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Introduction

The UK has one of the most comprehensive set of tobacco controls in the world. The scale of its policy development puts it at the forefront of a global model for tobacco policy led by the World Health Organisation, and at the top of the European league table for tobacco control (Mamudu et al, 2015). It has gone from 'laggard' to 'leader' over three decades.

The success of the UK tobacco control case is clearest when seen through the eyes of public health advocates, who identify tobacco as one of the world's largest public health problems and causes of preventable death, and who seek an 'evidence based' theory of change (Cairney, 2016). In this context, 'comprehensive' tobacco control relates strongly to preventing non-communicable diseases (NCDs) and early death by regulating the sale and use of tobacco and promoting healthier behaviour. In this case, long term *programmatic success* in terms of encouraging smoking reduction and 'denormalisation' of tobacco, was achieved through an incremental adoption of several evidence-informed policy instruments. It was the cumulative weight of measures dealing with price, promotion, education and health warnings, plain packaging, and the regulation of ingredients, sales, who can smoke and where they can smoke that led to such successful programmatic outcomes. To some extent, this approach is based on a pragmatic response to uncertainty: if the relative impacts of each policy solution on the population are uncertain, a combination of all known effective interventions can produce an effect greater than the sum of their parts. This approach to tobacco control serves as a model for countries around the world, as well as other public health measures within the UK (including alcohol and food policies – Cairney and Studlar, 2014).

The main explanation for this comprehensive policy change is how policymakers (re-)framed tobacco – from an economic good to a public health epidemic - and managed the policymaking environment and to produce conditions conducive to policy change. Policy changed markedly when public health actors used new scientific evidence to reframe tobacco from an economic good to a public health epidemic, and when policymaker attention shifted from '*should* we act?' to '*how* should we act?'. The health department became the key player, with rules on

evidence gathering and network formation favouring public health over industry cooperation. Further, socio-economic changes – including reductions in smoking, tobacco tax revenue, and opposition to tobacco controls – reduced the political costs of policy change. This trajectory highlights how a conducive environment and socio-economic context allowed interested entrepreneurs and motivated policymakers a 'window of opportunity' for policy change (Kingdon, 1984; Cairney and Yamazaki, 2018).

Explaining the policy design and choice, in this case, is helped by 'multiple streams analysis' (MSA). The UK's ban on smoking in almost all public places is symbolic of a long-term shift from minimal policy intervention in the 1980s to comprehensive policy by the mid-2000s. If seen through the eyes of public health advocates, this measure demonstrates *process success*, following high public attention and widespread political deliberation, and *political success*, as indicated by the perception among policymakers that they enjoy unequivocal support by key stakeholders and diminishing opposition to tobacco control among the public. Although tobacco control is not exactly popular in the UK, the government has used a 'permissive consensus' among the public, or a level of reduced – and comparatively low - opposition that has proved conducive to policy innovation in this field (Key, 1961; Cairney et al, 2012: 120).

Focusing alternatively on overall and individual policy changes provides different indicators of legitimacy and endurance. The trajectory towards comprehensive change in a series of incremental steps from the 1980s suggests that the overall project endured and is now almost taken for granted, even though each new instrument faced new challenges. A process of denormalising smoking has become normalised. A focus on the smoking ban shows that its design – to punish the building owner, and prioritise enforcement by environmental health bodies – mattered, and that popular support for the ban became more apparent after policy change. The ban on smoking in public places is a remarkable implementation success – it is flouted by almost no-one - and it opened the door for more restrictive measures such as a ban on smoking in cars with children present.

In the analysis and conclusion of this chapter, I draw lessons relevant to a dominant theme in public health research and beyond: a desire for 'evidence based policymaking'. By focusing on the conditions under which evidence 'won the day,' it becomes apparent how important context, power, and politics are in explaining the outcomes of this policy. This conclusion matters primarily for tobacco control's future success as a model of change for tobacco in other countries, but also for other public health initiatives in the UK. Therefore, attributing success

primarily to the production of scientific evidence would provide an incomplete and misleading story on which to build new strategies to emulate UK success.

Why does UK tobacco control count as a great policy success?

The UK's tobacco success is mainly *programmatic*, in terms of the social behavioural (and economic) outcomes produced by the policy reforms. In Table [X] (Chapter X), programmatic success involves an unusually 'well-developed and empirically feasible public value proposition and theory of change'. Tobacco control's claim to provide public value and beneficial social outcomes relates to smoking (and now environmental tobacco smoke) as 'the number one preventable cause of premature death and disease in the world' (Cairney et al, 2012: 1). The theory of change, to reduce smoking and ill health, is empirically feasible and based on global efforts to identify and share best practice. The policy has fulfilled its main aim by making a major and measurable contribution to reduced smoking prevalence (Feliu et al, 2018), albeit with benefits distributed unequally, since smoking remains a major cause of health inequalities. Programmatic success has also endured for the long term, with tobacco control increasing in scope and intensity over several decades, and minimal evidence of any policy reversals or reductions.

