REVIEW

Nine questions to guide development and implementation of Health in All Policies

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SUMMARY

Based on the policy science literature, we formulate nine core questions that can guide the formulation, negotiation, development and implementation of Health in All Policies (HiAP). Each question is grounded in the political and policy science literature and culminates in checklist items that HiAP developers must consider.

Key words: HiAP; theory; health policy; health politics

MAKING SENSE OF THE FUZZY

The recognition that determinants of health play out at many (proximal and distal, public and private, formal and informal, within and mostly outside the health system) levels has led to the assertion that responses to those determinants require a sophisticated (public) policy approach. The range of those responses can be captured by the term Health in All Policies (HiAP). The development and monitoring of HiAP is a necessarily complex affair. In the scholarly literature, this perspective has been described not just as complex, but as ‘messy’, ‘fuzzy’ or ‘wicked’ (Mitroff and Featheringham, 1974; Mitroff and Mason, 1980). These concepts are perhaps best illustrated by the (in)famous mapping of the obesity issue by the British Foresight Institute (Butland et al., 2007 – Figure 1).

The HiAP approach has been developed in response to the recognition that health is created across many sectors and elements of government, civil society and social action. WHO (World Health Organization, 2014) states: HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government. (…) Health and health equity are values in their own right, and are also important prerequisites for achieving many other societal goals. Many of the determinants of health and health inequities in populations have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies in all sectors and at different levels of governance can have a significant impact on population health and health equity.

These foundations of HiAP show that complex problems require complex solutions. For complex health solutions, it is clear that just one government sector, specializing in the management of care delivery, will not have all the tools, knowledge, capacity, leave alone budget, to address this complexity. Ministries of Health are not equipped to deal with the ‘causes of the causes’ (the social determinants of health, cf. Marmot et al., 2012) and even less the ‘causes of the causes of the
causes’ (the politics governing social determinants of health, Clavier and De Leeuw, 2013a). An integral (sectorally connected and politically sophisticated) approach is required. The HiAP approach is a new take on concepts that have been around for a while now, in some cases almost half a century such as whole-of-government, or healthy public policy notions. We could even say that the writings of classic philosophers, like Hippocrates, would reflect a profound insight in the necessity to deal with health and social issues in comprehensive and inclusive ways.

Thus, the argument for the need to deal with health and health equity in comprehensive ways is not new, but tuning policies and practices to this call is vastly more challenging.

The reasons for the challenges are varied. Government bureaucracies tend to be rather stable, some would call them ‘conservative’. Innovation and renewal are not necessarily their strong suits (Parker and Bradley, 2000). Also, the way society has organized itself (through its institutions and governance systems) has—since the industrial revolution in the nineteenth century—been increasingly in specialized ‘silos’. Those silos have comfortably defined their own mission parameters, through professional development and behaviour, through legislation, through networks of epistemic communities, through the establishment of hardware (e.g. hospitals, public health systems and industrial occupational protection arrangements) and through the development of intricate research and development systems.

HiAP in many ways call to transcend this established ‘silo’ system. Mere rhetoric that things need to change will not be sufficient to move beyond this comfortably stable system. Complex and chaotic systems as recognized in twenty-first century health require flexibility, adaptation and collaboration with cross-cutting higher-level learning systems that reach out between sectoral silos, governments, industry, civil society and the knowledge sectors such as universities and think tanks.

Describing the severity of the problems we are facing is hardly a sufficient condition to start taking action on solutions. Many conditions need to be met to enable a configuration of actors and factors that even starts the process of Health in All Policy

![Fig. 1: Obesity map UK Foresight Institute.](https://academic.oup.com/heapro/article-abstract/30/4/987/2355732)
development, monitoring and implementation. The political scientist Charles Lindblom argued that ‘The human condition is small brain, big problems. People then need help — devices, processes and institutions — to simplify problem-solving’ (Lindblom, 1977, p. 66). Perhaps it is worth observing that in many scholarly endeavours, the default condition is ‘big brain, small problems’, and that in health promotion that the twain have not—yet—met. But this seems the crux of further HiAP development and implementation: to make political and policy sense, firmly grounded in scholarly work, of the messy, wicked, and fuzzy world of social, political and commercial determinants of health (e.g. Hastings, 2012).

