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Federalism and Multilevel Governance in Tobacco Policy: the European Union, the United Kingdom, and Devolved UK Institutions*

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ABSTRACT

Most studies of tobacco control policy focus on the central level of national governments. Yet within the European Union, three levels of government have responsibilities for tobacco control: the EU; the central governments of member states; and provinces or devolved levels of government. This article examines the role of each in the formation of tobacco policy in the United Kingdom. It compares the theory of regulatory federalism with multilevel governance as explanations for tobacco regulatory policy within the EU. While executive-legislative fusion in the United Kingdom leads to the practice of discretionary federalism, the EU provides mixed support for the theory of regulatory federalism. There is significant policy innovation in the UK and its devolved territories as well as limited policy authority for tobacco control in the EU. Overall, multi-level governance (MLG) may be a superior, albeit incomplete, explanation of tobacco control within the EU and the UK.

Introduction

Tobacco control has evolved from a domestic to an international issue with regulatory measures championed by intergovernmental organizations. The World Health Organization (WHO) adopted the Framework Convention on Tobacco Control in 2003 to promote global tobacco control, while the World Bank will not support any activity that leads to the promotion of tobacco production or consumption (Asare 2007).

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Lower-level jurisdictions have also taken action. In some cases, provinces have adopted earlier and stronger tobacco control policies than the central government. This trend is strong in federal and quasi-federal jurisdictions (Studlar 2002; 2007; Cairney 2007a; 2007b; 2009; Asare 2007). Smoking prevalence has fallen significantly since the early post-World War II period, and government policy in most advanced democracies reflects and reinforces the 'denormalisation' of smoking (Studlar 2007: 1). Both the nature of government and tobacco policy have changed significantly.

Within the European Union (EU), three levels of government have responsibilities for tobacco control: (1) the EU itself; (2) the central governments of member states; and (3) in federal or quasi-federal systems, the provinces or devolved level of government. This article examines the role of each in the formation of tobacco policy in the past twenty years, focusing particularly on the United Kingdom (UK) since 1999. The most comprehensive benchmarking study indicates that the UK leads the rest of Europe on tobacco control (Joossens and Raw 2007). The UK is an ideal case study because policy is at an advanced stage, and the policy responsibility of each level of government is well established. Furthermore, constitutional developments in the UK since 1997 allow useful comparisons to be made with federal systems. The UK is often described as a 'quasi-federal' polity (Bogdanor 2003) to reflect the powers that devolved governments in Scotland, Wales, and Northern Ireland enjoy in practice (the most populous jurisdiction, England, remains under central government control).

There are two main ways to examine the consequences of these developments (Cairney 2006). The first focuses on federalism and intergovernmental relations (IGR), examining the separation of powers between jurisdictions, the interaction between levels of government, and recourses to formal dispute resolution. The second, derived from the study of 'multi-level governance' (MLG), examines informal relationships and the blurring of boundaries between public/private action and levels of governmental sovereignty. When studying tobacco policy in the EU, the advantage of MLG is that it was developed to address the idiosyncrasies of EU policy. A study of tobacco policy would be a unique addition to the policy-specific case study literature (see Bache and Flinders 2004). The advantage of federalism studies is that, if we can demonstrate their applicability to the EU, the results can supplement the more established literature and make our findings comparable with political systems such as the US.

Our strategy is to employ both approaches while being aware of their differences and limitations. For federalism, we outline Kelemen's (2004) study and explore its relevance to tobacco policy in the EU and UK.

Keleman's theory produces a very clear prediction: the structure and power relations of EU institutions produces a relatively top-down process, in which policy is passed at the top and its implementation is regulated at the bottom. We contrast this approach to MLG (Hooghe and Marks, 2003), which suggests that outcomes can not be deductively derived from structured institutional relationships. Rather, they follow an often indeterminate process of negotiation and exchange between levels of government and non-governmental actors, and the policy process is often bottom-up as well as top-down.

Federalism in the EU and UK

Federal relationships within both the EU and UK allow us to compare their patterns of behaviour. Kelemen's (2004) theory of EU policy contrasts regulatory federalism with the two classic perspectives, neo-functionalism (supranationalism) and intergovernmentalism. Kelemen's argument is two-fold. First, the vertical relationship (or the 'politics of competence') is similar in most federal systems: policymaking takes place at the federal (or central) level, while the responsibility for most implementation rests with the states (or sub-central authorities). Second, the extent to which the centre allows sub-central authorities the freedom to implement federal policy (the 'politics of discretion') depends on the levels of horizontal fragmentation within the central government. A highly fragmented system 'encourages an adversarial, litigious approach' (2004: 2). The competition between institutions makes them more protective of their authority and more likely to write detailed laws for the provinces to follow ('regulatory federalism'). In contrast, a concentration of power at the centre encourages 'discretionary federalism' or a 'less judicialised' approach (2004: 2). Written laws are broad, allowing flexibility in application by lower-level jurisdictions. Thus, the policymaking process is centralized in federal systems while the implementation process varies, depending on the separation of, and competition among, institutions.

Kelemen tests this explanation successfully for environmental policy. The US and EU are examples of regulatory federalism while Australia and Canada, with Westminster parliamentary systems and weak bicameralism, operate under discretionary federalism. Germany, with relatively strong central-level bicameralism and one legislative chamber representing the provinces, has moved toward regulatory federalism because of pressure from its membership of the EU (Kelemen, 2004: 102). Yet Kelemen's (2004: 165) summary table suggests that the EU may be more similar to Germany's medium position on regulatory federalism, with the US still clearly the leader in this respect. We examine whether

Kelemen's theory applies to the EU and UK on tobacco regulation. Not only do we explore a different policy area but also a quasi-federal state, the UK, not included in Kelemen's discussion.

