



Working for a tobacco-free Scotland

ASH Scotland response to Finance Committee Inquiry into preventative spending - call for evidence

August 2010

ASH Scotland welcomes the opportunity to respond to the Finance Committee's consultation on its inquiry into preventative spending. ASH Scotland is an independent Scottish charity working in partnership to protect people from the harm caused by tobacco. ASH Scotland works towards a tobacco-free Scotland through our campaigning work; designing and delivering training; co-ordinating tobacco control alliances involving health professionals, local and national government representatives, campaigners and researchers; providing a free expert information service on tobacco and smoking used by both the general public and professionals; and by working in areas of inequality and with youth groups. We strongly believe that tobacco control interventions have a great deal to contribute to a preventative approach to public spending, and can pay dividends in any long-term population-level strategy. This response will present evidence around smoking and tobacco policy in Scotland, the costs of tobacco use, the cost effectiveness of interventions, and a response to the Committee's key questions in light of the evidence presented.

Smoking in Scotland

Smoking in Scotland is in decline in recent years, from 31% of the adult population in 1999, to 24% in 2009¹. However, prevalence of smoking is strongly associated with deprivation; 43% of adults in the most deprived 10% of areas smoke compared with only 9% in the least deprived 10% of areas², resulting in marked inequalities in smoking-related disease and mortality. The effect of smoking on health inequality is profound; a recent study of fifteen thousand Scots living in Renfrew and Paisley found that smoking had a greater influence on mortality than social position³.

Smoking is estimated to cause nearly 13,500 deaths in Scotland each year⁴, a quarter of all deaths - but only 15% in the least deprived areas compared with 32% in the most deprived⁵. Analysis from the United States estimates that for every smoker who dies from a smoking attributable condition, another 20 experience smoking-attributable illnesses such as chronic bronchitis and emphysema⁶. Most smokers in the UK start when they are below the legal age of sale - two-thirds before they are under the age of 18, nearly 40% when they are under the age of 16⁷. The earlier a young person begins to smoke, the more likely they are to continue smoking throughout their lives, and the more likely they are to smoke heavily⁸.

Taking preventative action on tobacco

Smoking is a global epidemic⁹; a large and entirely preventable cause of disease and mortality which in Scotland is responsible for one in four adult deaths¹⁰. Acknowledging this has resulted in successive governments both in Scotland and Westminster implementing a range of evidence based tobacco control policies to reduce the damage cause by tobacco, including:

- **1965** - The Westminster Government uses the powers vested in it by the 1964 Television Act to ban cigarette advertisements on television
- **1998** - The Westminster Government publishes a White Paper on tobacco control, including new targets to reduce prevalence, a smoking cessation programme available on the NHS, and a 'clean air' charter intended to restrict smoking in the workplace
- **2001** - EU directives require larger and more prominent health warnings on tobacco packaging

- **2002** - A bill to ban mainstream tobacco advertising and promotion is passed by the Westminster Parliament, and the phasing out of tobacco sponsorship of Formula One is brought forward from Oct 2006 to July 2005
- **2005** - MSPs vote overwhelmingly to introduce a smoking ban in public places in Scotland
- **2007** - Both Scotland and Westminster raise the legal age of sale for tobacco products to 18
- **2010** - The Scottish Parliament passes a bill that will prohibit tobacco vending machines, the display of tobacco products in shops, and create a register for tobacco retailers.

All these actions served to reduce the harm tobacco causes through one or more of the following: i) encouraging and supporting existing smokers to quit; ii) preventing young people from becoming smokers and depriving the tobacco industry of new customers; iii) protecting the population from exposure to second-hand smoke; and iv) creating measures and controls that reduce the ability of the tobacco industry (whose goals are diametrically opposed to public health¹¹) to undermine any of the above. All these actions were carried out in the recognition that, while some benefits of tobacco control can be seen and experienced in the short term (e.g. the immediate benefits of smoke-free legislation¹², the role of tobacco smoke as a trigger for asthma attacks¹³, or the benefits of smoking cessation during pregnancy¹⁴), the mortality burden of smoking only manifests some 30-40 years after uptake¹⁵. In this sense, interventions designed to reduce harm caused by tobacco are all preventative in nature - as effort must be made at the current time to reduce or remove the risk of adverse future events.

