Cancer Research UK is pleased to submit evidence to this important and timely inquiry. Our primary concerns about local government finance centre on the damaging impact public health funding cuts are having on local authorities’ ability to deliver tobacco control and stop smoking services. The cuts to funding and the subsequent reduction in local services impedes the Government achieving the vision for a smokefree generation, where smoking prevalence is at or below 5% in England.

Failure to address local public health funding will widen health inequalities and undermine the ambitions of the NHS Long Term Plan. To address these challenges, Cancer Research UK is advocating the introduction of a tobacco industry levy in the forthcoming Spending Review. The additional funding generated from the levy can then be invested in evidence-based measures to encourage smokers to quit and discourage youth uptake of smoking both locally and nationally.

1. About Cancer Research UK
1.1 Cancer Research UK is the largest charitable funder of cancer research in the world, and the only charity funding research into over 200 cancers. In 2017/18, we spent £423 million on research in institutes and hospitals across the UK, supporting the work of over 4,000 scientists, doctors and nurses. We receive no funding from the Government for our research and rely entirely on the public for support. Our work has been at the heart of the progress that has seen survival rates in the UK double in the last forty years, so today, 2 in 4 people survive their cancer for ten years or more. Our ambition is to see 3 in 4 patients survive cancer by 2034.

1.2 We know 4 in 10 cancers are preventable, with smoking continuing to be the leading cause of preventable cancer. We want to ensure that all smokers across the UK have access to evidence-based support to help them quit. This means providing local authorities in England with sufficient public health funding to deliver evidence-based tobacco control and stop smoking services.

2. On the path to a “smokefree generation” in England: the role of local authorities
2.1 Smoking rates have been in decline since the early 1970s as a result of continued action on successful tobacco control. Mass media campaigns like Stoptober, raising the age of tobacco sale to 18 years, smoke-free public places, a point of sale marketing ban, regular tax increases and most recently standardised packaging have been instrumental in reducing smoking rates in England to around 14.9% in 2017.¹

2.2 However, smoking remains England’s single greatest cause of preventable illness and avoidable death,² and is one of the greatest drivers of health inequality in the UK³ accounting for around half the difference in life expectancy between the richest and poorest.⁴

2.3 In 2017, the Government announced their vision for a smokefree generation, which will be achieved when smoking prevalence is at 5% or below in England.⁵ Building upon this vision, Cancer Research UK want to see less than 5% of adults smoke across all socioeconomic groups.
UK-wide. Achieving 5% prevalence in the UK by 2035 could avoid around 97,000 new cases of
disease, including around 36,000 cancers over the next 20 years, saving around £615 million in
the year 2035 alone; this includes £67 million in direct health and social care costs.\(^6\)

2.4. Unpublished data from a modelling study commissioned by Cancer Research UK has found that,
based on current trends, the UK smoking prevalence will be 12.6% in 2022;\(^7\) a reduction of 2.3%
since 2017. If current trends continue, the UK will not meet the Government’s 5% smoking
prevalence target by 2039, let alone by 2035.\(^7\)

2.5. If the UK and England are to continue reducing smoking rates to achieve this 5% target, the
Government needs to take more action on tobacco control. Reducing the number of new
smokers by discouraging youth uptake will not be enough: we need to increase the rate at which
existing smokers quit. To this end, both the NHS and local authorities play a critical role.

2.6. Since the \textit{Health and Social Care Act 2012}, responsibility for funding and delivery of public health
has moved from the NHS to upper-tier local authorities. The public health grant, centrally
administered to councils, is currently the primary mechanism for funding public health in
England. These new responsibilities mean that \textit{councils are responsible for delivering local
tobacco control and commissioning stop smoking services, which are integral to reducing the
impact of tobacco on the health, welfare and productivity of our nation}.

