Institute for Government: reducing smoking rates policy reunion

Seminar report, 9 May 2011

Introduction

As part of the Institute for Government's Better Policy Making project, we are inviting in groups of people involved in successful policies of the last thirty years to talk through the process, the choices and the decisions that shaped the result. The aim is to produce an in-depth understanding both of the policy itself but also of the wider system within which it was shaped, to shed light on the role of Ministers, civil servants and external players (both inside and outside the process). IfG will use the "reunions" to inform our better policy making study as well as produce individual case studies.

On 9 May 2011, we invited Ministers, officials and external players who had been involved in the introduction of the legislative ban on smoking in enclosed public places in 2005 to come together to discuss the factors that lay behind that move and how it fitted into wider government action to reduce smoking over the preceding decades. . A list of those who attended is at Annex B and a timeline of the key events is at Annex C.

The objective of the reunion was to understand how the policy evolved and critical decisions were made; explore the interactions between Ministers and advisers within Whitehall, with Parliament and with the and the outside world; and draw out lessons for present-day policy makers.

As preparation, we asked all participants to fill out a "policy typology" to allow us to understand how much people shared the same views on key characteristics. Full responses are summarised in Annex D, but the key features to emerge from that typology were:

- General agreement that the policy represented a new response to an existing policy goal and it was perceived as a long-term issue
- Disagreement over who was the originating actor of this policy, although agreement that this had not been a policy that came from within UK government
- Disagreement about who was the main government 'owner' of the policy, but general agreement that the commitment of this individual had been strong and long-term
- General agreement that the goals and objectives of the policy were well-defined
- Agreement that there was a high level of non-governmental stakeholder power surrounding this policy, but differing views as to whether the goals were united or varying
- Disagreement over the level of party political controversy surrounding this policy, but general agreement that there was a significant degree of controversy within the governing party
- Agreement that the media reaction was significant and contested, but disagreement over the level of public salience surrounding this policy

This formed the starting point for the discussion.

Method

We conducted the reunion as a discursive process – designed to bring out differences and success factors at different stages. What follows are the key points to emerge in the session. This is not intended to be a comprehensive historic account, but to shed light on how events played out and what this tells us about the policy making process in Whitehall.

The reunion

Stage 1: the context

(In this section we wanted to explore what brought this issue onto the agenda? How did different players see the problem? Where were the politics? The media? How was the timeframe for action perceived?)

For over forty years, government public health policies have increasingly focused on reducing the toll of death and disease from tobacco use. These initiatives have reduced smoking prevalence from 70% of men in 1962 (the year the Royal College of Physicians published their groundbreaking study that concluded smoking was a cause of lung cancer) to 24% in 2005. While the ban on smoking in all enclosed public places in England in 2007 was not a culmination of this policy, it was a key turning point when public and cross-party support for strong regulatory action to tackle smoking crystallized.

The medical profession and others had been pushing for action to reduce smoking since the Royal College of Physicians report setting out a comprehensive strategy for reducing smoking prevalence was published in 1962. Throughout that period, experts saw their role as providing evidence and synthesising public data to make the case for government action, against the pressure from the tobacco industry in the other direction. In the early years, the tobacco industry had very strong links to top officials in the Department of Health, but these were long since gone.

Under the 1979-97 Conservative government, the emphasis had been on voluntary measures and taxation as the means of reducing tobacco use. There were cases where government funded agencies used their funds to promote action outside the government – for example, the Health Education Authority during the 1990s funded a QC to draft the private members bill that Kevin Barron promoted to ban tobacco advertising. Civil society organisations such as Action on Smoking and Health (ASH), set up by the Royal College of Physicians to help make the public case for action on tobacco, were funded by government. One of the distinguishing features of the Anglophone countries who tended to be in the lead on tobacco control measures was the leadership role assumed by medical professionals – in countries where doctors continued to smoke there was much less action. Tessa Jowell, who became Public Health Minister when Labour took office in 1997, had been a passionate campaigner on health inequalities and had an “overriding ambition to tackle health inequality”. That meant tackling smoking which was a huge driver of the differences in life expectancy between the North and the South. Her father had been a chest physician.