Numerous studies have concluded that the EU is a federation or quasi-federation (Sbragia 1992; Leibfried and Pierson 1995; Cowles et al. 2001; McKay 2001; Asare 2007). However, the key feature of Kelemen's analysis is that it shifts our focus from political structures and federal status to the *behaviour* of institutions which operate in a *federal-like way* according to the levels of horizontal fragmentation at the centre. The EU's primary focus is regulation and it *operates* as a federal system (Kelemen 2004: 1). Therefore, it can be compared to other federal polities, particularly since EU policy adoption occurs at the central level, with member states responsible for implementation.

Kelemen's theory can be situated in a literature that is still uncertain about the mix of EU and member state influence. For example, Leibfried and Pierson (1995), Sbragia (1992) and Castles (1998) argue that the EU has created conditions that undermine the individual social and labour market protection policies of member states. Castles (1998) links the growing role of the EU in domestic affairs to the emergence of an integrated market and the rapid steps towards monetary union. The authority at the disposal of the EU implies that a number of policies of member states have become standardized, and genuine European social and market policies are in the process of emerging. Equally, Kurzer (2001) stresses that member states are converging even in their morality policies such as drugs, alcohol, and abortion.

Yet, Cowles et al (2001) argue that while the 'Europeanization' of regulation has produced distinctly European policies in their domestic environments, member state idiosyncrasies have also shaped public policies. Those with similar political structures as the EU have fewer problems adapting to its policy direction (Cowles et al. 2001). In this federal-like arrangement, relations between the two centres of authority have not resulted in the latter completely losing their sovereignty (Mamudu and Studlar 2009). Rather, when the EU supersedes the domestic role in various policy sectors, it puts pressure on domestic institutions to reassert their autonomy (Cowles et al. 2001).

Numerous studies have also characterized the UK as 'quasi-federal' (Horgan 2004; Bogdanor 2003; Laffin and Thomas 1999) even though its structures are unusual. The UK shares many characteristics with federal states: a combination of shared rule with territorial self-government, a distribution of legal, executive and fiscal powers to allow devolved territories a level of autonomy, an 'umpire' to rule in disputes between levels of government and territorial representation at the central level (see Watts 2007; McGarvey and Cairney 2008). Although the UK lacks a

supreme constitution that is relatively immune from unilateral change from the top, it can be classed as quasi-federal in a functional sense because the UK government respects most decisions made in the devolved territories (Horgan 2004: 114; Bogdanor 2003: 228; Cairney 2006). For present purposes, the focus is on behaviour, or the movement towards 'federal relationships' (Watts 2007) rather than formal structures.

This treatment of the EU and UK as federal-like allows us to compare and predict their behaviour according to their respective levels of horizontal fragmentation. The fragmentation of power in the EU is high. Two independently-chosen legislative chambers, the Council of Ministers and the European Parliament, have policy authority, along with the European Court of Justice and the central executive, the European Commission (Schain and Menon 2007). At times the European Council of chief executives of member states also becomes involved, at least informally, in the policy process. The Commission also has limited powers to monitor implementation compared to more established federal systems such as the US. Based on this horizontal proliferation of institutions, Kelemen (2004: 2) predicts a form of regulatory federalism in which 'inflexible rulemaking and litigious enforcement' characterizes EU-member state relations. In contrast, the UK is a highly centralized Westminster system, usually under one-party rule, with minimal roles for the courts and parliament in policy-making and a strong asymmetry of power in UK-devolved relationships. Therefore, we should expect discretionary federalism to characterize state-devolved relations.

This may also extend to the role of the UK devolved governments in EU policy making. Since the formation of the advisory Committee of the Regions in 1993, subcentral governments are recognized as legitimate actors in the EU policy process, while the UK government encourages 'cooperative regionalism' (Bulmer et al. 2006): the UK and sub-central governments try to depoliticize issues, working through bureaucratic networks as much as possible rather than making them into visible political conflicts requiring submission to another institution, such as a judiciary, or allowing the public to become involved. This contrasts with regulatory federalism, where institutional competition for public support is the norm.

However, there are two problems with this framework. First, Kelemen's primary policy focus is environmental regulation, along with food and drug safety. Although Kelemen treats these as representative of all social regulation, a key tenet of policy analysis is variation by policy issue (John 1998: 9). Further, environmental policy is often considered, along with agriculture, to be among the most 'Europeanized' of policies (Jordan 2002; Weale et al. 2000) and therefore a likely source of top-down

control. In tobacco, the European Commission has struggled to establish its role as the main policy initiator, in part because some member states have challenged its authority, but also because tobacco regulation involves a wide range of new and untested policy instruments. While the Commission has taken control of some, member states such as the UK have gone beyond its minimum requirements, and UK devolved territories have become a source of policy innovation.

Second, a comparison between the EU and UK may set up a false distinction between levels of government by separating EU–member state political processes from relationships formed within member states, and by assuming that the direction of policy making flows from the top down to the bottom. This precludes a degree of policy innovation from and within the member states. It also highlights the broader problem in IGR when its predictions are based on an analysis of formal authority. The advantage of MLG is that the use of institutional frameworks to predict behaviour becomes more of an empirical question. Decision-making authority is dispersed and policy outcomes are determined by a series of negotiations between various levels of government and interest groups. The focus shifts from formal powers and the *capacity* to make and enforce decisions to the level of government in which the decisions *are* made.

