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Paul Cairney

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The role of ideas in policy transfer: the case of UK smoking bans since devolution

Paul Cairney

ABSTRACT This article explores the relationship between ideas and interests in policy change by examining tobacco control in each country of the United Kingdom (UK). In all four, the moves towards further prohibition reflected international trends, with evidence of policy transfer and the virus-like spread of ideas which has shifted the way that tobacco is framed. However, there are notable differences in the development of policy in each territory. This reinforces conceptions of transfer in which the importation of policy is mediated by political systems. Differences in policy conditions, institutions and 'windows of opportunity' mean that our conclusions on the role and influence of interest groups, institutions and agenda-setting vary by territory, even within a member state. This suggests that a focus on an 'idea whose time has come' should be supplemented by careful analysis of the political context in which the idea was articulated and accepted.

KEY WORDS Devolution; ideas; multiple streams analysis; policy transfer; tobacco policy.

INTRODUCTION

The 'messy' nature of policy-making in the European Union (EU) necessitates the use of different explanatory models in different circumstances (Richardson 2005). Further, the transnational nature of decision-making, combined with a complex agenda-setting process, suggest the need to focus significant attention on 'ideas, knowledge and expertise, rather than pure "interest"' (2005: 6). Kingdon's (1995) attempt to explain the power of ideas in the 'organized anarchy' of the United States (US) federal system is particularly relevant. Indeed, the phrase 'an idea whose time has come', which describes 'an irresistible movement that sweeps over our politics and our society, pushing aside everything that might stand in its path' (1995: 1), may be more significant in the relatively complex EU system. An idea's 'time' comes hand in hand with receptivity to that idea within the political system, requiring the motive and opportunity of decision-makers to translate ideas into policy (Lieberman 2002). Therefore, the more obstacles there are to that translation process (or constraints to the adoption of the same policies across the EU), the more explanatory weight can

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be given to the role of ideas when policy transfer takes place. The relationship between ideas and interests is also relevant to individual member states, even when government and group relationships are relatively stable, the policy environment is less crowded and the agenda-setting process appears to be more straightforward (such as in parliamentary systems). The common aim is to identify the adoption of one particular idea (at the expense of others) within a political process characterized by ambiguity (there are many ways to frame any policy problem), competition for attention (few problems reach the top of the agenda) and an imperfect selection process (new information is difficult to gather and subject to manipulation) (Zaharidis 2003: 2–15). The main thesis of this article is that the process of adopting simple ideas is remarkably complex even within parliamentary systems such as the UK. Kingdon's model applies as much to individual member states as it does to the EU.

EU tobacco policy highlights these issues well. Tobacco restrictions have caused smoking prevalence to fall since the post-war period and government (EU and member state) policy reflects and reinforces the 'denormalization' of smoking (Studlar 2007a: 1). However, the problems and delays experienced by the European Commission pursuing a tobacco advertising ban (Duina and Kurzer 2004) and the patchy adoption of other measures across the EU (Joossens 2007) demonstrate the difficulties in treating ideas as the sole explanatory factor. Tobacco control is not an 'irresistible movement'. While tobacco control was an 'idea whose time has come' there were important variations in the extent to which it affected different locales. Indeterminacy also existed in member states and, in the case of the UK, within the member state. This is demonstrated by the variable adoption of smoking in public places bans in the UK since devolution.

Tobacco control appears to be most strong in the UK. It leads the rest of Europe, scoring 93 per cent based on measures identified by the World Health Organization (WHO) (price of tobacco, smoking bans, advertising bans, health education, health warnings, treatment (Joossens 2007). The smoking ban in public places represents the 'missing piece in the jigsaw' (Action on Smoking and Health, ASH, 2007) and marks the UK's willingness to go far beyond the agenda set by the EU (the European Commission's Green Paper followed a year later). Further, although the responsibility for introducing a ban was devolved, and each government had the potential to go its own way, all four introduced comprehensive smoking bans by 2006 (with Scotland taking the lead). In turn, all four appeared to import the same comprehensive measures introduced by Ireland in 2004. However, while policy transfer within the UK *appeared* to be uniform, there were significant variations in policy development. In Kingdon's (1995) terms, four different 'policy windows' opened up to allow similar policy change.

To demonstrate this argument the article focuses on one case study to highlight the complex decision-making processes that may be missed in broader discussions. First, it identifies the global, virus-like spread of tobacco control ideas. Second, it identifies the relationship between ideas, their promotion

and receptivity to them. Third, it describes Kingdon's 'policy windows' to highlight the idiosyncratic reasons for apparently similar policy developments in different countries. Finally, it applies Kingdon's theory to UK smoking bans by identifying four distinct policy windows through which the idea of tobacco control had to pass. Overall, it highlights a spectrum of ways to consider the effects of ideas: from a sense of inevitability ('irresistible movement') to a sense of randomness and unpredictability (the conditions for acceptance came together at the right time).