However, in the period 1997-2001, there was a “terror of being seen as an agent of the nanny state” – both from the Prime Minister and the Chancellor; “the curse of the Daily Mail” in the words of Tessa

Jowell. So the emphasis in the tobacco White Paper *Smoking Kills* (1998), the first government White Paper specifically on smoking (seen as a very bold move by the new government by Chief Medical Officer, Sir Liam Donaldson) was on education, voluntary agreements and nicotine replacement therapy – all designed to make it easier for people to give up smoking, and to reduce the uptake amongst children and young people.

What changed was a growing confidence in the government, its resolve stiffened by the health community and public support, and a hardening of the evidence around the impact of passive smoking, whose impact had first been identified in the 1980s. These made it easier to consider "whole population" interventions like a smoking ban. There were also moves to ban smoking in public places in the Republic of Ireland and Scotland which made England look like "an oasis", and the hospitality trade missed one out of the two undemanding targets that they signed up to, making it clear that voluntary action was not going to be sufficient.

Stage 2: the initiation

(In this section we explore how the issue was specified. Who decided on the process and what were the choices that determined that? How were people brought into the process? What handling issues were identified and how was it proposed to resolve them? How was the team assembled? Were there resource issues and how were they decided? What else needed to be resolved before "work" could get going?)

In 2003 the CMO's annual report for 2002 was about to be published with a recommendation that the UK should move to a ban on smoking in public places. Sir Liam described the timing of the report as "terrible"; the report was always very independent, only shown to ministers the night before. So Sir Liam spoke to the then Health Secretary, Alan Milburn, who had OK'd it. But that night he stepped down from government, and John Reid was appointed in his place and there was a delay in publication. However, the government decided to produce a new Public Health White Paper and the CMO's report meant it was inevitable that the issue of the ban had to be addressed in time for the 2005 election manifesto.

The initial media reaction to Sir Liam's proposal was hostile on the leader pages, although the health journalists, who were aware of the evidence base, were supportive. There was a very strong and growing evidence base from the WHO, Royal College of Physicians (the original 'finger in the wind' estimates of 1000 annual deaths from passive smoking was "not quite big enough" – but were replaced by the RCP estimate of 11, 000 which was much more salient). The issue was also backed by a strong and very solid stakeholder movement with ASH and the RCP very prominent backed up by the trade union movement including the BMA and health charities. Within government Sir Liam could use his network of regional Public Health directors, and the public Big Smoke debates stirred up a lot of public interest. DH economists were less convinced about the immediate benefits from reducing passive smoking compared to other public health interventions – but they did see potential for significant health gains if the effect of the ban was to discourage uptake especially among 16-18 year old workers.

There were two critical elements in the decision. One was to go for legislation or not. It was clear that the earlier voluntary approach to smoke free was not working – with only a handful of pubs going smokefree. The failure of the voluntary approach forced ministers' hands on tougher action. ASH regarded the contribution of John Reid as critical here – only a Minister with his degree of clout in the Cabinet could overcome resistance to legislation in this area. He had initially been sceptical and came round when this became a media issue – fuelled in part by a misreporting of his comments on "letting the poor smoke". As the media ran with the story, ASH thought it became clear that the public cared and that public opinion was running ahead of politicians. A key argument used by campaigners was that everyone should have the right to a smokefree workplace. However, John Reid was concerned that this might lead people simply to smoke more in the home, increasing the exposure of children. ASH lobbied John Reid's political adviser; he agreed to meet them and then decided to go for legislation. The next decision was what should be in the legislation.

Stage 3: the options

(In this section we look at the process for surfacing options? What evidence was available and how was it used? What unexpected issues came to light? Who was involved and at what stage? Were there "unthinkable" options and how were they kept on or off the table? How were Ministers/ external stakeholders/implementers/ citizens involved? Other departments/ centre? How did the key choices emerge?)

John Reid's approach was based on (1) the principle for action; (2) the proportionality of state intervention; (3) what are the operational consequences and (4) the general mobilisation of public opinion. The issue on the ban on smoking in public places was how to decide what the state should do. The underlying principle was that the exercise of your rights should not impinge on the rights of others – and that justified action. There was no question of making smoking illegal; the issue was making illegal the capacity to injure others. On proportionality, the issue was to what extent you could curtail a legal activity. There were constant discussions with the CMO on the extent of the ban. John Reid's view was that there should be an exemption for private members' clubs which could vote – so people could smoke with other consenting adults in private. The government ended up with a hybrid proposal – to exempt private members' clubs and establishments which served food. But this was an area where a number of Cabinet ministers had sharply opposing views – and there were a large number of former health ministers who were sympathetic to the ban in other government departments.