Multi-level governance

MLG began as a means to address a false boundary between the study of domestic and international politics, neither of which captured, 'the shifting and uncertain patterns of governance within which the EU is just one actor upon a contested stage' (Bache and Flinders 2004: 1–2). It draws on the policy networks literature that stresses the role of interest groups and the blurred boundaries between governmental and non-governmental action. The blurring of formal and informal sources of authority is extended to the roles of government actors at various levels, with informal influence often more relevant than formal jurisdictions. This may also extend, as with Kelemen, to the fragmented horizontal power of central EU institutions: the more supra-state institutions such as the European Parliament (EP), the European Court of Justice (ECJ), and the European Commission have demonstrated a high level of independence in their decisions and are not dominated by the more state-centred institutions, the Council of Ministers and the European Council (Hooghe and Marks 2001; Marks and Hooghe 2004; George 2004; Bache and Flinders 2004)

However, the theoretical focus of MLG differs significantly from most studies of federalism. It establishes the significance of three tiers of actors

in decision making – supra-state, central state and sub-state – depending on degrees of Europeanization, the strength of the regional policy agenda, and the existing allocation of policy responsibilities entrenched in the laws of member states (Marks 1993). Like neofunctionalism (Haas 1975), it contends that states and international organizations are caught in a web of interdependence that allows supra-state organizations and organized interests (which now includes sub-state authorities) to shape both policy and integration. Furthermore, the flexibility of the framework allows MLG processes to be explored empirically in two contrasting ways: as a relatively stable set of relationships, with policy responsibility allocated according to territory and overlaps between jurisdictions minimized (Type 1) or as a relatively complex and fluid process, with the delegation of responsibility related to the nature of the policy rather than territory (Type 2) (Hooghe and Marks 2003). In either case, compared to Kelemen's framework, the focus is on the balance of authority among multiple governmental levels rather than an 'either-or' struggle between only two. There is no assumption about the 'direction of travel' or restriction of the role of member states or sub-state authorities as implementing bodies, subject to greater or lesser forms of control from the centre. The value of this difference becomes clear when we consider the innovative potential for the devolved territories in UK tobacco policy.

Tobacco control as a policy issue in the EU

The EU has taken steps to reduce tobacco consumption in member states since 1985 (Tables 1 and 2). The competence of the EU in health matters is limited, fragmented, and contested, but oriented toward the promotion of public health through preventive measures (Guigner, 2004; Strünck 2005). Directives and regulations to control tobacco consumption are binding on member states. Directives have to be adopted into state laws within a limited time period and permit adjustments to member states' specific circumstances, while regulations have to be immediately adopted by member states based on their original wording (Gilmore and McKee 2004: 233). The EU can also recommend action when its powers are less clearly demarcated or when there is not enough consensus to pass a directive. The evidence suggests that the EU has used a mixture of strategies to achieve change. Since 1989 it has passed labelling directives for package health warnings, limits on toxic ingredient yields, a ban on broadcast, print, internet and sponsorship advertising, and a minimum taxation level for cigarettes, in addition to several recommendations.

The directives were adopted initially because the EU wanted to curtail the level of tobacco consumption in all member states (Gilmore and McKee 2004). Most of the directives have been altered over the years to

meet changing conditions. For example, in 1989 the EU first required health warnings to cover a minimum of four per cent of cigarette packs. Now the size of health warnings has been extended to 30 per cent on the front and 40 per cent on the back (European Commission 2004). More recently, agreement has been reached on improved health warnings and bans on certain descriptor terms such as 'light and mild'. These developments have been accompanied by recommendations on sales restrictions, renewed discussions on tax harmonisation, and a more focused agenda on second hand smoke (European Commission 2007). The EU also began a media campaign against tobacco use in 2005, while agricultural production subsidies for tobacco (two per cent of the Common Agricultural Policy) are to be phased out by 2010. The EU actively participated as an organization in the Framework Convention on Tobacco Control (FCTC), where it acted to coordinate member state

Table 1. Chronology of Tobacco Control in the EU

1970	Tobacco growing subsidized in Common Agricultural Policy countries (CAP)
1972	First attempts at harmonisation of cigarette taxes
1985	First European anti-tobacco campaign announced (implemented 1987)
1986	*Single European Act*
1989	First EU health warnings; Television ad ban; Limits on product labelling; First EU nonbinding resolution on tobacco control, second hand smoke
1990	First limits on toxic ingredients
1992	Tax harmonisation for cigarettes becomes renegotiated every few years
1993	Maastricht Treaty expands EU role in health, also emphasizes markets and subsidiarity; EU-level tobacco industry became more organized
1994	First EU financing of NGO capacity-building projects
1995	First advisory body on tobacco control, BASP, ends, eventually replaced by ENSP (1997)
1996	First general EU statement on tobacco policy (others 1999, 2002)
1997	First EU general ad ban approved (TAD1)
1999	Amsterdam Treaty, Article 129, 'A high level of human health level protection shall be assured in the definition and implementation of all Community policies and activities.' EU recommended policies for member states
2000	ECJ strikes down TAD1; Lisbon Process
2001	Larger health warnings: Bans on 'light and mild' descriptors
2002	EU sues tobacco companies for smuggling in the US: Council recommendation on improving tobacco control
2003	Revised EU print, telecast, and internet ad and sponsorship ban (TAD2): Graphic warning labels approved;
2004	EU signs FCTC; ten new accession countries join EU
2005	Agricultural price support for tobacco reduced, to end by 2010; 10 Accession countries given delays for *acquis* on tobacco tax; Ratification of FCTC
2006	Commission refers Germany to the ECJ for lack of advertising ban transposition; Finnish Presidency emphasizes health in all policies, including tobacco
2007	Green Paper on second-hand smoke restrictions; Two new accession members; EU mandates fire-safe cigarettes by 2011

positions through both the Presidency and Commission (Mamudu and Studlar 2009; European Commission 2004). Subsequently the EU, as well as all but two of its member states, has ratified the FCTC. Such developments have made the EU a leading international tobacco control jurisdiction (Asare 2007) while providing a new institutional setting for agencies and groups to struggle over policy (Princen 2007).

