

All Party Parliamentary Group on Smoking and Health



Representation to the 2015 Spending Review

October 2015



About the All Party Parliamentary Group on Smoking and Health

The All Party Parliamentary Group (APPG) on Smoking and Health is a cross-party group of Peers and MPs which was founded in 1976 and is currently chaired by Bob Blackman MP. Its agreed purpose is to monitor and discuss the health and social effects of smoking; to review potential changes in existing legislation to reduce levels of smoking; to assess the latest medical techniques to assist in smoking cessation; and to act as a resource for the group's members on all issues relating to smoking and public health. The Secretariat of the group is provided by Action on Smoking and Health.

Expert witnesses providing evidence to the Inquiry orally and in writing:

- Professor Linda Bauld, Director of the Institute for Social Marketing and Dean of Research (Impact) at the University of Stirling.
- Dr J Robert Branston, Deputy-Director of the Centre for Governance and regulation, University of Bath
- Scott Crosby, Regional Tobacco Control Policy Manager, Yorkshire and the Humber
- Professor Kevin Fenton, National Director for Health and Wellbeing, Public Health England
- Dr Andrew Furber, Director of Public Health for Wakefield Council and President of the Association of Directors of Public Health
- Professor Anna Gilmore, Director, Tobacco Control Research Group, University of Bath
- Dr Andy McEwen, Executive Director, National Centre for Smoking Cessation and Training
- Professor Robert West, Director of Tobacco Studies, CRUK Health Behaviour Research Centre, University College London

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Introduction

1. The APPG on Smoking and Health launched this Inquiry in response to the call by HM Treasury for representations to feed into the Spending Review process. HMT has provided guidance for those wishing to respond that representations “*should contain spending and policy suggestions and explain the rationale, costs, benefits and deliverability of proposals. Your representation should also be evidence based, outlining how it contributes to the aims of the Spending Review.*”¹
2. In order to fulfil these requirements in developing its representation the APPG took into account evidence, orally and in writing, from 8 expert witnesses (for more information about the APPG and the expert witnesses see inside front page). Set out below are the rationale and the spending and policy recommendations of the APPG, based on this evidence.

Key recommendations

3. Over the Spending Review period Government funding for tobacco control should be increased by an additional £100 million a year, from around £200 million a year at present to £300 million a year. This additional investment could deliver a return on investment (ROI) of almost 1100% over 5 years and nearly double the rate of decline in smoking.
4. The cost of additional tobacco control funding should be met by an increase in the existing “tax escalator” on tobacco products, from the current 2% above RPI to 5% above RPI for the next five years together with changes in the tax structure.

1. HM Treasury. [Guidance for submitting Spending Review Representations](#). Updated 21 July 2015.

Rationale

5. In October 2014, NHS England published its “Five Year Forward View” document, which stated that: *“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.”*²
6. The Five Year Forward view forecasts a £30 billion shortfall in funding by 2020, and even after additional NHS funding committed by the Government, there remains a predicted funding shortfall of £22 billion by 2020. This funding gap is highly unlikely to be closed entirely through increased efficiency levels alone, since this would require efficiency savings of up to 3% per year.
7. Between 2004/05 and 2011/12 the NHS is estimated to have made efficiency savings of about 1.5% per year, and analysis by the Health Foundation suggests efficiency savings may have slowed down in the following two years, 2012/13 and 2013/14.³ The King’s Fund think tank has concluded that closing the gap to £8 billion would be *“very challenging”*. Therefore, to avoid large reductions in the supply of NHS services, it will be necessary to reduce demand for NHS services by improving public health. The Inquiry heard strong evidence that continuing to drive down smoking prevalence will be essential to the success of this strategy.
8. Smoking remains the major cause of preventable premature death. It is responsible for nearly 80,000 premature deaths every year in England, more than the next five causes put together, including obesity, alcohol and illegal drugs.^{4,5} Half die before normal retirement age,^{6,7} during productive life years. Twenty times the number of smokers that die each year suffer from disease and disability caused by their smoking.^{8,9} Research looking at the social care needs of smokers found on average they needed care and support nine years earlier than ex-smokers and those who had never smoked.¹⁰ Smoking is responsible for half the difference in life expectancy between the highest and lowest socio-economic groups.¹¹ It also has a major impact on the household incomes of poorer families. If the poorest smokers were to quit over half a million households would be lifted out of poverty.¹²
9. Evidence presented to the Inquiry by Public Health England shows that declines in smoking prevalence since the introduction of a comprehensive tobacco control strategy in 1998 have led to significant reductions in the cost of smoking to the NHS.