John Reid thought this was a compromise that would be acceptable to the public. Some in the Department of Health and outside doubted that the proposal as it stood was workable as research revealed that pubs which did not serve food were concentrated in poorer communities thereby having the effect of exacerbating health inequalities rather than reducing them.

The crucial impact of the hybrid proposal was to make the prospect of legislation inevitable. The public health community was united in its message that there had to be a total ban. One of the effects of the partial ban proposal was to divide the hospitality industry; the hospitality trade was concerned at the proposal to exempt private members' clubs, and food and non-food establishments wanted to see a level playing field. In the view of ASH, that policy formation was critical in swinging the

hospitality industry behind a total ban in a way which they would not have been if the government had, for example, proposed a smoking room option. Environmental health officers, who would have to enforce the ban, were heavily engaged by Department of Health policy officials in making sure the legislation was enforceable – they had regarded the voluntary agreement as a distraction and thought that a partial ban would be difficult to enforce.

As the debate continued, public opinion moved – though the answers varied depending on how the question was put. In 2004 only 50% supported a ban in all pubs; 18 months later that had moved to 2/3 of respondents. Sir Liam utilised his established links to health correspondents who were much more sympathetic to the case for the ban than their editors.

Stage 4: The decision

(In this section we explore the process around making the final decision. How were conflicting departmental positions/ HMT/ No.10 handled? Were there significant compromises? How were Parliament and the media handled? How was implementation set up? Who played what role in the process?)

The hybrid proposal appeared in the Labour manifesto for the 2005 election. After the election, John Reid was replaced as Health Secretary by Patricia Hewitt and she had to decide how to take legislation through. The Cabinet itself was highly split on the proposal and there was a strong external campaign running for a total ban. Those in favour of the ban were taking advice from ban proponents in New York on how to sell the change publicly – some lessons transferred better than others. The key messages were to frame the issue positively – smokefree rather than ban – and offered useful soundbites on the unsustainability of a partial ban ("half-chlorinated swimming pool"). The worker protection argument that played well in the US with its highly litigious culture was thought by Sir Liam to have played less well in England.

Immediately after the 2005 election, Kevin Barron was appointed chair of the Health Select Committee – and as he was a known longstanding advocate of measures to curb tobacco use, having sponsored private member's bills in the 1990s, he took his appointment as a signal from government to use the Select Committee on the issue. He therefore decided to use the Select Committee to hold an Inquiry into the legislation on smoking in public places under consideration by parliament. John Britton acted as one of the advisors to the Inquiry. At the start of those hearings, 11 of the members were not in favour of a complete ban. But the Committee took evidence in Ireland to see the ban in practice (including in a pub in Killarney) and during the hearings Northern Ireland announced it was going for a complete ban, which was a "gift to the committee" and they brought in the Northern Ireland secretary to give evidence. They also took evidence from the CMO who said there should be a complete ban – and when a member asked Sir Liam if he had considered his position, he said he had, which "lit the blue touch paper" – though he said that he had not given prior thought to saying that. By the time the inquiry was finished, 9 members signed the amendment to get rid of the clauses. One effect of the Select Committee hearings was to establish a cross-party consensus for legislative action – which proved a crucial tipping point and its timing, and the fact that members' opinions moved, was regarded by Sir Liam as "absolutely perfect".

Separately, and behind the scenes a coordinating group was meeting every Monday to plan tactics with Kevin Barron. The group included representatives from ASH and the All-Party Parliamentary Beer Group, met every Monday to plan their campaign and produced a spreadsheet with the expected voting intention of every MP. Since the tobacco industry's key argument was economic, that legislation would harm the hospitality trade, evidence from New York and Ireland was used to show this was not the case. What was notable on the other side was how the tobacco industry failed to build significant alliances.

A key moment came when the Opposition decided to give its members a free vote on the ban. Within the government, there was considerable restlessness over a number of difficult whipped votes. The Prime Minister indicated that he did not regard the smoking ban, even though a manifesto commitment, as being of the same importance as other issues which opened the way for a free vote on the government side.