All five major EU institutions have been involved in tobacco policy in important ways. Princen (2007) argues that the European Commission has been the major agenda-setter in tobacco control. Within the Commission, however, there is a fragmentation of bureaucratic agencies on tobacco policy. DG Sanco (Health) is usually the lead department for tobacco control matters, but several others are involved to some degree, depending on the issue. These include Agriculture, Economic and Financial Affairs, Trade, Enterprise and Industry, Employment and Social Affairs, Taxation and Customs Union, Consumer Affairs, Accession, and Justice. In some cases the Commission may have to seek compromise across departments to propose legislation (Guigner 2004), particularly since the EU remains among the largest producers of cigarettes in the world.

The Commission has engaged in frequent consultation with administrative and scientific experts in public health from member states in order to improve its technocratic credentials (European Commission 2004; Boyle 1997; Guigner 2004). However, the origin of the 'Europe Against Tobacco' program that, along with the *Single European Act*, began the EU effort in tobacco regulation, was the result of political entrepreneurship in the European Council by President François Mitterand of France and Premier Bettino Craxi of Italy.

There is input from member states both in the development of legislation and in its implementation. Officially there is a bicameral legislative process for tobacco control measures, with policy having to pass through both the Council of Ministers (through Qualified Majority Voting) and the European Parliament. Tobacco control was nearly a compulsory topic at meetings of the Health Council of Ministers between 1988 and 2003, being discussed in 31 of the 35 meetings (European Commission 2004: 115). The Council of Ministers also passed resolutions urging member states to take other actions limiting tobacco sales and consumption since 1989 (Princen and Rhinard 2006). The directly-elected European Parliament has taken an active role in some legislation, especially the first *Tobacco Advertising Directive* (TAD1) and the *Tobacco Products Directive* (European Commission 2004).

Directives allow some flexibility in implementation and are subject to negotiation with member-states through the comitology process, whereby the Commission consults with representatives of member states

(Bergström 2005). The court systems of member states also serve to enforce EU law, with the ECJ as the court of last resort (Hix 2004). Some member states, notably Germany, have challenged EU tobacco control directives through appeals to the ECJ. Although the Court overturned TAD1, it has upheld other EU tobacco control measures.

Non-state entities have also become prominent. The growing authority of the EU in tobacco control has led to a struggle among non-state actors for influence. The tobacco industry and growers have long recognized the policymaking authority of the EU in tobacco control and worked to influence it through sympathetic states and front groups (European Commission, 2004; Neuman et al. 2002). Since the late 1980s the EU has engaged in partnerships with civil society anti-tobacco groups, including 'positive lobbying' to finance new networks of advocacy groups promoting tobacco regulation at the EU level as well as enhancing their prospects for successful lobbying within their respective member states (European Commission 2004; Mamudu and Studlar 2009). This promotes a governance structure in which interest groups work together, through formal and informal networks, and through member states to influence EU policy.

While recognition of the EU as a federal system allows useful comparisons with others, it does not suggest: (a) what the nature of policy will be or (b) if detailed instructions to the member states will be followed, particularly since the EU has relatively weak powers to ensure implementation. The evidence on tobacco policy suggests that the effect in both cases is mixed. For example, in cases such as health warnings on cigarette packs, institutions have cooperated to increase policy coverage. In other cases such as tobacco advertising, the fragmentation of power has resulted in compromise and minimal standards. The battle over the ban on tobacco advertising in the EU culminated in the decision by the ECJ in 2000 to uphold a challenge by Germany and four tobacco companies to the first ban. This was followed by more limited legislation able to withstand judicial challenge. In 2002 the EU adopted the second version of the *Tobacco Advertising Directive* (TAD2), which banned international tobacco advertising, including sports sponsorship, in print media, on radio and over the internet, but not indirect advertising, brand stretching and advertising in non-EU media (Hervey 2001; Khanna 2001; Duina and Kurzer 2004; Strünck 2005).

The evidence on implementation also is mixed. For example, the agency only has a handful of staff with primary responsibilities in tobacco control (interview, official, DG Sanco). Implementation is largely left to officials in member states, with selective overview by the EU Commission. Some countries, such as Germany and Austria, however, may attract special scrutiny because of chronic implementation problems

Table 2. EU Tobacco Control Legislation and Recommendations

Name of Measure	Key Requirements
Labelling directives 1989,1992	Require rotating health warnings on tobacco products. Ban the marketing of certain tobacco products for oral use
Advertising directives 1989,1997,1998,2003	Ban all forms of TV advertising for tobacco products. Ban on tobacco advertising in the press, radio and on the Intern Ban on tobacco sponsorship of events with cross-border effects
Tar Yield Directive 1990	Sets a maximum tar yield of 15 mg per cigarette by December 31, 1992 and of 12 mg per cigarette from December 31, 1997
Tax directives 1992, 1995, 2002	Set minimum levels of excise duties on cigarettes and tobacco
Tobacco Product Regulation Directive 2001	Larger warning labels are required on all tobacco products; descriptors suggesting that one tobacco product is less harmful than another are banned; manufacturers and importers must submit a list of all ingredients used in the manufacture of tobacco products. Maximum levels of tar, nicotine and carbon monoxide are established for cigarettes (10 mg tar per cigarette, 1 mg nicotine per cigarette, 10 mg carbon monoxide per cigarette)
Workplace Air Quality directives 1989, 1992	Require employers to ensure that workers have access to fresh air and ventilation
Framework Directive on Health and Safety in the Workplace 1989	Requires a health assessment to be carried out by employees which should include exposure to second-hand smoke in the workplace
Resolution on smoking in public places 1989	Invites Member States to adopt measures banning smoking in public places and on all forms of public transportation (nonbinding)
Pregnant Women Directive 1992	Requires employers to take action to protect pregnant and breastfeeding women from exposure to an exhaustive list of substances, including carbon monoxide
Carcinogens Directive 1990	Restricts smoking in workplace areas where carcinogenic substances are handled
Council resolutions 1993, 1996, 1999	Proposals to Member States and the Commission – measures to combat smoking (nonbinding).
Council Recommendation 2003	Concerns aspects of tobacco control that are the responsibility of the Member States, including: tobacco sales to children and adolescents; tobacco advertising and promotion that has no cross-border effects; provision of information on advertising expenditure; environmental effects of tobacco smoke (nonbinding)