1991	2006	2012
£1.7bn	£2.7bn	£2.2bn
£3.25bn*	£3.38bn*	£2.32bn*

* at 2015 prices

2. [NHS Five Year Forward View: Chapter 2, page 9, October 2014](#)

3. Lafond S, Charlesworth A, Roberts A. [Hospital Finances and Productivity](#): Health Policy Foundation, 2015

4. [Statistics on Smoking, England - 2015](#). HSCIC, 2015

5. [Smoking statistics. Illness and death](#). ASH, November 2014.

6. Doll R, Peto R, Boreham J, Sutherland I. [Mortality from cancer in relation to smoking: 50 years’ observations on male British doctors](#). *British Journal of Cancer* 2005; 92: 426-429.

7. Pirie K, Peto R, Reeves GK, Green J, Beral V. [The 21st century hazards of smoking and benefits of stopping: a prospective study of one million women in the UK](#). *The Lancet* 2013; 381: 133-141.

8. US Department of Health and Human Services. [How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General](#). Atlanta, GA: USA, 2010.

9. [Cigarette smoking-attributable morbidity - United States, 2000](#) MMWR Weekly Report. 5 Sep. 2003

10. Reed H. [The Costs of Smoking to the Social Care System and Society in England](#). ASH, 2014

11. Jha P, Peto R, Zatonski W, et al. [Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America](#). *The Lancet* 2006; 368(9533):367-370

12. [Smoking Still Kills](#), ASH, 2015

10. Therefore, further reducing smoking prevalence rates must remain a high priority for public health. It is also a high priority if the NHS is to remain a sustainable service, providing comprehensive medical care free at the point of need.
11. Furthermore evidence to our Inquiry from the economist Howard Reed suggests that measures to reduce smoking prevalence are not just cost-effective but also revenue generating, because they lead to increased productivity and reductions in expenditure on the NHS, social care and benefits.
12. Tobacco control measures are exceptionally cost effective. An increase in spending from £200 million to £300 million, together with an increase in the tobacco tax escalator, would produce an even higher return on investment. Increased spending on tobacco control, including Stop Smoking Services, mass media campaigns and broader tobacco control measures at national, regional and local level, will be required if the NHS is to meet its predicted funding gap by 2020 without major reductions in services. The funds to increase total tobacco control spending could be found from raising tobacco taxation, which would also produce net additional revenue for central Government.

Spending and policy recommendations

13. Set out below are our more detailed recommendations. Our proposal meets the priorities for spending outside the core protected areas, as set out in HMT's Spending Review consultation document including "*promoting growth and productivity*", and "*driving efficiency and value for money across the public sector*". It is effective and feasible and represents good value for money from a relatively small public spending investment in addition to easy to achieve tax changes, and will help the NHS "to deliver on its commitment to achieve significant efficiency savings by 2020-21, as set out in the Five Year Plan".¹³

1) Over the Spending Review period Government funding for tobacco control should be increased by an additional £100 million a year, from around £200 million a year at present to £300 million a year. This additional investment could deliver a return on investment (ROI) of almost 1100% over 5 years, and increase the rate of decline in smoking prevalence by an additional 0.57 percentage points each year.

2) The cost of additional tobacco control funding should be met by an increase in the existing "tax escalator" on tobacco products, from the current 2% above RPI to 5% above RPI for the next five years. The tax structure should also be revised to introduce a minimum consumption tax (MCT) for all tobacco products, raise tax levels on handrolled tobacco (HRT) until they are equivalent to those on manufactured cigarettes, and make the specific tax element for manufactured cigarettes the maximum allowed under the current EU tax directive.

3) The UK should also press for changes to the EU Tobacco Tax Directive, currently under review, which would allow for a fully specific tobacco tax system and for implementation of a system of price-cap regulation.

4) Stop Smoking Services should become a mandatory rather than a discretionary service, both in primary and secondary care, and the Services should also be required to submit quarterly monitoring data.

5) The NHS should make it a requirement that NICE guidelines on tobacco harm reduction (PH45), Smoking cessation in acute, maternity and mental health services (PH48), and smoking cessation in pregnancy and following childbirth (PH26) are a minimum standard in all local NHS commissioning arrangements, and local authorities should do the same for NICE guidance on stop smoking services (PH10).