The issue for the ban campaigners then became how to get a big enough majority in the Commons to withstand pressure in the Lords. When the first vote was won, many members who had voted against the total ban ended up voting with the ayes on clause stand part – which ended up with a majority of 200, which enabled passage through the Lords – despite Lord Tebbit arguing in favour of reverting to the Labour manifesto commitment. The way in which Tony Blair and Gordon Brown voted was regarded as an important signal to others, and campaigners encouraged them to support the amendments on the grounds that otherwise they would end up having to implement a measure which they had voted against.

Stage 5: The hindsight

(In this section, we ask what worked and what didn't? What could/ should have been done differently? What were the big surprises?)

There was general agreement on the panel that the move to smokefree public places was a victory for Parliament and showed the power of Select Committees in establishing a basis for political action; it created a tipping point in willingness to contemplate legislative action that was now being followed through in the Coalition's tobacco plan that built on and went further in some respects than earlier Labour proposals. It was important, however, not to regard it as an end point. Further action is needed to reduce smoking, which remains the major cause of preventable premature death, whether through moves now proposed on plain packaging or promoting less hazardous alternatives as in Sweden.

It was also noted that this was a move that went with the grain of public opinion. In other countries (Ireland, Turkey, Scotland) government action had, through strong ministerial leadership, pushed ahead of public opinion, but in England the government had lagged behind the public. Countries such as Norway which had opted for the "smoking room" route, which might have been enacted if the government had proposed it in England, as it would have been supported by the hospitality industry, have moved to a full ban – so the change might have come to England but later.

Conclusions: the critical success factors

The critical success factors behind the smoking ban appear to be:

- A robust **evidence base** for action, marshalled over the years by a unified public health community and an effective framing of the issue;
- The **leadership role of the Chief Medical Officer** – a unique position in government combining internal management responsibilities within the NHS and as an adviser to ministers with the ability to take a public stance
- An acceptance by ministers that the voluntary approach favoured earlier in the government had failed to deliver and the willingness of **a powerful secretary of state to** push the case for legislative action;
- The choice of form of legislative action, which threatened to unlevel the playing field in the hospitality industry was critical in getting them to support a full ban as a less bad option and **split the opponents** of the ban; the tobacco industry failed to build any sort of effective alliance to oppose it;
- The **tactical use of the Health Select Committee** under a **committed Chair** to build a **cross party consensus** on the case for action
- The example of earlier action in similar jurisdictions – a sign of the policy learning potential from **devolved administrations** - Republic of Ireland, then Scotland and Northern Ireland
- Effective **campaigning** by external pressure groups combined with the Health Select Committee and the Chief Medical Officer adding pressure from their perspectives and the ability to create an effective coalition with the hospitality industry; these helped move public opinion to a position where it was in advance of political opinion and created an environment to go further

More generally, the most effective action on smoking over the last forty years occurred in countries where there was a combination of leadership from the medical community, leadership from within the policy community – both committed civil servants and ministers, and from wider civil society, creating a public climate conducive to action. In some cases (e.g. the Irish ban), individual ministers led public opinion and forced the pace of action; in others like England, ministers followed the movement in professional and public opinion.

Jill Rutter and Ed Marshall
Institute for Government, May 2011

Annex A: Lessons for policy making

Barrier	Manifestation	Significance	Resolution
Relationships between civil servants and Ministers	Unique role of CMO; DH official doubts about workability of compromise solution	H	Ministers accepted ability of CMO to take an independent stance;
Innovation	Ban was new departure in England	L	Able to look at evidence from implementation in other similar jurisdictions
Adversarial political culture	Concerns from government about accusations of nannying – especially potential press criticism	H	Initial voluntary approach; legislative compromise Efforts by pr-ban campaigners to neutralise editorial hostility by using specialist correspondents Key role of health select committee in establishing political consensus
Evidence	two sorts of evidence – evidential case for action; and evidence of workability	H	Evidence used be campaigners and CMO to build case for action; evidence from Ireland, Scotland and NY on public reaction and implementability
Evaluation			
Policy design	Critical – initial flawed proposal by government triggered support for full ba	H	Govt failed to achieve its objective of partial ban because failed to take proper account of stakeholder interests; political compromise satisfied no one.
Policy as a profession and a career	Long-standing championship of tobacco control agenda within DH inc by CMO	M	Civil servants built good long-term external links to external stakeholders (including funding ASH)
Europe	Ban not a European issue - unlike other moves eg advertising ban	N/A	

