Finance Committee

Draft Budget 2012-13

Submission from ASH Scotland

ASH Scotland welcomes this opportunity to submit evidence to the committee in advance of its scrutiny of the forthcoming Scottish Government draft budget for 2012-13 considering to what extent the Scottish Government is facilitating and encouraging a focus on preventative spend. We congratulate the committee on the decision to take forward the work of its predecessor, and believe the Finance Committee Report on Preventative Spending[1] is a helpful and illuminating discussion of the key issues in preventative public spending both in our own field of public health, and also more broadly.

ASH Scotland is a Scottish charity that works in partnership to reduce the harm caused by tobacco and smoking in Scotland. We work by campaigning for more effective regulation of tobacco; designing and delivering training; coordinating tobacco control alliances and partnerships; providing a free expert information service; and by working with youth groups and those who experience health inequality as a result of tobacco use.

We consider that interventions which seek to reduce the health harms caused by tobacco (and also other lifestyle risk factors like alcohol and obesity) are, by nature, preventative as they involve taking action now to prevent diseases that may occur only decades into the future. This response will provide a brief overview and evidence for the issues we consider to important in preventative spend relating to tobacco, before moving on to address the key questions in the general call for evidence raised by the Committee.

Key points on tobacco's economic and societal costs

As highlighted by the Chief Medical Officer in his evidence to the committee[2], there are a series of lifestyle behaviours which result in increased risk of disease, injury or death. Smoking has a causal relationship with many fatal and non-fatal diseases, including Scotland's 'big three' killers - cancer, heart disease and stroke - and hence incurs a significant burden of disease that could otherwise be avoided. The CMO's evidence[2] to the Committee estimates the direct treatment costs of smoking-attributable disease within NHSScotland in 2007/08 to be over £336 million (this is consistent with the order of magnitude of other estimates ranging from £271 million[3] to £409 million[4]).

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[1] Scottish Parliament Finance Committee. 1st Report, 2011 (Session 3). Report on preventative spending [online]. Available from: http://www.scottish.parliament.uk/s3/committees/finance/reports-11/fir11-01.htm [Accessed 19 August 2011]

[2] Dr Harry Burns, Chief Medical Officer for Scotland. Finance Committee, Inquiry into preventative spending, Submission from Dr Harry Burns, Chief Medical Officer for Scotland [online]. Available from: http://www.scottish.parliament.uk/s3/committees/finance/inquiries/preventative/cmo.pdf [Accessed 19 August 2011]

[3] ASH Scotland. Up in Smoke: The economic cost of tobacco in Scotland. November 2010 [online]. Available from: http://www.ashscotland.org.uk/media/3640/Up_in_smoke_Nov2010web.pdf [Accessed 19 August 2011]

Aside from direct treatment costs, there are a range of other societal costs that smoking incurs. We have recently estimated from the economic literature that, combined with direct healthcare costs, indirect costs of smoking are in the region of £1 billion[5] (£692m in productivity losses due to excess absenteeism, smoking breaks, and premature death; £60m for premature deaths due to second-hand smoke exposure in the home; £34m of street-cleaning costs; and £12m for fires caused by smoking in commercial properties). This is likely to be a conservative estimate.

Some of the indirect costs of smoking such as productivity losses may not be borne directly by the public purse, depending on the operation of the labour market (this is also true for other modifiable risk factors such as alcohol or obesity). However, they are still important to be mindful of, as time spent unable to work or otherwise not working due to smoking-attributable illness still has a value.

The health problems caused by smoking are magnified for some groups of society due to smoking's strong patterning by deprivation. 44% of adults in Scotland in the most deprived 10% of areas smoke compared with only 9% in the least deprived 10% of areas[6]. Smokers from more deprived areas are more likely to be 'hardened' smokers that are less likely to have made attempts to quit and exhibit greater signs of nicotine dependence[7]. Because of these features, the contribution of smoking to creating and maintaining health inequality is stark. A large cohort study tracking the mortality outcomes of fifteen thousand people from Renfrew and Paisley reported that smoking had a greater influence on mortality than social position - non-smokers from the lowest social classes outlived smokers from the highest social classes[8].