13. [A country that lives within its means](#). Spending Review 2015. Cm 9112. HM Treasury, July 2015.1

6) Part of the additional funding should be allocated for mass media campaigns in line with the evidence-base of what is effective in content and coverage, to discourage young people from starting to smoke and to encourage existing smokers to quit. All communications materials should publicise Stop Smoking Services and provide information on how these services can be accessed through GPs, online and by telephone.

7) Part of the additional funding should be allocated to provide sustained investment in regional tobacco control functions in line with NICE recommendations of at least 40 pence per capita.

8) In conjunction with the new Tobacco Control Plan currently under development, the Government should commit to a refreshed public health strategy, with a target financial contribution to reducing the projected gap in NHS funding by 2020 as set out in the NHS Five Year Forward View, related to specific public health objectives, including reductions in smoking prevalence.

Costs, Benefits and Deliverability of our recommendations

Cost Effectiveness of Tobacco Control

14. Over the last five years a combination of a tobacco tax escalator of 2% above RPI and investment of around £200 million per annum in a comprehensive tobacco control strategy has achieved an annual reduction in smoking prevalence of 0.66 percentage points a year. In public finance terms, if this level of investment and the current escalator are sustained it would equate to a return on investment of just over 300% over the next five years.¹⁴

15. This does not include the costs of HMRC compliance and enforcement programmes as investment by HMRC in tackling smuggling brings direct financial benefit to government by increasing tax revenues. Furthermore, in the summer Budget¹⁵ the Chancellor announced increased resources and the publication of an updated strategy including a package of new measures for tackling the illicit trade.¹⁶ Funding for the anti-illicit strategy is therefore outside the Spending Review remit.

Table 1: Current Annual Cost of Tobacco Control: England

NHS Stop Smoking Services and interventions	£140m
Wider tobacco control	£19m
Marketing budget	£15m
Other (incl. DH and Public Health England policy teams, regional teams, local enforcement)	£25m
TOTAL	c. £200m

16. Current spending levels in England are not yet optimal. The US Centers for Disease Control and Prevention (CDC) outlines the elements of an evidence-based state tobacco control program and provides recommended funding levels to substantially reduce tobacco-related disease, disability, and death in its Best Practices for Comprehensive Tobacco Control Programs.^{17,18}

14. [Tobacco Control Plan for England](#), Department of Health, March 2011

15. [Summer Budget 2015](#), HM Treasury

16. [Tackling Illicit Tobacco: From Leaf to Light](#), HMRC and Border Force, March 2015

17. Centers for Disease Control and Prevention. [Best practices for comprehensive tobacco control programs—2007](#). Atlanta, GA: U.S. Department of Health and Human Services, CDC, 2007

18. Centers for Disease Control and Prevention. [Best Practices for Comprehensive Tobacco Control Programs – 2014](#). Atlanta: U.S. Department of Health and Human Services, CDC, 2014

17. CDC's best practice recommendations include the following measures:
- Reduce affordability of tobacco (tax and illicit)
 - Mass media and social marketing campaigns
 - Enforcement to restrict youth access
 - Smoking cessation support
 - Smokefree places to limit secondhand smoke exposure
 - Program administration and management
 - Monitoring and surveillance
18. The evidence shows that States that made larger investments in tobacco prevention and control have seen larger declines in cigarettes sales than the United States as a whole¹⁹ and the prevalence of smoking has declined faster as spending for tobacco control programs has increased.^{20,21}
19. CDC's 2014 best practice recommendation for spend on tobacco control is \$10.53 per capita.¹⁸ At 2014 population estimates of 53.01 million for England,²² this would be equivalent to \$558 million, equivalent to about £357 million at today's exchange rates. The recommendation to the Inquiry that tobacco control funding be increased from £200 to £300 million per annum is therefore by comparison modest.
20. Mr Reed's evidence set out the fiscal impact of increasing the tobacco duty escalator from 2% to 5% (above inflation) for cigarettes and 15% above inflation for hand rolling tobacco, plus an increase in expenditure on tobacco control policies from £200 million per year to £300 million per year as follows.

