Using Devolution to Set the Agenda?

Venue shift and the smoking ban in Scotland

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Abstract

This article examines the changing agendas on smoking-related issues in Scotland. It charts the methods that groups, governments and MSPs use to frame and pursue or suppress discussion of the prohibition of smoking in public places. The article presents two narratives– one which stresses 'new politics' and the ability of groups to influence policy through Scottish Parliamentary procedures, and another which stresses Scottish Executive 'business as usual' and presents smoking legislation as a logical progression from early ministerial commitments. A combination of narratives suggests that tobacco legislation in Scotland was by no means part of an inevitable international trend towards prohibition and this article traces the precise conditions or 'policy windows' in which decisions take place. The discussion highlights the often unsettled nature of the devolution settlement and the ability of Scottish issues to influence UK agendas. [1]

[1] The definitive version is available at wileyonlinelibrary.com.

By 2006 all four countries in the UK had decided to legislate to ban smoking in public places. This, combined with measures on tobacco advertising, smoking cessation and health education, makes the UK one of the most progressive member states in the EU on tobacco policy (see Joosens, 2004). It also substantiates a long-term global trend towards tobacco prohibition in the developed world (Studlar, 2004). However, the picture has not been one of clear-cut and effortless policy change. The evidence from post-devolution Scotland in particular suggests that there was by no means an inevitable progression towards comprehensive tobacco prohibition. When the decision to legislate was made official in Scotland at the end of 2004, a complete ban went against the government position in England (a case made forcefully by then Secretary of State for Health John Reid).[1] The legislation was set to mark one of the most significant policy divergences between Scotland and England since devolution. It was one of the Scottish Executive's 'flagship' policies and, to this day, First Minister Jack McConnell calls it the most important achievement in his term of office. Yet, as recently as January 2004, he voiced public opposition to comprehensive legislation. In this light - of opposition from the UK health minister and ministerial equivocation within Scotland - tobacco policy change in Scotland is significant. We have witnessed policy change not only in terms of a break from the voluntary tobacco agreements of the past, but also a break from the policy of the UK government and a change of stated policy position by the Scottish Executive. So how do we explain this policy change?

Political science has long been dominated by theories which explain why policy does *not* change. For example, incrementalism points to the limits of rational comprehensive

decision making and a policy process which undermines radical policy shifts. Similarly, policy networks analysis focuses on close group-government relations which foster long-term consensus and attempt to minimise external interest in policy issues. Of course, problems arise when policy appears to change significantly and a lack of dynamic elements may be held responsible for the decreasing popularity of policy networks analysis. One notable exception is an attempt to combine theories of change and agenda setting with theories of stability and policy monopoly. The term 'punctuated equilibrium' describes lengthy periods of relative stability punctuated by the reframing of issues and brief but intense periods of policy change (Baumgartner and Jones, 1993). This approach is relevant to tobacco policy which appeared reasonably stable in the UK and therefore constrained in Scotland. The case study of smoking in public places demonstrates the importance of issue framing as well as venue shift in a continually evolving devolution 'settlement'. As Baumgartner and Jones (1993: 32) suggest:

> Policy venues are the institutional locations where authoritative decisions are made concerning a given issue. Policymaking authority is not automatically assigned to particular venues … Just as images may change over time, so may [issues] fall within several venues.

In the case of smoking policy and devolution in Scotland, successful attempts to reframe, or shape the policy image, of an issue *caused* a shift in the policy venue. This can be seen in two main ways:

1. A shift of the policy venue considering a smoking ban from the UK to the Scottish arena; caused by
2. A shift of group attention from the Scottish Executive to the Scottish Parliament.

Successful reframing causes venue shift and the scope for legislating in a devolved Scottish Parliament appears to grow. In this case, the process of changing the policy image is inextricably linked with venue shift, since it is now framed as a devolved rather than a reserved issue. However, the extent of this shift is open to debate and two distinct 'narratives' can be inferred from official reports and interviews conducted with groups, ministers and MSPs from 2003-6.[2] The first argues that smoking policy was established and accepted by the Scottish Executive as a reserved issue following devolution (in part to limit the potential for debate). However, a successful shift of group attention to the Scottish Parliament as a venue for change, coupled with the agenda-setting effects of Scottish Parliament legislative initiation, 'forced the hands' of Scottish Executive ministers in 2004. This shifted consideration of the issue from the UK to Scotland as the issue was reframed as a public health and therefore devolved issue. The venue shift allowed comprehensive policy change in Scotland which contrasted (at the time) with the UK reliance on voluntary agreements.

We can compare this with a second account which undermines the significance of this shift. The agenda on smoking has changed over a longer period and governmental positions in the UK and Scotland are fluid rather than fixed. While the Scottish Executive was committed from 2000 to a voluntary agreement in the UK mould, this is

explained by similar policy conditions rather than reserved constraints and the need to avoid political embarrassment. The Scottish Executive introduced the voluntary arrangement in the leisure industry as part of a series of smoking cessation measures and stated that this approach was a stepping stone to legislative change if the agreement was unsuccessful. The decision to legislate in 2004 was therefore a logical progression of the original Scottish Executive policy.

The focus on two narratives reflects the competing accounts of policy makers and pressure participants in the course of interview. However, there are a number of other causal factors which are common to both accounts – policy learning from the experience of Ireland, shifting public opinion, media opinion sympathetic to policy change and the policy stances of the major parties. This article therefore combines both narratives and draws on these shared elements to construct a 'third way' narrative of policy change in Scotland. The conclusion considers the extent to which lessons from the case study of tobacco are applicable to wider political science debates.