The belief that our current health problems are exceedingly complex may have an inherently paralysing effect. Following Lindblom’s suggestion that we need a problem-solving device, it may be helpful to consider the Cynefin framework (Figure 2, cf. Snowden, 2005; Van Beurden et al., 2013). ‘Cynefin’ is a Welsh word for ecosystem and habitat, and its various elements recognize the dynamic evolutionary nature of complex systems. A good foundational analysis of the problem we are facing determines the best approach. A ‘simple’ problem (e.g. one person with a bout of gastroenteritis) would require an embedded policy or protocol offering a standard, simple solution (oral rehydration, and possibly a course of antibiotics when warranted). A ‘complicated’ problem (e.g. a salmonella outbreak in an aged care home) would require multi-level investigation, data collection and analysis, and a more astute intervention (food preparation monitoring, isolation, disease management and clinical intervention). The more variables are added to the equation, the harder it will be to attribute critical importance to just one element: many things simultaneously impact on a range of issues. Our ‘binary’ approach to problem solving (good versus bad, success versus failure, etc.) makes it difficult to appreciate the synergies and linkages between elements.

HiAP development and implementation typically would not suit either simple or chaotic causal and final relationships. For the simple relationships, HiAP is not ‘fit for purpose’ (involving many more actors than required), whereas for the chaotic Cynefin relations HiAP parameters may be unaligned, badly connected or inappropriate. The challenge to distinguish between simple, complex, complicated and chaotic has been analysed and described at many different levels. Krieger (Krieger, 2008) shows that determinants may be solutions, and that a ‘proximal’ determinant may simultaneously have ‘distal’ dimensions (she takes apart the tobacco rhetoric convincingly). Smedley and Syme (Smedley and Syme, 2001), in an authoritative report published by the US Institute of Medicine, demonstrate that health analysts and policy makers need to invest in sophisticated tool boxes that allow for better understanding of those multi-dimensional, life course and intergenerational, and reciprocal relationships where combinations of approaches have synergistic effects.

This may sound rather abstract. This article will, rather than continuing the analytical and mostly intangible rhetoric, attempt to show the practicalities of applying a health political science view to integral policy making.

In a first draft of this material commissioned by WHO, we proposed a policy development and monitoring ‘cycle’ with nine elements in which each element interacted with all remaining eight elements. However, identifying those nine elements is arbitrary: they could be construed as permutations of a classical ‘stages heuristic’ policy cycle with only three components; problem–solution–evaluation. On the other hand, each element might be detailed and specified into a virtually infinite number of components, each continuously interacting with any other. The latter, of course, is how policy development works in reality (see also Clavier and De Leeuw, 2013b).

Although a cycle with a clockwise or anti-clockwise sequence satisfies our need to seek

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**Fig. 2:** Cynefin framework.
order, the reality of the policy process is that many things happen at the same time. For instance, political deliberation and implementation preferences often happen before a systematic overview of alternative approaches is being developed. Like jugglers, policy developers and politicians attempt to keep several balls in the air at the same time (Figure 3). The juggling metaphor is highly appropriate, because without order and discipline all elements would fall down. This may be frustrating for the technocratic civil servant wishing to neatly follow the stages of an ordered cycle. In the remainder, we will show that there is order in chaos; that chaos is in fact complexity; and that complexity can be dealt with systematically.

This is not the first or necessarily best ‘how-to’ approach to developing and implementing HiAP. Rudolph et al. (Rudolph et al., 2013) developed a 169-page practical guide for local authorities in the USA. Gase et al. (Gase et al., 2013) reviewed HiAP practices and come up with seven intersecting actions that contribute to the likelihood of effective HiAP formulation and implementation (Figure 4):

1. (1) developing and structuring cross-sector relationships;
2. incorporating health into decision-making processes;
3. enhancing workforce capacity;
4. coordinating funding and investments;
5. integrating research, evaluation and data systems;
6. synchronizing communications and messaging; and
7. implementing accountability structures.