POLICY TRANSFER AND THE ROLE OF IDEAS

Policy convergence refers to the evidence for similarities in policy across regions. This may be linked to a transfer of policy from one region to another. The transfer literature then extends to a series of questions, including: is transfer voluntary; which actors are involved; how much policy is transferred; and how do we explain variations in levels of transfer (Dolowitz and Marsh 1996, 2000; Bennett 1991; James and Lodge 2003; Page 2000; Rose 1993; Stone 1999)? The starting point for discussion of tobacco policy transfer is therefore the evidence of similarities in policy. A common feature in the EU (and most developed countries) is that smoking behaviour has become 'denormalized' (Studlar 2007a: 1). In part this is caused by similar policy instruments:

1 Similar 'successes'

- Most countries have warning labels on cigarette packets.
- Most have initiated health education campaigns since the mid-1960s.
- Most have advertising restrictions on TV and radio.

2 Similar 'failures'

- The enforcement of age-related restrictions has been lax.
- There is still state support for tobacco growers in the US and the EU.

3 Similar timing in the use of instruments

- Taxation as a major policy instrument has only been used in the past 20–30 years.
- Controls of smoking in public places have been more prominent recently (Studlar 2004).

As Feldman and Bayer (2004: 1) suggest, the driver for convergence has been increased acceptance of the scientific evidence on smoking and, more recently, passive smoking. The post-war scientific debate on the links between smoking and illness was replaced by acceptance (at least in government) of the evidence but uncertainty about the need to act. More recently, the debate has shifted to the question: what tobacco controls work best? This suggests that tobacco control based on public health is an idea 'whose time has come'. The case of tobacco accords with most discussions of ideas in the literature, including:

- 'Viruses' which 'mutate', take on a life of their own and infect political systems.
- Norms taken for granted, placing limits on policy debate.
- Competition to establish 'how the world works' and therefore what solutions are acceptable (Cairney 2009a; Campbell 2002; John 1998; Richardson 2000).

The post-war history suggests that scientific knowledge infected the political system, destroying previously closed policy communities and altering the balance of power between participants (from tobacco companies to public health). This knowledge was promoted by an 'epistemic community' (or network of knowledge-based experts – Haas 1992: 3) of doctors and public health officials providing the scientific basis for tobacco control, combined with a much broader 'advocacy coalition' (Sabatier 1998) of anti-smoking interest groups, public officials and interested individuals (Farquharson 2003; Cairney 2007b). The policy image was reframed (Baumgartner and Jones 1993) from an issue of economic benefit (taxes and exports) and civil liberties to public health and the need to intervene (particularly when a new strain of the virus – scientific knowledge of passive smoking – was accepted by governments). This contributed to a new world-view on tobacco, with the idea of tobacco control taken for granted and the agenda shifting to solutions rather than problems (Cairney 2007b).

LIMITS TO THE ROLE OF IDEAS IN POLICY TRANSFER

However, the response has varied according to the 'vested economic interests, cultural practices, and political factors' of each country and there are significant time-lags between the proposal and acceptance of scientific knowledge and the introduction of solutions (Studlar 2004, 2007b). This applies not only to Europe (13 out of 30 countries tracked by Joossens (2007) achieved a tobacco control score above 50 per cent), but also to the UK which has a post-war history marked by poorly implemented voluntary agreements even when the scientific evidence was accepted by the government (for passive smoking the gap between acceptance and legislation was eight years – Cairney 2007b: 50, 53). Therefore, few discussions treat ideas as the sole explanatory factor.

The successful *promotion* of ideas is one focus of 'punctuated equilibrium'. Baumgartner and Jones (1993) argue that since decision-makers, the media and the public all have limited resources (time, knowledge, attention) they cannot deal with the full range of policy problems. So, they ignore most and promote few to the top of their agenda. Problem definition is crucial since it determines the level of attention and the nature of government response. This explains tobacco policy monopolies: tobacco companies frame the policy image as a boost to the economy (and a matter of civil liberties). This limits the number of participants who can claim a legitimate role. Those excluded

from monopolies have an interest in challenging this image. The role of knowledge and new evidence (such as the experience of policy innovation in Ireland) is crucial to divert attention to other aspects of the same problem. If the scientific evidence associates smoking with ill-health and attention shifts to minimizing harm, the decision-making process widens to accommodate new experts. If this new image is stifled by policy monopolies, then groups pursue 'aggressive venue-shopping' to seek influential and receptive audiences elsewhere (the courts, other types of government, the media, the public).