Source: European Commission (2004)

(Cooper and Kurzer 2003). In some areas the levels of implementation flexibility (or lax enforcement) contradict the idea of inflexible and judicious enforcement associated with regulatory federalism. For example, cigarette and tobacco prices still differ markedly (with the new accession members in Central and Eastern Europe allowed transition periods for tax harmonisation) and this has led to smuggling problems (although the EU has pursued lawsuits against tobacco manufacturers for complicity).

Therefore, the degree of effective EU authority is debatable. Some see the EU as a weak tobacco control regime (Gilmore and McKee 2004; Duina and Kurzer 2004; Strünck 2005). Yet others (Princen 2007; Mamudu and Studlar 2009) consider it to be reasonably effective, especially considering that it has limited authority and has only developed policies over the past two decades. Even after the major setback of the ECJ decision overturning TAD1, the EU executive and legislature responded with TAD2. Further, by 2004, more than 70 per cent of member states had adopted policies banning most forms of tobacco advertising (European Commission 2004). Despite implementation problems, the EU Commission usually gets its way and enforces directives through a process of notifications, warnings to states, and, as necessary, references to the ECJ. The Commission took some states to the ECJ for failing to comply with the directive.

Europeanization has had considerably more influence on policy adoption in accession members lacking a substantial history and infrastructure (Gilmore et al., 2004; Frisbee et al. 2008). The process of 'unequal negotiation' during the accession process enables the EU to force applicant members to adopt tobacco control policies that harmonise with those of existing EU members. However, overall, while the EU's authority has grown to the point of sharing sovereignty with Member States (Mamudu and Studlar 2009), its authority is still limited to specific competences, particularly under the doctrine of 'subsidiarity', in place since the Maastricht Treaty of 1993 (European Commission 2004), which pushes decisions to the lowest possible level of authority. The EU has successfully politicized the tobacco control issue to enable it to take action on behalf of its members in a trans-European manner, but such authority is still limited, fragmented, and contested, in both policymaking and implementation (Guigner 2004).

Tobacco control in the UK

The EU's imposition of policy on reluctant countries such as Germany shows the effect of regulatory federalism in member states. However, its effect in the UK is less certain because many of the most important

advances in EU policy were welcomed in the UK at the time of their implementation. For example, although the UK's Conservative Government (1979–1997) opposed most interventionist tobacco control measures and voted against TAD1, its successor Labour Government introduced legislation (in 2002) that went beyond the requirements of TAD2 (Duina and Kurzer, 2004; Cairney 2007a).[1] Similarly, the EU directive on tax levels followed a long history of tax rises in the UK, and the principle of health warnings on cigarette packs was established in the UK before the first directive (see Table 3). Further, while the UK government's development of smoking bans in public places was tardy compared to the devolved territories (below), it introduced legislation before any EU requirement.

Developments under the Labour Government led the UK to high rankings in comparative expert surveys of tobacco control in Europe. In the latest survey (Joossens and Raw 2007), the UK is in a league by itself, scoring 93 out of a possible 100 points, based on measures identified by the World Health Organization (price of tobacco, smoking bans, advertising bans, health education, health warnings, treatment). Overall, the UK has moved from being a laggard to a leader.

Before the 1997 Labour Government, tobacco policy in the UK was shaped by three forces: (1) voluntary agreements between the government and the tobacco industry on regulations; (2) cigarette sales as a source of tax revenue; (3) few government policies other than bans on broadcast advertising and educational campaigns against smoking (which commanded far less expenditure than tobacco company advertising) (Baggott 1988; Read 1996; Berridge 2004; Cairney 2007a; 2007b; Leichter 1991). The voluntary agreements largely required the industry to regulate itself, while the UK government opposed tobacco control measures that curtailed individual freedoms, in contrast to countries such as France and Italy with more established histories of public health interventions (Duina and Kurzer 2004: 59). This approach was reflected in its behaviour in the EU Council of Ministers (European Commission 2004).