The prominence of the HiAP approach is also strengthened by a Canadian review (Shankardass et al., 2011) in which a claim is formulated that 16 countries have HiAP. This same group of authors more recently published a glossary for Health in All Policy implementation (Freiler et al., 2013). Both publications of this team suffer from substantial conceptual inconsistencies, in which ‘policy’ is confused with ‘action’ (HiAP is considered similar to ‘intersectoral action’), ‘policy development’ is a form of ‘policy implementation’ (whereas the policy theory literature would claim the reverse: implementation is a form of development, cf. Hill and Hupe, 2006), and behaviourist constructs are applied to political phenomena. We have earlier argued that

![Fig. 3: Juggling the HiAP planning and implementation ‘cycle’.](https://academic.oup.com/heapro/article-abstract/30/4/987/235732/18?download=true)
such misconceptions are a scholarly sin, in that they make Errors of the Third and Fourth type (Green and Tones, 1999; De Leeuw, 2009): asking the wrong question, and deploying an inappropriate inquiry system (Vandenbosch et al., 2001). By doing so, these authors exacerbate conceptual confusion, rather than clarifying matters. Hendriks et al. (Hendriks et al., 2014) acknowledge this confusion and set out to redress it. Interestingly (but not surprisingly, as the authors in majority have a—social—psychological background), the assumption in their analysis is that (integrated; whole-of-government; health-in-all; healthy public) policy would result in individual behaviour change on a number of parameters with policy interventions as the (resultant? Or determinant?) outer layer of a ‘Behaviour Change Wheel’ (Michie et al., 2011). Admittedly, this may be a useful perspective for technocratic public health engineers and traditional health educators, but it does not acknowledge the intrinsically political nature of policy development, as described by Leftwich (Leftwich, 1994): ‘...all the processes of conflict, cooperation and negotiation in taking decisions about how resources are to be owned, used, produced and distributed. Inevitably, the contours of politics are framed by the inherited institutional environment (both formal and informal), by the political culture and by the differing degrees and forms of power, which participants bring to the process, and by their interests and ideologies’.

It is for these reasons that in the following description of juggling policy balls, we take an explicit health political science perspective in which we adopt our earlier maxim (Clavier and De Leeuw, 2013a, b) that there is nothing as practical for health policy development as a good theory—in this case of the policy process.

![Fig. 4: Seven determinant groups of actions to facilitate HiAP (Gase et al., 2013).](https://academic.oup.com/heapro/article-abstract/30/4/987/2355732)

**JUGGLING BALL ✿: (RE-)DEFINE THE PROBLEM**

Although some policy solutions find and define a problem, usually the development and continuity of policy action heavily depends on a process in which first a problem is defined. ‘Fact’ plays a role in this as much as communication and interests.

**What is the evidence?**

Albert Einstein reputedly said ‘If I had an hour to solve a problem I’d spend 55 min thinking about the problem and 5 min thinking about solutions’.

The American sociologist Joe Gusfield (Gusfield, 1981) found in his research that policy stakeholders can own or disown a public problem through the way they define it. Owning a problem can be an advantage to groups and organizations—it may allow for increased credibility, funding and legitimacy. But health problems often remain defined in purposely ‘fuzzy’ terms because no stakeholder can see added value of owning complex problems.

This often means that the ownership falls onto the ‘default’ health actor: the ministry of (public) health or other institutional arrangement that has a statutory requirement to deal with health. At this stage, again, problem definition may or may not happen. Leaving the problem ‘fuzzy’ may allow for the default owner to bring others into the deliberations. As soon as a problem has been defined in specific operational terms, it may be more difficult to bring in other partners. Defining and reframing the problem would also allow for new ways of understanding. For instance, a health equity lens might be used, health might be redefined in terms of access rather than use of services, health could be seen as an (economic) asset, etc. Framing a problem in a facilitative Social Determinants way may well enable new stakeholders to engage in the policy process.

**The question**

The key question that therefore needs to be asked is:

How has the problem been framed and by whom?

**Checklist items**

- Has the problem been framed in terms that allow for multi-actor engagement?
- Is there the potential of shared ownership of the problem?
- Are there opportunities to re-frame the problem to bring in key partners?
HiAP development is not a tabula rasa (a blank slate). Opportunities may exist to adapt existing policies for health purposes, or take an existing policy as a model for a new one. However, some policies or conventions may also provide barriers for HiAP development. A wider policy audit is important.

