Written evidence submitted by Action on Smoking and Health (CSR0088)

About ASH

1. Action on Smoking and Health (ASH) is a health charity working towards the elimination of the harm caused by tobacco. ASH receives core funding from the British Heart Foundation and Cancer Research UK and has received project funding from the Department of Health for work to support the Government’s tobacco strategy for England.

Below we have responded to specific points raised in the terms of reference. We have shared similar information with the Treasury as part of our budget submission.

- Achieving efficiency savings: their source, scale and impact
- Achieving service transformation set out in the Five Year Forward View at scale and pace through transformation funds
- The impact and management of deficits in the NHS and social care

2. Since 1999 the government has ensured that there is a comprehensive strategy in place driving down smoking prevalence. Over time this strategy has had considerable impact. Smoking prevalence in England, as measured by government surveys, has fallen significantly over the last ten years, by an average of 0.66 percentage points per annum, from 25% in 2003 to 18.4% in 2013. Smoking rates among children aged 11-15 have fallen even faster over the same time period, from 9% to 3%, a fall of two thirds.

3. However, smoking remains the primary cause of preventable premature death, killing just under 80,000 people per annum in England and 100,000 in the UK, more than the next five causes put together, including obesity, alcohol and illegal drugs. Half die before normal retirement age, during productive life years, with twenty times as many smokers as die each year suffering from disease and disability caused by their smoking.

4. The NHS England Five Year Forward (FYFV) view forecasts a £30 billion shortfall in funding for the NHS by 2020. Even after the £8 billion in additional funding committed by the Government, there remains a predicted shortfall of £22 billion. This funding gap is highly unlikely to be closed through increased efficiency alone, since this would require efficiency savings of about 3% per year, a higher level of efficiency saving annually than the NHS has achieved since its foundation. Therefore, some of the funding gap will have to be met through cuts in NHS services, longer waits for treatment, or through reductions in demand for NHS services. This latter possibility requires a sustained effort to improve public health, and to tackle the major causes of illness, in particular smoking.

5. The FYFV further states 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.” The report notes that this has been long called for: “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.”

6. The in-year cut to public health funding of £200 million this year and the recently announced 3.9% annual cuts to local public health budgets over the next five years suggests that the Government has not heeded the recommendations of the FYFV nor the warning made by Derek Wanless in 2002.
7. The Government reiterated in the Comprehensive Spending Review their commitment to prioritise investment in the NHS and that cuts in other areas would be necessary. Public health funding has been excluded from this prioritisation and as such is subject to cuts despite the clear impact on NHS resources from reduced investment in activity to reduce mortality and morbidity in the population.

8. The Kings Fund has described the cuts to the public health budget as the ‘falsest of false economies’ a sentiment echoed by others including local authorities and those working in the NHS. In addition The King’s Fund has highlighted that many services are integral parts of the NHS: “The most significant local authority-funded public health services - including sexual health, substance misuse, smoking cessation - and ‘NHS’ health checks services are either intimately entwined with NHS pathways or are directly commissioned from the NHS.” An example of the relationship between NHS and public health services is the support to pregnant women to quit smoking. Treatment for pregnant women who smoke is part of enabling a healthy pregnancy as smoking is the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health. Loss of investment in public health risks undermining such services.

9. Cuts are being made in services to reduce smoking – at a national level (see paragraphs 13-15) and a local level (see paragraphs 16-21). The impact of cuts are already being felt with evidence emerging that England’s declining smoking rates, which have been the envy of many countries round the world, may have stalled and be starting to increase (see paragraph 22).

10. Smoking not only creates a burden of death and disease but costs society as a whole £13.9 billion with NHS costs at least £2 billion annually and the cost to social care is at least £1.1 billion (including local authority and self-funded care).

11. Serious questions need to be answered regarding whether cutting tobacco control budgets can deliver ‘efficiency savings’ or if cuts are merely a false economy that will cost both the NHS and the wider economy dearly in the long run and decrease the likelihood the NHS can achieve the aspirations set out in the FYFV.