Annex B – Participants

Participant	Role during this 'Policymaking Process'
Chair: Andrew Adonis	
Rt. Hon. Lord Reid of Cardowan	Secretary of State for Health, 2003-2005
Sir Liam Donaldson	Chief Medical Officer, Department of Health, 1998-2010
Rt. Hon. Tessa Jowell MP	Minister for Public Health, 1997-1999, and Secretary of State at the Department of Culture, Media and Sport, 2001-2007
Rt. Hon. Kevin Barron MP	Chair of the Health Select Committee, 2005-2010
Deborah Arnott	Director, Action on Smoking and Health (ASH), 2003 to Present
Prof. John Britton	Professor of Epidemiology, University of Nottingham, and Chair of the Royal College of Physicians' Tobacco Advisory Group
Steve Woodward	Director of ASH Australia, 1981-93; Deputy Director, ASH UK, 1993-4

Annex C – Smoking policy timeline

1950

Publication of ground-breaking research by Richard Doll and Austin Bradford Hill

Richard Doll and Austin Bradford Hill conduct first large-scale study into the link between smoking and lung cancer. In September 1950, they published their preliminary findings in the *British Medical Journal*, based on a survey of lung cancer patients in 20 London hospitals, which confirmed the link between smoking and lung cancer for the first time. In a follow up report, published in December 1952, they concluded that "the association between smoking and carcinoma of the lung is real".

Smoking Rates: **Men 80%** **Women 38%**

1956

New report published by Richard Doll and Austin Bradford Hill

Despite growing medical evidence about the dangers of smoking, the government was reluctant to intrude into what was perceived as an issue of personal responsibility and direct government action was ruled out. Indeed, Rab Butler, Lord Privy Seal, commented in May 1956 that "From the point of view of social hygiene, cancer of the lung is not a disease like tuberculosis; nor should the government assume too lightly the odium of advising the general public on their personal tastes and habits where the evidence of the harm which may result is not conclusive."

By 1956, Richard Doll and Austin Bradford Hill had expanded their research project to cover other areas of the country. In November, they published a report confirming their original results, which also found that death rates from lung cancer among heavy smokers are 20 times those among non-smokers, and that death rates decline in proportion to the length of time since stopping.

1957

Statement by the Medical Research Council

The Medical Research Council published a statement in the *British Medical Journal* that announced "a direct causal connection" between smoking and lung cancer, and argued that it was likely about one in eight lifelong cigarette smokers would die of the disease. In response, the Ministry of Health declared that the government now fully acknowledged these facts, although the spokesman made this announcement while smoking a cigarette and repeated the government's position that "we cannot interfere with what is a matter for the individual."

1962

Report by the Royal College of Physicians

On 7 March, the Royal College of Physicians published *Smoking and Health*, which announced 70 per cent of men and 43 per cent of women smoked, and went on to argue the "there can be no doubt of our responsibility for protecting future generations from developing the dependence on cigarette smoking that is so widespread today."

Smoking and Health reviewed the evidence from more than 200 epidemiological and biological studies, and concluded that smoking is a cause of lung cancer, bronchitis and probably contributes to coronary heart disease. It recommended tougher laws on cigarette sales, advertising and smoking in public places. In order to curb the rising consumption of tobacco, the report outlined the following government actions:

(i) more education of the public and especially schoolchildren concerning the hazards of smoking:
(ii) more effective restrictions on the sale of tobacco to children:
(iii) restriction of tobacco advertising:
(iv) wider restriction of smoking in public places:
(v) an increase of tax on cigarettes, perhaps with adjustment of the tax on pipe and cigar tobaccos:
(vi) informing purchasers of the tar and nicotine content of the smoke of cigarettes:
(vii) investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking.

Smoking Rates: **Men 70%** **Women 42%**

1964

The United States Surgeon-General's report *Smoking and Health* became the first declaration by an official of the American government to confirm the negative health effects of smoking.

In Britain, the Cohen Report on Health Education marked a shift in the nature of public health from local information giving to a greater degree of central publicity, using habit-changing campaigns and social surveys, as well as advocating a rethinking of the profession of health educators as persuaders. The report's recommendations led to the establishment of a new central public health agency, the Health Education Council (HEC) set up in 1968 and reformed in 1973.