This discussion of *receptivity* to ideas is key to an understanding of 'policy windows'. According to Kingdon (1995), policy change requires the coming together of problems (policy issues deemed to require attention), policies (ideas or solutions proposed by pressure participants) and politics (changes in the political system that affect the receptivity to ideas). While solutions already exist, their proponents must wait for the right opportunity to present them and have them adopted. This window of opportunity opens when: 'Separate streams come together at critical times. A problem is recognized, a solution is developed and available in the policy community, a political change makes it the right time for policy change, and potential constraints are not severe' (1995: 165–6). This treatment of ideas shifts the focus from an 'idea whose time has come' (suggesting inevitability, with the idea as the main source of explanation) to the need for a range of conditions to be satisfied before a policy will change (suggesting uncertainty, with the acceptance of the idea more important than the idea itself). As Lieberman suggests:

> An idea's time arrives not simply because the idea is compelling on its own terms, but because opportune political circumstances favour it. At those moments when a political idea finds persuasive expression among actors whose institutional position gives them both the motive and the opportunity to translate it into policy – then, and only then, can we say that an idea has found a time.
>
> (Lieberman 2002: 709)

Since a policy window does not stay open very long, an 'idea's time comes, but it also passes', particularly if the reasons for a particular level of attention to the policy problem fade before a coalition behind policy change can be mobilized (Kingdon 1995: 169).

FOUR WINDOWS OF OPPORTUNITY IN THE UK

The relevance to our case study is that while we can identify the *strength* and *promotion* of ideas, we know much less about the *receptivity* to ideas in particular circumstances. To pursue Kingdon's model requires the identification of four distinct 'policy windows' which explain the motive and opportunity of decision-makers to translate public health-driven ideas into tobacco control policies. To this end, the article explores four main sources of explanation for tobacco policy change – institutions, public/media opinion, pressure groups

and policy transfer (see Studlar 2007a). It shows that in each country the explanatory power of each factor differed significantly. First, each devolved government was constrained by uncertain policy competence, while the role of parties within parliament was crucial in each country for different reasons. Second, each reacted differently to public and media opinion. Third, each experienced different levels of pressure group activity. Fourth, each reacted differently to international policy developments. Therefore, the nature of the 'window of opportunity' differed and in each country the rejection of further tobacco controls (in this form at this time) was a realistic prospect. These findings are based on 50 interviews with interest group, civil service and elected representatives from 2004 to 2006 (as part of a broader project – 300 interviews examining developments in public policy in the UK since devolution – Keating *et al.* 2008).

POLICY COMPETENCE

Each devolved territory was uncertain about its ability to change policy. This is clearest in Northern Ireland since the decision to introduce a comprehensive ban was made by an English health minister in the Northern Ireland Office (Shaun Woodward), rather than the (suspended) Assembly, in October 2005. While the National Assembly for Wales (NAW) was the first body to signal its intention to introduce a ban (January 2003), it did not have the legislative capacity to do so. Although non-legislative solutions were mooted, none were likely to be effective. Therefore, Wales was not able to change policy until an enabling clause was passed under Westminster legislation (the Health Act 2006 which introduced England's ban).

While the Scottish Parliament was the first to act, its ability to legislate was uncertain. The ban in Ireland is based on health and safety and employment law, while key debates in Westminster focused on the health and safety of bar workers if pubs or private clubs were exempt from legislation. The decision for Northern Ireland was also framed as 'a policy about protecting workers' (Shaun Woodward, HC 485-III: 73, Q504), while the European Commission's (2007: 19) most likely action is to extend its directive on workplace safety and health (89/391/EEC). This was not a route available in Scotland since these are reserved issues set out in the concordat with the Health and Safety Executive and acknowledged in Scottish Executive documents (Cairney 2006: 437–9). This constrained policy development from 2002 to 2003, with civil servants unwilling to discuss a smoking ban because they deemed it outside their competence (interview, British Medical Association Scotland, 2004). Group frustration prompted greater support for a Member's Bill pursued by Scottish National Party MSP (Member of the Scottish Parliament) Stewart Maxwell. However, Maxwell also reports a feeling of constraint which is reflected in the extent of his bill (to devolved areas, such as where food is served) (interview, 2005). Maxwell was advised never to mention workplaces in the same sentence as the legislation (to avoid legal challenges). A Scottish Executive minister also

advised Maxwell that a 'Sewel motion' was necessary (a Sewel motion is passed by the Scottish Parliament to give Westminster consent to legislate in areas with devolved and reserved elements – Cairney 2006). Yet, when the Scottish Executive decided to legislate, these problems dissolved. The legislation was framed in terms of public health measures and no significant legal challenges materialized. While this may be seen as Scottish Executive success in reframing its own boundaries in the face of UK ministerial opposition (Health Secretary John Reid was opposed to a comprehensive ban), such occurrences are rare (Cairney 2006, 2007a). A better explanation is UK support: Department of Health civil servants helped to draft the Scottish legislation to make sure that it was 'watertight' (interview, Scottish Executive, 2004).