The *process* and *political* elements of this case are more difficult to assess, particularly since stakeholder assessments about adequate deliberation and popularity relate strongly to their own support or opposition to policy change. However, key measures have received widespread consultation and public attention and there is now public support for measures – such as a ban in smoking in public places – that would have seemed unimaginable until the mid-2000s. Further, although most policy change happened under the control of one party (Labour), it was reinforced by the other (Conservative) to produce a strong sense of policy commitment and endurance. Overall, this paradigmatic policy change is here to stay.

Programmatic success

The UK is one of very few countries at the forefront of the global tobacco control agenda. Programmatic success equates to progress towards 'comprehensive' tobacco control via the adoption of a collection of the most evidence-informed policy instruments. Comprehensiveness is measured according to criteria derived from the WHO Framework Convention for Tobacco Control (FCTC), which provides a list of measures to which 181 'parties' (covering 90% of the global population) have committed (WHO, 2018):

- 'Tobacco taxation policy – price and tax measures to reduce demand for tobacco

- Smoke-free policy – protection from exposure to second-hand smoke
- Tobacco product regulation – regulation of contents of products (toxic ingredients)
- Ingredient disclosure – regulation of public tobacco product disclosures
- Health warning labels – at least 30 per cent of the package of tobacco products should be a health warning
- Education and advocacy – to improve health education, communication, training, and public awareness
- Banning tobacco advertising, promotion, and sponsorship
- Smoking cessation services
- Prohibiting the illicit trade in tobacco products
- Banning tobacco sales to minors (under 18)
- Litigation against tobacco companies
- Research to monitor and evaluate tobacco control
- Support for economically viable alternatives to tobacco growing' (Mamudu et al, 2015: 860).

If this list represents indicators of comprehensive policy change, the UK is a key leader within a group of only nine countries demonstrating the most significant adoption and implementation of such measures. Although almost every country has committed to the FCTC in writing, very few have successfully turned that commitment into meaningful policy change on the ground (Mamudu et al, 2015: 865). Self-reported progress by each country highlights very uneven global implementation, and expert assessment highlights very limited change in most countries in key areas such as the regulation of products and illegal sales. Further, very few countries have matched the UK's intensity, including relatively high taxation and a ban on smoking in public places with almost no exceptions (2015: 867-9; Warner and Tam, 2012).

A further measure of success comes from the UK's shifting position from laggard to leader. In the 1980s, the UK oversaw minimal control, with little prospect of policy change (Taylor, 1984; Read, 1996). Baggot (1988: 5) compared the UK unfavourably to Norway. While both entertained the same measures, Norway's had statutory weight while the UK relied on ineffective voluntary measures favoured by the tobacco industry. The UK was, in many respects, closer to countries like the Netherlands and Japan, in which tobacco companies had a major presence and preferred non-statutory measures (Willemsen, 2018: 81; Cairney and Yamazaki, 2018). By 2007, the UK had left such countries behind *and* leapfrogged Norway to

reach the top of the first 'tobacco control scale' (TCS) (Joossens and Raw, 2007; 2017) which measures 'the implementation of a comprehensive set of control measures in Europe' (Cairney and Yamazaki, 2017: 3). The scale uses the top six policy instruments deemed most important by the World Bank and assigns percentage points to reflect their importance: price (30), bans on smoking in public places (22), health education (15), advertising bans (13), health warnings on products (10), and smoking cessation treatment services (10) (Joosens and Raw, 2017: 8). It then asks country experts to assign scores according to policy intent and delivery. In each ranking, from 2007-16, the UK has been ranked first.

This shift of status reflected a shift from voluntary to statutory measures combined with relatively high commitment to important non-legislative policy instruments. Key policy changes included, legislation to ban tobacco advertising (2002), a ban on smoking in almost all public places (2006), an increase in the minimum age for the sale of cigarettes from 16 to 18 (2007), the introduction of plain packaging for tobacco products (2015), a ban on smoking in private cars with children present (2015), high levels of taxation designed to reduce smoking demand (from the 1980s) coupled with greater customs enforcement, higher spending on smoking cessation services, and a shift towards unequivocal health education (2017: 3, drawing on Cairney et al. 2012: 101–102).