The Venue Shift Narrative: Limits to Policy Change and the UK Context

In many ways it is easier to explain why policy would not change in Scotland. The UK position was that a voluntary agreement with the leisure industry and an Approved Code of Practice on smoking in the workplace was the best means to address the issue of smoking in public places (see Cm 4177, 1998; Read, 2005). This had an overarching influence on the scope for change in Scotland, given what we know about the power

relationships which have developed since devolution. First, the UK government has a strong influence over the Scottish Executive, through the Treasury, party and civil service links. Scottish divergence is either unlikely given their shared aims, or undermined by the need to avoid political embarrassment or repercussions. For example, the decision to take a separate line on free personal care for the elderly was met with Treasury inflexibility over Attendance Allowance payments, while Hepatitis C compensation was delayed in Scotland because of a Whitehall challenge on the basis of devolved competence (Cairney, 2004; Keating, 2005; Keating et al, 2003; Lodge, 2003; McMahon, 2002; Simeon, 2003). Second, the Scottish Executive enjoys an 'old-Westminster' style relationship with the Scottish Parliament and the Labour and Liberal Democrat coalition in Scotland whips as effectively as a majority government in Westminster (Arter, 2004a; 2004b; Cairney, 2006a). Third, groups in Scotland talk about increased and better access, but also cosmetic consultation and a lack of translation of access into influence, especially when the Scottish Executive has stated its position.

Therefore, any change in a stated Scottish Executive position (with a UK basis) is surprising. This explains the importance of venue shift – if groups are frustrated by a fixed position in one decision-making venue then it is in their interests to foster a shift to a venue with a more sympathetic audience. This is made possible by the power of the Scottish Parliament to set the policy agenda and force the hand of the Scottish Executive.[3]

Two 'New Politics' Explanations?

New politics is a reference to the development of a Scottish political system designed in contrast to 'old Westminster'. This includes the strengthening of committees within parliament and a focus on government by consensus (see McGarvey, 2001; Mitchell, 2001; Arter, 2004b; Keating, 2005; Shephard and Cairney, 2005; Cairney, 2006a). In this light we can examine two Scottish differences as a means to explain policy initiation. The first is increased group influence in more than one venue. While the effect of devolution is often exaggerated, groups generally report an increased willingness of the Scottish Executive and Parliament to maintain regular and frequent links. This may be associated with a lack of policy capacity in Scotland. Decision-makers did not have the expertise and research base to initiate policy in the early years of devolution, and so were reliant on groups (and local government) to make up this shortfall. There is also evidence of a stronger role for public sector professionals in Scotland, as well as a greater concentration of medical and Royal College influence in Scotland (Keating, 2005; Greer, 2004). As a result, strong links are apparent between groups and the Executive, while groups have the ability to 'hedge their bets' (see HC 518-iii, 1988) with a Scottish Parliament equipped with more powers than Westminster (and most West European legislatures – see Arter, 2004a; 2004b; Cairney, 2006a).

Second, there is increased scope for agenda-setting in the Scottish Parliament through the powers that committees enjoy, as well as the increased scope for non-executive bills. In Westminster there are 3 main ways in which to pursue a Private Members' Bill, with the

highest chance of success granted for those backbench MPs whose names appear near the top of a ballot held within 2 weeks of the commencement of each parliamentary session (Convery, 2000). MPs assume their bills will fail without government support and may not decide which Bill to pursue until they are sure that they are high enough on the list. They may put their name forward with more intention to trade the parliamentary space or introduce Members' Bills as a form of pressure – to highlight an issue or to encourage the government to introduce its own bill.

In Scotland the process is more straightforward and non-executive legislation (members', committee and private bills) accounts for a relatively high proportion of the total (11 of 61 Bills from 1999-2003). An MSP with agenda setting motives has a better chance of public debate and attention. The MSP registers a proposed Bill with the Clerk and it is published in the Business Bulletin. S/he then has one month to gather the support of at least 18 other MSPs.[4] If this support is demonstrated the Bill is subject to committee investigation and then plenary debate. In the case of tobacco advertising, this allowed opposition MSPs to put pressure on the UK government to reintroduce legislation which fell after the dissolution of Parliament in 2001. This was a relatively simple process, since the issue was not of policy but of legislative time and inclination (the bill had already been introduced in Westminster and legislation was needed to fulfil EU requirements – see Read, 2005). Therefore, when the bill was introduced in Scotland it was difficult for the Scottish Executive or UK government to discourage Scottish legislation on policy grounds. The Scottish agenda on smoking in public places also spurred on the UK's white paper *Choosing Health* (Cm 6374, 2004), while the timing of

the introduction of a smoking ban in Scotland was used by MPs and public health groups in the UK to embarrass the UK government and press for a free vote (Cairney, 2006c). However, the difference is that the Scottish bill on public places did not have a UK counterpart at that time, while the policy debate was less settled and there was still competition surrounding the framing of the issue.

Venue Shift and Framing as a Reserved and a Devolved Issue

International experience of tobacco policy framing shows that the Scottish experience is not unique. For example, we see a shift in issues of *causality*. In the early post-war period this reflected an association between active smoking and lung cancer. More recently, this attention has shifted to the carcinogenic effects of passive smoking, as well as the effectiveness of ventilation in public places. The identification of cause influences debates over the means to *categorise* the smoking issue. For most of the 20th century in the UK the significance of tobacco to the economy and the rights of the individual to smoke took precedence over health issues particularly before the evidence on passive smoking was linked to health and safety (Cairney, 2006c). Policy can also be framed in terms of *comparisons* and policy learning across countries. While the Irish comparison has been so significant in Scotland (see below), it took action after New York, California, Canada, New Zealand, Australia and Sweden (see http://www.globalink.org/tccp; Studlar, 2004). Debates also revolve around the success and failure of initiatives in other countries.