Professor Sir Michael Marmot and colleagues in their recent and comprehensive strategic review of health inequalities in England[9] conclude that reducing health inequalities will provide economic as well as social benefits. Using data from England, the authors find that, if everybody in England enjoyed the life expectancy of the most advantaged, people who currently die as a result of health inequality would have 1.3 million to 2.5 million extra years of life, and a further 2.8 million years free from any limiting disability. Putting a figure to this loss of healthy life, they estimate that inequality accounts for £31-33 billion in productivity losses in England per year, a further £20 - £32 billion in lost taxes and higher welfare payouts, and NHS costs associated with inequality are around £5.5 billion per year. The report also states that '*[t]obacco control is central to any strategy to tackle health inequalities.*'[10]

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[4] Allender S, Balakrishnan R, Scarborough P, Webster P, Rayner M. The burden of smoking related ill health in the UK. Tobacco Control . 2009;18:262-267.
[5] ASH Scotland. Up in Smoke: The economic cost of tobacco in Scotland. November 2010 [online]. Available from: http://www.ashscotland.org.uk/media/3640/Up_in_smoke_Nov2010web.pdf [Accessed 19 August 2011]
[6] Scotland's People Annual report: Results from 2009/2010 Scottish Household Survey [online]. August 2011. Available from: http://scotland.gov.uk/Publications/2011/08/17093111/0 [Accessed 30 August 2011]
[7] Jarvis MJ, Wardle J, Waller J, Owen L. Prevalence of hardcore smoking in England, and associated attitudes and beliefs: cross sectional study. BMJ. 2003 May 17;326(7398):1061.
[8] Gruer L, Hart CL, Gordon DS, Watt GC. Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study. BMJ. 2009 Feb 17;338:b480. doi: 10.1136/bmj.b480.
[9] Strategic Review of Health Inequalities in England post-2010. Fair Society, Health Lives: The Marmot Review [online]. February 2010. Available from: http://www.marmotreview.org/ [Accessed 19 August 2011]
[10] Ibid

Are interventions to reduce tobacco use cost effective?

As continued smoking brings serious health consequences, interventions to either assist current smokers to stop or to prevent prospective smokers from taking up the habit are generally very cost effective, particularly when compared to other medical preventative or screening interventions[11]. This is particularly true for increases in tobacco taxation, which is generally regarded as the most effective and cost-effective measure to reduce consumption[12], even when increased health care costs in years of life gained are taken into account[13]. However, it is important to remember that increases in tobacco taxation are regressive, in that they impact disproportionately on those with lower incomes (who are also more likely to be smokers). While stopping smoking brings large health and economic benefits for those who are encouraged to give up by duty increases, for those who are not it can have a negative impact on household finances.

Because of this it is important to offer stop-smoking support services and drivers to those services (mass media/social marketing campaigns) to maximise the impact of duty increases on health and minimise the regressive effect. Appropriately designed stop smoking mass media campaigns[14,15], telephone quit lines[16], one-off events like no-smoking day[17], and specialist behavioural and pharmaceutical support for smoking cessation[11] are all cost effective in preserving life. Smoking cessation interventions tend to remain cost-effective, even if the individual has smoked for many years.

Response to key questions in the Committee's call for evidence:

1. **The previous Scottish Government said that: "Preventative action is integral to the approach to government in Scotland and delivering the outcomes set out in the National Performance Framework". What spending commitments and priorities would you like to see in the 2012-13 draft budget and spending review in order to ensure that progress is being made on preventative spending and, in particular, Early Years intervention?**

   As described in the sections above, ASH Scotland considers spending on tobacco is fundamentally preventative in nature. Effective interventions that seek to prevent children and young people from ever taking up smoking (two-thirds of smokers start under the age of 18 and nearly 40% under the age of 16[18]) have the

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[11] NHS Health Scotland and ASH Scotland. *A guide to smoking cessation in Scotland 2010* [online]. 2010. Edinburgh: Health Scotland. Available from: http://www.healthscotland.com/documents/4661.aspx [Accessed 19 August 2011]

[12] World Health Organisation. WHO Technical Manual on Tobacco Tax Administration. WHO: Geneva. 2010.

[13] van Baal PH, Brouwer WB, Hoogenveen RT, Feenstra TL. Increasing tobacco taxes: a cheap tool to increase public health. Health Policy. 2007 Jul;82(2):142-52. Epub 2006 Oct 16.

[14] Ratcliffe J, Cairns J, Platt S. Cost effectiveness of a mass media-led anti-smoking campaign in Scotland. Tob Control. 1997 Summer;6(2):104-10.

[15] Hurley SF, Matthews JP. Cost-effectiveness of the Australian National Tobacco Campaign. Tob Control. 2008 Dec;17(6):379-84. Epub 2008 Aug 21.