Table 2: Fiscal impact of the recommended policy package (£m, 2015 prices)

Category of Impact	2016	2017	2018	2019	2020	NPV
Increased tobacco tax revenue	267	510	731	933	1,024	3,166
Savings to NHS	23	46	71	96	117	321
Savings to LA social care	20	39	57	75	89	255
Extra tax from increased years of healthy life	85	171	258	343	408	1,152
Extra tax from reduced absenteeism	19	40	61	84	103	279
Reduced disability benefits	56	109	160	207	241	706
Increased pension payments	-26	-51	-77	-101	-119	-341
TOTAL	444	864	1,261	1,638	1,862	5,539

21. By comparing the net present value of the fiscal benefits from these recommendations to the Spending Review with the NPV of the cost of extra spending on tobacco control initiatives, it is possible to calculate a figure for return on investment (ROI) of tobacco control policies.
22. The upper row of Table 3 (see below) presents the estimated ROI from current tobacco policies (the 2% escalator plus expenditure of £200 million per year on tobacco control initiatives) relative to a situation in which there was no expenditure on tobacco control initiatives, and tobacco duties were simply raised in line with price inflation. The lower row of Table 3 presents the estimated ROI from the additional measures being proposed (increasing the escalator and increasing tobacco control expenditure by an extra £100 million per year) relative to previous policy (2% escalator and £200 million per year expenditure).

19. US Department of Health and Human Services. [The Health Consequences of Smoking - 50 Years of Progress](#). A Report of the Surgeon General, 2014. Atlanta, GA: USA, 2014

20. Farrelly MC, Pechacek TF, Thomas KY, Nelson D. [The impact of tobacco control programs on adult smoking](#). *Am J Public Health* 2008; 98:304-9.

21. Tauras JA, Chaloupka FJ, Farrelly MC, et al. [State tobacco control spending and youth smoking](#). *Am J Public Health* 2005; 95:338-44.

22. ONS statistical bulletin. [Annual mid-year population estimates 2014](#). ONS, June 2015

Table 3: ROI of existing tobacco control policies and of increased tax and spending

Policy	Gross fiscal benefits 2016-20, £m	Tobacco control spending 2016-20, £m	ROI (%)
2% escalator and £200m/ year tobacco control spending	3,925	932	321
Increase escalator to 5%/ increase tobacco control spending to £300m/year	5,539	466	1,088

23. Based on these calculations an additional investment of £100 million each year for tobacco control measures for the next five years, with an increase in the tax escalator for cigarettes to 5% above inflation and other tax adjustments,²³ could deliver a return on investment (ROI) of almost 1100% over 5 years and increase the rate of decline in smoking prevalence by an additional 0.57 percentage points each year.

Is there scope for greater tax increases?

24. Evidence to our Inquiry from Professor Gilmore and Dr Branston showed that the British tobacco market is dominated by four large multinational companies, and the top two firms combined account for 73% of the market. The industry has made at least £1bn in profits annually since 2009, and possibly up to £1.5bn in the UK alone. The global tobacco market is extremely profitable and, despite declining tobacco sales, tobacco industry profits continue to increase.^{24,25,26} The sustained high profits enjoyed by the major tobacco companies are significantly higher than those earned on other consumer staples.

25. Tobacco companies in Britain segment the market using differently priced brands and products to maximise profits on their more expensive brands while simultaneously selling brands at the other end of the market cheaply to maximise the number of smokers remaining in the tobacco market and the volume of tobacco sold. Cheaper tobacco products are used by the young, the disadvantaged, and those living in areas of the country with high smoking rates and it is therefore likely that the industry's pricing strategy drives inequalities in smoking rates.²⁷ In recent years, the increase in the use of cheap products is most marked in the youngest (16-24 year old) smokers; almost 75% of young smokers were using cheap products by 2008.²⁷

26. The industry differentially shifts tax increases between brand segments and at the time of the excise increase each year absorbs the tax on its cheapest products rather than transferring it to consumers. For example, between November 2006 and November 2009, in the first half of the year (when taxes increase) the average real price (net of tax) of Ultra Low Price (ULP) brands fell by an average of 3.1 pence while the price of premium brands increased by 2.9 pence.²⁸ This differential pricing strategy undermines the intended public health impact of the Government's tobacco taxation policy. In recent years, about half of the overall price increase in cigarettes is due to the tobacco industry increasing its prices (the other half attributable to tax increases)²⁹; this signals the scope for further increasing taxes.

