that credibility is related to trust, and within the policy environment trust can potentially break down barriers that would otherwise remain impenetrable (Carey and Crammond 2015). In the case studies presented in this study there are several examples related to trust. For example, in the Victorian case study leaders in the health department worked hard to build trust between the health and education departments so that collaboration was possible. Building trust, in this instance, meant that a social determinants of child health approach gained legitimacy within the education department. This is important because evidence suggests that cross-departmental collaboration is an essential part of applying the social determinants of health in child health policy (Irwin et al. 2007, CSDH 2008, Mustard 2008). Another example of trust is the way two policy entrepreneurs in WA used their credibility to build trust by being part of the medical profession. In turn, this association allowed them to gain the trust of high-level decision makers and resulted in the entrepreneurs convincing them to broaden their clinical agenda to consider a SDH approach. Other scholars have found that the medical profession is influential in the Australian health policy environment, with most research in this area

implying that the medical profession predominantly influences the government to increase funding for biomedical services (Lewis 2006, Baum et al. 2013). However, my research differs by suggesting that paediatricians are prepared move away from their clinical mindset and advocate for a SDH agenda. The findings suggest that their influence is instrumental in bringing about change and legitimising a SDH agenda in Australian health departments.

Because the constructs of leadership and credibility are linked, they are placed together on the third layer of Figure 6 (see p. 169).

A summary of the constructs described in this section is given in Table 19.

Table 19: Description of constructs – politics, ideology, leadership and credibility

Theoretical construct	**Description**
Politics	The construct of politics within the Australian child health policy environment is a dynamic process that involves a range of policy actors, policy networks and institutions from inside and outside government interacting with the neoliberal political context with which they work. It involves policy actors using evidence, professional experience, knowledge and beliefs to develop tactics where policy actors construct storylines to frame the social determinants of child health in different ways. These efforts are applied throughout the agenda setting and policy development processes in an attempt to legitimize a SDH agenda in Australian health departments.
Ideology	The construct of ideology is a series of political and ideological boundaries that result in underlying assumptions (of which there are similarities and variations in each state/territory in Australia) that constrain or facilitate the possibilities for a social determinants approach to be applied to child health policy in Australian health departments.
Leadership	Leadership involves an influential individual, group or institution that plays an integral part in advocating for a social determinants approach and sustaining the collective effort through a variety of strategies, which are evident at different times throughout the entire child health policy development process.
Credibility	The construct of credibility as a set of ideals and skills that policy actors build up throughout their career; the respect and cohesion of a policy network (either at a formal or reputational level); a set of values and principles that institutions build up over a number of years (and are known for widely). These attributes can be are drawn on to elevate an idea to a level where it is seriously considered on the Australian child health policy agenda. In this way credibility is the systematic actions taken by policy actors to gain legitimacy for their preferred solution to improve child health.

5.2.5 Summary

In summary the four synthetic constructs, politics, ideology (underlying assumptions), leadership and credibility, provide a solid foundation from which to understand the circumstances that facilitate or constrain policy action on the social determinants of child health in Australia. As illustrated in Figure 6 (p. 169), together these constructs depict how the agenda setting and policy development processes operate in the Australian child health policy environment, and assist in explaining the challenges policy actors face when formulating policy with a focus (SDH) that is contrary to the neoliberal governance style within which they work.

5.3 Policy development tactics and constructed storylines

5.3.1 Introduction

In the following section I identify and discuss four policy development tactics that emerged from the data where policy actors constructed storylines to 'sell' the SDH in different ways. The policy development tactics presented (and the associated storylines) are divided into four categories, extension, selective, adaptive and diversion. This discussion provides insight into real-world policy formulation in Australia, particularly at the state/territory level. These storylines are shown at the centre of Figure 6 (p. 169) indicating that according to the findings these activities are at the core of policy formulation that aims to legitimise a SDH agenda in the Australian child health policy environment.

5.3.2 The extension tactics and storyline category

The underlying assumption of the extension category is that the neoliberal governance style within health departments limits policy options for improving child health predominantly to biomedical strategies. A key policy development tactic is to involve the medical profession (paediatricians) in policy development. This is seen as an effective tactic for navigating a neoliberal governance style because the medical profession is known to have influence in Australian health departments (Lewis 2006, Baum 2013). Therefore, the data suggest that by highlighting their expertise in child health, medical policy entrepreneurs construct a storyline suggesting that because this policy is about children (not adults), a SDH agenda deserves some consideration. Thus, they aim to include the SDH by achieving an extension to a predominantly biomedical policy agenda.

The WA case study in Chapter 4 provides insight into the development of this category. It involved credible leadership from the medical profession and a united policy community, both with a strong

understanding of the need for a SDH approach to child health policy. Medical power was used in an attempt to counteract the dominance of the biomedical agenda that was evident within the WA Health Department. Two medical entrepreneurs used their credibility, including their medical expertise, to argue for child health policy to be exempt from the clinical networks approach being applied as part of health reform in WA. They demonstrated credible leadership when they argued that a social determinants of health approach was core business in their work as paediatricians, therefore it should be core business in the development of policy that aims to address the health of children. However, despite these efforts throughout policy development, it became evident that the final policy, named a framework, was subjected to measures to reduce its scope to conform to the neoliberal governance style of the WA Health Department. Therefore, the intention to implement the policy became unclear, especially the funds allocated to implement strategies.