What is the evidence?
The political scientist John Kingdon (Kingdon, 1995) found that ‘The best condition for new policy is a disaster’. This statement shows that only radical circumstances can lead to radical new policy. Usually, new policy follows in old traditions by tweaking goals, objectives and resources. This incrementalism is labelled in the literature as the ‘punctuated equilibrium’ approach (Baumgartner and Jones, 1993): policy evolves in steps from one point of stable policy to the next point of stability (see also Howlett and Migone, 2011).

Kingdon himself showed that those smaller or more radical steps of policy change depend on the opening of windows of opportunity between problem deliberations, the existing evolution of all public policy, and the flow of politics. Policy entrepreneurs seeking such windows of opportunity map and massage all three of these ‘streams’.

Suggestions for new policies always have to compete with (a) existing policies and (b) other new policies. Policy entrepreneurs see the potential of opening windows of opportunity through a clever awareness of the problems, politics and policies. In this step, we focus on opportunities that existing policies present.

The question
The question that needs to be asked is therefore:

Within the problem definition and tentative policy logic, which policies are already in force or in development? Are there any measures of success?

Checklist items
• In your or other sectors: are there existing policies that would possibly support solving the problem identified?
• Do policies exist that present institutional, fiscal or regulatory barriers to a policy that would address the problem identified?
• Is there evidence of effectiveness of these policies (e.g. through policy analyses, audits or parliamentary deliberation)?
• Can policy entrepreneurs (and processes of alternative specification they deploy) be identified that allow for the opening of windows of opportunity for HiAP?
JUGGLING BALL 1: ESTABLISH THE POLICY LOGIC BASED ON SOCIAL DETERMINANTS

Political decision-makers are sometime accused of irrational choice. They may also be criticized for not responding to constituents’ wishes. In the trade-off between facts, interests, options and opportunities each policy will find its own logic. (Re)constructing that logic provides pathways into policy development.

What is the evidence?

One of the fathers of political science, Harold Laswell (Lasswell, 1936), succinctly defined politics as answering ‘who gets what, when and why?’

If the political and policy-making enterprise were a value-free, objective and rational exercise, there would be full policy homogeneity between similar countries, like cities, and comparable sectors. Fortunately, humankind cherishes its diversity, culturally and politically, and expresses its preferences through democratic and participatory processes. One of the consequences of the resulting political landscapes is that priorities are different, and that the internal logic of policy making may depend on a spectrum of political beliefs (e.g. liberal or social-democratic).

A wealth of evidence posits that it is possible to appreciate these policy logics. The literature also uses terms such as ‘policy theory’ or ‘policy ontology’. These terms all denote internally consistent sets of related facts, ideas and assumptions that drive and sustain policy development. Usually, the literature distinguishes between causal (ideas about cause-effect relations), final (ideas about interventions and resulting impacts/outcomes) and normative (cultural and statutory, e.g. the Napoleonic Code or Sharia) approaches. Clearly, there may be a difference between the facts of evidence and the ideas about that evidence. For instance, in some countries, obesity is seen as a behavioural problem, and in others as an urban planning and cultural problem. How differently this has happened in sun tanning and skin cancer in three different countries has been documented by Garvin and Eyles (Garvin and Eyles, 2001).

We know that by making the policy logic explicit and visible, policy options emerge and opportunities arise. Being adroit in the policy relevant evidence base on social, political and commercial determinants of health helps clarifying the often implicit logic. Making it explicit allows for new opportunities.

The question

The question that needs to be asked is therefore:

What facts, ideas and assumptions constitute the policy logic in relation to the problem?

Checklist items

- Can an overview be made of ideas in your country about the causes of the problem?
- Can an overview be made of ideas in your country about the best interventions to solve the problem?

JUGGLING BALL 2: DEVELOP ALTERNATIVES WITH STAKEHOLDERS

In negotiating the best policy option, it is important to consider different alternative (pathways to) solutions. Even when the social epidemiological evidence is crystal clear, it will have to be adapted to local circumstances with a particular social and economic context, not to speak of the preferences of a complex set of policy stakeholders and target groups.

What is the evidence?