23. The tax policy would be: an increase in the tax escalator for cigarettes to 5% above inflation; an increase in tax on handrolled tobacco by 15% above inflation for four years, until tax is equivalent with that on manufactured cigarettes, and then 5% above inflation, in line with the cigarette tax escalator, in the fifth year; and the introduction of a Minimum Consumption Tax.

24. Gilmore A, Sweanor D, Branston JR. [The case for OFSMOKE: how tobacco price regulation is needed to promote the health of markets, government revenue and the public](#). *Tobacco Control* 2010; 19:423-430.

25. Branston JR. & Gilmore A. [The case for OFSMOKE: the potential for price cap regulation of tobacco to raise £500M per year in the UK](#). *Tob Control* 2014; 23:45-50

26. Branston JR. and Gilmore A. [The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy](#). University of Bath, 2015

27. Gilmore A, Tavakoly B, Hiscock R, Taylor G. [Smoking patterns in Great Britain: the rise of cheap cigarette brands and roll your own \(RYO\) tobacco](#). *J Public Health* 2015; 37(1):78-88

28. Gilmore A, Tavakoly B, Taylor G, Reed H. [Understanding tobacco industry pricing strategy and whether it undermines tobacco tax policy: the example of the British cigarette market](#). *Addiction* 2013; 108 (7): 1317-1326.

29. Gilmore A, Reed H. [The truth cigarette price increases in the UK](#). *Tobacco Control* Published Online First: 12 August 2013, doi: 10.1136/tobaccocontrol-2013-051048.

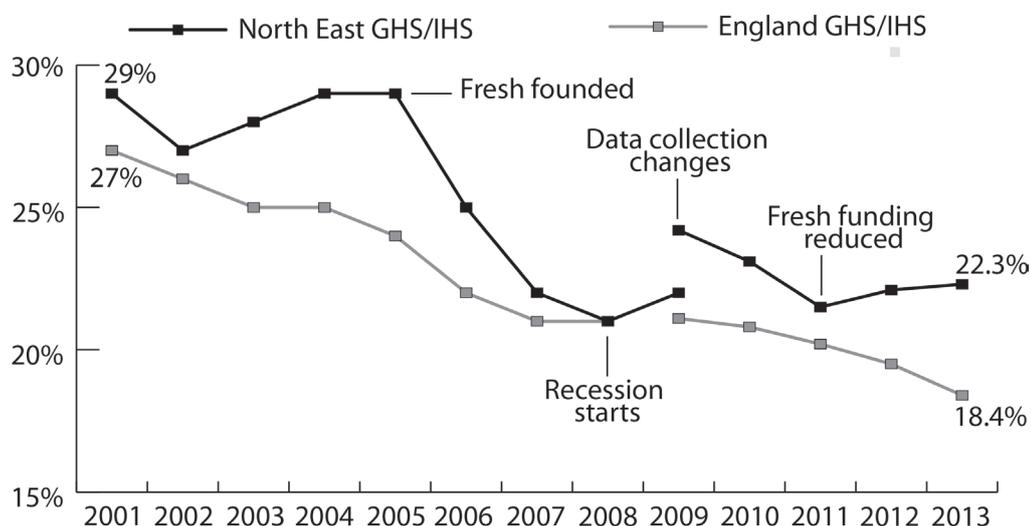
27. Therefore:

- a. There is scope for greater tax increases, with specific tax strongly favoured over ad valorem taxes.
- b. There is a need to narrow the price differential between expensive and cheap cigarettes, and between manufactured cigarettes and hand-rolled. Measures such as prohibiting prices lower than the tax paid and the imposition of a minimum consumption tax, are currently possible and would address the sale of the very cheapest products.

