Policy Frames, Networks and Communities:
Environmental Tobacco Smoke Legislation in Prince Edward Island

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Introduction

In 1999, a group of researchers at the University of Waterloo began an investigation of environmental tobacco smoke (ETS) bylaws in ten municipalities in Ontario[1]. In each community, we carried out a document review and semi-structured interviews with key informants (proponents, opponents, administrative staff, and local councillors), using a snowball sampling process. The originating research question was "How does issue framing affect ETS bylaw outcomes at the local level?" On the basis of our initial findings, we expanded the conceptual framework to include a consideration of the shape of the issue framework. For although it was clear that a framing was a strong predictor of bylaw strength (a health frame resulted in a strong bylaw; an economic frame resulted in either a weak or no bylaw), we wanted to understand what factors contributed to the emergence of these different frames. We focussed on examining the shape of the policy community on the issue of ETS in each municipality, and on explaining the different kinds of issue networks that emerged. We then revised our research question to the following: **How does issue framing interact with agenda-setting and issue network structures to affect ETS outcomes at the local level?** The evidence from these community studies suggests that a concertation network that links health-focussed bylaw proponents with councillors is essential for the emergence of a predominantly health-focussed frame (and subsequently a strong ETS bylaw). In either a pressure pluralist or a corporatist[2]

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[1] The ten communities were Brampton, Cornwall, Dryden, Ear Falls, Hamilton, Kenora, Orillia, Rainy River, Red Lake, and Waterloo Region. These communities were selected on the basis of several criteria: (1) they had recently enacted an ETS bylaw, or were in the process on considering enacting a bylaw; (2) half of the communities had or were considering weak bylaws, and the other half strong bylaws; (3) they were small to medium in population.

[2] Leslie Pal (1992) defines a concertation network as one where the state agency (in this case, the local council) is strong and autonomous, and the associational system is dominated by one organization. In a corporatist network, the state agency also is strong, but the associational system includes a few powerful groups. In the pressure pluralist network the state agency is strong, but the groups are weak and dispersed.

environment, the economic frame occupies most of the political space, and opponents are more likely to prevail. (Campbell et al. 2004 and 2005).

We concentrated in 1999 on bylaw development within municipalities, since at the time the provinces were still quite far away from considering province-wide ETS legislation. In addition, we were interested in applying some of the conceptual frameworks in the policy literature to local level activity. But by 2003, we agreed that we had reached a good understanding of the bylaw development process. When Newfoundland and Prince Edward Island moved forward with provincial legislation, we decided to shift our attention to the provinces, in order to see if similar forces were at work at this broader level. We carried out a document review (Hansard; media reports; government documents) of Prince Edward Island early in 2003. Between May 12 and May 21, 2003 we interviewed sixteen key informants in the province (7 government members, 2 health department officials, 4 members of the Federation of PEI Municipalities, and 3 members of other stakeholder groups), with a slightly modified questionnaire that included most of the questions asked at the local level, but also took into account the provincial context. We followed the same procedure somewhat later in 2003 for Newfoundland, and interviewed seventeen key informants (5 government officials, 3 former Ministers of Health, 7 proponents, and 2 opponents) between June 2 and 6, 2003 and March 22 and 29, 2004.

In this report, we describe the process of legislative development in PEI, and compare it with our findings in the Ontario municipalities. We examine the PEI process in the context of other legislative initiatives at national and sub-national levels, focussing in particular on the findings of Donley Studlar in his examination of ETS legislation in Australia and New Zealand (Studlar, 2005). The Newfoundland story will follow in a subsequent paper.

The PEI Story

Prince Edward Island is a province of only 140,000 people, but it has "one of the highest smoking rates in the country", "the highest rate of asthma in North America", and "the highest rate of male deaths due to lung cancer in Canada" (key informant interviews). In addition, it has a history of tobacco growing, and a perception among at least some government members that tobacco was a vital part of the PEI economy. One government member interviewed noted that "one of the most successful industries that we have ever had on PEI was tobacco growing". But throughout the 1990s, there were several challenges to tobacco's prominence as an economic activity as well as a lifestyle choice.

1) A Multi-pronged initiative

By the late 1900s, the province was moving toward an environmentally conscious and healthy lifestyle approach to policy. Some of the local businesses were in the forefront of this transition. In 1990, the province's Tim Horton franchises were the first in the country to go smoke free. They were followed by Wendy's, and the Holiday Inn. Even the bingo halls became smoke free in 2002. One of the province's largest employers, Cavendish Farms, went smoke free in the

1990s, and required the farmers providing produce to their processing plants to refrain from smoking near their crops. As reported in Hansard (April 24, 2002, pp. 1829-30), “they don’t want a cigarette butt showing up in their fries”.