However, the added element in this case is competition surrounding the framing of the devolution settlement and Scottish Parliament competence. An unanticipated consequence of devolution is the often fluid boundary between reserved and devolved issues. When there is a drive to reframe policy issues there is scope for MSPs to push the boundaries of Scottish Parliamentary competence (a process also apparent in the European Parliament – see Hix, 2002).

The initial framing of smoking in public places as a reserved issue arises from the basis of its prohibition. In Ireland the smoking ban was based on health and safety and employment law, with the agenda driven by an emphasis on bar workers. Similar debates dominated the run up to the free vote in Westminster, with the initial food/ non-food distinction criticised because it protected the rights of restaurant but not bar workers. However, in Scotland there was clear reticence to use these arguments since the basis of legislation would impinge on reserved territory. As the concordat between the Health and Safety executive and the Scottish Executive suggests, 'The regulation of smoking and passive smoking in work places is a reserved matter' (http://www.Scotland.gov.uk/concordats /hse-00.asp; see also Scottish Executive 2004a: 26). Further, groups such as the British Medical Association in Scotland expressed frustration that civil servants within the Scottish Executive (in early 2003) would take this stance when engaged in consultation – they would not discuss a smoking ban because they deemed it outside Scottish competence. While the reserved element is based on a concordat rather than a specific reference to smoking in the Scotland Act, the scope for negotiation was also restricted in discussions with the civil service: 'You couldn't talk to

them about the specific issue. It is a 'ministerial decision'' (interview, chief executive ASH Scotland 2004). In other words, the framing of the smoking ban as a reserved area by the Scottish Executive was a classic example of *non-decision making*, by rejecting Scottish competence and therefore limiting discussion in meetings with groups.

However, groups had a realistic alternative venue to pursue the issue in the Scottish Parliament. MSPs and ASH Scotland set up a cross-party group on tobacco control (in 2000) and part of its agenda was to tackle smoking in public places by framing it in terms of devolved competence:

> We can't do health & safety in Scotland and so to get rid of smoking in the workplace we would need a Westminster bill. But we can do it through public health and therefore legislate on closed public places (which are mainly workplaces) (interview, ASH Scotland 2004).

The main output of this process was a members' bill lodged by Stewart Maxwell MSP (Scottish National Party) in February 2004. This was limited in scope, applying to premises where food (largely a devolved area) is served and consumed (SPICE, 2004a; SP Bill 20-PM 2004). Maxwell was constrained by uncertainty over the extent to which public health measures could be extended and he was even careful to avoid mentioning workplaces in public to avoid a legal challenge.

The process which followed the introduction of the bill demonstrates two aspects of the distinctiveness of the Scottish process. First, Maxwell was aided by the Non-Executive Bills Unit, designed to address the problem of MSP resources when drafting legislation. Second, the lack of MSP ability to consult widely with groups and affected interests is addressed by the committee process in the lead up to its stage 1 report. At this stage the lead committee takes responsibility for the development of the bill. The Health committee received 323 written submissions and met 7 times to discuss the bill in 2004 before delivering its report. The report was supportive of the evidence on passive smoking and the principles of the bill and critical of the voluntary arrangements. It concluded that if anything the 'bill does not go far enough.' (Scottish Parliament Health Committee, 2005).

The Effect of Venue Shift

In January 2004 the Scottish Executive First Minister rejected calls for legislation on this issue. However, the result of pressure - from groups acting in two venues, a member's bill making good progress in the Scottish Parliament, and a supportive committee process - was a reversal of this position. This narrative is confirmed by Mike Rumbles MSP (Liberal Democrat):

> Stewart Maxwell's bill deserves the credit. The pressure from him made the difference. While in June 2004 our policy committee made us the first party to formally adapt a no-smoking policy, when I led the Liberal Democrat team in

> negotiations over the Partnership Agreement [in 2003], even none of us went that far.

Maxwell's bill would have made 'great progress' because of the scope for cross-party support and the lack of an effective opposition:

> This is the power of the committees and the Labour government is aware of this. Once you get the committee on board it is difficult to block it. It is far more important to get it past committee discussions than, say, a full discussion at stage 3. The leisure industry and tobacco lobby didn't realise the momentum building from the stage 1 committee review and the evidence the process gathered. The collection of evidence is what the committee system is based on and the medical evidence was unequivocal.[5]

When Maxwell's bill was taken on by the Health committee a head of steam built up in Parliament around the unanimous public health message presented to it by groups during the evidence sessions. The committee's deliberations eventually produced a recommendation for a comprehensive ban. Although the committee held back its report until January 2005 (two months after the Scottish Executive had decided to legislate), the shifting views of the committee members were known to Scottish ministers well in advance since they were expressed in meetings between the deputy health minister and Labour members (which were held directly before health committee meetings).

The Scottish Executive was therefore faced with the choice between supporting an opposition member's bill, challenging vocal and relatively powerful public health interests in Scotland, or pursuing more ambitious legislation in an effort to 'trump' Maxwell's bill. The response following a public consultation was the latter:

> Legislative action is now required if we are to make any real progress in this area … Although there is much support for an approach that would create separate smoking or non smoking areas within leisure and hospitality premises, such an approach is difficult to justify on public health grounds given that there is no defined safe level of exposure to second hand smoke (Scottish Executive, 2004d).

This statement marks a significant shift in policy since Jack McConnell previously argued that legislation would be 'draconian, difficult to implement and unpopular' (interview May 2005). There is also evidence that Scottish ministers clung on to the idea of voluntary regulation during the consultation period:

> I went with McCabe [the deputy health minister] on panels around Scotland to have the debate and he hadn't decided exactly which way to go – the strengthening of the voluntary agreement (perhaps with local authority input) was another option (interview ASH Scotland 2004).