Interventions at national, regional and local level

- 28. Comprehensive tobacco control strategies have existed in England since 1998 in line with CDC recommendations, and have proved very effective. Evidence to the Inquiry on the contribution of regional and local tobacco control was provided by Mr Crosby, Regional Tobacco Policy Manager for Yorkshire and Humber and Dr Furber, President of the Association of Directors of Public Health.
- 29. Regional offices have been in place for around 10 years although the application of this model has varied significantly across the country. Such operating models are supported by NICE, and the NICE Return on Investment economic modelling tool recommends a minimum per capita contribution of 40 pence to achieve a comprehensive evidence based tobacco control programme. This includes activity on mass marketing, delivering joined up activity across a region (such as tackling illicit tobacco) and ensuring local delivery is supported to achieve a high standard.
- 30. The first regional office for tobacco control was set up in the North East, the area with the highest rates of smoking in the country, with a mandate to address the inequalities experienced by those in the North East in relation to smoking. The office in the North East, called FRESH Smokefree North East, has demonstrated that comprehensive regional working in collaboration with localities can deliver an accelerated prevalence reduction.
- 31. Until 2010-11, when Department of Health funding for regional activity ceased, Fresh was receiving annual funding equivalent to the NICE recommended minimum level of 40 pence per capita. Although local commitment and funding levels have been maintained, the DH funding cuts reduced spend to only around three quarters the NICE recommended level. Since 2012 the rate of decline in smoking prevalence in the NE has slowed, coinciding with a reduction in funds and the economic downturn experienced by the region (see graph below).

Table 4: Adult smoking prevalence - twice the decline as national average

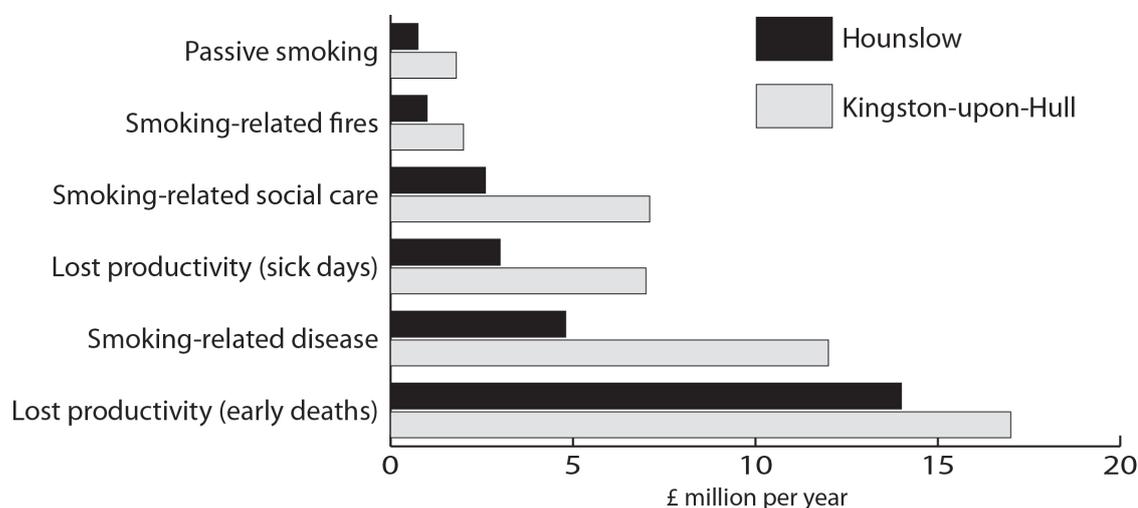


32. There is no region in England which is currently investing in regional tobacco working at this level. Although they have been shown to contribute to local outcomes they are all underfunded to deliver a comprehensive regional tobacco control offer. The regional tobacco control model is currently underutilised across England and better outcomes could be achieved with sustained investment in line with NICE recommendations.

Local Authorities and Tobacco Control

33. Smoking has a major impact on local communities and services, and is a principal driver of health inequalities. Evidence to our Inquiry compared two local authorities, Kingston-upon-Hull and the London Borough of Hounslow. These local authorities have similar size populations (around quarter of a million) but very different rates of smoking. In 2013, Hull had a smoking prevalence of 29.4 per cent, the highest in England, and Hounslow had a prevalence of 13.2 per cent, the fifth lowest in England. These differences can be seen in the cost of smoking to their communities³⁰:

Table 5: Cost to the local economy of Smoking in Two English Local Authority Areas



34. In 2013 local authorities took responsibility for public health and tobacco control. A “ring-fenced” public health budget was allocated to local authorities, to ensure that the money was spent on public health. The total grant was £2.8 billion a year of which just under 6% is spent on tobacco control and smoking cessation. The requirements of the public health grant ring-fence means that local authorities must spend the funding on improving and protecting the public’s health.³¹ There are a series of prescribed services which must be funded. However, this does not include tobacco control or smoking cessation services which are listed as ‘non-prescribed’.