3. Local authorities have faced significant and sustained cuts to public health funding
leading to significant cuts to tobacco control

3.1. In the 2015 Budget, the Chancellor announced a £200 million in-year cut to the public health
grant, followed by a further real-terms cut averaging 3.9% each year (until April 2020) in the
2015 Spending Review.\(^8\) Overall, the public health budget will have seen a £700 million real
terms reduction between 2014/15 and 2019/20—a fall of almost a quarter (23.5%) in spending
per person.\(^9\) Almost all local authority public health services faced cuts between 2014/15 and
2019/20.\(^9\)

3.2. \textbf{Tobacco control has been among the worst hit of all the areas of public health spending.}
Between 2014/15 and 2017/18, total local authority spending in England on stop smoking
services and wider tobacco control fell by £41.3 million (a fall of 30%). Spending per resident
smoker fell from £17.87 to £14.86.\(^10\)

4. These cuts are impacting, and will continue to impact on the delivery of local
functions and services and severely hinder ambitions for a smokefree generation

4.1. Because of the funding cuts, local authorities’ ability to deliver vital tobacco control and stop
smoking services are being severely compromised. Local authorities have made efficiencies
through better commissioning, but cuts are nevertheless impacting frontline prevention
services.

4.2. Councils have been forced to make difficult decisions about which services they prioritise with
their diminishing funds, and the impact has been felt across a wide range of public health
functions and services. Under the \textit{Health and Social Care Act 2012}, local authorities are required
to deliver a number of public health functions and services, including selected sexual health services, the National Child Measurement Programme and children’s health services. Tobacco control is not mandated under the Act, meaning these services are often among the first to be cut.

4.3. Following the continued reductions to the public health grant, 38% of local authorities that still had a budget for stop smoking services cut this budget in 2018, following similar cuts in 50% of local authorities in 2017.10

4.4. For tobacco control, the principal outcome of the sustained public health budget cuts has been the loss of the universal offer of specialist stop smoking support.10 In 2018, 65% of local authorities commissioned a specialist stop smoking service (down from 74% in 2017) and only 56% commissioned a universal specialist service open to all local smokers. Other local authorities have switched to the ‘integrated lifestyle’ service model (22%), have reduced their service to support from GPs and pharmacists (9%), or have decommissioned altogether (3%).10

4.5. These specialist stop smoking services, which provide smokers with a combination of behavioural support and prescription medication, offer smokers the best chances of quitting.11 Smokers using these services are around three times more likely to quit successfully than those attempting to quit unaided.12,13 In England, self-reported successful smoking cessation using a stop smoking service was as high as 51% in 2018.14

4.6. Local services must be sufficiently resourced to retain universal access to their services if they are to deliver change for all smokers. The shift away from specialist services may save money in the short term but risks a failure to deliver results if specialist smoking cessation support is lost in the process.10

4.7. Worryingly, things are likely to get worse; local authorities in England currently face an overall funding gap of £3.1 billion, which is expected to rise to £8 billion by 2024/25.15 These cuts will undoubtedly threaten local authorities’ ability to deliver a number of functions and services, not least those that support public health and prevent ill-health such as social care, housing, education, transport, and leisure services.

5. Investing in local public health will prevent ill health, narrow the health inequalities gap and support NHS sustainability

5.1. Taking funds away from public health is a false economy, increasing pressure on our overburdened NHS and social care system. In his speech on 5th November 2018, the Health and Social Care Secretary Matt Hancock highlighted the “need to focus more on prevention to transform our health and social care system, save money, eliminate waste and make the extra £20.5 billion we’re putting in [to the NHS] go as far as it can.”16 The recent NHS Long Term Plan made some important commitments to prevention,17 but action in the NHS is only part of the solution; local authorities must be equipped to deliver public health functions and services locally. Unless we restore public health to meet the needs of the population, our health and care system will remain locked in a ‘treatment’ approach, which is neither sustainable nor protects the health of the population as it should.
5.2. The burden of preventable illness on the NHS remains significant. Around 40% of the uptake of health services may be preventable by taking action on smoking, drinking alcohol, physical inactivity and poor diet alone.\textsuperscript{18} Preventable ill-health accounts for an estimated 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days.\textsuperscript{19} Smoking is a key component of this burden.