This equivocal approach is confirmed in *A Breath of Fresh Air For Scotland* (Scottish Executive 2004a: 25):

> Clearly legislation is one option but, equally, an extension of the voluntary approach remains an option also. Much progress has been made in smoke-free environments in public places in Scotland through voluntary action … in our view statutory controls would only be truly effective – and ultimately enforceable – if they take place in an environment in which the legislation reflects rather than attempts to force public opinion on what remains essentially an issue of personal behaviour.

The Logical Progression Narrative: A Fluid Rather Than Fixed Position

The logical progression narrative challenges the idea that legislation marked a significant policy shift. It suggests that UK and Scottish positions on smoking were fluid rather than fixed and that a subtle reweighing of Scottish Executive priorities produced policy change which only *appears* to be a U-turn. The voluntary agreement was a stepping stone towards smoking prohibition and recent legislation is part of a wider package of public health policies aimed at reducing tobacco consumption in Scotland.

We can outline the first point by examining the susceptibility of decision maker preferences to changing policy images and the change in those images over time. As Jones (1994: 5) argues, decision-makers have a multiplicity of preferences and so they 'value or weight preferences differently depending on the context in which they are

evoked'. Jones and Baumgartner (2004) suggest that information is freely available but varies in reliability and weight: 'a decision-maker explicitly forms an index out of numerous often noisy sources of information, and keys future choices to the value of the index'. The reliability of sources and the weight attached to indicators changes over time, and the salience/ weight of the issues can change quickly. This process can also be used as a *resource* by decision-makers who have attached different weights to their preferences in the light of new information. In other words, stated preferences are subject to change if policy problems are framed in a different light, perhaps following successful advocacy, a changing public mood or new evidence (including the experiences of other countries). Therefore with smoking policy it may not take much to cause what *only appears to be* a large shift in policy if the policy image of an issue or external consideration of that issue has changed.

A gradual shift in attitudes towards tobacco is apparent over a long period. As Baumgartner and Jones (1993: 90-2) discuss, in the US attitudes revolved around tobacco as a positive (a valuable export crop which attracted government subsidy) and as a negative (public health effects). At the start of the 20th century, tobacco attracted minimal media attention and most government attention was favourable. Tobacco was an important industry and governments deferred to experts in agriculture. Industry leaders benefited from a period of low attention to public health followed by a 'true glorification of smoking immediately after the war' (1993: 93).

Since the 1960s we have seen a shift of emphasis, including raised and negative media coverage reflecting the success of health professionals in mobilising opposition. Baumgartner and Jones (1993: 91) identify an exponential rise in the number of negative articles on tobacco from pre-1950 to the 1980s, as well as a similar drop in public consumption of tobacco over the period. Crucially, this rise in negative attention to the issue leads to a reappraisal of the positive aspects. In this case, the economic benefits are undermined by a focus on rising health insurance and decreasing worker productivity (1993: 114). If we look at the issue of tobacco from the post-war period in the UK we can see similar periods of reframing, including:

1. Changing messages about the risks of smoking – studies in the 1950s reporting the relationship between smoking and lung cancer; publicity surrounding the Royal College of Physicians report, 'Smoking and Health', the first US Surgeon General report on 'Smoking and Health' in 1964, and the WHO report on 'The limitation of smoking' in 1970.
2. Changing private sector responses to smoking – a general move towards increasing the provision for non-smoking in airlines, cinemas and public transport from the early 1970s.
3. Progressive governmental responses – from the first voluntary agreement with the industry on advertising and health warnings on packs in 1971, to legislation in 1991 addressing the sale of cigarettes to children (ASH, 2005).

In other words, UK government policy on smoking is fluid rather than fixed, with a long-term trend towards smoking prohibition. While we may identify periods of industry influence even in modern times (e.g. in the reliance on voluntary schemes), these are subject to continuous challenge from public health professionals and groups. A more recent shift followed the election of a new party of government in 1997. The Labour Government's White Paper *Smoking Kills* (Cm 4177, 1998) represented a watershed in the debate.

The Logical Progression of Scottish Policy

This allows us to view the Scottish response in a different light – as an extension, rather than a contradiction, of a longer-term UK policy which was moving incrementally in a similar direction. Scottish health ministers also challenge the idea of UK interference and 'turf wars' over competence. Indeed, while John Reid was speaking out against a comprehensive ban in England, civil servants within the Department of Health were more supportive of Scotland's efforts behind the scenes. The issue of devolved competence was a routine problem whose solution was only sought after the decision was taken to legislate in the light of new evidence.

Recent moves to legislate marked a logical progression to the initial introduction of a voluntary scheme. At the time of the its introduction in Scotland (2000), the view of Scottish Executive ministers was that a voluntary scheme was necessary to build up a

'head of steam' and create a sense within the tobacco and leisure industry that things would change in the future:

> We were very explicit that we had to go down the voluntary route first. You couldn't go from a standing start. There was a whole load of other things to consider and progress – the need for education, backing and a sense among those affected that a change was on the horizon.

We can also see the legislation as a logical progression to: a wider public health agenda promoted by the Chief Medical Officer since 1999; the Scottish Executive's equalities agenda[6]; and to wider smoking related initiatives such as providing nicotine patches on prescription and increasing smoking cessation services. In various publications and public statements the Scottish Executive stressed the need to constantly assess its position as part of a broader public health strategy (see SPICE, 2004b). For example, following Chief Medical Officer pressure, the profile of health improvement was raised within the Scottish Executive's 2002 White Paper *Partnership for Care*. This identified five factors at the root of health improvement – tobacco, alcohol, diet, exercise and drugs – and the CMO identified tobacco as the biggest of the five in the 2003 launch of his annual report. The Scottish Executive was committed to monitoring and evaluating the voluntary agreement and commissioned ASH Scotland and NHS Health Scotland to produce a report in October 2003. It suggested that an evaluation would be combined with the pursuit of higher targets on smoke-free public places (Scottish Executive 2003: 32).