The issue with the extension category is that it is associated with a neoliberal context that promotes a reduction of health departments' involvement with children unless they are sick or their parents are incapable of looking after them (Carter et al. 2009). As demonstrated with the lack of implementation in the WA case study, a SDH agenda appears to be thought of as a recommendation to extend a biomedical perspective rather than for a SDH agenda to be a core component of Australian health departments' plans to improve child health. While the extension category represents a realistic approach within a neoliberal policy environment, it is unlikely that it will reduce health inequities for children and youth in Australia in the long term (Irwin et al. 2007, Mustard 2008).

5.3.3 The selective tactics and storyline category

The underlying assumption of the selective category is that the neoliberal government favours a biomedical approach but through advocacy efforts policy actors perceive that certain elements of an SDH agenda (e.g. access to health care) are beginning to be legitimised within a health department. Therefore, a key policy development tactic is to break down the evidence on the social determinants of child health into small segments that are perceived most likely to fit within a neoliberal style of governance. A storyline is then constructed to sell a selected version of a SDH agenda to gain some traction (rather than no traction) in the health department. However, the storyline continues to evolve because after gaining initial political priority for a selected element of a SDH agenda, such as access to healthcare, policy actors then use other policy tactics to broaden this perspective later in the policy

development process. The data suggest that this category can be used when a particular demographic group, such as youth, is missing from policy within a particular jurisdiction. Policy actors initially perceive they have limited power to resist the dominance of a biomedical agenda and therefore, they believe their advocacy efforts are best served by selecting segments from a SDH agenda at the beginning of the policy development process then pushing the ideological and political boundaries once they have achieved initial success.

The NSW case study from Chapter 4 provides insight into the selective category. Policy actors perceived there was a mandate within the NSW Health Department to focus on healthcare provision and some aspects of prevention. The data suggest that the message from high level decision makers was that prevention strategies would only be included if the suggested actions could be justified as relating only to the NSW Health Department. This finding may reflect the nature of neoliberal governments in Australia which favour small government, seen in the case study as increasing the Health Department's mandate but reducing resources (Germov 2005). It also ignores evidence that a comprehensive SDH agenda requires health departments not only to lead taking action on the SDH but to co-ordinate suggested actions in other departments (CSDH 2008).

Therefore when there was competition for resources in the health sector a biomedical approach appeared to receive preference within the NSW Health Department, which in turn meant that only a selected version of the SDH (access to healthcare) was included, and the broader determinants of youth health were excluded. In a pragmatic response to this neoliberal policy context both the policy entrepreneur and the guiding institution demonstrated credible leadership qualities by advocating for a youth health policy in NSW and initially constructed a selective storyline that promoted a selected version of the social determinants of health agenda, which included equitable access to healthcare. The data from this study suggest that one reason policy actors chose this approach was because they were cautious about the political context within which they were working given that youth health had not received any policy attention from the NSW Health Department in the previous 12 years. Once youth health was firmly on the policy agenda, one of the tactics used to incorporate a SDH agenda was to consult young people and the broader youth sector on their recommendations for strategies they thought would improve youth health. This tactic was successful because those involved outlined a social determinants of health agenda as the best way to address the health and wellbeing for this demographic

group. This finding is significant and adds to the literature because it highlights how a constructed storyline has the potential to change through the policy process. Therefore, advocates, particularly leaders, may need to stay engaged over the entirety of the agenda setting and policy development processes or otherwise they may miss an opportunity to bring about change.

While this process should have built legitimacy for a social determinants approach to be applied to youth health policy, it did not result in significant change to policy outputs because at the end of the policy process, during the approval phase, strategies related to the broader social determinants of health were again excluded (or placed in an Appendix) because they were considered to be outside the political and ideological boundaries of the NSW Health Department.

The selective model has one important limitation. The elements of a social determinants of health agenda that may be legitimised in a neoliberal policy environment most likely would not include the structural determinants of health that are known to reduce health inequities such as income support, housing and social connectedness that are known to improve health outcomes for all children (CSDH 2008).

5.3.4 The adaptive tactics and storyline category

The underlying assumption of the adaptive category is that the health agenda favoured by the neoliberal governance style in Australian health departments is an individualist behavioural approach. Therefore, the key tactic for taking action on the social determinants of health approach is to identify a core strategy (such as supportive environments) and then construct a storyline that fits an individualist behavioural agenda into this framework. The aim of this tactic is to work within the constraints of a neoliberal policy (individualised) context to strengthen the place of prevention in a health system dominated by a biomedical approach, while at the same time including some foundations of a SDH approach so if the policy context changed in the future it would be easy to add more SDH strategies.