The legislature was also involved in the early development of ETS legislation. One key informant noted that, almost ten years before the current legislation, there were several attempts to draft laws restricting smoking in public places. The Federation of Municipalities (which includes 38 of the province’s 74 municipalities) was active in these earlier initiatives. Legislators who were interviewed for this study noted that the issue had been “kind of simmering with respect to various initiatives in various places”.

The province had an active anti -smoking lobby as well throughout this period. In the forefront was PETRA, the PEI Tobacco Reduction Alliance. This group was active in conducting public opinion polls, contacting the media, and lobbying legislators. PETRA initiated a telephone campaign, to contact legislators and push for a smoke-free law. PETRA also contacted other organizations in the province, and encouraged them to push forward on a lobbying campaign. The Council for a Smoke Free PEI was active as well in this campaign. The Council predates PETRA, although the membership list overlaps. When PETRA formed in 1999, it decided to keep the Council alive, in spite of the overlap. One PETRA member reported that “we kept the Council for a Smoke Free PEI because we wanted an independent advocacy wing...PETRA had some funding out of Health and Education and we didn’t want to be constrained in any way. Dr. Paul Doucette was the Medical Society of PEI’s representative on the Council, and he was an active proponent of smoke-free legislation as well. In January, 2002 the local paper, *The Guardian*, published his editorial in which he put forward the argument that a ban on smoking in public places would establish a level playing field for all business owners on the island.

2) The Government’s Position

In December 1999 opposition members began asking questions about the province’s smoking policy. These questions continued through the following two years. When the leader of the Opposition asked, in April 2002, if the government would be bringing in legislation to ban smoking in public places, the response was negative. The caucus was still thinking about the issue in economic terms, and concerned about what they saw as possible negative economic impacts. But by November, the position had changed..

Officials in the Department of Health and Social Services were influential in bringing about this shift. They had been meeting with PETRA, and the Council for a Smoke Free PEI since 1999, and worked with the Director of Occupational Health and Safety to prepare draft legislation. The timing was right, since the Occupational Health and Safety Act was up for revision, and smoking figured into those healthy workplace deliberations.

The municipalities were also urging the provincial government to take action on the smoking issue. At the 2001 Annual Meeting of the Federation of PEI Municipalities, the mayors

were notified by the Minister Responsible for Community and Cultural Affairs that the province was going to take on the issue and produce legislation soon (key informant interview). One of the mayors reported that:

> it was an open forum, and the Minister was standing there and all of the municipalities were represented and it was a perfect time to ask.... But I didn't know what the reaction of the other municipalities would be...So I went up to the mike and I asked the question and I got a standing ovation from all the rest - the other municipalities. I thought, oh, this is good. This is looking good.(key informant interview)

That announcement by the Minister was reported by the press the next day, and the legislative process was underway. But it was by no means a simple process. This press release generated strong negative reactions from groups that saw such legislation as an economic disaster. The Minister of Health and Social Services reported that "I had the Canadian Food and Restaurant Association, I had bar owners, I had private club owners, I had owners of workplaces coming to see me saying that you can't do this. I'm going to go out of business, and there is going to be rioting in the streets and all this stuff. So we put it on the shelf in 2001" (interview, 2003).

And yet, the government did move forward. In the November 14, 2002 Speech from the Throne the Conservative government indicated that it would introduce a *Smoke-Free Public Places Act.* The first reading of this bill took place on November 20. By November 26, the bill had passed third reading and moved into provincial law. The legislation came into effect on June 1, 2003. PEI's law prohibits smoking in public and work places, but permits smoking in specially-ventilated smoking rooms, or designated smoking rooms (DSRs). Dalhousie University extended the ban to the entire campus on May 5, 2003. There was brief exemption for the province's correctional facilities, based on fears of inmate violence (key informant interview). But even the prisons were brought into the ban by September 30, 2004, following extensive lobbying by the province's prison guards.