Therefore, the UK government influenced the final decision in all four countries. This qualifies discussions of transfer which stress the influence of the rest of the UK on English policy. There is a long tradition of campaigning 'clientelism' in the UK's Department of Health. In the past, when the tobacco policy community was dominated by the Treasury and Department of Trade and Industry, it would fund groups such as Action on Smoking and Health (ASH) to raise issues and criticize policy (Cairney 2007b). Now, this influence extends to the devolved territories, signalling a complex process of multi-level governance – the influence of devolved policies on the English agenda is furthered by (parts of) the UK government.

THE ROLE OF PARTIES AND PARLIAMENT

The role of parliament varied in each country. Its role appeared to be most significant in Wales. The motion passed by the Assembly in 2003 was the first in the UK. It also set the Welsh agenda since it received support from all major parties (including the Conservatives who voted against in Scotland and England). The main result was the formation of the NAW Committee on Smoking in Public Places which took evidence and studied bans in other countries. In Northern Ireland the suspension of political devolution undermined the formal importance of parliament. However, Northern Ireland was marked by all-party support for tobacco control (particularly after the perception of unnecessary delays by Woodward – see below).

In both Scotland and England the opposition of the Conservatives to tobacco control meant that Labour opinion swung the vote in both Parliaments. However, the role of Parliament differed. In Scotland, the straightforward process to introduce a Member's Bill meant that Parliament could perform an agenda-setting role. In contrast to the convoluted process in Westminster, the Maxwell Bill required 11 MSP signatures to progress to stage 1 examination by a select committee. The Health Committee then took responsibility for bill development, receiving 323 written submissions and meeting seven times to take oral evidence in 2004. The report supported the evidence on passive smoking and the principles of the bill (Scottish Parliament Health Committee 2005). While its findings were moot since the Executive had already decided to

legislate, the attitudes of its members were known well in advance and there was a significant degree of cross-party support for the measures. This acted as a spur and a *resource* for Labour ministers looking for a 'big idea' and no longer worried about the party political effects of tobacco control during the 2005 UK elections (Cairney 2007a).

In England, there was no equivalent to the Scottish process. However, the role of Parliament was just as crucial (Cairney 2007b). The background was a series of 'rebellions' by Labour Members of Parliament (MPs) on issues such as education reform and identity cards. The prospect for further revolt (and a Cabinet split) on an issue not high on the government's agenda was key to the decision to allow a free vote (which was crucial given Conservative opposition to legislation). The threat of revolt was furthered by Kevin Barron MP, chair of the Health Select Committee. Barron was instrumental in undermining Reid's insistence that Labour MPs stick to the 2005 manifesto commitments. He secured committee time to examine the legislation and highlight issues to MPs (including a suggestion from the Chief Medical Officer that he considered resignation following frustration with the UK government line). He secured an agreed line from the committee report and could 'deliver' many MPs to vote for a complete ban (interview, Barron, 2006). Barron and David Taylor MP (chair of the All-Party Parliamentary Group on Smoking and Health) met Tony Blair in November 2005 and persuaded him that a free vote would rescue some leadership credibility within the party (interview, Taylor, 2006). The result was an overwhelming majority who voted for comprehensive legislation (Cowley and Stuart 2006).

PUBLIC AND MEDIA OPINION

Public opinion became the key battle ground for pressure participants pursuing different policy solutions. We can identify three main aspects:

1. The use of different opinion polls or the selective use of the same data.
2. The use of consultation documents rather than opinion polls to demonstrate support.
3. The less precise *feeling* among decision-makers about changing levels of public opinion and the scope for change.