For public health advocates, the UK's experience is an 'evidence based' model for future tobacco control across the globe (Cairney and Yamazaki, 2017). Smoking is an urgent domestic and global problem, initiatives such as the tobacco control scale and FCTC help us identify the most technically feasible responses, and the UK was one of the fastest and most intense responders, at the forefront of processing politically feasible options. Further, tobacco control contributed strongly to reductions in smoking prevalence, such as from 35/31% in men/ women in 1986 to 22/17% in 2015 (ASH, 2010; 2015). As Feliu et al (2018) report in their comparison and quantitative assessment of EU Member State tobacco control, 'countries with higher scores in the TCS, which indicates higher tobacco control efforts, have lower prevalence of smokers, higher quit ratios and higher relative decreases in their prevalence rates of smokers over the last decade'. As a leader in adopting and implementing precisely those policy instruments which are empirically linked to the primary goals of tobacco control, the UK case is an example of programmatic success.

Process success

The *process* assessment of tobacco control is more difficult to determine because the divisions between pro- and ant-smoking coalitions (Cairney, 2007: 57) necessarily produced winners and losers. This division reduced the possibility that all stakeholders could see policy deliberation and action, during policy design and choice, as 'just and fair'. Indeed, the history of UK tobacco policy is of one coalition being privileged to the exclusion of another. From the early post-war period, and over several decades, medical and public health groups complained of exclusion from a close-knit policy community between treasury and trade departments and the tobacco industry, which had gained a patriotic reputation during WW2 and had the resources to maintain its insider position (Read, 1996). Now, becoming a party to the FCTC commits countries to exclude tobacco companies from formal consultation on policy. This position gives industry stakeholders their turn to describe the policy process as exclusionary (Cairney et al, 2012: 214), while public health stakeholders would see the exclusion as good policy and policymaking. In a field with such clear winners and losers, it is difficult to incorporate the role of consensus-seeking or collaborative policymaking as an indicator of success.

There is, however, more evidence of the 'robust deliberation' of process assessment, at least in relation to key instruments. For example, the UK Government was initially guided strongly by survey opinion which favoured a ban on smoking in public places but with exemptions for pubs and clubs, and policy only became more restrictive following wide deliberation and a 'free vote' for MPs in Westminister (Cairney, 2009: 478). In Scotland, in which some tobacco control is devolved to the Scottish Parliament – the smoking ban represented policy innovation within the UK and it became the 'big idea' used by the government (led at the time by a Labour-Liberal Democrat coalition) to legitimise Scottish devolution and enhance the 'political capital' of Scottish politicians (Cairney, 2007b: 86). The Scottish Government oversaw a mass consultation in which most respondents favoured major policy change.

Political success

The same divisions which clouded procedural success limited the policy's *political success*. There are clearly pro- and anti-smoking coalitions, but over time the former diminished and the latter grew in importance. Tobacco control in the UK is not popular *per se*, but there has been growing citizen acceptance which allows (a) public health coalitions to push for more tobacco control in line with the FCTC aims, and (b) governments to show leadership, while confident that the measures will be accepted over time. Similarly, association with tobacco

control does not exactly 'enhance the political capital' of policymakers, but the UK Labour government from 1997-2010 was willing to use much of its new capital - after a landslide electoral victory - to reform, introduce, or accelerate tobacco control measures (Cairney and Yamazaki, 2018: 255). Indeed, the UK government's narrative of policy change was 'deliberately incremental, with measures to influence, but not get ahead of, public opinion' (Cairney, 2007a: 50). Further, the Scottish Government was careful not to go *too far* ahead of opinion without the support of its consultation exercise, while acting on the correct assumption that public opinion for tobacco control becomes more supportive after policy change (Cairney, 2011: 170).

The policy's political success can also be linked to its longevity. Tobacco control, including the smoking ban, has proved to be highly durable. There is no equivalent to the Dutch partial reversal of smoking in public places and there were few implementation problems. Enforcement came largely under the purview of environmental health officers who made it an initial priority, but seemed to face minimal opposition, partly because – based on learning from Ireland - the legislation placed the onus on premises owners to enforce customer behaviour on the government's behalf (Cairney, 2009: 482).

Contexts, challenges, agents: the conditions conducive to policy change

Policy theories shed insight on the contexts and challenges shaping the success of tobacco control in the UK (Cairney et al, 2012; Heikkila and Cairney, 2017; Cairney and Weible, 2017; Cairney, 2016; John, 2003). Five key factors or concepts identify the constituent parts of the policymaking 'environments' which provide the conditions conducive to policy change:

1. *Actors*. There are many actors – policy makers and influencers - operating in many 'venues' (arenas in which authoritative decisions are made) across many levels and types of government.
2. *Institutions*. Each venue has developed its own rules, from the formal rules which are often written down and well understood, to the informal rules which are often not well known and communicated in ways that are difficult to identify from the outside. Institutions also help create a sense of 'path dependence' when choices made in the past make it relatively expensive to change course (Pierson, 2000).
3. *Networks*. Such rules can relate to the ways in which policy makers interact with other actors, based for example on levels of trust built through regular contact and exchanges of information.