35. Uncertainty regarding the future of the ring-fence has created significant challenges for local planning.³² Some local authorities have used some of the budget to cover the cost of activities they were already undertaking before the transfer of public health.³³ There is a significant risk of further reductions in local authority grants under the current Spending Review, which is designed to deliver a further £20 billion reductions in departmental budgets over the next four years.

30. [ASH Ready Reckoner Tool](#), 2014

31. [Public health ring-fenced grant conditions 2015-16](#), Department of Health, Dec 2014

32. [Public Health England’s grant to local authorities](#), Public Accounts Committee, March 2015

33. [Local Authorities Plunder Ring-Fenced Public Health Funds](#), BMA Media Release, 23 January 2015

36. In July 2015 the Chancellor announced a £200 million in-year cuts to the local public health budget equating to 6.2% of the allocation to local authorities.³⁴ Findings from a Faculty of Public Health survey of members indicated that a majority of public health professionals (66%) were concerned that ‘non-prescribed’ stop smoking services would be reduced as a result.³⁵ An Association of Directors of Public Health survey of members raised concerns about the impact of the reduced grant on front-line services.³⁶
37. Initial findings from an ASH/Cancer Research UK survey this year found that nearly halfway through the financial year over half of tobacco control leads in local authorities did not know what the impact of the lower grant would be to local cessation and tobacco control services.³⁷ According to the ASH/CRUK survey over a third of tobacco control professionals report cuts in their smoking cessation budgets and a quarter report cuts in their wider tobacco control budgets.

Provision of Stop Smoking Services

38. The largest single budget item for most local authority tobacco control work is the delivery of Stop Smoking Services. According to data from Department for Communities and Local Government about £140 million a year is spent on local delivery of these services across England.³⁸ These are among the most effective of all healthcare interventions, quadrupling the success rate of quit attempts and costing under £1,000 for each additional Quality Adjusted Life Year (“QALY”).³⁹ This compares with, for example, up to £57,000 per QALY for statins to prevent coronary heart disease,⁴⁰ up to £130,000 per QALY for treatments for COPD, and as much as £100,000 for just one course of treatment of the new lung cancer treatment opdivo.⁴¹
39. In the last financial year over 450,582⁴² people set a quit date with Stop Smoking Services in England and 51% had successfully quit after four weeks. This includes nearly 19,000 pregnant smokers, 47% of whom successfully quit. More people from routine and manual groups use the stop smoking services than any other socio-economic group, and because disproportionately more smokers from these groups use the services they can help reduce health inequalities.^{43,44} These services are considerably cheaper than treating long-term conditions caused by smoking such as lung cancer and coronary heart disease.^{28,29} They also help to prevent the uptake of smoking amongst children, through assisting adults to quit. Children growing up with both parents who smoke are three times more likely to take up smoking compared with children whose parents do not smoke.³¹ Effective stop smoking services also improve local economies by reducing days off work and loss of productivity due to cigarette breaks.
40. The underlying uncertainty over the future funding of local tobacco control work has already had a serious impact on Stop Smoking Services. Evidence to our Inquiry from Dr McEwen and Professor Bauld presented a disturbing picture of reduced funding, and reduced use of the services by smokers seeking to quit. Manchester City Council has already announced the complete disinvestment in stop smoking services for 2015/16⁴⁵ and there are reports of planned cuts in other local authorities.

34. [Local authority public health allocations 2015-2016](#), Department of Health, July 2015

35. [Children’s health could be affected by cuts, say public health experts](#). Faculty of Public Health, 17 Sept. 2015

36. [Association of Directors of Public Health - Submission to Spending Review 2015](#), Para 3.12

37. *To be published shortly*

38. [Local Authority Revenue Expenditure and Financing: 2014-15 Budget](#), England (Revised). Department for Communities and Local Government, 22 Oct. 2014

39. Flack S. Taylor M. Trueman P. [Cost-Effectiveness of Interventions for Smoking Cessation](#). York Health Consortium for NICE 2007.

40. Ward S et al. [A systematic review and economic evaluation of statins for the prevention of coronary events](#), Health Technology Assessment 2007; Vol. 11: No. 14

41. Gapper J. [The unhealthily high price of cancer drugs](#). Financial Times, 3 June 2015

42. [Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015](#), HSCIC, 2015

43. Chesterman J, Judge K, Bauld L and Ferguson J. [How effective are the English smoking treatment services in reaching disadvantaged smokers?](#), Addiction 2005; 100: 36-45.