The Victorian case study provides insight into the adaptive category. Initially, a storyline was constructed to sell the social determinants of health within a Healthy Cities framework and this was considered a comprehensive way of ensuring an SDH approach was embedded in all prevention efforts across Victoria. Legitimacy for a prevention agenda that included the SDH should have been achieved in Victoria because of the re-issuing of the *Public Health and Wellbeing Act 2008*, which for the first

time included the SDH. However, part way through the policy development process it became evident that federal government funds would be used to implement the policy through the NPAPH. Therefore, although there were significant legislative strategies in place to legitimise a social determinants agenda in Victoria, a competing agenda of individualised behavioural change designed to tackle chronic disease was coming from the federal government, specifically COAG. This agenda became dominant. Therefore, an experienced team of qualified bureaucrats adapted the already constructed storyline to represent both the social determinants agenda coming from the state government and an individualist behavioural agenda coming from the federal government. To do this, they kept the framework of health settings but adapted the language to focus on individual rather than collective responsibility, suggesting that by creating supportive environments individuals were more likely to change and take responsibility for their own health related behaviour, meaning that governments would need to take less responsibility for child (and family) health.

While the adaptive category provides a storyline that sells a social determinants of health approach, the main strategies in the policy privilege a neoliberal policy context, which 'blames individuals for unsuccessful modifications to their lifestyle' (Alvaro et al. 2010, p. 92). However, in Victoria, there appeared to be two conflicting agendas to address prevention and the constructed storyline was perceived by policy actors to be necessary to navigate the neoliberal policy context within which they were working.

5.3.5 The diversion tactics and storyline category

In the diversion model the underlying assumption is that although a neoliberal ideology is present the policy actors perceive that political boundaries have shifted and therefore may present an opportunity to apply an alternative agenda in child health policy. With the knowledge that a neoliberal governance style has, in the past, limited a social determinants of health approach, when policy actors advocating for a SDH sense this opportunity, a key tactic they use to sell a SDH agenda is to embed it in an agenda that is already legitimised in that jurisdiction, for example the *Human Rights Act*. The construction of the storyline therefore involves diverting attention away from overtly promoting a social determinants of health agenda to focus instead on a credible framework such as UNICEF's Child Friendly Cities initiative which has an embedded SDH agenda.

The ACT case study provides insight into the development of the diversion category. This case demonstrates a jurisdiction where, at the time of policy development, a social approach to policy development was favoured by government. The ACT was the first jurisdiction to have a *Human Rights Act (2004)* so child rights were also high on the government's agenda. Thus, the government was relatively open to addressing the social determinants of health that were known to reduce health equity and improve child health in policy. This was seen in the Canberra Social Plan, from which the directive to develop the ACT Children's Plan originated. The policy actors in this case also perceived the pressures of neoliberal policy measures were less prominent in the ACT because the territory had not been self-governing for long, it had a small government serving a relatively small population, and it was a long-term Labor government supported by the Greens. Data suggest that the Greens were associated with a more progressive policy agenda which allowed them to focus on child rights and the social determinants of health.

Leadership was demonstrated in this case study by a core group of individuals from inside and outside government who, beyond their role in the formal structures of government, adopted a range of tactics to sell a child-friendly city approach incorporating the SDH over several years. These included presenting at interdepartmental forums, collecting evidence on frameworks that would enable the adoption of a SDH approach in policy, and making sure that political champions were aware of the evidence on child rights and the SDH. The data suggest that the interdepartmental committee set up to guide the development of the ACT Children's Plan was seen as merely ticking the boxes and was easily convinced that a child-friendly city approach was the best way forward. Credibility and momentum for this agenda was systematically built through the individual careers of the core group of policy actors, the credibility of UNICEF within the ACT government, the *Human Rights Act 2004* (including the Commissioner and staff), and the community consultation with children, parents and professionals working in this sector, which was fully integrated into the content of the policy.

The four tactics and storylines identified and developed in this section are summarised in Table 20.

Table 20: Four types of tactics and constructed storylines

	Policy development tactics and constructed storylines
Extension	The underlying assumption of the extension category is that the neoliberal governance style within health departments limits policy options for improving child health predominantly to biomedical strategies. A key policy development tactic is to involve the medical profession (paediatricians) in policy development. This is seen as an effective tactic for navigating a neoliberal governance style because the medical profession is known to have influence in Australian health departments Therefore, the data suggest that by highlighting their expertise in child health, medical policy entrepreneurs construct a storyline suggesting that because this policy is about children (not adults), a SDH agenda deserves some consideration.
Selective	The underlying assumption of the selective category is that the neoliberal government favours a biomedical approach but through advocacy efforts policy actors perceive that certain elements of a SDH agenda (e.g. access to health care) are beginning to be legitimised within a health department. Therefore, a key policy development tactic is to break down the evidence on the social determinants of child health into small segments that are perceived most likely to fit within a neoliberal style of governance. A storyline is then constructed to sell a selected version of a SDH agenda to gain some traction (rather than no traction) in the health department. However, the storyline continues to evolve because after gaining initial political priority for a selected element of a SDH agenda, such as access to healthcare, policy actors then use other policy tactics to broaden this perspective later in the policy development process. The data suggest that this category can be used when a particular demographic group, such as youth, is missing from policy within a particular jurisdiction. Policy actors initially perceive they have limited power to resist the dominance of a biomedical agenda and therefore, they believe their advocacy efforts are best served by selecting segments from a SDH agenda at the beginning of the policy development process then pushing the ideological and political boundaries once they have achieved initial success.
Adaptive	The underlying assumption of the adaptive category is that the health agenda favoured by the neoliberal governance style in Australian health departments is an individualist behavioural approach. Therefore, the key tactic for taking action on the social determinants of health approach is to identify a core strategy (such as supportive environments) and then construct a storyline that fits an individualist behavioural agenda into this framework. The aim of this tactic is to work within the constraints of a neoliberal policy (individualised) context to strengthen the place of prevention in a health system dominated by a biomedical approach, while at the same time including some foundations of a SDH approach so if the policy context changed in the future it would be easy to add more SDH strategies.
Diversion	In the diversion model the underlying assumption is that although a neoliberal ideology is present the policy actors perceive that political boundaries have shifted and therefore may present an opportunity