[16] Tomson T, Helgason AR, Gilljam H. Quitline in smoking cessation: a cost effectiveness analysis. Int J Technol Assess Health Care. 2004 Fall;20(4):4

[17] Kotz D, Stapleton JA, Owen L, West R. How cost-effective is 'No Smoking Day'? Tob Control. 2011 Jul;20(4):302-4. Epub 2010 May 14.

[18] Office for National Statistics. General Lifestyle Survey 2009 – Smoking and Drinking among adults 2009 [online]. Newport: Office of National Statistics. 2010. Available from:

potential to offer the greatest benefits, as they avoid completely the health and economic burden of tobacco attributable disease. Even interventions that occur many decades after an individual has begun smoking - like media campaigns or behavioural support to encourage adults to give up - has a strongly preventative component, as ending tobacco use is always associated with better future health outcomes and reduced likelihood of illness.

Hence we believe it is vital for the Government's tobacco control budget be maintained so the spectrum of work that goes on in tobacco control in Scotland through prevention, cessation, education and enforcement continue to be effective in preventing future ill-health.

Lastly, it is important to note here that Government action or spending in any particular area should not be considered in isolation as complex interactions between interventions exist. For example, based on the results of a large prospective study on obesity in the West of Scotland[19] it is suggested that - as smoking is increasingly being reduced as a risk factor in the development of disease - other risks such as increased obesity may take part of its place in generating avoidable disease[20]. It follows that it is important for any particular lifestyle change intervention to be planned in awareness of any interaction or displacement effects, and highlights the importance of cross-discipline (e.g. alcohol, tobacco, obesity) working.

2. **The Scottish Government has emphasised an outcomes based approach through both the National Performance Framework and Single Outcome Agreements. What, if any, additional national and local indicators would you like to see as a means of supporting the shift towards a greater focus on preventative spending?**

Exposure to second-hand smoke in homes and cars is a strong predictor and cause of a range of childhood diseases[21] in addition to its established effects on adult health[22]. We currently have limited reliable data, and no targets, for the reduction of second-hand smoke in specific different environments such as the home or private vehicle. National indicators (due to the scale of data collection required, local indicators would likely be challenging to obtain) and targets on these areas would be welcomed to drive progress. Reliable prevalence data could also increase the effectiveness awareness raising campaigns, allowing them to be targeted at demographics where exposure is highest.

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http://www.statistics.gov.uk/downloads/theme_compendia/GLF09/GLFSmoking-DrinkingAmongAdults2009.pdf [Accessed 19 August 2011]

[19] Hart CL, Gruer L, Watt GC. Cause specific mortality, social position, and obesity among women who had never smoked: 28 year cohort study. BMJ. 2011 Jun 28;342:d3785. doi: 10.1136/bmj.d3785.

[20] Mackenbach JP. What would happen to health inequalities if smoking were eliminated? BMJ. 2011 Jun 28;342:d3460. doi: 10.1136/bmj.d3460.

[21] Royal College of Physicians. Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010

[22] Scientific Committee on Tobacco and Health (SCOTH). Secondhand smoke: review of the evidence since 1998. Update of evidence on health effects of secondhand smoke [online]. London: Department of Health, 2004. Available from: www.advisorybodies.doh.gov.uk/scoth/PDFS/scothnov2004.pdf [Accessed 19 August 2011]

As described above, smoking is strongly patterned by social deprivation. No targets exist for reducing smoking prevalence in the most deprived groups at the population level or reducing the gap in prevalence between the best off and worst off in society at the population level (though a target with an inequalities focus does exist for NHS smoking cessation services particularly[23]). Considering the powerful role smoking plays in creating and maintaining health inequality between groups, it would seem justified to create and maintain national (and possibly local) outcomes that attempt to tackle this.

3. **The Scottish Government's response to the Committee's** *Report on preventative spending* **stated that: "The Spending Review that will follow the Scottish elections in May will provide another opportunity for the Scottish Government to support delivery agencies in their efforts to increase the proportion of their budget dedicated to preventative activity." What support should the Scottish Government provide in its spending review to support delivery agencies in increasing preventative activity?**

The Government should provide strategic emphasis on the importance of taking a preventative approach to spending, and resource services accordingly. It is important to note that, because some preventative approaches may take many years or decades for their benefits to accrue, there will be similar-to-present levels of demand for most acute services in the short-to medium-term.

4. **What long term planning is carried out to fully deliver on preventative spending strategies and how do you plan for this within short term budget periods?**

   ASH Scotland is an evidence-based voluntary organisation. However as a significant proportion of our work in tobacco control is based on outcomes that will only become apparent in the future, for reasons already discussed, we plan our work based on this fact.