- The distribution of funding for health and social care across the spending review period
- The effect of cuts to non-NHS England health budgets e.g. public health, health education and Department of Health, and their impact on the Five Year Forward View

12. Despite investment in tobacco control being shown to be highly cost effective cuts in budgets are being seen at every level of Government.

13. The cuts hit national spend on mass media campaigns in England first. These were cut in advance of the general election in 2010 and were only reintroduced subsequently at a significantly lower level (see table below). In 2009-10 funding was nearly £25 million, in 2010-11 it was less than £1 million. Although it was subsequently increased it has been declining year on year since 2012-13 and is estimated to be only £5.86 million for the year 2015-16 (see below), and further cuts are likely.

14. Mass media campaigns to reduce smoking are proven to be highly cost-effective, if properly funded. 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, around ten times the amount currently being
spent. The cost per quality adjusted life year (qaly) of the recent FDA campaign *Tips from Former Smokers* was calculated to be $383\textsuperscript{16} (the equivalent of £240 at current rates of exchange) way below the £20,000 to £30,000 cost per qaly threshold set by NICE.\textsuperscript{17}

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<th>Financial year\textsuperscript{18}</th>
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16. Furthermore there have been significant cuts in local authority public health budgets which threaten resourcing for both treatment services and the wider tobacco control work undertaken by local authorities. In 2013/14, local authorities received £2.7 billion as a ring-fenced grant for public health services, in 2014/15 the grant was £2.79 billion, and the original grant for 2015/16 was also £2.79 billion (a reduction of 2% in real terms).\textsuperscript{23,24} However, in his 2015 Budget statement, the Chancellor announced a further in year reduction in the 2015/16 grant of £200 million, and in the Autumn statement in 2015 further progressive reductions in real terms of 3.9% annually over the next five years.\textsuperscript{25}

17. The Department of Health has conducted a public consultation on how public health funding should be allocated between local authorities from April 2016 onwards.\textsuperscript{26} Analysis by the Faculty of Public Health suggests that the DH proposals could result in a reduction in the share of resources going to poorer local authority areas relative to richer ones, from a ratio of about 2.5 to 1 per head to about 2 to 1, making the impact on public health worst in those areas with the greatest problems, including the highest smoking prevalence rates.\textsuperscript{27}

18. There are already wide variations in council spending on reducing smoking. Using local authority revenue expenditure and financing for 2015 to 2016, ASH calculated the intended spend per smoker by each local authority for this financial year.\textsuperscript{28} The average intended spend is £21 per smoker and the range is from £4 per smoker to £49 per smoker (excluding City of London and Isles of Scilly). There is no strong correlation between local authority areas with high rates of smoking and their spending on reducing smoking.

19. There is also evidence of disinvestment in tobacco control at a local level. A survey by ASH and Cancer Research UK, conducted during summer of 2015 ahead of CSR announcements, found that smoking cessation budgets were cut in 39% of upper-tier local authorities in England in 2015-16, including 29% where the cut was greater than
5%. Budgets increased in 5% per cent of local authorities. Wider tobacco control budgets were cut in 28% of local authorities and increased in 10%.

20. Further analysis undertaken since the above findings were published has found uneven distribution in cuts across the country. For example the North East saw the lowest levels of cuts to budgets while London saw the highest levels. Rates of smoking are higher overall in the North East (19.9%) than in London (17%) however, there are parts of London where rates are as high or higher than in the North East and while there are around 400,000 smokers in the North East there are over million in London.

21. Local authorities are also making difficult decisions about what they will continue to fund. In the South West local authorities have funded a regional office of tobacco control since the transition of public health (prior to this the office was funded by PCTs). This regional function has made a major contribution in particular through the development and delivery of high profile mass media campaigns and coordinated activity on illicit tobacco and has been found to be cost effective by NICE. Following the CSR local authorities in the South West have terminated funding citing the outcome of the CSR and cuts to the public health budget as driving the decision.