There is also a commitment to consult on increasing smoke-free restaurants and pubs in the 2003 Partnership Agreement (Scottish Labour & Scottish Liberal Democrats, 2003).

The main driver towards legislation was the outcome of the monitoring process of the voluntary agreement. ASH Scotland and NHS Health Scotland found that 7 out of 10 pubs did not implement the voluntary arrangement and this prompted deputy health minister Tom McCabe to pursue the matter further within the Scottish Tobacco Control Strategy Group. This process produced *A Breath of Fresh Air For Scotland* (Scottish Executive 2004a: 26) and McCabe announced a consultation on the back of the pressure surrounding the issue (which included the chief medical officer's call for legislation at the public launch of his annual report). Following this consultation the Scottish Executive found that the area was more conducive to policy change than it thought and acted accordingly.

Developing a 'Third Way' Narrative

It is inevitable that evidence from actors competing within political systems produce incomplete and often contradictory explanations for policy change. The venue-shift narrative suggests that the scope for policy change in Scotland was limited by a combination of the UK government's position, its relationship with the Scottish Executive and the Executive's control of the Scottish Parliament. The reframing of smoking policy in terms of public health rather than health and safety, combined with the improved agenda-setting ability of the Scottish Parliament caused a venue-shift and contributed to significant policy change. However, this is undermined by the lack of

evidence of Whitehall control and the fluid nature of UK and Scottish ministerial positions on the issue. While the reliance on voluntary agreements may suggest a level of tobacco-lobby influence, it is difficult to demonstrate that the move to legislate marked a reversal rather than an acceleration of Scottish Executive policy. The logical-progression narrative suggests that comprehensive legislation was consistent with earlier Scottish Executive strategies. The voluntary approach marked a starting point for change and when the Scottish Executive confirmed its limitations, legislation was introduced to further the smoking agenda. The voluntary approach was therefore consistent with the decision to legislate. However, this narrative alone does not explain the timing of the decision to legislate, particularly since the inadequacy of the voluntary approach was related to ministers at least three years before the introduction of the Scottish Executive's bill (interview, ASH Scotland, 2004). It also struggles to explain the First Minister's stated opposition to legislation as recently as January 2004 and the frustration of public health groups with the Scottish Executive's lack of progress. It is therefore necessary to supplement these narratives with more attention to the causal factors identified in both narratives - policy learning, media opinion, public opinion, and the role of parties.

A degree of broad policy learning is apparent during the Scottish process with, for example, the Health Committee taking evidence from public health interests in New York. However, the Irish experience in particular is relevant to Scotland for three reasons. First, as Rose (1993) suggests, policy learning is fostered by 'geographical propinquity'. Scotland and Ireland already had close cultural and governmental ties, while similar populations and geography often makes policy learning between Ireland

and Scotland particularly relevant. The lead up to the Scottish decision was marked by frequent delegations of ministers and MSPs to Ireland to see successful policy in action. Second, the Irish approach to tobacco policy was particularly relevant. Until Ireland legislated the accepted model for change was incremental. In California, New York and New Zealand bars were initially exempt from legislation but eventually isolated until public opinion shifted enough on the issue for a full ban. The Irish model was wholesale, from relatively few restrictions to a complete ban on smoking in public places in a short space of time (a '50%' policy announced in November 2002 was quickly replaced by '100%' measures in January 2003). This was a model rarely pushed by pressure participants in the UK who felt incremental change and leaving bars to last was the more realistic option. Incremental change was the model adopted by the Scottish Executive and it is clearly the approach favoured by Stewart Maxwell whose focus on food was based on a belief that a comprehensive ban on smoking in public places was possible but 'not in our lifetime'. The Irish success therefore had a profound effect on Scottish Executive thinking and support for measures beyond Maxwell's bill.

Third, the Irish experience had a significant effect on the media coverage of Scottish policy. Media opinion sympathetic to policy change was already apparent in 2003 in part because there was not an effective opposition to more prohibitive measures. While in the past this may have been expected from tobacco companies, in 2003 the leisure and tobacco groups did not take the prospect of legislation seriously (even when giving evidence to the health committee on Maxwell's bill). Maxwell in particular reports a 'free run' in the press from summer 2003 until 2004 and this agenda was strengthened by

widespread coverage of the success of policy in Ireland. The Scottish Executive then used this coverage to good effect when Jack McConnell visited Ireland in August 2004. Building on the image of Irish success, the trip took on a *Conversion of St Paul* quality, in which the First Minister and key MSPs all had their views 'reversed' by the Irish experience. However, it is just as likely that the trip was used to portray Scottish developments in a positive light, especially since Scottish-Irish contact took place on a regular basis before the trip and the evidence of implementation success was already apparent in Ireland and other countries.

The effect of public opinion is less certain although most interviewees share the view that the scope for comprehensive change has come only recently. Early Scottish debates on health were characterised by cross-party consensus on the need to address health improvement through public health measures, and the first Minister for Health Susan Deacon used this support to pursue measures on tobacco. However, the suggestion in 1999 (after a BBC straw poll) that 6 of the 11 members of the Health Committee were in favour of a smoking ban met with vehement opposition and media reports suggest that the Scottish Executive was forced to reassure the industry that this would not happen.[7] One of the committee's MSPs also reports having 'my knuckles rapped in my constituency'. The perception of constraint was still apparent in the lead up to the 2003 elections, with tobacco receiving no discussion in the Scottish Labour manifesto, a vague commitment from the SNP to consult on smoking in public places and a Liberal Democrat commitment to consult on the prospect of a ban phased in over *ten years* (the Conservatives opposed further prohibitive measures).