	to apply an alternative agenda in child health policy. With the knowledge that a neoliberal governance style has, in the past, limited a social determinants of health approach, when policy actors advocating for a SDH sense this opportunity, a key tactic they use to sell a SDH agenda is to embed it in an agenda that is already legitimised in that jurisdiction, for example the *Human Rights Act*. The construction of the storyline therefore involves diverting attention away from overtly promoting a social determinants of health agenda to focus instead on a credible framework such as UNICEF's Child Friendly Cities initiative which has an embedded SDH agenda.

5.3.6 Summary

Other studies have reported on policy actors' attempts to present health policy agendas in ways that they perceive governments will most likely act on (Breton et al. 2008, Bowen et al. 2009, Scmidt et al 2010, Carey and Crammond 2015). However, in this thesis, I argue that policy actors go one step further and develop a range of policy development tactics and construct storylines to sell the SDH in different ways. This finding builds on research that suggests that 'proposed actions to improve the social determinants of health needs to be 'broken down' so they can be communicated in ways that 'fit' discretely within government departments…and that solutions need to be conceptualised in ways that do not jar government's sense of its own capacity to enact reform' (Carey and Crammond 2015, p. 138).

Carey and Crammond (2015) asked policy actors to reflect on general advocacy for a SDH approach during policy development in Australia, but in this thesis a more detailed picture is presented. This is because the focus of this study was on current Australian child health policies and policy actors provided insight into the factors that enabled them to legitimise a SDH agenda in a real-world policy making situation, with a specific policy in mind. Furthermore, I was able to identify, describe and categorise four policy development tactics and associated storylines. In the following section I present a Figure to illustrate these findings.

5.4 Policy Formulation Model

The Policy Formulation Model (Figure 6, p. 169) has been developed to illustrate the way in which the constructs identified and developed in this thesis – politics, ideology, leadership and credibility – operate in the Australian child health policy environment. Politics is placed on the outer layer because this construct describes overarching agenda setting and policy development activity. Ideology is placed on

the next layer because underlying assumptions (including a neoliberal governance style) present challenges for policy actors selling an alternative agenda (such as the social determinants of child health) in Australian health departments. Leadership and credibility are placed on the next layer because when marketing a social determinants of health approach a leader is integral to bringing policy networks together to promote the SDH to a health department in different ways, which include being able to develop tactics to navigate the neoliberal governance style in the Australian child health policy context. Furthermore, through these tactics, leaders build credibility to gain legitimacy for a SDH agenda in Australian health departments. At the centre of the model are the four types of policy development tactics and constructed storylines identified in this thesis: extension, selective, adaptive, and diversion. Together these categories indicate that the tactics and associated storylines are core elements of the policy formulation process within the Australian child health policy environment, particularly when advocating for an agenda (such as the SDH) that is contrary to the current neoliberal governance style in Australian health departments.

Overall this model illustrates the complex nature of formulating Australian child health policy that applies a SDH approach. It also shows how cross-disciplinary research between public health and political science is useful for understanding why a SDH agenda has gained limited policy attention in the Australian child health policy environment and how the agenda setting and policy development processes operate to facilitate or constrain policy action in this area.

