The Economic Case for Local Investment in Smoking Cessation

Background

Tobacco is still the largest preventable cause of death in the world, and causes 15% of all cancer cases in the UK. In 2015, smoking caused an estimated 105,000 deaths in the UK — almost a fifth of all deaths from all causes.1 Smoking is one of the largest causes of health inequalities: the difference in life expectancy between the poorest and the richest can be as much as nine years2, of which approximately half can be attributed to smoking.

Across England, 15.5% of the adult population, over 10% of pregnant women and 8% of 15 year olds regularly smoke.3 Stopping smoking is the best thing an individual can do for their health, and comprehensive tobacco control is the best thing a local authority can do for public health. Treating tobacco addiction in the community can deliver significant cost savings to the health and social care system, helping support its future sustainability, and also helping to return money to families in need.

Unfortunately, local investment in tobacco control is decreasing. In 2017:

- **Budgets for Stop Smoking Services were cut in 50% of local authorities in England.** This follows cuts in 59% of local authorities in 2016;
- Only 61% of local authorities commissioned a Stop Smoking Service that could be accessed by all people who smoke in the local area;
- At least one local authority did not offer a smoking cessation service of any kind.4

The cost of smoking

According to the Government’s Tobacco Control Plan for England, smoking costs our economy in **excess of £11bn per year**. Of this, £2.5bn falls to the NHS, £5.3bn falls to employers, and £4.1bn falls to wider society. It is also estimated that smoking-related health conditions creates a demand pressure on local councils of £760m a year for social care services.5

‘Action on Smoking and Health’ (ASH) has developed a ‘Ready Reckoner’ tool to estimate the economic costs of smoking to each local economy.6

Assess the cost of smoking to your local economy by using to ASH ‘Ready Reckoner’ tool, available [here](#).

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The cost-effectiveness of tobacco control

According to the National Institute for Clinical Excellence (NICE), every £1 spent on smoking cessation saves £10 in future health care costs and health gains. A tobacco control strategy is therefore a long-term investment.

A comprehensive tobacco control strategy should include:

- Prioritisation and sustained funding for tobacco control
- Provision of evidence-based specialist smoking cessation services (‘Stop Smoking Services’)
- A coordinated tobacco control alliance to provide:
  - Local mass media campaigns
  - Measures to target the illicit trade in tobacco
- Targeted action to accelerate progress to reduce health inequalities
- Recognition of the WHO Framework Convention on Tobacco Control (WHO FCTC), to ensure the tobacco industry does not influence public health.

More information on delivering a comprehensive tobacco control strategy is detailed in the CRUK Tobacco Control Local Policy Statement.

Stop Smoking Services

Specialist smoking cessation services, or Stop Smoking Services, deliver face-to-face behavioural support combined with pharmacotherapy. This type of intervention been shown to be highly effective in improving long-term quit rates, offering smokers the best possible chance of quitting. Smokers who use these services are around three times more likely to successfully quit than those attempting to quit unassisted.\(^7\)\(^8\) NICE NG92 guidance sets out recommendations to ensure that these services are as effective as possible.\(^9\)

Moreover, these specialist interventions have been shown to be among the most cost-effective interventions available in the healthcare sector: it is estimated that behavioural support and

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pharmacotherapy cost less than £6,000 per QALY (Quality Adjusted Life Years), well below the NICE ‘cost-effective’ threshold £20,000 - £30,000 per QALY.  

Mass media campaigns

Mass media campaigns have been shown to be highly impactful and cost-effective in encouraging smokers to quit. NICE modelling shows that if a campaign costs £100,000, five smokers need to quit (over and above the background quit rate) for the intervention be cost effective. Evidence shows campaigns are only effective if they are sufficiently well funded – and the UK is currently spending far less than the recommended amount. We want the Government to increase spending on mass media campaigns to at least 2010 levels (£25 million).

Case study – Don’t be the 1

1 in 2 smokers will die from a tobacco related disease, but most vastly underestimate the risks and a survey in the North East found 9/10 smokers thought the odds were much lower.

The ‘Don’t be the 1’ campaign, run by Fresh from 2014-17, has raised awareness of these risks and made smokers think more about the devastating impact smoking can have not just on them but their loved ones.

The campaign has featured 60 second and 30 second TV adverts, cinema advertising, radio adverts, website and social media and video campaign, with a partners toolkit. Fresh also worked with ex-smokers, including brave Michelle Barthram, who tragically died from lung cancer less than a year after she backed the campaign as a warning to others, aged just 48.

The campaign saw a 125% increase in smokers aware of the ‘1 in 2’ risk, with almost a third of smokers taking some form of action – from quitting, seeing their GP, cutting down, setting a future quit date or switching to a pure nicotine replacement. The campaign won two national Roses advertising awards and has been rolled out in other areas, including Wales. More information is available here.

For further information email us at localengagement@cancer.org.uk

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10 Shahab, L. (2014). Effectiveness and cost-effectiveness of programmes to help smokers to stop and prevent smoking uptake at local level.
11 Breathe 2025 (nd). Breathe 2025: Inspiring a smoke-free generation. Available here
12 CDC (2014). Best practices for comprehensive tobacco control programmes. Available here