1965

The Cohen Report called tobacco advertising "propaganda" and argued that it had to be countered. When Labour took power in 1964, Health Minister Kenneth Robinson, a former GP, introduced legislation to ban cigarette advertising on television, which came into effect on 1 August 1965.

1971

The Royal College of Physicians established Action on Smoking and Health (ASH) as a 'ginger group' to put pressure on the government and educate the public about the dangers of smoking.

Government health warnings were introduced on all cigarette packets sold in the UK, following an agreement between the government and the tobacco industry.

Smoking Rates: **Men 55%** **Women 44%**

1973

Representing a change in public health policy in the 1970s, which put greater emphasis on individual lifestyle advice, an advertising campaign used a picture of a mother smoking with the tag line: "Is it fair to force your baby to smoke cigarettes?" The campaign was an early success for a new advertising agency, Saatchi and Saatchi.

1975

Imperial Tobacco agrees to drop brand names and logos from racing cars in UK races, as control of tobacco advertising switches from the industry to the independent Advertising Standards Authority.

Smoking Rates: **Men 49%** **Women 40%**

1976

Richard Doll and Richard Peto published the results of a 20 year study of smoking among male doctors and concluded that one in three would likely die from the habit.

1983

A Royal College of Physicians report outlined the dangers of passive smoking for the first time. It also asserts that more than 100,000 people die every year in the UK from smoking-related illness.

National No Smoking Day, which takes place on the second Wednesday in March, was launched.

Smoking Rates: **Men 37%** **Women 32%**

1984

Smoking was banned on London Underground trains.

1986

New advertising and promotion guidelines were agreed, including the banning of tobacco advertising in cinemas and a range of new health warnings.

1987

Following the King's Cross station fire, in which 31 people died, London Underground's smoking ban extended to stations and entire network.

1988

A report by the Independent Scientific Committee on Smoking and Health concluded that non-smokers have a 10-30% higher risk of developing lung cancer if exposed to other people's smoke.

Smoking Rates: **Men 33%** **Women 30%**

1989

A court ruled that injury caused by passive smoking can be an industrial accident.

1991

In the Budget, the Conservative government increased VAT from 15% to 17.5%.

1992

Nicotine skin patches became available on prescription for the first time in the UK.

1993

Richard Doll's latest study results suggested that smokers are three times more likely to die in middle-age than non-smokers, and up to half of all smokers may eventually die from their habit.

In the Budget, the Conservative government introduced a tobacco duty 'escalator' that committed them to raising tobacco duties by at least 3% per year in real terms.

1997

May **New Labour government pledges to ban tobacco advertising**

The government initially calls for Formula One to be exempt from proposed EU directive on tobacco advertising and sponsorship, but backs down in the face of widespread criticism.

In the Budget, the incoming Labour Government committed to raising tobacco duties by 5% per year in real terms.

Smoking Rates: Men 30% Women 26%

1998

The Labour government announced the first ever tobacco White Paper, *Smoking Kills*.

In the White Paper, the government set out a package of measures to reduce adult smoking rates to 21% or less by 2010, a target which has been achieved.

The government appointed Scientific Committee on Tobacco and Health issued a report stating that passive smoking is a cause of lung cancer and heart disease in adults.

2001

A new EU directive on product regulation (2001/37/EC) required more prominent health warnings to be displayed on tobacco packaging, covering one-third of the main pack face (from September 2002), and banned misleading 'light' branding (from September 2003).

Nicotine Replacement Therapy (NRT) products became available for general sale (outside pharmacies) and all NRT products were made available on prescription.

2002

Parliament passed legislation, which began as a Private Member's Bill, banning tobacco advertising on billboards, in newspapers and on websites. The deadline for phasing out sponsorship of Formula One was also brought forward to comply with the EU directive.

December — The British Medical Association called for a ban on smoking in public places because of the threat to non-smokers.

Smoking Rates: **Men 27%** **Women 25%**

2004

January — Launch of media campaign, funded by the Department of Health, for the British Heart Foundation called "Give up before you clog up" which showed that "every cigarette makes fatty deposits stick in our arteries".

March — In what Taoiseach Bertie Ahern described as "landmark legislation", Ireland introduced the toughest anti-smoking laws in Europe with a complete ban in workplaces.