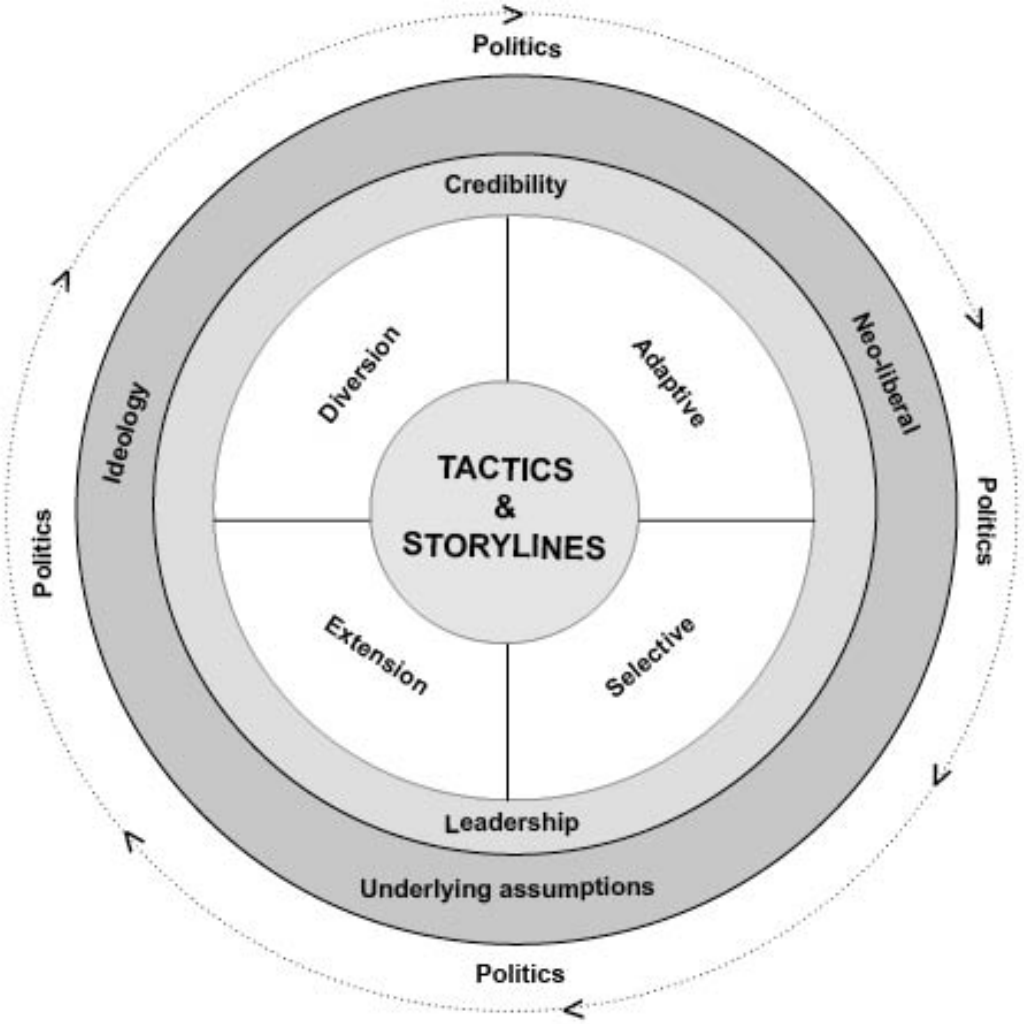

Figure 6: Policy Formulation Model

5.5 Methodological reflections

In this section, I reflect on the methodological successes and challenges I experienced through conducting qualitative research for my PhD candidature. In doing so I indicate that with any research project there are potential successes and failures, with the most important aspect of these lessons being to learn from them (Yin 2014).

Cross-disciplinary research

As identified throughout this thesis, there has been much discussion in public health circles about adopting a political science approach to explore the politics of developing health policy. However, to date there has been limited empirical research that has comprehensively applied political science theories to the real world of health policy making. In this thesis I adopted a political science perspective to design my methods and analyse data. This perspective privileged the voices of policy actors responsible for developing child and youth health policies in Australia that (to varying degrees) addressed the social determinants of health and health equity. While I found the prospect of working across two academic disciplines exciting, with most of my previous education and work experiences being in public health, it was also daunting. To overcome this hurdle I conducted a critical synthesis of the literature (study 1) to ensure that I was able to interpret the literature from both disciplines; I ensured both public health and political science academics were on my supervisory team; and I attended a range of public policy workshops/conferences where I was able to view presentations on this topic and speak to experts. With the guidance of my supervisory team, I believe that my application of political science theories was effective and that this thesis offers an original contribution to a growing cross-disciplinary research area that addresses the politics of developing health policy specifically to address complex health issues and implement solutions such as the SDH. However, there were several limitations associated with this approach including: the different disciplinary emphasis on how the stages of the policy process work ie political scientists list the stages to problematize the idea of a cycle and public health accounts of policy making take the stages far more seriously; and by using a range of political science theories, rather than selecting one, I did not provide a comprehensive account of these theories. It is acknowledge that this approach to combining theories may have been different in a purely political science study.

Interviews with policy actors

In study 3, I conducted 27 policy interviews with policy actors from inside and outside government. Although I believe I planned my research thoroughly, a few areas were less challenging than expected while others posed unexpected challenges. I anticipated it would be difficult for me to recruit policy actors who worked for government and for them to gain permission to participate in the study. To counteract this, my principal supervisor wrote an introductory letter to the Director of the health department in each state/territory selected for the study. Once this was received, the contact persons they nominated for me to work with to recruit participants made every effort to accommodate my research and gave full permission for staff to participate. I attribute this success to the credentials of my supervisors and the associated research centre. Interestingly, because I was a PhD student, I anticipated there might be some power dynamics at play when interviewing high-level decision makers, but the opposite occurred, and the fact that I was a student appeared to put them at ease. For example, many participants currently or previously had been involved in research and seemed particularly keen to be part of this process, which they considered an essential part of improving policy outputs in Australia. However, because many of the policy actors had been advocates for a social determinants approach throughout their careers (sometimes for over 30 years), there were instances when some of them wanted to go off topic and tell me about their specific advocacy or research efforts in general. Patton (2015) suggests that building ‘rapport’ with ‘neutrality’ is important when conducting interviews on topics that participants are passionate about. Therefore, in these instances, I let participants finish what they were saying, showing that I valued what they were sharing with me, and then when appropriate gently bought them back to the schedule of questions (Patton 2015). In most cases I was successful in doing this. However, there were also instances where policy actors adhered to the schedule almost too much, and in these cases I had to use probing questions to encourage them to elaborate. Therefore, similar to Lancaster's (2017) study with policy actors working in the drug policy domain, the participants in my study were not a ‘homogenous group’, and the ‘dynamics between researcher and participant’ did not ‘play out in a predictable or consistent way’ (p. 98). I believe I accommodated these different interview styles during the data collection phase of this thesis.