The cost of smoking in Scotland

In addition to the clearly established costs to the health of Scotland's population, and the incalculable human cost that loss of friends and family members through smoking-related illness incurs, smoking also carries economic costs that the Scottish economy must bear.

	Estimated costs per annum
Direct healthcare costs to the NHS for the treatment of smoking related disease	Estimates for this vary depending on assumptions used, however are consistent in order of magnitude. £200 million¹⁶ to £409 million¹⁷
Lost output and productivity to employers, through excess absence, and productivity lost through smoking breaks	£490 million¹⁸
Reduced consumer expenditure through premature death	£143 million¹⁹
Fire damage to commercial properties caused by smoking materials	£4 million²⁰
Fire damage to residential properties	£48 million²¹

The figures in the table above are likely to significantly underestimate the true economic cost of tobacco to Scotland, as several figures are based on estimates and research from the previous decade, hence do not reflect current values. Extrapolation of Scottish costs from UK-wide data is also likely to underestimate true costs for Scotland due to higher smoking prevalence north of the border.

Although tobacco sales brings in revenue to the UK treasury through duties (an estimated £10 billion in 2008-09²², some of which will be apportioned to the Scottish Government), it is clear that tobacco use also incurs significant costs. A recent report by the Policy Exchange²³ using UK-wide data estimates the total societal costs of smoking amount to £13.74 billion annually, nearly four billion more than the Government recovers in tobacco duties, concluding that *'every cigarette smoked is costing us money'*.

The cost effectiveness of tobacco control interventions

Due to the enormous toll that tobacco takes worldwide, a large volume of high-quality international research has gone into the planning of effective interventions to limit the harm smoking causes. These measures are embodied in the World Health Organisation's Framework Convention on Tobacco Control (FCTC)²⁴ to which the UK is a signatory. The FCTC is the first international health treaty, and one of the most widely embraced treaties in UN history, with 171 parties internationally.

The FCTC provides a roadmap to reducing tobacco-related harm, and Scotland has already travelled far down this route. As it has done so, the body of research on the cost efficacy of tobacco control interventions has continued to grow, finding that the interventions to reduce tobacco consumption as advocated by the FCTC are amongst the most effective of any type of public health intervention. This is the case for tobacco taxation increases^{25,26}, annual events like 'No Smoking Day'²⁷, appropriately designed stop smoking mass media campaigns^{28,29} and preventative educational interventions³⁰, telephone quitlines³¹, 'brief interventions' to encourage individuals to stop smoking by health professionals like GPs³², and more intensive stop smoking interventions involving specialist support and the provision of pharmacotherapy (for example nicotine replacement gum or patches)³³.

ASH Scotland believes that most tobacco control interventions are preventative in nature, as, regardless of approach, they seek to limit the number of people who use an addictive product which ultimately kills half its long-term users³⁴. A range of effective tobacco control interventions have been demonstrated to be cost-effective, and ASH Scotland would commend them to administrations seeking to plan public spending focussed on preventing, rather than reacting to, negative societal outcomes.

ASH Scotland's response to the Committee's specific questions is outlined below, in light of the evidence presented throughout this submission.

Response to key questions

1. How can public spending best be focussed over the longer term in trying to prevent, rather than deal with, negative social outcomes?

In the context of health outcomes related to smoking, which ASH Scotland believes to be fundamental in tackling any social outcome related to health or inequality, spending should be focussed on interventions which can demonstrably: help smokers to quit; prevent young people from starting smoking; limit the harm caused by exposure to second-hand smoke; and prevent tobacco industry attempts to undermine any of the above.