5.3. On its own, smoking causes around 79,000 preventable deaths in England each year, and in 2015/16 there were approximately 474,000 smoking-related hospital admissions.\textsuperscript{20} Smokers see their GP 35% more than non-smokers,\textsuperscript{21} adding to the great burden on our strained NHS. The cost of smoking on the English economy is in excess of £12.6 billion per year, of which £2.5 billion falls on the NHS. Around £8.4 billion of potential wealth is lost from the national economy as a result of lost productivity due to smoking, which includes the cost on employers due to sick leave and smoking breaks, and £1.4 billion falls to the social care system.\textsuperscript{22}

5.4. In the context of financial constraint, tobacco control remains a sound financial investment; every £1 invested in smoking cessation saves £10 in future health care costs and health gains.\textsuperscript{23} Similarly, investment in specialist stop smoking services, which provide smokers with a combination of behavioural support and prescription medication, cost less than £6,000 per quality adjusted life year (QALY), and this is often sufficiently less than this amount. This cost falls well below the National Institute of Health and Care Excellence (NICE) cost-effectiveness threshold of £20,000–£30,000 per QALY.\textsuperscript{11}

5.5. The Government must increase its investment in public health so that resources are available to prevent ill health, narrow the health inequalities gap and support NHS sustainability.

6. Increased, sustainable and equitable public health funding is essential at the 2019 Spending Review

6.1. The Government currently plans to phase out a number of central grants, including the public health grant, by April 2020, after which they propose to fund these services via 75% local business rates retention. At its 2019/20 value of £3.1 billion, the public health grant would be the single biggest revenue stream replaced by business rates retention.\textsuperscript{24}

6.2. Under this model public health funding would no longer be protected by a ringfence, meaning resources could be redirected elsewhere at a local authority’s discretion. If business rates retention is expected to fund public health, there needs to be a clear set of conditions outlining which public health services should be commissioned—and consideration given to whether and how services should be mandated. This will ensure local authorities are made accountable for spending, the commissioning process is transparent, and services are consistently delivered to an evidence-based standard.

6.3. Areas with higher deprivation tend to have weaker local economies and will therefore generate less revenue from business rates retention compared to more affluent areas;\textsuperscript{4} these areas also tend to have poorer health outcomes.\textsuperscript{4} There is a real risk that funding public health through business rates retention could exacerbate health inequalities unless appropriately adjusted for.
6.4. Moreover, under business rates retention, local authorities will become reliant on the rates generated by businesses in the area, which will make long-term financial planning extremely difficult due to uncertainty in the income they generate year-on-year. It will become extremely difficult for local authorities do accurate financial forecasting over the longer term, which will impact local public health commissioning.

6.5. In order to reduce health inequalities in line with the Government’s priorities, public health funding must be allocated to local authorities based on need. The Advisory Committee on Resource Allocation (ACRA) formula originally recommended how health spending should be distributed across local authorities to support ‘equal opportunity of access for equal need’ and reduce avoidable health inequalities. Initially, ACRA recommended that public health funding allocations be redistributed gradually, with faster growth in spend allocated to those areas worse off. This principle worked well between 2013/14 and 2014/15, when public health funding increased in real terms.

6.6. However, since 2015 the public health system has experienced a period of rapid change and significant cuts are being made to services. As such, the public health funding available to each local authority in 2019/20 is a significant shortfall to what is required to meet the public health needs across all local authorities in England, as originally recommended by the ACRA formula.

6.7. At the 2019 Spending Review the Government should, as a minimum, restore public health funding to 2014/15 levels to enable local authorities to commission the services they need, without leaving local authorities with less money than they are currently allocated.

6.8. Whatever model is ultimately implemented, it must:
6.8.1. Generate enough funding for local authorities to deliver their public health responsibilities to meet the needs of the population;
6.8.2. Enable transparency and accountability; and
6.8.3. Be equitable so that areas with greater health needs receive sufficient funding.