Finally, as outlined in section 4.3.6, participants were made aware that data collected from interviews would be treated with strict confidence and every attempt would be made to conceal their identities in publications that arose from the research, this could not be wholly guaranteed. However, during the interview process and while writing up each policy case study it became clear that the roles within

government held by certain policy actors were particularly relevant to the case analysis, and that the selected quotes were sometimes directly related. Lancaster (2017) suggests that although policy elites may not be seen as particularly vulnerable, their participation in research about the policy development process is political and has the potential to 'expose them to retaliation from others in the policy sphere, embarrassment, potential job loss, or compromise organizational partnerships, damage relationships and jeopardise delicately balanced politicised policy processes underway' (p. 99). Yin (2014) suggests that the choice not to disclose the identities of participants is not taken lightly and must be followed by a range of strategies to ensure that accuracy of the case is still upheld (p. 197). As described in section 4.3.6, I gave participants the opportunity to review their transcripts, and 14 of the 27 participants took the opportunity to do so, with only two transcripts returned with minor changes. Several participants who did not request to see their transcript responded with comments such as 'I don't think there's anything in there that I wouldn't say again', or 'I'll leave it up to you'. Therefore, I took this responsibility very seriously and chose not to reveal participants' professional roles, instead identifying participants only by sequential numbers and as working inside or outside government. If there was a quote that had the potential to identify a particular policy actor, I did not use it verbatim but instead expressed the participant's views as my interpretation through plain text. In this way, and in accordance with my ethics agreement, I believe I handled the participants' data in good faith, with the care necessary to protect their best interests.

Choice of positive cases

Early in my PhD candidature I decided to select positive policy cases, by interviewing policy actors who were directly involved in the development of policies that did (to varying degrees) address the social determinants of health. Initially I was concerned about this decision because much of the political science literature, especially at a global level, tends to discuss negative cases. In some ways I was concerned I might not collect enough data through positive cases but in retrospect this was a good decision. Instead of a focus on the constraints in this area, this decision also allowed me to explore the circumstances under which a SDH approach can be applied to child health policy in Australia. However, as can be seen by the analysis in studies 2 and 3 there was a limited range of Australian child health policy that presented as good practice (or positive case studies), and although my decision provided

fruitful findings for this thesis it also provided me the opportunity to understand the barriers in this analysis.

5.6 Strengths of this research

One strength of this thesis is that I conducted three complementary studies which significantly add to a growing area of cross-disciplinary research (public health and political science) in Australia by exploring the politics of developing health policies that addresses complex health problems. My research adds to the theoretical and empirical bodies of research in this area.

Another strength is that in this thesis I present the first systematic analyses of Australian child and youth health policies, giving a comprehensive assessment of the current state of Australian child health policy in relation to the social determinants of health and health equity. A major strength of study 1 is that it included all strategic health policies relating to children and young people in the period 2008–13. Furthermore, the methods used in this study could be applied to other policy areas. I have also published an article on this topic.

In my work, I adopted multiple political science theories and frameworks to gain a detailed understanding of the circumstances with which a social determinants approach can be applied in Australia. This research adds to the small amount of empirical research in this area and it is especially relevant because previous research in this area has been criticised for being a theoretical. The Shiffman and Smith (2007) framework was particularly useful for identifying factors that were strong or weak in each case study and for providing a common framework within which to bring together multiple political science theories. In addition, its comprehensive and easy to use format enabled a systematic unpacking of the political factors that constrain or facilitate change at a policy level.

The other political science theories (Sabatier 1988, Lewis 2005, Kingdon 2011) that were used were also useful, and, as described in Chapter 4, were particularly applicable in drawing out specific findings in the four case studies. Kingdon's theories (2011) on policy actors, particularly policy entrepreneurs, were useful in explaining some of the intricacies associated with skills and argumentation needed to influence the policy agenda. However, the findings from study 3 extended Kingdon's (2011) work and confirmed findings from study 1, that the policy entrepreneurial role can emerge from a range of different professions (e.g. medicine) and professional levels and can influence policy processes at several

different times. Furthermore, my findings suggested that there was a hierarchy of policy actors within the policy community who took either a leadership or supportive role at specific points in time throughout the policy development process, and that the timing of their efforts was vital in influencing the degree to which their efforts made a difference. The ideal time for them to act was associated with the power and influence they held within their professional roles. Persistence was essential whether in a leadership or supportive role because collective pressure from the whole policy community was an important facilitator for change. The cases in study 3 therefore extend Sabatier's (1988) Advocacy Coalition Framework on policy networks, suggesting that coalitions are complex but co-ordinated and have a range of layers of influence and a network of policy actors that act collectively to bring about change at a policy level.