4. *Ideas*. One way of thinking about the world, or a policy problem, can be taken for granted or dominate discussion for extended periods of time. Such dominance – expressed with reference to terms such as paradigms, hegemons, or core beliefs – provides the context for discussion of potential policy solutions.
5. *Context and events*. Policymakers face socioeconomic conditions and events over which they have limited control, but can interpret and respond to them in different ways.

In the UK before the 1980s - and in most countries to the present day - the tobacco policymaking environment was not conducive to policy change (Cairney et al, 2012). 'Critical junctures', that can be traced back to WWII, helped produce a series of decisions to produce conditions conducive to tobacco production and consumption for decades (Cairney et al, 2012: 220). Policymaking power was concentrated primarily in treasury and trade departments in this era. Those departments tended to reproduce rules which minimised tobacco control. Their closest networks were with a small number tobacco companies, built initially on the patriotic image of companies providing cigarettes to aid the war effort in WWII, and reinforced by tobacco strategies to influence the production and dissemination of science and work closely with policymakers to produce largely-voluntary responses to potential smoking harms. Throughout, the dominant image of tobacco was as an economic good, providing export revenue, tax revenue, and jobs, with health as a secondary concern addressed primarily with reference to personal responsibility for healthy behaviour. Socioeconomic conditions were largely supportive of this position, particularly when tobacco prevalence and taxation was high and public support for policy change seemed low (albeit in the absence of routine polling, which meant that elected policymaker *perceptions* of attitudes were key).

In this context, paradigmatic policy change would be remarkable, even if it took place over decades. As Table 1 shows, this is what happened in the UK. In terms adapted from Howlett and Cashore (2009) and Cashore and Howlett (2007), policy change is associated with a shift in policy ends *and* means. Past tobacco control policy was based on a political economy frame, which emphasised the economic benefits of the industry and the freedom to make choices such as to smoke. Contemporary UK tobacco policy is now premised on a public health frame in which smoking is an epidemic and the challenge is to tackle preventable NCDs and early mortality by combining a wide range of policy instruments.

Table 1: a shift of policy towards comprehensive tobacco control

	High Level	Programme Level	Specific On-the

	Abstraction	Operationalization	Ground Measures
Policy Ends or Aims	A shift in *goals*, from an economic towards an epidemic frame (let's support production versus let's eradicate the epidemic).	A shift in *objectives*, from maximising revenue and economic activity, towards preventing NCDs and premature death.	On-the-ground requirements include a tipping point of pricing (to prompt people to quit smoking) and a growing sense that smoking is not a normal part of social life.
Policy Means or Tools	A shift in *instrumental logic*, from voluntary measures and exhortation towards more coercive instruments.	A shift in *policy instruments* from voluntary agreements with the tobacco industry towards legislation and regulation, taxes to discourage consumption, limit promotion, and provide unequivocal health messages.	For example, tax rises are calibrated in line with the potential for illegal imports and counterfeit cigarettes (a public health disaster); the smoking ban extends to almost all public places, and individual choice is a less convincing narrative in the UK.

There is some debate on how to describe such profound but incremental change in the absence of a 'big bang' event associated with 'punctuated equilibrium' accounts of institutional change (Studlar and Cairney, 2014: 519; Hay, 2002: 163; Streeck and Thelen, 2005: 9; Palier, 2005: 129). It is also difficult to provide a highly specific and definitive account of the causal mechanisms of this change process, or the policy's main drivers and stewards, since many factors reinforced one another and each cause of change was necessary but insufficient.

However, we can describe key elements of each change and relate them to the actors and conditions which produced a policymaking environment far more conducive to control.

First, scientific evidence was key to long term policy development. It has been the main driver in shifts of practitioner, public, media, and policymaker understanding, by identifying a clear causal link between smoking (and 'passive smoking'), NCDs, and premature death (Cairney et al, 2012: 67). The UK was a key player in producing early key evidence (e.g. Doll and Hill, 1950) and disseminating it to doctors and policymakers. The production and effective use of new scientific evidence helped actors reframe tobacco as an urgent public health epidemic (also producing economic harms), and shift the question from 'should we control tobacco?' to 'how should we control tobacco?' (Feldman and Bayer, 2004).