First, we see differences in emphasis according to the agenda pursued. For example, in 2004, while ASH Scotland (2004) used the Office for National Statistics Omnibus Survey to show high levels of support (over 80 per cent) for restrictions in most public places and growing support for restrictions in pubs (to 54 per cent by 2002), the Tobacco Manufacturers' Association suggested that, according to a Scottish Executive commissioned poll, Scottish opinion was 50:50 on the same issue, with 77 per cent against a total ban (BBC News 2004; Curtice 2006: 57). In Northern Ireland, the Health Promotion Agency (2005a) was selective in highlighting its research, stating that '61 per cent of respondents support a law to make all workplaces smokefree

and just 16 per cent oppose the idea' but not that only 34 per cent wanted a complete ban in pubs (2005b: 8). While Alun Pugh AM (Assembly Member) suggested that 'eighty per cent of the public supports controls' (NAW Official Record 22.1.03: 65), the Committee on Smoking in Public Places (2004) reported that attitudes varied, with 91 per cent in favour of restrictions in schools but only 50 per cent in pubs. In England, the UK government was arguably the only one to follow public opinion to the letter:

> Surveys . . . show 86% of people in favour of workplace restrictions, and a similarly substantial majority of people supporting restrictions in restaurants. But when people are asked whether smoking should be restricted in pubs the figures fall substantially – to around 56% – and when people are asked which sort of restrictions they would prefer in pubs only 20% of people choose 'no smoking allowed anywhere' and the majority tend to be opposed to a complete ban.
>
> (Cm 6374, 2004: 98)

Second, since surveys were so subject to manipulation, they could not provide a popular mandate for governments (particularly since the aim of many was to get ahead of and change attitudes). The alternative was to use consultations since they often exaggerated opinion (those most in favour were the most likely to respond). This was done first by the Scottish Executive which distributed 600,000 copies in June 2004 and received over 53,000 responses by October. The response suggested that 80 per cent supported a smoking ban and 56 per cent rejected any exemptions (see Cairney 2007a: 84). Consultation was also a key factor in Northern Ireland, with a strong pressure group and media campaign to highlight the figure of 91 per cent (of 70,000) in favour of a comprehensive ban between the publication of the results (June 2005) and Woodward's final decision (October) (*Belfast Telegraph* 2005a; *Guardian* 2005). This was also used by Woodward to highlight public opinion differences in Northern Ireland (as a justification for policy divergence with England) caused by its proximity to the South (HC 485-III: 72–5). However, the strategy of the UK government showed that information is weighted differently: the results of a similar consultation were ranked below 'the balance of public opinion and the commitment made in the Labour Party Manifesto' (Department of Health 2005: 3).

Third, we may be more interested in élite perceptions of the scope that public opinion affords for change. In Scotland, most interviewees suggested that the conditions for a comprehensive ban only materialized in 2004 (in part following positive media coverage of Ireland). In 1999, a discussion of legislation caused a backlash, prompting the Scottish Executive to back voluntary measures (Cairney 2007a: 83). The perception of constraint was still apparent in the lead up to the 2003 elections, with no party making legislative proposals. Even by 2003 the Chief Medical Officer met with public resistance when publicizing the issue, while the limited nature of Maxwell's bill partly reflected his perception of public opinion. When asked in 2003 why he would not pursue

comprehensive legislation, he suggested it 'was utterly opposed by so many that a full ban would happen but not in their lifetime' (interview, 2005). The Scottish Executive only felt able to pursue a ban when it sensed a shifting public mood (interview, former deputy health minister, 2005). This *sense* of rapid public opinion change was also a feature in England. While John Reid's feeling was that even partial measures would be getting ahead of public opinion (by 2005 33 per cent were in favour of complete restrictions in pubs), the fact that opinion was shifting quickly (pro-restriction in pubs rose from 48 per cent to 56 per cent from 1998 to 2003, and then to 65 per cent in 2004), and that the Ireland and Scotland bans *shifted* public opinion, was one of a number of tipping points for Labour MPs (interview, Department of Health, 2006; Office of National Statistics 2006: 85–7).

PRESSURE PARTICIPANT INFLUENCE

We can identify three main phases of group–government relations. The immediate post-war phase shows domination by tobacco to the exclusion of public health, with a policy image related to the economic benefits (jobs, exports, government revenue) and minimal knowledge of the association between smoking and illness (Cairney 2007b; Read 1996; Taylor 1984). In the second phase, although this link was becoming established, the response was mediated by a policy monopoly and subject to minimal competition from public health groups. The organization and funding of public health opposition was low and the economic benefits of smoking plus the assumption of personal responsibility for health underpinned government attitudes to policy. In the current phase, the socio-economic basis for tobacco support has diminished, the evidence on passive smoking has reframed the policy image and public health groups are relatively organized, numerous and respected within government. In each country we can see high degrees of co-operation among public health groups and the devotion of a disproportionate amount of lobbying time by key groups such as the British Medical Association (BMA). However, there is considerable variation in group strategy and influence.