In Ontario, we classified ETS bylaws on a three-point scale: no bylaw; weak bylaw; or strong bylaw. Only municipalities that enacted a 100% ban (with no exceptions) on smoking in public places were coded as strong. Although PEI does provide for designated smoking rooms, we nevertheless consider this legislation to be moderate to strong, for the following reasons. First, the rules for DSRs are very strict. They cannot be more than 25% of the total floor area. The DSR cannot be a room that is normally used by non-smokers. As one Petra spokesperson noted, "we decided to make DSRs as hard to put in and maintain as possible, so people don't do it...They have to be vented to the outside. There has to be a closed door. They have to be empty, nobody smoking in them and so many air evacuations before an employee goes in there." And as a result, very few businesses opted to put them in their establishments. Secondly, the rules are very strict with respect to workers' rights. Employers cannot require their employees to enter a DSR. Even in the case of employees who volunteer to work in these rooms, the working time in the DSRs cannot be more than 20) of the work day or shift. In addition, employees are not permitted to serve food or beverages in a DSR. According to a 2006 report of Physicians for a Smoke-Free Canada, about 40 bars and restaurants in the province have set up these rooms (Physicians, 2006).

How can we explain this turn of events, from no action, to action, to no action, and then a return to action? For our analysis, we revisit the explanations that emerged in the Ontario studies, and consider as well the evidence from Studlar's analysis of Australia and New Zealand.

The Analysis of the Process

1)The Issue Frame

The majority of our key informants agreed that the health frame predominated throughout most of the process, with only a minor setback following the 2001 announcement that draft legislation was in the works. Repeatedly, the key informants noted that health was a driving force. In searching for the reasons why health ultimately trumped economics, we noted factors very similar to the ones we found in the Ontario municipalities: personal stories; economic benefits; the privileged position within government of health department officials; and a well-organized and politically savvy pro-ETS legislation lobby. We did not see any evidence of the international policy transfer/convergence that Studlar found in Australia and New Zealand.

i) Personal experience was a strong motivating factor. Key informants from within government talked about friends and relatives who had developed lung cancer, following careers in the hospitality industry. One Department of Health and Social Services official noted: "We see the effects of smoking within the Health Department in terms of deaths per year or symptom-related illness. It is a very real figure here that the department contends with."

ii) As in some northern Ontario municipalities, ETS legislation was also viewed as a tourism hook. The province was moving toward a green agenda at the same time, and ETS legislation fit within that frame. PEI's Minister of Health and Social Services saw the legislation as a "positive tourism promotional thing. Come to our island. We are smoke free. You don't have to worry about where you are going to public places, it's going to be smoke free" (key informant interview).

iii) The Minister of Health and Social Services at the time was a supporter of the legislation. This support was crucial, for it gave health officials in the province a privilege position in government deliberations. One PETRA member noted that, "without the Minister, we probably wouldn't have this legislation." A Department official echoed this assessment: "We have the benefit of having a Minister who is quite well informed and quite articulate. He challenges people...He will bring them to some common ground with some other folks rather than just leaving them where they are...I think that has been a big help to us as well" (key informant interview).

iv) The anti-smoking lobby was well prepared, and conducted a series of public opinion studies showing that the majority of the province's population was in favour of a smoking ban in public and work places. It had media support in this campaign, and was able to publicize the results of its surveys.

2)Knowledge Transfer

In Waterloo Region, the science behind the analysis of the long-term costs of smoking to the health system, to restaurants and bars (clean-up, renovations), as well as evidence of the health risks of ETS to non-smokers was well received by regional councillors. This was due primarily to the skill of the anti-smoking lobby. They understood the culture of regional council, and worked within the rules of council procedure. In PEI we noted the same lobbying skill by the anti-smoking lobby in bringing the science behind smoking costs (both economic and health) to the attention of government officials and decision-makers. This knowledge transfer was facilitated by the close working relationship between Department of Health and Social Services officials and groups like PETRA. One Health and Social Services official noted "the NGOs have paid a lot of attention to getting some good facts out on the table." PETRA members "knew that we needed evidence...We wanted some hard economic analysis evidence." (Key informant interview) Much of that evidence was gleaned from members of the anti-smoking lobby in other parts of the country.

In addition, unlike the situation we found in some of the communities in the Rainy River Kenora District, there was no public opposition to the argument that smoking is harmful to your health. Even the groups opposing a ban on smoking in public places acknowledged the health risks of smoking, but were concerned about the possible economic impact on the island's businesses. There was a clear intersection in PEI between the predominance of the health frame, and the power of the science behind the anti-smoking argument. In contrast, in the community of Red Lake Ontario, the mayor and the majority of councillors challenged the health frame, arguing that the science was imprecise, and that the adverse effects of smoking were not well understood.. They were particularly resistant to the argument that second-hand smoke kills. In PEI, as in the Ontario municipalities that passed strong bylaws, both proponents and opponents accepted the science and looked for ways to accommodate health risks and economic interests. This was a strong facilitating factor in the PEI process.