The truth is rarely pure and never simple.—Oscar Wilde, The Importance of Being Earnest

Deborah Stone (Stone, 2002), in her aptly titled book ‘Policy Paradox’, describes how the development of alternative policy scenarios always is about ‘the strategic representation of situations’. In simple terms, the preferred alternative must win as much support over any competing alternatives as possible. In this negotiated outcome, different policy intervention options (including mixes of communicative, facilitative and regulatory interventions), consequences (such as the redistribution of resources, intended and unintended impacts and outcomes) and contexts (‘best fit’ with current policy, the degree of change involved, etc.) will be framed differently to different people and groups involved in the political process.

Kingdon calls this a process of ‘alternative specification’ between the different participants in different policy streams. In this process, there are a number of ‘soft’ principles: (a) simple always wins over complex; (b) lowest cost versus highest benefit wins; (c) apply the ‘least coercion’ rule (this rule states that governments typically are most hesitant in forcing stakeholders into action and prefer ‘softer’ communication approaches); (d) culture and rights-based allegiances may be challenged by short-term opportunism, but tend to win in long-term processes.

Context is not just a confounder. Context determines feasibility and effectiveness and is integral to policy negotiations. This has been recognized in recent advances in the evaluation field, where now tools and technologies exist to appreciate the diversity and complexity of health and health equity issues, and the range of interventions and policies to deal with them. Guba and Lincoln (Guba and Lincoln, 1981) developed the ‘Fourth Generation Evaluation’ approach in which evaluation parameters (including best methodology and types of outcomes) are negotiated between sets of stakeholders. Pawson and Tilley (Pawson and Tilley, 1997) and Pawson (Pawson, 2006) advocated ‘realist evaluation’. In this methodology, diverse context is recognized as an integral element of the evaluation. The
absence of a ‘level playing field’ (or controlled conditions for a study) is taken into account.

The question
The question that needs to be asked is therefore:

What evidence, experience and opportunity exist to develop winning alternative approaches?

Checklist items
- What is the evidence about the most cost-effective policy option?
- What other alternatives have been proposed? By whom?
- Have alternatives been field-tested with whom, and if so, to what effect?
- For different policy alternatives with different stakeholders, what is the contextual feasibility?
- For different policy alternatives with different stakeholders, what is the contextual effectiveness?

JUGGLING BALL a.: MATRIX POWER, INTEREST AND PRIORITY

Perhaps the most critical element of a policy development guide is trying to figure out support and opposition to the proposals. Negotiations may have led to a number of actors agreeing to a policy proposal, but operational implementation depends on wider support than just the main players.

What is the evidence?
If you are far from the enemy, make him believe you are near—Sun Tzu, The Art of War

Opposition is not necessarily enmity; it is merely misused and made an occasion for enmity—Sigmund Freud

In 1972, William Coplin, Michael O’Leary and John Vasquez published Everyman’s Prince: A Guide to Understanding Your Political Problems. ‘Prince’ was an acronym for the four steps in the process: ‘Probe, Interact, Calculate, Execute’. Prince helps to calculate policy opportunities (Figure 5). Series of calculations are required to map actors in the Prince system and draw policy development conclusions. Another tool doing this is the PolicyMaker software (www.polimap.com). A third approach, in French, is the ‘Petit Manuel’ established? What gains can be identified?

Checklist items
- What social gain comes out of the HiAP, and who will benefit from this gain?
- What economic gain comes out of the HiAP, and who will benefit from this gain?
- What institutional gain comes out of the HiAP, and who will benefit from this gain?
- What investment is required to attain those gains, and who will benefit from this investment?
Checklist items

- Has a systematic inventory of all possible stakeholders and their positions for the policy proposal been developed?
- Can stakeholders be characterized as supportive, powerful and giving the proposal priority?
- Can strategies be developed to move actor positions toward higher support and priority for critical stakeholders?

JUGGLING BALL ✓: CONSIDER POLITICAL STRATEGY

Policy development may be a slightly technocratic and bureaucratic exercise, involving careful manoeuvring and negotiation between stakeholders. Policy initiation, adoption and preparations for implementation, however, are crucially political enterprises. High-level political support for HiAP, inside and outside of the health bureaucracy, is important. Executive support facilitates political change towards HiAP.

What is the evidence?