In Wales, ASH Cymru did not focus on Welsh institutions before the Alun Pugh motion in 2003. In part this reflects organizational devolution in which devolved arms of UK organizations struggle to command the resources to devote to policy. It also reflects a feeling before 2003 that smoking was a reserved issue. The motion 'came out of the blue' and ASH Cymru was 'still creating press locally to put pressure in Westminster' (interview, 2005). Even after the assembly vote, there was a general feeling (interviews, BMA, Royal College of Nursing and ASH Cymru, 2005) that the overwhelming majority (39 AMs to 10) reflected the lack of NAW powers to act. However, the Committee on Smoking in Public Places became a focus for pressure, particularly after the development of policy in Ireland and the committee's recommendation (May 2005) that Wales should follow. Group pressure focused on ensuring that

the Welsh Assembly Government (WAG) treated the issue as a priority when seeking enabling legislation, and making sure that AMs did not change their minds when a ban became more realistic.

In Northern Ireland the most intense period of group activity took place after the consultation was announced. The Smoke Free Coalition (36 statutory, private and voluntary organizations) was launched in February 2005 to promote a public coalition behind a comprehensive ban during the consultation (which ended 25 March). The June announcement by Woodward calling for more time and research was followed by months of media coverage in which public health groups were almost unopposed and the figure of 91 per cent was cited as proof of public opinion (*Belfast Telegraph* 2005b, 2005c).

In Scotland, we see a longer-term and more significant influence of public health groups based on the scope for venue shift to the Scottish Parliament. Frustration with Scottish Executive inaction prompted groups to back a Member's Bill. This support hardened following the evaluation of voluntary measures in October 2003 which suggested that seven out of ten pubs did not implement them. Maxwell's bill was seen as a good start and a way to pressure the Executive. This came to a head when Maxwell arranged for a range of groups to appear alongside him as he published his bill in February 2004. At short notice, most groups pulled out of the event on the assurance that the Executive would introduce comprehensive measures (interview, 2005). Groups were then used by the Executive to promote comprehensive legislation during its consultation period.

In England, significant pressure was directed towards 'quiet persuasion' within government. This was mostly to the Department of Health but was also crucial to developments in the Treasury. The Treasury-commissioned Wanless review (2004) was critical of efforts to meet targets in the reduction of smoking (a key determinant of health inequalities) and recommended that the government consult on public support for 'firmer action' such as a smoking ban. This led to the *Choosing Health* White Paper (Cm 6374, 2004) and its consultation. However, when it became clear that the UK government legislation would produce a partial ban, public health pressure shifted significantly to Parliament in the run-up to the vote in February 2006. The resultant level of MP support was achieved following an unusual amount of pressure. Groups like the BMA and ASH not only targeted MPs directly, but also through the local media, while local doctors put pressure on at the constituency level. The timing of the English vote (February 2006) also ensured that the Irish experience and the decisions already taken in the rest of the UK could be used to influence MPs.

INTERNATIONAL INFLUENCE AND POLICY LEARNING

In the UK there were two main sources of policy learning. The accepted model by governments and public health pressure groups (based on the experiences of California, New York and New Zealand) was of incremental change until bars

were isolated and public opinion shifted (interview, Department of Health civil servants, 2006; Cairney 2007b: 51). Then, the Irish experience demonstrated that a relatively quick and complete ban was politically acceptable, while the implementation experience was positive (Cairney 2007a; Howell 2005). The use of this international experience differed within the UK. Each country *seemed* to flirt with the idea of incremental change before appearing to be swayed by their visits to Ireland. However, this process varied according to the timing of each country's announcement (in relation to the level of Irish experience that could be drawn on) and the dynamics within each system.

In Northern Ireland, tobacco control measures were mooted in December 2004. Within a broader vision of public health, the health department highlighted three options for change: voluntary measures, a partial ban in line with England, or a comprehensive ban following Ireland and Scotland (DHSSPS 2004: 9). When consultation produced widespread support for the third option, Woodward announced in June 2005 the intention to introduce at least a partial ban, but with more consultations with businesses/unions and visits to New York and Ireland required to assess the effects. Then in October 2005 Woodward announced comprehensive measures. There is some debate about the effects of policy transfer. Wilford and Wilson (2006: 66) suggest that media and pressure group attention to the Irish success, and the decision in Scotland to follow it, made the decision almost inevitable, particularly since cross-border comparisons were so stark. Yet, Woodward points to public opinion and the visit to New York (with a greater evidence base) as the key factors (HC 485-III: 72–5).

In Wales the initial motion to seek the powers to legislate (22 January 2003) was passed eight days *before* the Irish announcement and so could not draw on this experience (Ireland initially announced a partial ban in November 2002). This is reflected in the statement from the motion's most fervent proponent (Alun Pugh) suggesting initially exempting pubs, night clubs and private members' clubs in line with the established international approach (NAW Official Record 22 January 2003: 65). The staged approach identified in California was also favoured by the Welsh Assembly Government (NAW Official Record 22 January 2003: 83). By May 2005, the NAW's Committee on Smoking in Public Places report called for the legislative power to follow Ireland's example.