November — A Public Health White Paper, *Choosing Health: Making Healthy Choices Easier*, proposed introducing a smoking ban in workplaces by 2008, with pubs that do not serve food and private members clubs exempted. The legislation would apply to England and Wales, but the Welsh Assembly had said it would amend the Bill to create a comprehensive ban when it gained Royal Assent in England.

December — UK ratifies the World Health Organisation's Framework Convention on Tobacco Control, the world's first international treaty on public health.

2005

March — A *British Medical Journal* report published the most authoritative data yet on the impact of passive smoking with research suggesting it killed 11,000 a year in the UK.

April — MSPs voted by 83 to 15 to introduce a ban on smoking in public places from April 2006. Smokers who defied the ban would be liable to pay a £1,000 fine.

October — Northern Ireland agreed a smoking ban in all workplaces and public spaces to come into effect in April 2007. Meanwhile, discussions over the England

smoking ban break down at cabinet level, causing the smoking ban bill to be delayed and leading to doubts over how a ban will be introduced.

Smoking Rates: **Men 25%** **Women 23%**

2006

14th February — UK MPs voted for completely smoke free enclosed workplaces and public places in England by a majority of 200 following a free vote.

March — A ban on smoking in public places, including bars and restaurants, was introduced in Scotland on 26 March.

December — The government announced that a smoking ban in England would come into effect from 1 July 2007.

2007

April — A ban on smoking in enclosed public places introduced across Wales on 2 April. Northern Ireland followed suit on 30 April.

July — England's smoking ban came into force on 1 July.

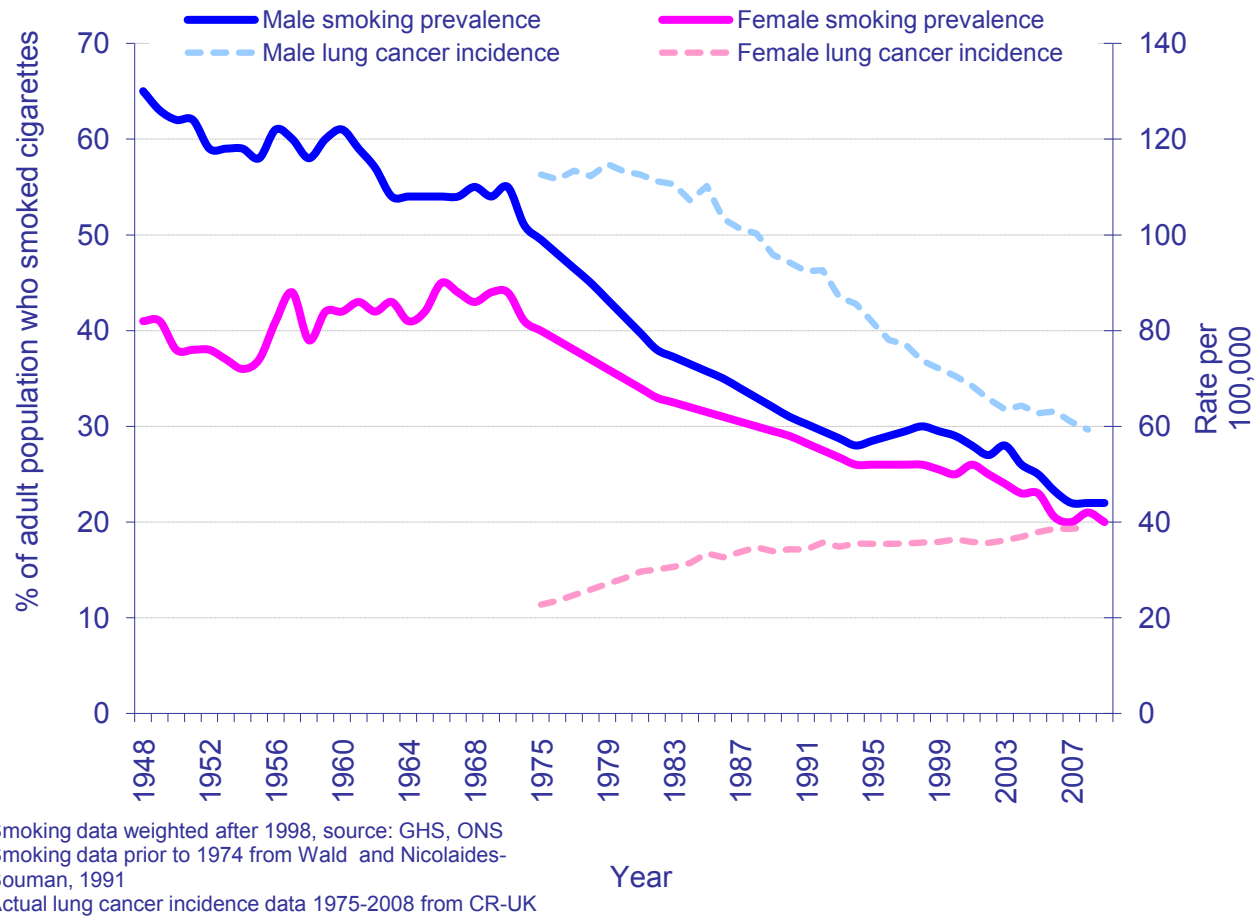
August — The government introduced regulations that required picture warnings on all cigarette packs sold (by October 2009) and all other tobacco products (by October 2010). The UK became the first EU country to do this.