Kingdon's multiple streams theory (2011) provided a simple explanation for the way in which the different elements of the policy development process come together to create windows of opportunity to bring about change at a policy level. While useful for this study, the findings from this study reflect the findings of other scholars who concluded that multiple theories are beneficial when dealing with complex health issues and the health policy agenda (Cairney 2013, Carey and Crammond 2015, Baker et al. 2017, Fisher et al. 2018). The addition of Lewis's theory (2005) was beneficial especially because her work provided an Australian perspective on the health system and added to the exploration of framing a social determinants approach through the concepts of surface and deep structure ideation. The three main filters that can be applied to policy to describe different combinations of change at the surface and deep structure levels were particularly important. *Impermeability* refers to situations where 'change does not occur' at either the deep structure or surface level of ideation (Lewis 2005, p. 104), and none of the case studies reflected this category. *Incorporation* refers to change that occurs at the surface level only while deep structure ideation remains unchanged (Lewis 2005, p. 105), and three case studies fell into this category (NSW, WA and VIC), while *transformation* refers to change that occurs at a deep structure level, where there is 'a paradigm shift' and change happens. The ACT case study fell into this category (Lewis 2005, p. 108)

The Advocacy Coalition Framework (Sabatier 1988) was useful for investigating the influence and ideology behind policy networks (as described above), but because of the nature of the selection of cases there were some elements that were less useful. Because I selected positive cases for the

adoption of a social determinants approach and policy actors were selected using purposeful sampling, the concept of competing coalitions that is integral to the Advocacy Coalition Framework was not present.

Interestingly, actor power (Shiffman and Smith 2007) was strong across all cases with exemplary examples of cohesive policy communities, policy entrepreneurship, leadership, and support. Guiding institutions and legislative action to gain sustained support for a social determinants approach was also strong, and a facilitator of change. In contrast, issue characteristics (Shiffman and Smith 2007) gained the least coverage across cases. This suggests that while general research on health equity and the social determinants of health is gaining traction, it needs to be accompanied by research that is specific to the demographic group(s) and location(s) that the policy is being developed for. This requires expenditure from government but as was demonstrated in the first case study, it can have a profound effect on keeping government accountable.

In summary, while all three political science theories were very useful to this study, the Shiffman and Smith (2007) framework proved most effective for bringing these theories together and importantly provided a practical and thorough way to analyse and present data. The findings from this thesis reflect those of other researchers on this issue, who have concluded that multiple theories are beneficial when dealing with complex health issues and the health policy agenda (Cairney 2013, Baker et al. 2018, Baum et al. 2018). The methods used in study three could be applied to other policy areas such as education, social inclusion policy etc.

Specifically, the interviews with policy actors inside and outside government contributed valuable insights into how and why policy actors influence the agenda setting and policy development processes, an area that until recently has been largely neglected in the public health literature. This may be because of the difficultly of gaining access to policy actors who work within government and/or the difficult ethical issues faced by researchers and the researched around anonymity and confidentiality. The methods used in this thesis provide a good protocol for future research in this area and demonstrate that it is possible to tell the story of policy development without compromising participants' employment in government.

A further strength of my work is that by adopting a political science perspective I have been able to unpack the term *political will*, which has often been used in the public health literature to explain why complex health issues do not reach the health policy agenda. Therefore, this research fills a significant gap in the understanding of politics in the public health literature.

Through this thesis I have generated relevant findings in relation to the way politics, ideology, leadership and credibility operate within the Australian health policy environment, particularly the key policy development tactics and constructed storylines generated by experienced policy actors at a bureaucratic and high decision-making level that bring about change. I have incorporated my findings into a policy formulation model that consolidates the theoretical perspectives from this thesis and shows their relevance to the Australian child health policy environment.

Qualitative methods were useful for obtaining in-depth accounts about the child health policies under examination. In addition, while policy actors across cases conveyed different perspectives and added to the limited range of examples in the literature, there were similarities across cases that provided real-world examples of working in a neoliberal policy context to apply a social determinants of health approach to child health policy.

The following related article and conference paper were published during my candidature:

Phillips, C., M. Fisher, F. E. Baum and C. MacDougall (2014). Australian child/youth health policies: are we taking action on the social determinants of health? In SA State Population Health Conference. Adelaide, South Australia. October 2014.

Phillips, C., M. Fisher, F. E. Baum, C. J. MacDougall, L. A. Newman and McDermott, D.R. (2016) “To what extent do Australian child and youth health policies address the social determinants of health and health equity? A document analysis study.” *BMC Public Health* **16**: 512.

In this thesis, I have contributed theoretically driven contemporary research in the growing cross-disciplinary area of political science and public health. Together, the three studies successfully address the aims and objectives of this thesis.

5.7 Limitations of this research

A limitation in study 1 was that by focusing on empirical research only (which is justified on page 26) the search technique could be seen to exclude a range of political theoretical contributions that were relevant to the guiding question. However, this is accounted for because this type of search technique is common practice in public health research with the particular aim of searching for depth not breadth, and, is addressed by engaging extensively with political science and policy theories in the other two studies that make up this thesis. A limitation of studies 2 and 3 in this thesis was that only health department policies were included. It is recognised that the policies of other departments have a significant effect on child health and wellbeing; however, the scope of this study was restricted to health sector policies to assess action on the social determinants of child and youth health in that sector. There are also variations in how state and territory governments structure how they address child health in policy and some of the findings in this thesis may be influenced by these structures. Another limitation in study 3 is that, potentially, not all policy actors involved in the policy development process for each case study were interviewed. Although there is no specific evidence of this occurring, potential participants may have declined the opportunity to be interviewed because of their desire not to be recognised in a study that had the potential either to misrepresent or identify interviewee data, thus having consequences for current or future employment opportunities. As mentioned in section 4.3.6, every effort was made to ensure this did not happen during policy selection.