44. Bauld L, Judge K and Platt S. [Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study](#). Tobacco Control 2007;16(6): 400-404.

45. [Decommissioning Information for the Stop Smoking Service in Manchester](#), Manchester Local Pharmaceutical Committee, 8/06/2015

41. Since 2011/12 the number of people setting a quit date has fallen by 45% as a result of three consecutive years of declining numbers, and there is no sign the rate of decline is slowing in fact it has increased year on year since 2012/13.⁴²

Table 6: Changes in the number of people setting a quit date

Year	Numbers setting a quit date	% change on previous year
2011/12	816,444	4% increase
2012/13	724,250	11% decrease
2013/14	586,340	19% decrease
2014/15	450,582	23% decrease

42. A recent study has shown just how valuable an effective stop smoking service can be to individual GP practices. Twelve month comparative data from a GP surgery in the West Midlands, before, and after, a specialist stop smoking service was hosted in the surgery, shows that the number of registered smokers reduced by 27%, appointments for long term conditions reduced by over 40%, the average home visits per month for smokers with long-term conditions dropped by over 50% and the total unplanned admissions for smokers with smoking related illness reduced by 49%.⁴⁶
43. The Inquiry also heard from Public Health England that if the NHS were to do more to provide smoking treatment this would make a major contribution to the sustainability of the NHS by 2020. Approximately 1.1 million smokers are treated in English hospitals each year, receiving a total of 2.6 million episodes of care. Around 1,260 admissions per day in England are due to smoking which amounts to:
- 1 in 20 of all admissions
 - 1 in 4 respiratory admissions
 - 1 in 6 cardiac admissions
 - 1 in 10 cancers are due to smoking
44. Public Health England recommended that NICE Guidance PH48, PH45 and PH26 should be a minimum quality standard required in all local NHS commissioning arrangements. This would ensure that:
- All patients in primary and secondary care are screened for smoking at each episode of treatment.
 - All smokers are offered high quality smoking cessation support.
 - Those who refuse are offered harm reduction support.
45. If smoking cessation and harm reduction were delivered as a routine component of hospital care, marked reductions in the prevalence of smoking could be achieved, improving the cost-effectiveness of NHS hospitals. Public Health England provided an illustrative estimate that up to £120 million in-year cumulative savings could be achieved in year 5 from quitting in hospital settings by:
- Increased ‘screening’ & brief interventions (aim for 100% of all patients)
 - Increased uptake of treatment (from 1.3% of hospitalised smokers to 80%)
 - Maintaining good outcomes / quit rates (from 57% to 60%)

46. Croghan, E. [Learning from those that have achieved success](#). UK Nicotine and Smoking Cessation Conference, Manchester 11-12 June 2015

Mass media and marketing campaigns

46. There is clear evidence that mass media campaigns can be effective in promoting quit attempts.⁴⁷ A recent study found that tax increases, more comprehensive smoke-free laws and mass media campaigns independently accounted for 76% of the reduction in smoking prevalence in Australia between 2001 and 2011.⁴⁸
47. Studies carried out in the UK in the past few years have found that mass media campaigns have been effective in triggering quit attempts and have been responsible for a significant proportion of the reduction in smoking prevalence,⁴⁹ and that the freeze on mass media campaigns was associated with a reduction in quitting activity.⁵⁰ A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost effective.⁵¹
48. An obvious, but important, point made to the Inquiry is that these campaigns need to have sufficient intensity and be sustained in order to have a meaningful effect.⁵² CDC's 2014 best practice recommendation for spend on what they call '*mass reach health communication interventions*' is \$1.69 per capita. At 2014 population estimates of 53.01 million for England, this would be equivalent to \$90 million, around £57 million at today's exchange rates. In recent years the spend on mass reach health communication interventions in England has fallen considerably and is estimated currently to be only £15 million, not much more than a quarter of the US CDC best practice recommendation.

Conclusion

49. A sustained comprehensive strategy to reduce smoking prevalence at national, regional and local level, funded and implemented in line with the evidence-base, would be highly effective, cost-effective and revenue generating.
50. Over the Spending Review period Government funding for tobacco control should be increased by an additional £100 million a year, from around £200 million a year at present to £300 million a year. This additional investment, invested in line with our recommendations (see paragraph 11) could deliver a return on investment (ROI) of almost 1100% over 5 years, and nearly double the rate of decline in smoking.

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