October — The age of sale was increased from 16 to 18.

Smoking Rates: **Men 22%** **Women 20%**

From 2008 onwards policy changes have continued and a ban on the sale of tobacco from vending machines will be introduced in October 2011 and on the display of tobacco in large shops in April 2012 and in small shops in April 2015. The Coalition government has committed to consulting on the implementation of plain packaging for all tobacco products by the end of 2011.

Lung cancer incidence and smoking trends, Great Britain, by sex, 1948-2009



Smoking data weighted after 1998, source: GHS, ONS
Smoking data prior to 1974 from Wald and Nicolaides-Bouman, 1991
Actual lung cancer incidence data 1975-2008 from CR-UK

Source: Cancer Research UK

Annex D – Typology Questionnaire Summary

1) Who was the originating actor of this policy?	Other	Other (non-media) Stakeholder	Other (Public Health lobby)	Other (European directive)
2) Who was the main UK government 'owner' of this policy?	Senior Civil Servant (Chief Medical Officer)	Multiple Secretaries State	Other (Kevin Barron)	Single 'Junior' Minister
3) How strong was the commitment of this main 'owner' to the policy?	Strong, long term	Uncertain	Strong, long term	Strong, long term
4) How well defined were the goals and objectives of this policy?	Well-defined	Contested	Well-defined	Well-defined
5) What degree of change to existing policy did this policy represent?	New response to an existing policy goal	New response to an existing policy goal	New response to a perceived new policy goal	New response to an existing policy goal
6) What was the perceived urgency of this policy?	Long-term issue (ie main impacts beyond lifetime of Parliament)	Long-term issue (ie main impacts beyond lifetime of Parliament)	Long-term issue (ie main impacts beyond lifetime of Parliament)	Urgent

7) What evidential foundation was there for this policy?	Contested	Contested	Unambiguous	Unambiguous
8) What type of internal dependencies were involved with this policy?	Multiple Whitehall departments, simple 'delivery chain'	Multiple Whitehall departments, complex 'delivery chain'	Multiple Whitehall departments, complex 'delivery chain'	Multiple Whitehall departments, simple 'delivery chain'
9) What level of non-government stakeholder power surrounded this policy?	High power and varying goals	High power and united goals	High power and united goals	High power and varying goals
10a) Were there other dependencies surrounding this policy?		Yes		Yes
10b) If 'Yes' please give details		The hospitality trade and the tobacco industry with differing goals opposed the policy. Neither wanted legislation but once it became clear legislation was inevitable the hospitality trade wanted national legislation while the tobacco industry would have preferred local legislation.		Tackling health inequalities

11) What kind of legislation was required for this policy?	Primary legislation	Primary legislation	Primary legislation	Secondary legislation
12) What level of party political controversy surrounded this policy?	Present, but not a 'frontline issue'	Other (significant within as well as cross party conflict)	Present, but not a 'frontline issue'	Limited because agreement
13) Was there a significant degree of controversy within the governing party?	Yes	Yes	Yes	No
14) What level of public salience surrounded this policy?	Limited but controversial	Significant and controversial	Significant and controversial	Significant but non-controversial
15) What was the anticipated media reaction to this policy?	Significant and contested	Significant and contested	Significant and contested	Significant and contested