In Scotland, the prospect of a smoking ban arose in a parliamentary debate in 1999 (Scottish Parliament Official Report, September 1999, Col. 48). However, after a public backlash, a serious attempt did not materialize until Maxwell's bill was publicized in June 2003 and examined by the Health Committee from June 2004. Given that dissemination of the Ireland experience began from March 2004, it becomes difficult to disentangle the reasons (policy transfer versus internal politics) for moving from Maxwell's partial ban to a comprehensive ban. Maxwell's initial reticence to go comprehensive was in part based on a perception of unfavourable public opinion. Then the Irish experience shifted élite perceptions on the popularity of more ambitious measures. Ireland also became a focal point for Health Committee analysis of

Maxwell's bill and was widely credited with changing the minds of many MSPs after a series of delegations. This included (then) First Minister Jack McConnell who had suggested in January 2004 that a ban was unworkable, but then supported it after his trip in August (Cairney 2007a: 83). However, there are equally convincing internal reasons for the shift, with several interviewees stressing the desire of the Executive's Labour Party to 'trump' Maxwell's bill after it became clear that the Health Committee would support it (2007a: 79). More importantly, Maxwell suggests that *Labour's decision was already made by February 2004* (i.e. before the Irish implementation) and a deal was struck with Maxwell: if he stopped criticizing the Executive's stance, they would appear to come round to the idea of a ban over time (interview 2005).

In England we see similar policy shifts resulting from a change in 'ownership'. In this case it shifted from the government to Parliament. Although the value of the Irish approach was accepted in all three devolved jurisdictions, John Reid initially ensured that the UK response was incremental. The argument was that England is bigger than any other country which has gone for a complete ban and the implementation would be more difficult (interview, Department of Health 2006). This stance was articulated by the Department of Health during Westminster's Health Committee inquiry (HC 485-III: 8, Q12). A wholesale shift more sympathetic to the approach taken by Ireland was made possible only when government policy was overridden in Westminster.

In all four countries the propensity to transfer policy from Ireland appears to be the deciding factor. Yet, in each case the extent of transfer is unclear. First, a common feature of the transfer process is that governments look to international experience to legitimize their own aims (Dolowitz and Marsh 1996: 347). While the Scottish Executive used Ireland, the UK government chose the US. Second, although all four countries are geographically close to Ireland, it is only the devolved territories which engage regularly in learning with it. The size of England (and the attitude of its decision-makers) leads to a search in bigger European countries or to the US (interview, Department of Health, 2006; Dolowitz and Marsh 2000). Third, the influence of the Irish experience was only made possible by delays in the final decision associated with devolved competence. If the Welsh decision had not been delayed, it would have led the way with a partial ban. Fourth, in Scotland and England the move to comprehensive legislation may be better explained by venue shift. In Scotland the shift from Parliament to Executive ensured that the decision took place *before* implementation in Ireland, while in England a shift in the opposite direction undermined a UK government commitment to incremental change. Further, by this time the pressure from decisions made in the rest of the UK was more significant than Ireland (Cairney 2007b: 55).

DISCUSSION

The process of adopting apparently simple ideas is remarkably complex even when: (a) the political system does not appear to be as 'messy' as the EU or

US; and (b) a relatively simple policy solution is available to transfer from another country. A full examination of the role of ideas requires the identification of 'windows of opportunity' when problem, policy and politics streams come together for short periods (Kingdon 1995). In our case study of smoking bans in the UK, this necessitates the identification of four distinct windows. These windows bear a family resemblance since two of the three 'streams' are very similar. The balance of power within government between public health and tobacco company interests (and therefore the power to frame the policy problem) and the policy solutions available (the status quo, partial ban, comprehensive ban) are common to each country. The difference comes in the politics stream which refers to the changes in the political system required to make attention to the problem and receptivity to one particular solution more likely.

In England we see that, in the post-war period, health ministers were often marginalized by more powerful interests in the Treasury and Department of Trade and Industry who enjoyed a close relationship with tobacco companies (Cairney 2007b). The effect of John Reid's appointment as Health Secretary was to ensure that the Department of Health became central to tobacco control policy, which gave greater prominence to its Chief Medical Officer, and accelerated the rising influence of public health groups and the fall from grace of tobacco interests already suffering from the decline of smoking and tobacco-related benefits to the UK economy. However, the centrality of Reid also ensured that a comprehensive ban was resisted by the UK government until Westminster reversed this decision. This level of parliamentary influence is unusual, with the crucial free vote only made possible by a period of Labour rebellions and the prospect for further revolt on an issue about which the UK government was ambivalent. In turn, Labour MP support was made possible by health committee influence, unusual levels of pressure participant activity, and developments in Ireland and the rest of the UK which contributed to rapidly shifting public opinion and a growing perception that England should follow suit. This direction of indirect coercive transfer is unusual since England normally looks elsewhere and takes the lead in the UK (Cairney 2007b).