...there is nothing a government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult.—John Maynard Keynes

The political craft can include the capacity to gauge prospects; exercise leadership; network support; exploit institutional opportunity; demonstrate vision; craft allegiances; shape direction; and invent and apply rhetoric (see Appendix I for some examples of political action). Although the study of politics has been a rather successful enterprise for about a century, it is clear that successful politicking itself is a tougher trade.

Yet, gaining the support from a critical mass of politicians to initiate policy development, support its evolution and then guide and endorse it through the final legislative process is essential in making HiAP work. A full appreciation of the political determinants and political processes for health and health equity is critical to nudge HiAP through to success. Identification of politicians or political groupings in favour and in opposition of HiAP is a key element for this.

The question

The question that needs to be asked is therefore:

What politics are involved in the initiation and final stages of policy development and adoption?

Checklist items

- Can politicians or political groupings be identified that are (not) in support of HiAP?
- Is there political leadership for HiAP?
- Is there institutional and rhetorical opportunity for HiAP?

JUGGLING BALL &: DESCRIBE AND PLAN IMPLEMENTATION

Sometimes policy is of a symbolic nature only—it is designed to show that government cares for an issue. This how-to guide, however, aims at effective implementation with tangible health gains and reductions in health inequities. Implementation must therefore be an explicit consideration.

What is the evidence?

You can’t build a reputation on what you’re going to do.—Henry Ford

Implementation research has gained prominence in recent decades. We can distinguish at least three perspectives: (a) implementation of behaviour (e.g. Diffusion of Innovations Theory), (b) implementation of clinical protocols (e.g. Quality Assurance and Knowledge Translation approaches), and (c) policy implementation. The application of an appropriate disciplinary ‘gaze’ (in this case, politics) is essential.

The policy implementation literature, again, has applied different gazes and sees implementation as a matter of governance (Hill and Hupe, 2006), as a management issue, as a planning problem or as part of the general political enterprise (Mazmanian and Sabatier, 1989). Taking a slightly wider angle, the general body of literature identifies unique barriers and facilitators of implementation.

These can be grouped in issues of (a) policy complexity, (b) support, (c) capacity, (d) resources, (e) partnerships, and (f) timeframes. For each of these dimensions, the policy entrepreneur or owner of the problem and its solution should engage in its management. Previously in this guide, we have started to
address complexity, support and partnerships. Creating and supporting capacity, resources and clear timeframes should not be left until it is too late, that is, when the policy is formally adopted. Considering, analysing and taking to task, all six policy implementation dimensions should be integral to policy development.

**The question**
The question that needs to be asked is therefore:

Have policy implementation barriers and facilitators been considered and integrated in policy formulation?

**Checklist items**
- Can implementation issues like (a) policy complexity, (b) support, (c) capacity, (d) resources, (e) partnerships, and (f) timeframes be identified in the policy proposal?
- Can these issues be characterized as sufficient supporters of policy?
- Are procedures in place to monitor and continue implementation support?

**APPENDIX 1: EXAMPLES OF POLITICAL ACTION**

**How to discredit an unwelcome report (from TV series Yes Minister):**

**Stage One: Refuse to publish in the public interest saying...**
1. There are security considerations.
2. The findings could be misinterpreted.
3. You are waiting for the results of a wider and more detailed report which is still in preparation. (If there isn’t one, commission it; this gives you even more time).

**Stage Two: Discredit the evidence you are not publishing, saying...**
1. It leaves important questions unanswered.
2. Much of the evidence is inadmissible.
3. The figures are open to other interpretations.
4. Certain findings are contradictory.
5. Some of the main conclusions have been questioned. (If they haven’t, question them yourself: then they have).

**Stage Three: Undermine the recommendations. Suggested phrases:**
1. ‘Not really a basis for long term decisions’.
2. ‘Not sufficient information on which to base a valid assessment’.
3. ‘No reason for any fundamental rethink of existing policy’.
4. ‘Broadly speaking, it endorses current practice’.

**Stage Four: Discredit the person who produced the report. Explain (off the record) that...**
1. He is harbouning a grudge against the Department.
2. He is a publicity seeker.
3. He is trying to get a Highness/Chair/vice Chancellorship.
4. He used to be a consultant to a multinational.
5. He wants to be a consultant to a multinational."

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