3) Networking

We found a concertation network between Department of Health and Social Services officials and the anti-smoking lobby that emerged as early as 1999, when PETRA was formed. Here too, we note the similarity between PEI and Ontario communities such as the Region of Waterloo. In Waterloo there were very strong informal ties between officials in the region's health unit and the Council for a Tobacco Free Waterloo (a coalition of anti-smoking advocates). In PEI, the coalition was more formal. PETRA was formed in 1999, and brought together 15 organizations devoted to health promotion and smoking cessation. The province's Department of Health and Social Services is a partner in PETRA, and there is a close working relationship between the department and PETRA's member groups. PETRA's secretary had worked for the department, and had close ties with department officials. In addition, the group hired a former government minister to assist in the process.

PETRA quickly developed strong networking skills. Early on, the group forged an

alliance with the Federation of PEI Municipalities. A more difficult process involved working with the Restaurant Association. "So we started having small informal meetings with them, and then some more formal, and when there were no more formal meetings we would write back to them and say, this is what we agreed on...This is networking, because eventually we came to some consensus and they became partner" (key informant interview).

PETRA also kept in close contact with members of the legislative assembly, including opposition members as well in that process. A clear theme emerges in the reporting of these contacts. PEI is s small province, with small ridings of often less than 3000 constituents. There were close family and friendship ties among the government members and the various advocacy groups. And this was clearly an important part of the networking process. Typical was this comment from one PETRA member: "I have been in government. I know how they think. I know all the deputy ministers. So even though I am a member of a different political party, I know them all and think that I have a pretty good relationship with them."

Contact with people in other parts of Canada was also very important for the members of the anti-smoking lobby. Members of the Federation of PEI Municipalities observed the by-law development process in provinces such as Ontario, and watched closely to determine if there were high levels of resistance to ETS bans. "At one point I think I had a folder this thick of just everything that we could get our hands on in terms of possibilities. Nova Scotia was just going through this process. Newfoundland had just gone through it. Many of us had been to conferences where we watched Newfoundland's slide show of how to do it."

4) Policy Convergence

There is clear evidence in this case study of policy convergence, of PEI moving forward with legislation under discussion in a few other provinces, but already law in many municipalities across the country. The Minister of Health and Social Services was well informed about events occurring in other parts of Canada, and was particularly interested in the Newfoundland experience. (Newfoundland passed a Smoke-Free Environment Act in 1994, prohibiting smoking in some public places. Its more comprehensive legislation did not come into force until July 1, 2005. As in PEI, the province makes provision for DSRs. But no such rooms have been built.) There is evidence as well that health and social services department officials were closely watching events in municipalities (key informant interview). The pattern of provincial legislation is presented in Table One.

Evidence from the key informant interviews suggests that the experiences of the municipalities of Halifax and Ontario were particularly important. But it is also clear that PEI was in the forefront of provincial legislation, and moved forward primarily as a result of the close network established among PETRA , the Department of Health and Social Services, and the Department of Labour (undergoing its review of occupational health and safety regulations). According to one health and social services department official, "the Minister asked me to see what was going on in other jurisdictions. In Newfoundland it was health. In BC it was labour. So we had both fronts going at the same issue, and that is the effects of secondhand smoke. So

actually when we first started talking about it, we were trying something completely new in that both ministers [Health and Social Services and Labour] and it was going to be brought by both ministers as being both a health concern and a workplace, occupational health and safety concern" (key informant interview).

Table One: Provincial and Territorial ETS Legislation

Province	Legislation
BC	Workers Compensation Board regulations, 2000 (originally no DSRs, but DSRs permitted effective 2001)
PEI	Smoke Free Places Act, 2002 (provision for DSRs)
Nova Scotia	Smoke Free Places Act, 2002 (provision for DSRs)
NWT	workplace smoking bans, 2004
Nunavut	workplace smoking bans, 2004
New Brunswick	Smoke Free Places Act, 2004 (no DSRs)
Manitoba	Non-Smokers Health Protection Act, 2004 (no DSRs)
NewfoundlandSmoke	Free Environment Act, 2005 (provision for DSRs)
Ontario	Smoke-Free Ontario Act, 2005 (no DSRs)
Saskatchewan	Tobacco Control Amendment Act, 2005 (permits smoking rooms in workplaces)
Alberta	Smoke-Free Places Act, 2005 (restricts smoking in places where minors are permitted to enter)
Quebec	revisions to Quebec's Tobacco Act, 2006 (DSRs until 2008)