However, we can also see in the UK a lag of 20-30 years between the production of the evidence and a proportionate response, from the evidence of smoking harm in the 1950s (major policy change began from the 1980s) to newer evidence on environmental smoke effects from the 1980s (the smoking bans began from 2005). To some extent, the lag reflected early debate on the causal connection between smoking and illness until unequivocal statements by the UK Royal College of Physicians in 1962 and US Surgeon General in 1964 (Pearl and Mackenzie, 2018: 167-9). However, the lag also reflected a wider policy environmental problem in which the evidence alone would not disrupt path dependence.

During this transition, we can see a slow process of change in other key factors. For example, the evidence of harm encouraged behavioural and attitudinal change. Socio-economic conditions changed gradually over time, including reductions in smoking and tax revenue, while reduced opposition to regulations reduced the perceived political cost of policy change. The effective use of scientific evidence in persuasion strategies also helped reframe tobacco's policy image, which gave health departments more relevance, which increased demand for public health evidence, and so on. However, during this long transition, opponents of tobacco control were able to influence the production and interpretation of evidence (by commissioning research and hiring scientists to undermine other research) and to promote less radical solutions - such as to foster individual choice and trust the industry to regulate its own activities – 'to make it look like the problem had been solved' (Cairney et al, 2012: 68). Indeed, a shifting frame to incorporate addiction over choice only took off from the 1980s, while the new moniker 'Big Tobacco' - to describe high power and low credibility – only took off when industry chief

executives were exposed as giving misleading testimony to US Congress in 1994 (Cairney et al, 2012: 132).

Second, policymaking responsibility shifted from treasury and trade towards departments of health. The department of health became a key player which was increasingly likely to consult with the medical and public health groups who shared their understanding of the problem and were the routine sources of evidence on possible solutions. While the Treasury was still involved, its role changed under the Labour government, when it took responsibility for reducing health inequalities and therefore reframed its definition of tobacco from an economic good to describe smoking as 'the single most significant causal factor for the socio-economic differences in the incidence of cancer and heart disease' (HM Treasury and Department of Health, 2002; Cairney, 2007a).

Third, the role of interest groups is now key, but their strategies took decades to consolidate and come to fruition. Action on Smoking and Health (ASH) was often working on a shoestring budget, the British Medical Association (BMA) was not as focused on public health campaigns as it is now, and cancer charities such as Cancer Research UK have only become overtly politically active since the early 2000s (Baggott, 1988: 15; Cairney, 2007a). Further, some groups have, in the past, entertained the idea of policy change through incremental steps, and their unequivocal stance on health education, policy change, and relationships with the industry seem to have hardened *after* policy change began from the 1980s. On the other hand, their role seems particularly important in a comparative context. For example, the lack of a public campaigning role of public health groups in Japan is one factor in its relatively slow policy change (Cairney and Yamazaki, 2017), and the inability of NGOs to organise in any comparable way in China (at least until 2009) puts the role of UK interest groups in a new perspective (Cairney et al, 2012: 176).

Finally, the party in government mattered for policy innovation. The main impact occurred when Labour accelerated policy change from 1997, making policy for the UK in some cases, and providing the conditions for devolved government policy innovation. It also represented the removal of UK government opposition to European Union pressure in key areas (with a temporary exception in advertising - Duina and Kurzer, 2004: 67), and the UK generally went far beyond minimum European Union standards (Cairney and Yamazaki, 2018).

Design and choice: the window of opportunity for a smoking ban

A focus on the policymaking environment largely describes conditions conducive to policy change. In addition, to provide a more detailed and convincing account of the drivers for policy design, we need to explain the different ways in which different policy instruments came to exist. Each instrument has its own story relating to the motive to propose and design policy in a more or less ambitious way, the measure of success, and the role of key actors. To demonstrate, I draw briefly on MSA to provide a more detailed explanation of the design and choice of the ban on smoking in public places in the UK. MSA invites us to focus on the need for three 'streams' to come together during a 'window of opportunity' for policy change (Kingdon, 1984; Jones et al, 2016; Cairney and Jones, 2016):

- *Problem stream – attention lurches to a policy problem*. There are no objective indicators to determine which problems deserve attention, and perceptions of problems can change quickly. In some cases, issues receive attention because of a crisis or change in the scale of the problem, but the emphasis of MSA is on the more or less successful framing strategies of participants competing for policymaker attention. Getting attention to one way of looking at a problem is a major achievement which must be acted upon quickly, before attention shifts elsewhere.
- *Policy stream – a solution to that problem is available*. While attention lurches quickly from issue to issue, viable solutions involving major policy change take time to develop. Kingdon describes ideas in a 'policy primeval soup', evolving as they are proposed by one actor then reconsidered and modified by a large number of participants.
- *Politics stream – policymakers have the motive and opportunity to turn it into policy*. They have to pay attention to the problem, and be receptive to the proposed solution, perhaps because it is consistent with their beliefs, fits the 'national mood', or represents a way to address the feedback they receive from interest groups and political parties.