In Scotland, the window opened following the introduction of a Member's Bill which gathered parliamentary support following health committee investigation, and public health group support following reports that the voluntary system was not working. While Labour ministers in the Executive could have defeated Maxwell's bill, there was a greater incentive to 'trump' it and address the need felt by ministers for a 'big idea' to deflect attention from unfavourable publicity surrounding the Scottish Parliament building, and show that devolution could 'make a difference' in the light of unfavourable comparisons (with England) of service delivery in the National Health Service (Cairney 2007a). These factors, combined with the appearance of public opinion shift and the lack of opposition in the other parties, were exploited by an Executive minister personally committed to tobacco policy change.

The analysis of Wales suggests that the most crucial factor in Scotland was the scope for difference afforded by the devolution settlement. While we can identify a series of reasons for the NAW to support comprehensive legislation – an early debate which established the principle, a Welsh commitment to public health policies, a committee process which reinforced demands for change in the light of Irish experience, shifts in public opinion and the efforts of pressure participants to keep the issue high on the Welsh agenda – the window of opportunity remained closed for years and only opened when the issue was considered in Westminster. This contrasts to an extent with Northern Ireland, which appeared to have less scope for divergence following the suspension of political devolution, was characterized as the territory least likely to engage in significant health policy change (Greer 2004), and which visited the issue relatively late as part of a broader strategy on public health. Yet, the window was less sticky in Northern Ireland following the apparent success of policy in the South which contributed to a strong steer from public consultation, media coverage, group and party pressure. The role of the Northern Ireland minister as decision-maker (rather than the intermediary role performed by the Secretary of State for Wales and Northern Ireland) ensured that this swell of opinion could be translated to policy change in a way not possible in Wales.

This experience tells us two things about the role of ideas in policy transfer. First, Kingdon's discussion of 'an idea whose time has come' has a strong resonance. In all four countries the new knowledge associated with passive smoking and the Irish experience appears to be the most crucial factor enabling uniform policy change to take place within the UK. The influence of ideas associated with the smoking ban was strong and the promotion of these ideas within government was effective (in part since previous battles on tobacco control had already been won). This process has become increasingly significant to the EU, since similar changes are taking place throughout most member states (albeit at a slower rate – see Joossens 2007). The explanatory power of the role of ideas is that the same basic idea has persisted in slightly different forms and set the agenda throughout multiple political systems.

Second, an idea's 'time' comes hand in hand with receptivity even in cases where the influence of ideas is strong. Our explanation for the adoption of policy is incomplete without a detailed exploration of 'windows of opportunity' (Kingdon 1995). Although the same policy was adopted by four governments, the differences in timing, motive and opportunity were significant. Uniformity was not inevitable. Indeed, the problem with this line of reasoning is that we can only come to such conclusions *after the fact*. While convergent policy change may *now* seem inevitable, a more detailed analysis shows the dependence of policy change on a wide range of actors, institutions and factors which just happened to be common to each country in this case. In most other devolved UK policy areas this has not happened to the same degree and it is often difficult to identify a common idea at the heart of policy (Cairney 2009b). Further, since there is an almost infinite number of ideas which could rise to the top of the political agenda, we can usefully see the process as one of competition to

dedicate political time to one idea at the expense of the rest. Therefore, a focus on the success of one idea exaggerates the role of ideas in general, since it ignores the failure of most others. In most developed countries, the post-war tobacco experience suggests that the idea took a long time in coming. There were significant time lags (often lasting decades) between the production, acceptance and use of scientific knowledge which undermine the picture of inevitable change. The international experience suggests that the idea has only become an irresistible force in some countries. Therefore, a focus on comparative policy windows reinforces the symbiotic relationship between ideas and interests. An idea's 'time' comes hand in hand with receptivity, requiring the motive and opportunity of decision-makers to translate ideas into policy.

Biographical note: Paul Cairney is a Lecturer in Politics, School of Social Science, University of Aberdeen, UK.

Address for correspondence: Paul Cairney, School of Social Science, Edward Wright Building, University of Aberdeen, Aberdeen AB24 3QY, UK. email: paul.cairney@abdn.ac.uk

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