In late 2003 the limited nature of Maxwell's bill partly reflected the perception that public opinion was not conducive to comprehensive legislation. Even the Chief Medical Officer (credited with much of the shift in Jack McConnell's thinking) met with significant public resistance in 2003 when publicising the issue during the launch of his annual report. The Scottish Executive only felt able to pursue a comprehensive line on smoking prohibition in 2004 when it sensed a shifting public mood towards the issue: 'The fact that we can now have the debate marks just how much public opinion has changed' (interview, former deputy health minister, 2005).

However, the evidence also suggests that comprehensive legislation went beyond the levels of public opinion expressed in 2004. This is demonstrated well by the decision of the UK government to propose a partial ban on smoking in public places on the basis of similar survey evidence. The UK's White Paper in 2004, suggests that the 'majority tend to be opposed to a complete ban' (Cm 6374, 2004). It draws on Office of National Statistics surveys which suggest that although support for restrictions on smoking in pubs rose from 48% in 1996 to 56% in 2003, only 20% (of the 56%) supported an all-out ban. Curtice (2006: 57) suggests that Scottish attitudes were not significantly different, with only 25% opting for a complete ban in pubs (in 2004). Therefore, the legislation should be characterised as an attempt by 'Scotland's political elite to change the attitudes and behaviour of people in Scotland' (2006: 57). While more recent survey results suggest that this strategy has worked, a more short-term problem was constructing enough legitimacy for comprehensive legislation. This was achieved

through one of the largest consultations conducted by the Scottish Executive (2004b). It distributed 600,000 copies in June 2004 and received over 53,000 responses by October. The report on the responses suggested that 80% supported a law to make enclosed public places smoke-free and 56% felt that there should not be any exemptions (Scottish Executive 2004c). The Scottish Executive used the consultation results to justify introducing a comprehensive ban on smoking in public places (Scottish Executive, 2004d). The consultation became a key resource for pursuing comprehensive legislation since it gave the Scottish Executive 'the moral authority and we couldn't act otherwise' (interview, Irene Oldfather MSP, 2005).

The final factor is the role of parties. In the first Scottish Parliamentary session (1999-2003) there was potential for the SNP (holding 35 of 129 seats) and Conservatives (18) to exploit Labour (56) and Liberal Democrat (17) coalition divisions on 'flagship' policies. In particular, the introduction of free personal care was ensured by the Liberal Democrats threatening to use the strength of opposition and vote against Labour (see Simeon, 2003: 230). In the case of smoking, while the Liberal Democrats were committed to smoking prohibition, the fact that the Conservatives were likely to oppose the bill on principle meant that it would not progress past stage 1 without Labour support. The scope for Scottish Executive control of the issue was therefore more significant and at the time there was potential to follow England in the pursuit of partial measures. However, this is not to say that the role of parties was insignificant. The popularity of an SNP bill on smoking was not only a driver for relatively quick Scottish Executive action (with Scottish ministers openly praising Maxwell's earlier work), but also persuaded

McConnell that there was enough cross-party support to make this a non-issue in the lead up to the 2005 UK general election.

Policy Windows

In this context, we may view factors such as the Ireland experience, media and public opinion, group influence and Scottish Parliament activity as a *spur for change* but also a *resource* for Scottish ministers looking to initiate a potentially unpopular policy. There is little evidence to suggest that the strength of media or public opinion forced policy change, since incremental and partial shifts in policy would still be in line with public attitudes to a complete ban. Similarly, there is little evidence to suggest 'indirect coercive' policy transfer (Dolowitz and Marsh, 2000) since the Scottish Executive *fostered* Irish comparisons and had the established experience of incremental policy change in other countries to draw on when considering a more limited policy response. Rather, these factors opened up a 'policy window' for change. As Kingdon (1984: 165-6) suggests, political change also requires a set of circumstances to come together at the right time:

> 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 … these policy windows, the opportunities for action on given initiatives, present themselves and stay open for only short periods.

The positive reception to Stewart Maxwell's bill combined with the Ireland experience and public health support made it difficult for the Scottish Executive to oppose the bill without providing an alternative. The support for legislation *in progress* undermined the ability of the Scottish Executive to put off legislative change until after the UK general election in 2005 or until the UK government 'caught up' and legislated for the UK as a whole (interview, Stewart Maxwell MSP, 2005). However, there was also clear political will to legislate. The then Deputy Health Minister Tom McCabe was not only personally committed to policy change, but also saw the opportunity to do so when witnessing the momentum building up in the health committee and the effect of the Irish experience on media and public opinion. Similarly, Maxwell was aware of the limitations of his bill as well as his chances of direct success. As a result, both agreed to pursue the issue in tandem. Ministers agreed to acknowledge Maxwell's contribution to the debate and Maxwell agreed to refrain from criticising the position of ministers, since he became aware (four months in advance of the consultation process) that they were in the process of changing it.

In this case the desire of ministers to avoid political embarrassment following policy divergence was outweighed by the desire of ministers to 'make their mark' and point to divergence as a justification for devolution. Smoking came at a good time for a First Minister tainted by the Holyrood building project and accused of presiding over an 'administration' rather than an Executive. Legislation was the opportunity to give the Scottish Parliament direction and provide the 'Big Idea' that Jack McConnell was looking for. Public health with smoking at the centre was to be 'Jack McConnell's free

personal care'. Finally, a crucial factor was the lack of costs, not only in terms of political popularity but also resources invested in current policy. Theories based on path dependence suggest that when commitment to a policy has been established and resources devoted to it, over time it becomes increasingly or relatively costly to choose a different policy. In the case of smoking, few Scottish Executive resources were invested in existing policy and any 'sunk costs' (such as the investment in ventilation as part of the voluntary charter) would be met by the private sector.