5.8 Chapter summary

In this chapter, I have discussed the findings from all three studies in this thesis. First, to better understand the circumstances that facilitate or constrain policy action on the social determinants of child health, I developed the four synthetic constructs from study 1, politics, ideology, leadership and credibility. After describing each construct, I discussed my interpretation in relation to the broader literature and illustrated how they operate within the Australian health departments (with examples from study 2 and 3). Second, I identified and discussed four policy development tactics that emerged through this thesis where policy actors constructed storylines to ‘sell’ a SDH agenda in different ways. The policy development tactics presented (and the associated storylines) were divided into four categories, extension, selective, adaptive and divergent. Then I presented the Policy Formulation Model that illustrates the synthetic constructs and policy formulation tactics/storylines operating within the Australia

child health policy environment. Finally, I presented my methodological reflections and highlight the strengths and weaknesses of this thesis.

CHAPTER 6: CONCLUSIONS

In this thesis, I set out to explore how child health policy with a focus on the SDH was formulated in an Australian context. In particular, I was interested in the circumstances that facilitate (or constrain) the application of a SDH approach in Australian child health policy. After conducting a CIS review of the public health and political science literature I adopted a cross-disciplinary approach (public health and political science) to explore this topic. From this review I generated four theoretical constructs to guide this study, politics, ideology, credibility and leadership.

Next, in study 2 I systematically analysed all Australian child health policies published between 2008 and 2013. All policies addressed health inequities to some extent, with the best examples in Aboriginal or child protection policies, and whole of government policies with strong links to health departments. However, there appeared to be limited action on the social determinants of child health within Australian health departments because, while evidence on the SDH was acknowledged or audited at the beginning of policies, only 10% of action strategies were directed to this area. With some exceptions, upon closer examination strategies that initially appeared to be addressing important social determinants of health, such as early childhood development and healthy settings, often resulted in narrow actions that placed the focus back on individuals.

This led to a further exploration of ideology and underlying assumptions within Australian health departments that demonstrated how the neoliberal governance style within which Australian child health policy is developed limits the amount of space in health departments for a SDH approach. I found that a neoliberal governance style promotes policy measures that focus on biomedical and/or behavioural strategies with a focus on individual responsibility to improve child health with Australian health departments.

By adopting a political science perspective, specifically the Shiffman and Smith (2007) framework, I was able to better understand how policy actors navigate this style of governance. To achieve this, I

explored policy actors' perceptions about four Australian child health policies that did most to address the SDH and health equity. I found that in these policies the agenda setting and policy development processes were supported by a cohesive policy network, including a range of leaders who were successful in building credibility to partially legitimise a SDH approach in Australian health departments. The framing of issues varied across cases, and early childhood development, health equity, and child rights were clear motivators for policy action in this area. Through these case studies I gained a better understand the circumstances that facilitate (or constrain) policy action on the social determinants of child health. I identified and discussed four policy development tactics that emerged in this thesis, where policy actors constructed different storylines to promote a SDH agenda in Australian health departments. The policy development tactics presented (and the associated storylines) were divided into four categories, extension, selective, adaptive and diversion.

Finally, to illustrate how the four synthetic constructs, policy development tactics, and storylines, operated within the Australia child health policy environment I developed a policy formulation model consolidating the theoretical perspectives used in this thesis. While not generalisable to other policy settings, the lessons learned may assist policy actors advocating for a SDH in future policy development efforts.

The next step in this research, which has already begun, is to design a guide for policy actors working in government to assist them in advocating for alternative policy solutions to solve complex health problems. The guide will raise awareness about different ways to legitimise alternative policy solutions in an environment where the ideology presents constraints. It is hoped that the guide will help policy actors to reflect on their recent policy development advocacy efforts and guide their thinking on the way they interact with the agenda setting and policy development processes to bring about change in the future. This level of understanding could, in turn, bring about health policy reform in Australia.

This thesis demonstrates the usefulness of cross-disciplinary research (public health and political science theory) for understanding the complex policy environment within which child health policy is developed in Australia. In particular, the underlying assumptions, policy development tactics and constructed storylines offer a better understanding of what is required to gain legitimacy in Australian health departments for alternative health policy agendas such as the social determinants of child health.

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Appendix 1

Responsibility for Health - different levels of government in Australia (AIHW 2016)	
Federal level responsibility	Medicare, general practitioner services, the Pharmaceutical Benefits Scheme, community controlled Aboriginal and Torres Straits Islander (ATSI) primary health care, healthcare for service veterans, medical research and access to regulation of private health services.
State level responsibility	Management of public hospitals, the licensing of private hospitals, public community-based primary health care services, screening and immunisation programs and ambulance services.
Federal/State shared responsibility	Regulation of the health workforce, regulation of pharmaceuticals and pharmacies, funding of public health programs and services, and funding of ATSI services