Overall, British tobacco policy was considered relatively weak in comparison to some Nordic countries and others such as Canada, Australia, and New Zealand. The most prevalent explanation for this was the dominant influence of the domestic tobacco industry within government, based on the British preference for cooperative regulatory relationships (voluntary agreements) and the strong socio-economic position of tobacco companies. Smoking prevalence was relatively high and the industry supported over 40,000 jobs, raised the equivalent of £10 billion per year in tax revenue, and provided a significant source of export revenue (Cairney 2007a: 47). This cemented its strong position within key

Table 3. Chronology of Tobacco Control in the United Kingdom

1908	First age limit on sales to minors
1950	First large-scale epidemiological study of the relationship between smoking and lung cancer Doll and Hill in the British Medical Journal
1954	Health Minister: Revenue from tobacco makes discouraging smoking difficult
1956	First government-funded anti-smoking education initiatives
1957	British Medical Research Council: smoking-cancer link
1962	Royal College of Physicians (RCP) report, 'Smoking and Health'
1964	The US Surgeon General report on 'Smoking and Health'. Banning of cigarette advertising on television
1967	Minister of Health notification: government legislation forthcoming to control cigarette smoking
1971	First of voluntary agreement with the tobacco industry; first health warnings. Founding of ASH (Action on Smoking and Health), anti-smoking group funded by the state
1973	Announcement that an independent executive committee for guidelines and testing of cigarette contents
1976	Health Education Authority (HEA) anti-smoking campaign aimed at young people.
1980	The Government announces a new voluntary agreement with the tobacco industry. First rotating health warnings, four new ones
1981	Cigarette tax increases by largest percentage price rise since 1947
1984	British Medical Association (BMA) becomes more active on smoking issues
1987	New voluntary agreement with greater restrictions on advertising
1990	Government ban on oral snuff products comes into force
1991	Government intention to legislate for tougher new health warnings, in line with European Community directive requirements. Green Paper, *The Health of the Nation*
1994	Government Action Plan to reduce smoking with five goals: price, increasing awareness of health risks and providing support for smokers who want to give up, effective controls on advertising, protecting smokers from passive smoking, and improving scientific understanding of the risks of tobacco
1997	Labour manifesto promise to ban tobacco advertising. Labour government announces it would take action on cigarette smoking. First Minister for Public Health appointed
1998/1999	White Paper, Smoking Kills; Government-subsidized cessation services begin. Higher taxes, anti-smuggling enforcement improved; Scientific Committee on Tobacco and Health official government report on dangers of second-hand smoke; New voluntary code on non-smoking indoors
2000	Introduction of Tobacco Advertising and Promotion Bill to ban advertising 2002 Tobacco Advertising and Promotion Act passed, implemented 2003
2003	National Assembly for Wales requests legislative power on second-hand smoke
2004	Wanless Report, Securing Good Health for the Whole Population; White Paper, Choosing Health; Scottish Executive proposes indoor smoking ban, after a Private Member's bill
2005	Scottish Parliament passes the Smoking, Health and Social Care (Scotland) Act for ban in workplaces and public places, implemented in March 2006. Labour election manifesto promises partial smoking ban. Northern Ireland Minister announces in October smoking ban in workplaces for April 17, 2007
2006	House of Commons votes to introduce indoor non-smoking ban in England, implemented July 1, 2007; also allows National Assembly for Wales authority to make decision for Wales. Wales bans smoking indoors on April 1, 2007

Source: Berridge (2004), Cairney (2007a, 2007b), Asare (2007), ASH-UK www.ash.org

government departments, the Treasury and Department of Trade and Industry, while public health interests were marginalized to the less influential Department of Health (Baggott 1988; Read 1996, Leichter 1991; Berridge 2004).

However, the advent of the Labour Government in 1997 eventually led to the demise of voluntary agreements for regulation (Asare 2007). The first Labour party manifesto pledged stricter regulations on tobacco consumption (Cm 4177, 1998). This government was more committed to interventionist tobacco control as a key driver in public health policy, and its new approach accelerated the decline of tobacco company influence within government, particularly since public attitudes to smoking were changing, prevalence was relatively low, and the economic contribution of tobacco was diminishing (Cairney 2007a: 56). See Table 3.

Two government white papers, *Smoking Kills* (1998) and *Choosing Health* (2004), guide recent tobacco policy. In both documents, the government outlined four major policies to reduce smoking prevalence: (1) a comprehensive ban on tobacco advertising; (2) increased tax on tobacco products; (3) limiting smoking in public places and workplaces; and (4) providing publicly funded Nicotine Replacing Therapy services (NRT). Policies were also adopted to prevent children under 16 years of age and pregnant women from smoking (Cm 4177, 1998).

To control tobacco advertising, the government went beyond EU requirements by effectively implementing TAD1. The *Tobacco Advertising and Promotion Act 2002* ended almost all forms of tobacco advertising in the UK, including over the internet, by 2005 (Cm 6374, 2004; Berridge 2004; Asare 2007). Although its slow pace of legislation rankled public health advocates and prompted a Scottish Parliament attempt to introduce its own legislation (Cairney 2007a: 55), the legislation passed before TAD2 was adopted in the EU. The Labour Government also went beyond EU requirements in most areas, including a five per cent annual increase in tobacco products in real terms to discourage smoking and tasking the NHS with providing free NRT to the poor.

The exception to this new direction was the UK's attitude to smoking in public places. Although the government accepted the scientific evidence on passive smoking in 1998, it chose to address the issue with voluntary measures (Cairney 2007a: 50). For workplaces, a government agency (the Health and Safety Commission) produced an Approved Code of Practice on smoking in 1999. A special case was made for bars and restaurants. The voluntary code with the leisure industry required only that business introduced ventilation systems or put a sticker in their window saying that smoking was allowed (Cairney 2007a: 53). Most policy innovation in the UK came from its devolved territories.

Devolved government and tobacco control in the UK

From 1999, tobacco control shifted from being solely a responsibility of central government to one in which power is shared with devolved jurisdictions. This extends to various aspects of health policy (such as NRT) and health education. However, the most significant developments took place around the issue of smoking in public places, since policy innovation in the rest of the UK was a factor in the UK government's decision to introduce a comprehensive ban. Scotland took the lead by legislating in 2005 and Wales and Northern Ireland both signalled a desire to follow its lead before a decision was made at Westminster in February 2006.