Conclusion: Can We Generalise from a Case Study?

In many ways the case study of smoking is atypical. First, the evidence from most policy areas with blurred boundaries is that they are dealt with by referring the issue back to Westminster. The competition to reframe the issue is not routine (Cairney and Keating, 2004). Second, the level of Scottish influence on UK policy is also unusual since the evidence from public service efficiency, health policy, housing stock transfer and tuition fees suggests that pressure towards policy transfer tends to come *from* England (Cairney, 2006c). Third, the level of Scottish parliamentary attention on one issue was unusual and suggests less attention and influence over the remainder of governmental activity. Fourth, the level of medical influence marks Scotland out from the rest of the UK and marks out health (and perhaps education) policy from the remainder of the devolution settlement. Finally, the decision to shift policy was based on the assumption of minimal cost. The scope for change is less apparent in policies which involve distribution rather than regulation (Mitchell, 2004).

However, while the general significance of venue shift may be less than it first appears, the *potential* to reframe policy issues and therefore reframe the devolution settlement itself is one of the most significant developments of devolution. The case study also has implications for the comparative study of policy. There may be a temptation to view the UK policy experience as a whole and to view tobacco policy change as an almost inevitable development of global policy shifts based on shifting public attitudes. Yet, the case study shows not only the significance of Scottish policy change within the UK, but also the relative unpredictability of policy and the requirement of a number of policy conditions for significant change to take place. This 'micro-political' explanation is often lost in broader comparative studies.

References

ASH (2005) 'Key dates in the history of anti-tobacco campaigning', http://www.ash.org.uk/html/schools/keydates.html

Arter, D. (2004a) *The Scottish Parliament: A Scandinavian Style Assembly?* (London: Frank Cass)

Arter, D. (2004b) 'The Scottish committees and the goal of a 'New Politics': a verdict on the first four years of the devolved Scottish parliament', *Journal of Contemporary European Studies*, April 2004, 12: 1, 71-91

Baumgartner, F. and Jones, B. (1993) *Agendas and Instability in American Politics* (Chicago: University of Chicago Press)

Cairney, P. (2004) 'Convergence and Divergence Following Devolution in Scotland : An Implementation Agenda', Paper for discussion at Centre for Public Policy and Management, Glasgow Caledonian University, 22nd November 2004

Cairney, P. (2006a). 'The Analysis of Scottish Parliament Committee Influence: Beyond Capacity and Structure in Comparing West European Legislatures', *European Journal of Political Research*, 45: 2, 181-208

Cairney, P. (2006b) 'The Scottish Parliament' in (ed) P . Jones *Scotland Devolution Monitoring Report January 2006* (London: The Constitution Unit) http://www.ucl.ac.uk/constitution-unit/research/devolution/Monitoring%20Reports/Jan06/Scotland%20Jan06.pdf

Cairney, P. (2006c) 'Applying Models of Policy Change: the Case of Tobacco Policy in the UK', Paper for ESRC conference on Interest Groups, University of Newcastle, May http://www.abdn.ac.uk/pir/notes05/Level3/PI3546/Paul%20Cairney%20Smoking%20UK%202006.doc

Cairney, P. and Keating, M. 'Sewel Motions in the Scottish Parliament', *Scottish Affairs*, 47: 1, 115-34

Cm 4177 (1998) *Smoking Kills - A White Paper on Tobacco*, presented by the Secretary of State for Health and the Secretaries of State for Scotland , Wales and Northern Ireland (London: The Stationery Office)

Cm 6374 (2004) *Choosing Health: Making healthier choices easier, Department of Health*. (London: The Stationery Office)

Consultative Steering Group (1998) *Shaping Scotland 's Parliament*

http://www.Scotland .gov.uk/library/documents-w5/rcsg-00.htm

Convery, J. (2000) *The Governance of Scotland : A Saltire Guide* (Edinburgh: The Stationery Office)

Curtice, J. (2006) 'Public Attitudes and Elections' in (ed) P . Jones *Scotland Devolution Monitoring Report January 2006* (London: The Constitution Unit)

Dolowitz, D. P. and Marsh, D. (2000) "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making", *Governance*, 13: 1, 5-24

Greer, S. (2004) *Territorial Politics and Health Policy* (London: UCL)

HC 518-iii (1988) *Parliamentary Lobbying*, Third report from the Select Committee on Members' Interests, Session 1987-8 (London: HMSO)

Hix, S. (2002) 'Constitutional Agenda-Setting Through Discretion in Rule Interpretation: Why the European Parliament Won at Amsterdam', *British Journal of Political Science*, 32: 2, 259-80

Jones, B.D. (2001) *Politics and the Architecture of Choice* (Chicago: University of Chicago Press)

Jones, B.D. and Baumgartner, F. (2004) 'A Model of Choice For Public Policy' *Journal of Public Administration Research and Theory*.
http://polisci.la.psu.edu/faculty/Baumgartner/Jones_Baumgartner_JPART_2005.pdf

Joosens, L. (2004) 'Effective Tobacco Control Policies in 28 European Countries' http://www.ensp.org/files/Effective_tobacco_control_policies_in_28_European_countries.pdf

Keating, M. (2005) *The Government of Scotland* (Edinburgh: Edinburgh University Press)

Keating, M., Stevenson, L., Cairney, P. and Taylor, K. (2003) 'Does Devolution Make a Difference? Legislative Output and Policy Divergence in Scotland', *Journal of Legislative Studies* , 9: 3, 110-39

Kingdon, J.K. (1984) *Agendas, Alternatives and Public Policies* (New York: Harper Collins)

Lodge, G. (2003) 'Devolution and the Centre', Constitution Unit Monitoring Report May 2003, http://www.ucl.ac.uk/constitution-unit/monrep/centre/centre_may_2003.pdf

McGarvey, N. (2001), 'New Scottish Politics, New Texts Required', *British Journal of Politics and International Relations*, 3: 3, 68-70.