22. Early indications are that funding cuts in mass media spend and public health budgets are already threatening our ability to continue to reduce smoking prevalence. The latest data from the Smoking Toolkit Study, a monthly household survey of representative samples of approximately 1800 adults per wave (16+ years old) in England amounting to more than 20,000 respondents per year, suggests that smoking prevalence has stopped declining and may have started to go up again (headline figures are 18.5% in 2014 to 18.7% in 2015 with 95% confidence intervals of ±0.5%). This is the first time since the survey started in 2007 we have seen an increase in the headline figure.

23. This is in line with what has happened in other jurisdictions when funding has been cut. For example New York City, where sustained investment from 2002 led to declines in smoking rates until 2010, when the decline ceased following funding cuts. Investment was reinstated in mass media campaigns in 2014 and the rates began to decline again.

24. The proposed solutions in the CSR for the future funding of public health is to return more of the business rates to local authorities and fund PH through this route. As highlighted in our evidence to the Health Select Committee Inquiry on public health post 2013 we have serious concerns about how equitable this arrangement might be given that areas with the highest rates of smoking tend to be areas with lower levels of business rates. If such an approach was to go ahead then action must be taken to ensure there are appropriate levels of funding for areas with high levels of disadvantage.

- Progress on achieving parity of esteem through funding for mental health services.

25. People with mental health conditions die on average 10-20 years earlier than those without. Increased suicide rates are not responsible for this discrepancy, but in fact it is due to socioeconomic, healthcare, and clinical risk factors.

26. Smoking is the single largest contributor to this reduced life expectancy. While smoking rates in the general population have fallen steadily to 19% in 2013, rates in those with a mental health condition have not changed remaining around 40% throughout the last 20 years. In order to tackle this huge loss of life, those with a mental health condition need the same access to stop smoking support, and the support needs to be tailored to their specific needs. More work is being done in this area, particularly following the publication of NICE guidance in 2013. However, funding pressures mean that specialist services
may not be available to people in the future particularly at the level needed for those with a mental health condition who faced increased barriers to quitting have higher rate of addiction. Cuts to local public health budgets will seriously undermine the ability of public health to take action to tackle this significant inequality.

1 Smoking Still Kills. Protecting children reducing inequalities. ASH. 2015.
2 Smoking drinking and drug use among young people in England in 2014.
9 Buck D. Cuts to public health spending: the falsest of false economies. The Kings Fund, 6 Aug 2015
11 Nurses condemn ‘false economy’ of public health spending cuts. Royal College of Nursing, 28 Oct 2015
12 Buck D. Cutting the public health budget will cost the NHS. Local Government Chronicle, 10 June 2015
14 ASH Local Toolkit ASH, 2016
17 NICE. Measuring effectiveness and cost effectiveness: the QALY Measuring effectiveness and cost effectiveness: the QALY. 20 April 2010
18 Data taken from Parliamentary questions: http://bit.ly/1UyijYs updated by PHE to include figures for 2013 onwards. Figures for 2015-16 are provisional.
23 Public Health England’s grant to local authorities: National Audit Office, 17 Dec 2014
26 Public health formula for local authorities from April 2016 Department of Health consultation, first published 8 Oct 2015
27 Spending review - public health funding cuts set to increase health inequalities Ben Barr, Senior Clinical Lecturer in Applied Public Health Research and David Taylor-Robinson Senior Clinical Lecturer in Public Health, University of Liverpool 7 Dec 2015
28 Letter to the Chancellor Smokefree Action Coalition, 26 Nov 2015
29 Reading Between the Lines: results of a survey of tobacco control leads in local authorities in England ASH and Cancer Research UK, Jan 2016
30 NICE. Tobacco Return on investment tool.
31 Smoking Toolkit Study. STS 140721. Top Line Findings from the STS. 31 December 2015.
32 Goldberg D. NYC smoking rate drops to lowest on record. Politico New York, 16 Sept 2015


Thomcroft G. Premature death among people with mental illness: At best a failure to act on evidence; at worst a form of lethal discrimination. BMJ 2013 May 14; 346:f2969


Health Survey for England 2013. HSCIC, 10 Dec. 2014


27 January 2016