A variety of reasons have been used to explain the decision of devolved governments to go their own way. For example, each jurisdiction focused more strongly on the issue of public health, in part because the health of their territorial populations was relatively poor (Greer 2004; Asare 2007). In each case, while broader public health plans featured action on exercise, eating, and alcohol consumption, tobacco control was the main plank (see Scottish Executive 2003; DHSSPS 2005). Second, each devolved territory was influenced heavily by the decision in Ireland to introduce a comprehensive ban quickly, while England was more likely to seek lessons from larger countries, such as the US, which introduced change incrementally (Cairney 2009). Third, in Scotland and Wales, the differences were influenced by venue shift and the ability of public health interests to influence new political actors (Cairney 2007b; 2009). However, for present purposes it is more important to explore the *scope* for this new direction. In tobacco-related health policy and health education, it is relatively easy to demonstrate discretionary federalism, since UK government involvement tends to be as part of professional networks sharing best practice. The nature of UK and devolved relationships is less clear with smoking bans. At face value, there are signs of regulatory federalism in each country: in Northern Ireland the suspension of devolution led to a UK minister taking the decisions; in Wales policy innovation was constrained by the inability to secure legislative space in Westminster; and in Scotland the UK Health Secretary, John Reid, sought to block policy innovation through First Minister Jack McConnell (Cairney 2009; 2007a).

However, in each case this picture is misleading. In Northern Ireland, the link between political turmoil and general inattention to public policy better explains the delays in policy innovation (Greer 2004). Further, health minister Shaun Woodward's decision to introduce a comprehensive ban was made separately from the UK policy process, with Prime Minister Tony Blair unaware of the decision until after it was made

(Cairney 2009). In Wales, the lack of legislative powers that the National Assembly for Wales (NAW) required to innovate stemmed more from an unconvincing demand for devolution (Johnson 2007) than a desire of the UK government to manage specific issues. As soon as Westminster passed the *Health Act 2006*, the NAW was free to take its own decision, regardless of the decision made for England (Cairney 2009). Further, the NAW's original decision (in 2003) to ban smoking in only some public places was very similar to the approach outlined by the UK Government in the White Paper *Choosing Health* (Cm 6374, 2004).

Similarly, in Scotland, early policy decisions did not diverge significantly from the UK line. In May 2000, the Scottish Executive (now Scottish Government) introduced a voluntary agreement with the hospitality industry. The Scottish Voluntary Charter merely required that pubs and restaurants provide designated smoke-free places in their facilities. Although the Executive hinted that legislation would be adopted if the agreement failed to produce favourable results, the low rate of compliance (ASH Scotland 2005; Asare 2007) was followed in 2004 by a reinforced commitment to voluntary measures (Scottish Executive 2004). When the Executive finally decided to legislate, UK opposition was limited to the personal beliefs held by John Reid. The Department of Health was far more supportive. Indeed, it helped find a solution to uncertainty regarding Scotland's powers to legislate, on public health grounds, in an area previously considered to be a centrally reserved health and safety issue (Cairney 2007b; 2009).[2] In this light, there is significant evidence of discretionary federalism.

Yet, the experience of smoking bans since devolution still stretches Kelemen's focus to the limits, since we are really witnessing policy innovation in the devolved territories rather than the discretion to implement central policy in a distinctive way. The MLG focus on multi-directional rather than linear sources of policy formulation seems more appropriate, particularly since policy change in the rest of the UK influenced UK government policy. The value of a focus on governance is reinforced when we consider the 'campaigning clientelism' role of the UK's Department of Health. As well as funding groups such as Action on Smoking and Health (ASH) to raise issues and criticize policy when it could not, the Department made key contributions to the development of legislation in at least one devolved territory (Cairney 2007b). This action highlights a complex process of multi-level governance: the influence of devolved policies on the English agenda is furthered by parts of the central UK government (Cairney 2009).

Tobacco also provides a problem for the comparison of EU and UK regulatory regimes. In other policy areas, there are clear links from the top (EU) to the bottom. For example, most devolved environmental

policy is Europeanized, and the devolved territories may be charged with the implementation of directives, monitored by the UK government as the member state. Similarly, in agriculture the coordination of devolved government policy by the UK government is significant, allowing us to compare its conduct with the EU in very similar policy terrain (see Keating 2005; McGarvey and Cairney 2008). While the EU's reach into health policy has become increasingly significant, this relates more to areas such as working conditions, patient rights, and private health insurance than public health and health education (Greer 2008).

In tobacco, the legislative reach of the EU rarely extends to the responsibilities of the devolved territories. For example, before the smoking ban legislation in 2005, Scotland's role was limited to issues such as health education, NRT, smoking cessation clinics, and the enforcement of age-related restrictions, with taxation, labelling and tar yield reserved to the UK. In these specific devolved issues, although we can confirm discretionary federalism in the UK, we cannot demonstrate regulatory federalism in the EU. Since EU competence in tobacco policy thus far has been based on harmonizing policies for fair competition in the single market rather than public health directives *per se* (Khanna 2001), its role is often one of coordinating, complementing, and supporting public health efforts. Therefore, the EU's role (to date) on passive smoking has largely been supportive, suggesting discretionary federalism in some areas of tobacco control.

Conclusions

Over the past two decades the UK government's monopoly on all tobacco policy has been replaced by shared control among three levels of government. The central state now shares authority with the EU for policies on taxation, health warnings, advertising and tobacco contents. It has also devolved responsibility on health education, smoking cessation strategies, and indoor non-smoking regulation to Scotland, Wales and Northern Ireland. This article presents two main ways to examine the effects of such developments: (1) an application of Kelemen's theory of federalism to highlight the value of treating the EU and UK as quasi-federations, and (2) multi-level governance, which examines shifting jurisdictional boundaries and the blurred lines between formal and informal sources of influence.