Mitchell, J. (2001), 'The Study of Scottish Politics Post-Devolution: New Evidence, New Analysis and New Methods?', *Parliamentary Affairs,* 53: 3,216-33.

Mitchell, J. (2004) "Scotland: Expectations, Policy Types and Devolution" in (ed) Trench, A. (2004), *Has Devolution Made a Difference? The state of the nations 2004* (London: The Constitution Unit)

McMahon, P. (2002) **'**Two factions, two agendas and mistrust and jealousy at centre of power', *The Scotsman*, 28.01.02

Paterson, L. (1994) *The Autonomy of Modern Scotland* (Edinburgh: Edinburgh University Press)

Read, M. (2005) 'Anti-Smoking policy in the UK: A matter of Political Will?', Paper presented to the Political Studies Association conference, Leeds, April

Rose, R. (1993) *Lesson-Drawing in Public Policy* (New Jersey: Chatham House)

Scottish Executive. (2003) *Improving health in Scotland : the challenge.* (Edinburgh: Scottish Executive)

Scottish Executive. (2004a) *A Breath of Fresh Air*. (Edinburgh: Scottish Executive)

Scottish Executive. (2004b) *Smoking in public places, a consultation on reducing exposure to second hand smoke* (Edinburgh: Scottish Executive)

Scottish Executive (2004c) *Smoking in Public Places: A Consultation on Reducing Exposure to Second Hand Smoke - Key Findings of Responses to a Public Consultation* (Edinburgh: Scottish Executive)

Scottish Executive (2004d) *Smoking, Health And Social Care (Scotland)*

Bill Policy Memorandum

http://www.scottish.parliament.uk/business/bills/pdfs/b33s2pm.pdf

Scottish Labour & Scottish Liberal Democrats (2003) *A Partnership for a Better Scotland: Partnership Agreement Edinburgh: Scottish Executive*.

http://www.Scotland .gov.uk/library5/government/pfbs-00.asp

Scottish Parliament Health Committee (2005) *Stage 1 Report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill*, 1st Report, 2005 (Session 2), SP Paper 263, http://www.scottish.parliament.uk/business/committees/health/reports-05/her05-01-01.htm

Shephard, M. and Cairney, P. (2005) "The Impact of the Scottish Parliament in Amending Scottish Executive Legislation", *Political Studies*, 53: 2, 303-19

Simeon, R. (2003) 'Free Personal Care. Policy Divergence and Social Citizenship', in (ed.) R. Hazell *The State of the Nations 2003* (London: Imprint)

SP Bill 20-PM 2004 *Prohibition Of Smoking In Regulated Areas*

(Scotland) Bill Policy Memorandum http://www.scottish.parliament.uk/business/bills/pdfs/b20s2pm.pdf

SPICE (Scottish Parliament Information Centre) (2004a) *The Prohibition Of Smoking In Regulated Areas (Scotland) Bill* 04/39, 27.5.04, http://www.scottish.parliament.uk /business/research/briefings-04/sb04-39.pdf

SPICE (Scottish Parliament Information Centre) (2004b) *Smoking, Health And Social Care (Scotland) Bill: Smoking Ban In Certain Wholly Enclosed Public Places*, http://www.scottish.parliament.uk/business/research/briefings-04/sb04-100.pdf

Studlar, D. (2004) 'Tobacco Control Policy in a Shrinking World: How Much Policy Learning?' in (eds) Vigoda-Gadot, E. and Levi-Faur, D. *International Public Policy and Management: Policy Learning and Policy Beyond Regional, Cultural and Political Boundaries* (New York: Marcel Dekker).

Tsebelis, G. (1994) 'The Power of the European Parliament as a Conditional Agenda Setter', *American Political Science Review*, 88: 1, 128-43

[1] After a "frank exchange of views", Reid made it clear to McConnell that the UK Government would not pursue a comprehensive ban ('McConnell in Smoke-free Isolation', *The Scotsman*, 29.9.04).

[2] Interviews on tobacco policy in Scotland were conducted with the first minister, former ministers of health, MSPs, civil servants and pressure participants in the public health field. This article also draws on a series of interviews (approximately 100) conducted as part of a broader study into policy communities in Scotland since devolution (see Keating, 2005). Evidence on the effect of Scottish policy in the UK draws on interviews with similar actors in London.

[3] I do not argue that this is a power unique to Scotland. A similar process of agenda-setting and exploiting uncertain constitutional powers is apparent in the European Parliament (Hix, 2002; Tsebelis, 1994). However, this article focuses on the powers of the Scottish Parliament compared to Westminster.

[4] Although from 1999-2004 this number was 11. For details of the increase see http://www.scottish.parliament.uk/business/so/revisions/index.htm. For a discussion of further measures which appear to restrict an MSP's ability to introduce successful legislation, see Cairney, 2006b: 30.

[5] Hence attempts to 'kill the bill' by giving it to a different committee, such as local government which would have considered problems of implementation rather than the health benefits (interview, Stewart Maxwell MSP, 2005)

[6] This arises from evidence to suggest that: (a) rates of smoking among social class V are far higher than social class I; and (b) a ban only on pubs serving food would lead to concentrations of smoking pubs in the least affluent areas. The Chief Medical Officer in Scotland's argument was that any legislation concentrating on food alone would have the least effect on its target population.

[7] 'Parliament Retreat On Smoking In Public Ban' Daily Mail, 12.11.99; 'Executive Backs Down On Public Smoking Ban', Daily Record, 12.11.99; 'MSPs Ditch Plans To Ban Smoking In Public' Evening News, 12.11.99