MSA also emphasises the role of key actors – 'policy entrepreneurs' – with the skills, tenacity, and connections to know how to frame policy, propose solutions, influence policymaker receptivity, and therefore help exploit those windows of opportunity (Cairney, 2018). In particular, they help develop technically and politically feasible solutions in anticipation of future attention to problems, then find the right time to exploit attention.

In this case, there were actually four separate windows of opportunity in the UK because there were four relevant governments from 1999: the UK, making public health policy primarily for

England (and legislating to allow Wales and Northern Ireland to act), the Scottish Parliament with legislative powers, the National Assembly for Wales which showed the earliest interest but did not possess sufficient powers, and the Northern Ireland Assembly as the last to pay attention to this issue during the suspension of devolution (Cairney, 2009; Cairney and Yamazaki, 2017). All three devolved governments relied on direct support from the UK government to pursue their aims, but their actions also influenced the Westminster debate and subsequent vote for a full ban (Cairney, 2009: 476-7). Although they produced similar policy choices and outcomes, the timing and content of debate differed, and some comparisons help us clarity the relationship between conducive conditions and key actors/ interventions. Described initially in terms of the three 'streams' (see Cairney, 2009):

- *The problem stream.* Policymakers in each territory paid high attention to the issue from the early 2000s and paid greater attention to the need to restrict smoking in public places, but framed evidence (such as on public opinion) differently.
- *The policy stream*. The UK Government was learning primarily from US experience, in which key states introduced partial and incremental bans. The Irish experience of a complete ban in 2004 had a greater influence on the devolved agenda.
- *The politics stream.* The party of government mattered, with Labour in office in the UK, Scotland (in coalition), and Wales, and generally more in favour of tobacco control than the Conservative Party (in Northern Ireland, there was cross party support for tobacco control to emulate Ireland) (2009: 477).

In the UK, Health Secretary John Reid (2003-5) played an unusual role as a major influence supporter of other entrepreneurs. As a senior member of the government, he ensured that the Department of Health was central to policy, allowing actors in favour of tobacco control, such as the Chief Medical Officer, to set the agenda at the expense of tobacco companies. However, Reid also opposed a full ban on smoking in public places (a position reflected in Labour's 2005 general election manifesto), so the Department of Health described survey opinion (correctly) as in favour of a partial ban which exempted pubs and clubs and pursued the relatively incremental strategy to limit smoking in stages. The full ban only took shape after Reid's replacement as Health Secretary in 2005 by Patricia Hewitt, who opposed it but less vigorously. In the lead up to passing the legislation in 2006, several actions were key:

- Health Select Committee chair Kevin Barron, and All-Party Parliamentary Group on Smoking and Health chair David Taylor persuaded Prime Minister Tony Blair to allow a 'free vote' on the legislation (crucial because, at the time, most Conservative MPs opposed the legislation).
- The BMA (and local doctors) and ASH pursued an intense lobbying campaign in many MP constituencies.
- Groups like Cancer Research UK (lobbying government in this way for the first time) and Chartered Institute of Environmental Health highlighted major problems with a partial ban.
- When the government appeared to strengthen its ban, and only exempt private clubs, the British Beer and Pub Association reversed its economically-driven opposition to exemptions (in other words, it was not part of a well-coordinated action built on other concerns, such as a libertarian argument - Cairney, 2007a: 58).

Overall, policymaker and public attention to the proposed legislation was high, multiple solutions (including a full or partial ban) existed, the free vote gave Labour MPs the opportunity to vote for a full ban, and lobbying campaigns in favour of legislation reinforced their motive (Cairney, 2007a)

In Scotland, the process played out differently (Cairney, 2007b). Early legislation took shape from the early 2000s, via a Member's Bill developed by a cross-party group including the BMA Scotland and ASH Scotland, taken forward by Scottish National Party (SNP) MSP Stewart Maxwell in 2003. This bill was relatively unopposed by a tobacco industry that did not take devolution particularly seriously (Cairney, 2009: 481). The bill proposed a smoking ban in areas such as government buildings, partly to reflect (a) Maxwell's perceived limits to Scottish Parliament powers and (b) wider politician uncertainty about public opinion in the early 2000s. Several factors then contributed to the Scottish Government's decision to introduce a full ban in 2005:

- The Scottish Parliament Health Committee signalled to Scottish ministers that they would support Maxwell's bill after scrutiny
- The BMA and ASH Scotland had agreed to participate in a press conference lauding Maxwell and criticising government inaction.
- Ireland had produced comprehensive legislation.