7. Making the “polluter” pay: introducing a tobacco industry levy at the 2019 Spending Review

7.1. Alongside Action on Smoking and Health and over 120 other health-related organisations, Cancer Research UK recommends the Government introduce a ‘polluter pays’ charge on the industry at the forthcoming Spending Review to help address the growing gap in tobacco control funding.

7.2. This tobacco industry levy should be structured as a charge on each tobacco manufacturer, designed to deliver a fixed sum annually to the Government to fund high impact, evidence-based measures to encourage smokers to quit, and discourge youth uptake both locally and nationally.

7.3. The levy would provide the funding to ensure that money will be available to sustain our investment in tobacco control. The funding would be in addition to, not as a substitute for, the funding going into public health through the public health grant.
7.4. The tobacco manufacturers are highly profitable and could afford to pay at least the £150 million per annum which the Government based its analysis on, and up to the £500 million recommended by Action on Smoking and Health and Cancer Research UK.\textsuperscript{29} The amount to be paid by each manufacturer should be based on the volume of smoked cigarettes they sell in the UK market, as it is smoked tobacco cigarettes that do the damage.

7.5. In England, the tobacco industry has approached a number of local authorities and offered to fund their stop smoking service. However, accepting these offers is inappropriate and not in line with the UK’s legal obligations as a party to the WHO Framework Convention on Tobacco Control (FCTC).\textsuperscript{30} Legislation requiring the tobacco industry to contribute to a Government-administered fund formalises the funding offer, and doesn’t contravene the UK’s obligations under Article 5.3 of the WHO FCTC to protect health policies from commercial and other vested interests of the tobacco industry.

7.6. The funding generated would be a public health fund collected by HM Revenue & Customs. It would be for the Department of Health and Social Care and Public Health England to allocate specifically for local tobacco control activity and stop smoking service provision, with help from an advisory committee including tobacco control experts from the academic, voluntary sector and clinical community. The fund would be earmarked to pay for the recurring costs of tobacco control measures which have been proven to motivate successful quitting and reduce uptake.

8. At the 2019 Spending Review, Cancer Research UK recommend the Government:

8.1. Increase its investment in public health so that resources are available to prevent ill health, narrow the health inequalities gap and support NHS sustainability. As a minimum, the Government should restore public health funding to 2014/15 levels to enable local authorities to commission the services they need, without leaving local authorities with less money than they are currently allocated.

8.2. Ensures the funding mechanism for public health: (1) generates enough funding for local authorities to deliver their public health responsibilities to meet the needs of the population; (2) enables transparency and accountability; and (3) is equitable so that areas with greater health needs receive sufficient funding.

8.3. Introduce a ‘polluter pays’ charge on the industry at the forthcoming Spending Review to help plug the growing gap in tobacco control funding.

April 2019

Reference:

\textsuperscript{1} Office of National Statistics. \textit{Adult smoking habits in the UK: 2017}. Accessed November 2018.


\textsuperscript{3} Public Health England. \textit{Public Health Outcomes Framework} (using ONS mortality data and the DCLG IMD 2010 data – indicator 0.2i).
7 UK Health Forum, as-yet unpublished analysis commissioned by CRUK, 2019; figures are for UK adults (males and females combined) aged 20+, using data from Annual Population Survey 2010-2017.
9 The Health Foundation. Briefing: Taking our health for granted – plugging the public health grant funding gap. The Health Foundation; 2018.
11 Shahab, L. Effectiveness and cost-effectiveness of programmes to help smokers to stop and prevent smoking uptake at local level. National Centre for Smoking Cessation and Training; 2015.
16 Department of Health and Social Care. Prevention is better than cure – Matt Hancock’s speech to the International Association of National Public Health Institutes.
18 House of Lords Select Committee on the Long-term Sustainability of the NHS. Written Evidence submitted by the Health Foundation (NHS0172).
23 National Institute for Health and Care Excellence. Local Government Briefing: We all benefit.