5) Consensus-Building

There was an additional factor at work in PEI, that we didn't find in the Ontario studies, and that doesn't factor into the Australian and New Zealand experience. PETRA's attempts to forge an alliance with the restaurant industry was a key factor in the government's decision-making process. In the Ontario studies, we found a strongly oppositional culture within the tobacco advocacy network. Proponents and opponents of ETS legislation were unable to communicate with each other. In PEI, as a result of PETRA's networking efforts, the two sides were able to come together and agree on a compromise solution. The resulting legislation was somewhat weaker than the proponents had hoped for. But given that PEI was the first province to move forward with a provincial public and work place strategy, that compromise was key to success. In a small province that relies heavily on stakeholder consensus, that compromise was essential. In the end, all stakeholders were satisfied with the outcome. A PETRA member commented, "to be honest, I have a hard time finding opposition to it". An official with the Ministry of Health and Social Services noted: "I don't know of anybody - I don't know of any elected official who wasn't supportive." There was a clear sense in all of the key respondent interviews that the process was right, the legislation was good, and no one could complain about the outcome.

Conclusions

The findings in PEI support the conclusions we made in our studies of municipalities in Ontario. A strong health frame is an essential element for strong ETS legislation. That health frame can only emerge as predominant if there is a policy community (Pross 1992) framework within which health officials have sway, and work closely in a concertation network with health-promoting advocacy groups. Within the health policy community on PEI throughout the period of legislative development there was evidence of high individual capacity (champions within government and the pro-ETS legislation advocacy groups) combined with a system-level commitment to reducing health care costs; promoting PEI as a green tourism site as well as a healthy place to live; and leading the way provincially on tobacco policy. Compromises worked out with industry were key in the process as well.

PEI's small size and culture of close contact between elected officials and constituents played an important role in the process, and contributed to the fact that the province looked more like a municipality than a province or nation in its deliberations. As in the case of Ontario municipalities that enacted strong bylaws, we conclude that issue framing interacted with the local culture and the shape of the issue network But our findings do not contradict Studlar's conclusions. Like Studlar, we did find evidence of policy convergence. But in PEI this convergence was from Canadian municipalities and provinces, rather than from nation to nation. Like Studlar, we conclude that a strong health minister who has a powerful position is cabinet is essential to the process. And finally, the skills of the pro-ETS legislation advocacy groups combined with their insider status within the Health and Social Services Department were key to the success of the legislation.

> We conclude this study with the words of an official within Health and Social Services: it didn't kind of rise up overnight. It was a gradual process that brought the community to the sense of yes, we are ready for this....it's just everyone's feeling that this is the right thing to do.

References

Bowen, S. and A.B. Zwi (2005). "Pathways to "Evidence-informed" Policy and Practice: A Framework for Action" [electronic version] *PloS Medicine*, 2 (7), 600-5.

Campbell, H. Sharon, Sandra Burt, and Candace Nykiforuk. (2004). "Environmental Tobacco Smoke Bylaw Development in Rainy River Kenora District: Revisiting and Explanatory Framework", paper presented at the Annual Meeting of the Canadian Political Science Association, May 2004.

Campbell, H. Sharon, Sandra Burt, Candace Nykiforuk, Linda Mayhew, and Beth Kawash. (2005). "Understanding the Policy Process at the Local Level: The Role of Isue Framing in Environmental Tobacco Smoke Bylaw Development in the Region of Waterloo", Working Paper Series No. 83. Ontario Tobacco Research Unit, Toronto.

Pal, Leslie A. (1992). *Public Policy Analysis: An Introduction*. (2nd ed.) Scarborough: Nelson Canada.

Physicians for a Smoke Free Canada (2006). "Background on Protection from Second-Hand Smoke in Canada". Ottawa: 1226 A Wellington Street.

Pross, P.A. (1992). *Group Politics and Public Policy*. (2nd ed.) Toronto: Oxford Univ. Press.

Studlar, Donley (2005). "The Political Dynamics of Tobacco Control in Australia and New Zealand: Explaining Policy Problems, Instruments, and Patterns of Adoption". *Australian Journal of Political Science*, 40 (2), 255-74.