- Some key actors - including Deputy Health Minister Tom McCabe and the Scottish Government's Chief Medical Officer - had already signalled internal support for more action and began to see their chance to act more intensely.

First Minister Jack McConnell was able to use these conditions to sell policy change, with reference to committee activity, McCabe, the CMO, and the Irish experience. Indeed, the smoking ban legislation gave the Scottish government the 'big idea' that it sought to justify the cost of Scottish devolution 2007b: 86), emphasising the scope for policy innovation within the UK, three-party support (Labour and Liberal Democrat in government, and the SNP as the main opposition) and the popularity of the move in relation to a massive public consultation to demonstrate majority support for a full ban akin to that in Ireland (Cairney, 2009: 478-9).

In each case, the main point is that we can identify a policymaking environment conducive to policy change, but politics and perceptions of public opinion really mattered. Throughout this period, there was a strong element of contingency, and the possibility of an extreme range of results, from no legislation at all (up to 2003) to a partial ban (2003-4) and the realistic prospect of a comprehensive ban on smoking in public places (from 2004). Perhaps the strongest indicator of contingency is the surprise expressed by participants that the issue rose so quickly on the agenda, and a full ban became politically feasible, after such a long period of legislative hesitancy (Cairney, 2007a; 2007b). For example, devolution occurred in 1999, the first Scottish Government initially favoured voluntary measures - agreed with industry stakeholders - to give premises the choice to allow smoking or not, the BMA expressed frustration *in 2003* that policymakers would not even discuss the issue, and yet the full ban was government policy by 2004 (Cairney, 2007b). Similarly, Scotland's Chief Medical Officer would not propose a full ban because it 'was utterly opposed by so many that a full ban would happen but not in their lifetime' (Cairney, 2009: 480). Even by 2004, the Scottish Government was expressing caution:

> *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* (Scottish Executive, 2004: 25).

Although it subsequently went ahead of public opinion, the Scottish Government only decided to do so when ministers 'sensed a shifting public mood' and predicted that public opinion would – as in Ireland - shift after policy change (Cairney, 2007b: 84).

The UK Government had been even more reluctant to get ahead of opinion. For example, John Reid expressed concern in public that tobacco control would be seen as a punishment for the working classes (an argument expressed over several decades by Labour politicians – Cairney, 2007a: 62). The UK government maintained a commitment to incremental change before its position was quickly overtaken by events and choices in Westminster (Cairney, 2007a). In that context, the sense among Labour MPs that public opinion was changing – and would change after legislation - combined with BMA and ASH pressure, and scientific evidence on the harms of passive smoking, to produce policy change during a window of opportunity (Cairney, 2009: 480).

Delivery, legitimacy and endurance: smoking denormalisation

The long term legitimacy of tobacco control is best indicated by four main factors. First, there has been no significant public debate or pressure to reverse or reduce the smoking ban since its introduction (unlike the Netherlands, in which a partial reversal is apparent - Willemsen, 2018). Instead, UK public opinion has shown majority support for the ban after its implementation (Cairney et al, 2012: 117).

Second, the delivery or implementation of the smoking ban appears to be one of the most impressive cases of its type, in which it is difficult to find any evidence of a breach of policy in any public places (with the exception of very few bars, in which *this* illegality would be low on the list of government priorities). In part, successful implementation resulted from: (a) the high priority given to enforcement by environmental health officers (signalled in the run up to enactment), (b) the onus on premise owners, not customers, to enforce (producing vivid stories of bar owners using baseball bats to discourage high fines), and (c) the socioeconomic conditions, in which bars and restaurants were relatively able to accommodate policy change via beer gardens and on-street smoking (in Japan, the relative infeasibility of enforcement – and potential to affect small business - is a factor in limited change – Cairney and Yamazaki, 2018: 26).

Third, since the acceleration of tobacco control took place during Labour's term, a key test of the endurance of tobacco control came with the election of a Conservative-led coalition (2010-15) and single party government (from 2015). The Conservative Government did not reverse, *and often reinforced*, strong public health measures. For example, it banned smoking in cars with children in 2015 and obliged plain packaging for tobacco products by 2017 (the packets

are sludge green, with large and vivid anti-smoking messages). These measures would have seemed unimaginable even during Labour's government.