   We have found it helpful to consider within a logic model framework what the long-term outcomes are that we want to achieve, and then link the longer term outcomes to surrogate measures of our main outcome that are observable in the short time. We have found this to be helpful in evidencing our work and benchmarking progress when the outcomes are events like lung cancer, heart disease or stroke rates that will occur 20+ years from the time the intervention is made.

5. **What baseline evidence is used to measure preventative outcomes?**

   The evidence that can be used to gauge whether a preventative outcome has been achieved is dependent on the nature of the preventative outcome being examined. A common and acceptably robust (if used appropriately) approach to

[23] The Scottish Government. HEAT Target: Smoking cessation [online]. Available from: http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/smokingcessation [Accessed 19 August 2011]

measure preventative outcomes in health and social care is to measure changes in existing routine datasets using a time-series approach while controlling for existing trends prior to the preventative intervention in question. Well-designed cohort studies where individuals are followed for long periods of time can also be a useful (and in some cases, the only) way of gathering data on whether a preventative intervention has had the desired effect.

As described in the response to the question immediately above, when expected actual preventative outcomes are far in the future, yet data is required in the short to medium term, a surrogate outcome that has a technical or theoretical link with the actual outcome can also be used to measure progress.

6. **In oral evidence to the Committee, COSLA stated that: "we want budgets to be thought of more as being part of the public purse than as belonging to the council or NHS". To what extent are you able to pool your budget, or even reallocate budgets to other agencies, and make joint spending decisions through initiatives such as the Integrated Resource Framework?**

   From our experience of working with local authorities, NHS bodies, and other public sector organisations in tobacco control alliances and partnerships[24] we have seen that changes to public funding structure have offered both opportunities and challenges to local tobacco control groups. For example, the development of the Concordat Agreement provided the opportunity to identify and explicitly record the value of tobacco control work and how it contributes to reaching the outcomes chosen by each local authority. It also brought difficulties as, in the removal of ring-fenced funding as part of the agreement, some councils reduced funding from agencies that were vital to carrying out the objectives agreed to (e.g. trading standards being inadequately funded has had a knock on effect in failure by some councils to achieve agreed work in enforcing the law on tobacco sales.)

7. **The Committee will be writing separately to individual Community Planning Partnerships but would welcome views from other interested organisations on what elements should be in the spending review and the 2012-13 draft budget to support more effective collaborative working in moving towards a more preventative approach to public spending?**

   It is important, as in the example in the response to the question immediately above, that other Government mechanisms for taking policy from the national to the local level - such as the Single Outcome Agreements - are consistent with the vision for preventative spend that the Government wishes to adopt. Otherwise there is a risk that, particularly in the current climate when acute services are likely to be under budget pressure, national-level priorities which may rightly focus

[24] ASH Scotland, NHS Health Scotland, Scottish Government. Tackling tobacco together: The final report of ASH Scotland's Local Tobacco Control Alliances Project (2006 - 2011) [online]. Available from: http://www.ashscotland.org.uk/media/3864/Tackling%20Tobacco%20Together%20The%20final%20report%20of%20ASH%20Scotlands%20Local%20Tobacco%20Control%20Alliances%20Project.pdf [Accessed 19 August 2011]

on preventative approaches may not receive the action and attention they need at local level.

How can good examples of collaboration be encouraged and shared nationally across key agencies and what is the role for the Scottish Government here?

The Government has a key role in presenting, highlighting and sharing at the national level examples of good practice in collaboration. This is particularly pertinent because, as described in the response to question 1, some preventative interventions may interact with others, and a view at the national level can provide a broader perspective and recognise such relationships where they exist. The Government can then play a valuable role in encouraging relevant partners to work in a more effective joint manner. The voluntary sector also has a key role to play in this regard due to the typical flexibility it can show in testing new approaches, adapting and responding quickly to changing circumstance, delivering services tailored to particular community needs and advocating for change. ASH Scotland has recently published the final report of a five year project that developed and supported local tobacco control alliances in Scotland[24]. Through it we have demonstrated that a nationally managed project can help those working locally to make the best use of opportunities and developments that national level government policy can provide. Through our continuing work in coordinating the Scottish Tobacco Control Alliance (STCA) - a national multi-disciplinary forum for discussion and collaboration on all aspects of tobacco control - we have received positive feedback from public sector and third sector organisations on the value this kind of collaboration adds to ongoing work.