The findings from tobacco control provide mixed support for Kelemen's (2004) thesis. The growth of EU-determined policies, along with public disputes among central institutions and judicial appeals over interpretation of statutes, suggests regulatory federalism. While decisions made at the EU level are left to individual countries to implement, the

European Commission and the ECJ exercise considerable executive oversight and judicial powers. In contrast, discretionary federalism is the norm within the UK. This is consistent with Kelemen's argument that the executive in a centralized parliamentary system is less concerned with making sure that details of policy are followed across lower level jurisdictions. In most aspects of tobacco policy, the UK government respects the devolution settlement, with intervention largely restricted to professional networks and best practice.

However, tobacco policy qualifies Kelemen's thesis in a number of ways. First, there is a difference between the existence of a separation of powers and the practice of regulatory federalism. There is considerable debate about the influence the EU has on member state implementation. Implementation success, measured in terms of an acceptable level of member state uniformity, takes time to materialize. Second, there is considerable variation in implementation, depending on the existing level of policy development in each member state. There is considerable flexibility in implementation through the complex process of comitology between member states and the EU Commission, a process Kelemen does not discuss. Through comitology the states, especially through 'national experts', have a role in developing the guidelines for policy implementation (Blom-Hansen 2008). Once these are agreed, all member states are supposed to abide by them. Thus the separation of powers at the EU central level does not preclude negotiations about implementation and is not entirely reliant on the relatively inflexible and 'judicialised' approach to implementation that regulatory federalism indicates. As Hix (2004) describes, some comitology procedures are based more on a separation of powers, others on a fusion of power. Third, unlike Germany, which is increasingly subject to EU imposition on tobacco policy, the UK shows that the authoritative role of the EU is relatively insignificant when a member state's policies have gone beyond EU requirements in both tempo and content. In effect, evaluations of discretionary or regulatory federalism will depend significantly on the level of policy maturity in the EU compared to member states. The EU has least authority over member states with the most restrictive tobacco control policies. While ostensibly it has more authority over laggard and accession states, laggards have the capacity to resist, as do accession states once they become full members.

In environmental policy, Kelemen's main object of study for regulatory federalism, the authority of the EU, while slow to develop, has been established for longer and perhaps with less controversy than in tobacco control. In many areas of tobacco policy, the EU is still finding a role and there is more evidence of discretionary federalism, particularly when the authority of the EU remains in considerable doubt. In other words, the

EU may be a regulatory state but, in tobacco policy, regulation often accounts for a small proportion of public policy.

Fourth, the evidence from other policy areas (particularly when they have a strong finance or social security component) suggests that the UK government does not always display discretionary federalism (McGarvey and Cairney, 2008; Keating, 2005; Cairney, Keating and Hepburn, 2009). Finally, since policy innovation from the UK central state and its devolved territories is a key feature in tobacco control, this takes us some distance from Kelemen's focus on the EU to explain policy development. In such cases, the MLG focus on shifting jurisdictional boundaries and uncertain formal influence is better equipped to explore the role of policy innovation in devolved territories that influences policy development in the UK and EU.

Based on this study, the effect of EU social regulation appears to vary by policy issue and country. For example, the UK displays more decentralization in tobacco than on environmental issues. While Germany may be becoming more centralized on the environment, despite its internal federal system, on tobacco control it has continued to respect a division between central and provincial authority. Even with increased informal pressure from the EU to pass stronger second-hand smoke laws, this issue has been left to the provinces (Grüning et al 2008). Thus it would seem that not all social regulation is equal.

While the pattern of competitive involvement of horizontally-fragmented EU institutions in tobacco policy formation is broadly congruent with Kelemen's (2004) concept of regulatory federalism, Guigner (2004) is correct that policymaking on tobacco issues involves limited and sometime grudging responsibility for EU institutions. Regulatory federalism has the advantage of parsimony, but one of the problems of theorizing federalism has been the differences in policy authority in such systems worldwide. The EU, as a level of suprastate authority, is unlikely to behave like state-centred federal systems for all policy areas. The very design of the EU gives it different amounts of competence in various policies.

Tobacco policy is one in which EU policy competence has been slow to develop, has been contested, and, while considerably greater than it was 25 years ago, is still only partial, with states and sometimes their subdivisions retaining considerable power. The regulatory federalism of separate EU institutions aids understanding of some dimensions of tobacco policy, but the governance of this policy area is shared between both formal and informal institutions, as well as among levels. Therefore our research finds that, overall, MLG provides a superior framework to describe EU tobacco policy. MLG is more able to reflect the complexity and variation of EU regulatory policies and the contingencies of both

policy formation and implementation. Yet, this statement arguably suggests the need for more research into different policy sectors and institutions. Since MLG is such a flexible concept it is able to accommodate a wide range of behaviour. However, its flexibility makes it difficult to *explain* that behaviour more generally. Part of the explanation for MLG ambiguity is the nature of its object of study – a relatively fluid and often indeterminate process, with levels of power diffusion varying across time and policy issues, requiring a relatively flexible theoretical framework to accommodate empirical studies. In effect, the choice of MLG over Keleman's version of federalism suggests drawing conclusions on an empirical, case-by-case basis rather than embracing, perhaps prematurely, a deductive, general theory of federalism in the EU.

NOTES

1. Britain still voted against the second version of the TAD2 in 2002, ostensibly to delay its applicability to Formula One international racing events (Duina and Kurzer 2004).
2. Note that in the EU the reverse is true. The Commission must frame its directive on health and safety, not public health, grounds.

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