Fourth, the endurance of comprehensive tobacco control in the UK is best evidenced by the continuous accumulation of policy change. The process to 'denormalise' smoking – largely by making it harder to buy and find places to smoke – has become a normal part of UK policy. Each successful policy measure *reflects and reinforces* an environment conducive to policy change. It began slowly in the 1980s under a Conservative government which proved to be relatively in favour of the status quo, experimenting with voluntary measures in areas such as advertising and promotion, coupled with health education and high taxation (Cairney et al, 2012: 104). The election of a Labour Government in 1997 prompted a major acceleration of policy change, including new measures and more intensity in most others (2012; 104). Further, policy change has continued in earnest to this day.

In global terms, the UK is one of a very small number of countries in which the implementation of key measures is relatively consistent and meaningful (Mamudu et al, 2015: 866). In many cases, implementation success is highly visible: there are media bans on smoking advertising, combined with plain packaging, health warnings, and education campaigns; the rate of tax is comparatively high; and, there is demonstrable funding for smoking cessation services through the national health service. Only in some cases is implementation success difficult to gauge: the success of customs and excise bodies in limiting illegal imports and counterfeit products (the existence of which limits the impact of tax rises); and the ability to restrict sales to over 18s (a policy that is not enforced well in most countries).

Analysis and conclusions: a success story for 'evidence based policymaking'?

The UK success story tends to be used as a model for others to emulate. Tobacco control advocates across the globe seek lessons to import, and UK public health actors seek lessons for alcohol and sugar, salt, and obesity policies. Tobacco represents a totemic example for the wider effort to regulate behaviour, and promote healthy behaviour, to reduce preventable NCDs.

In this context, it is common to view this process through the lens of contemporary debates on 'evidence based policymaking' (Cairney, 2016), particularly since policy success seems to relate the relatively strong and clear association between smoking and ill health (although with alcohol and food, it is not as possible to make the argument about no safe or beneficial level of consumption). However, it would be a mistake to place so much emphasis on the role of

evidence, since it would suggest that the UK's experience can be replicated in a straightforward way without considering the role of temporal politics (windows of opportunity) and the conducive conditions that developed over decades. Evidence of the unhealthy effects of smoking is available to all countries, but policy actors may use information as a resource in very different ways in each political system.

To understand how (or if) to replicate UK tobacco control success, a wider perspective is needed. Scientific evidence was pivotal, but the extent to which it 'won the day' should be situated within the context of the multiple contingencies involved. Successful use of evidence relies on policy framing, a policymaking environment more or less conducive to policy change, and the sense of serendipity that accompanies discussions of windows of opportunity. We can summarise these factors with reference to three main conditions (Cairney, 2019).

First, actors were able to use scientific evidence to persuade policymakers to pay attention to, and shift their understanding of, policy problems. In leading countries like the UK, it took decades to command attention to the health effects of smoking, reframe tobacco primarily as a public health epidemic (not an economic good), and generate support for the most effective evidence-based solutions. To do so, influential groups such as the BMA and ASH had to find ways to frame the evidence successfully in relation to the language of NCD epidemics (and that language developed via global efforts led increasingly by the WHO).

Second, the policy environment became conducive to policy change. A new and dominant frame helps give health departments a greater role; health departments foster networks with public health and medical groups at the expense of the tobacco industry; and, they emphasise the socioeconomic conditions supportive of tobacco control: reductions in (a) smoking prevalence, (b) opposition to tobacco control, and (c) economic benefits to tobacco. When policymakers in health departments took primary responsibility, they were able to support key health actors to take forward the policy agenda, in cooperation with public health groups and to the exclusion of anti-tobacco groups.

Third, actors exploited 'windows of opportunity' successfully. A supportive frame and policy environment maximises the chances of high attention to a public health epidemic and provides the motive and opportunity of policymakers to select relatively restrictive policy instruments. However, the smoking ban example highlights contingency, particularly in relation to the relationship between shifting levels of public opinion and the willingness and ability of policymakers to get ahead of and shape opinion.

Scientific evidence is a necessary but insufficient condition for major policy change and enduring success following implementation. Key actors do not simply respond to new evidence. They use it as a resource to further their aims, frame policy problems in ways that will generate policymaker attention, and underpin technically and politically feasible solutions that policymakers will have the motive and opportunity to select. This remains true even when the evidence now seems unequivocal and when countries have signed up to an international agreement, the FCTC, which commits them to major policy change. Such commitments can only be fulfilled over the long term, when actors help change the policy environment in which these decisions are made and implemented, to produce the conditions conducive to policy change.

We know that politics matters because there was a major gap between the production of evidence and policy in the UK, and it is far wider in most countries across the globe. So far, successful paradigmatic policy change has not occurred in most countries or, in other aspects of public health in the UK. Therefore, it would be a mistake to treat this policy success as inevitable or the emulation of policy success as straightforward.

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