2. What evidence can you provide from the UK and abroad to show that promoting preventative spending has been effective?

There is a wealth of international journal-published research evidence, a small proportion of which is referenced in this response, on effective measures to reduce the harm caused by smoking. In Scotland, through a range of interventions over the past four decades, we have seen smoking prevalence drop from nearly half the population in 1972³⁵ to under a quarter in 2009³⁶. Smoking rates during pregnancy have dropped by a third from 1995 to 2008³⁷, and we have seen substantial reduction in smoking prevalence among 13 and 15 year olds³⁸. As smoking is strongly associated with all of Scotland's big killers - cancer, heart disease and strokes, declining smoking prevalence will have contributed to the reductions in male lung cancer rates³⁹, coronary heart disease⁴⁰ and strokes⁴¹ we can observe in national statistics.

3. The Finance Committee has recommended that the Scottish Government continue to direct its spend towards preventative programmes. Which programmes should be prioritised?

ASH Scotland does not take a position on recommending one preventative programme over another, only that, for any preventative programme where any of the intended outcomes are health related, the inclusion of evidence-based tobacco control interventions is vital. Further, it is necessary for any preventative strategy intended to tackle a complex socially embedded issue such as tobacco use to be multifaceted and comprehensive in order to be truly effective.

4. To what extent is preventative spending effective in addressing the financial impact of demographic change?

Many interventions designed to reduce tobacco harm have been tested internationally, in different populations with different demographics so well-designed interventions, tailored when necessary, have the potential to be of significant benefit regardless of the target population's age (as stopping smoking at any age has health benefits⁴²), gender or ethnicity.

5. What are the main barriers to trying to focus spending on preventing, rather than dealing with, negative social outcomes? Is a focus on preventative spending less likely in the current financial climate?

Even in less difficult financial climates, it can be challenging to focus on outcomes that only become apparent one or more decades in the future, spanning the terms of several governments. While current difficulties make a strategy of trading long term losses for short term gains appear more attractive, ASH Scotland believes that care must be taken not to ignore or undermine the importance of a long-term prevention strategy, and consideration of the economic costs of smoking (as outlined in this document) in addition to the health costs. It should also be kept in mind that, in tobacco control, interventions with long-term aims frequently also bring short-term benefits.

6. How do we ensure that we monitor the impact of preventative spending over the longer term and shape budgets accordingly?

ASH Scotland believes that it is vital to have research and evaluation structures in place to monitor the outcome of preventative spending. While many public health interventions have been studied extensively to determine their efficacy prior to implementation, so future outcomes may be extrapolated from past data, robust research and evaluation frameworks are still necessary to monitor differential effects in a changing population and to continue to grow the evidence-base on what works. Because of the impact smoking has on a wide range of outcomes, smoking prevalence itself serves as a useful proxy measure for a range health and social indicators.

7. Is the effectiveness of a preventative spending programme influenced by whether the relevant services are provided by the public, private or voluntary sector?

Given the complex, multi-faceted nature of tobacco use, reducing tobacco-related harm requires a multi-sector approach. ASH Scotland has found through its extensive work in alliances and partnerships that the coordinated efforts of public, voluntary and private sectors (e.g. through promoting stop smoking services in the workplace) give the best chance of success. The voluntary sector has a key role to play, particularly in testing new approaches, adapting and responding quickly to changing evidence, delivering person-centred services and advocating for change. ASH Scotland also notes that there is a body of evidence^{43,44,45} to demonstrate that public health interventions developed by, or in collaboration with, the tobacco industry are likely to be ineffective and diversionary in the aim of reducing smoking consumption. ASH Scotland emphasises the importance of following Article 5.3 in the WHO's Framework Convention on Tobacco Control which outlines the need to protect preventative public health policies from the *'commercial and other vested interests of the tobacco industry.'*⁴⁶

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