ASH spending review representation

Introduction

1. This Spending Review representation is submitted by Action on Smoking and Health (ASH), which is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK.

2. This representation on behalf of ASH is co-produced with Howard Reed, Landman Economics, consultant to ASH; Dr J Robert Branston, Associate Professor of Business Economics, University of Bath; Professor Jamie Brown, Professor Lion Shab and Dr Emma Beard from the Tobacco and Alcohol Research Group, UCL; Dr Anthony Laverty, Senior Lecturer in the Public Health Policy Evaluation Unit in the Department of Primary Care & Public Health, Imperial College London and Dr Tessa Langley, Associate Professor in Health Economics at the University of Nottingham. None of the authors have any direct or indirect links to, or receive funding from, the tobacco or nicotine industries, except for nominal shareholdings in Imperial Brands and British American Tobacco for advocacy and research purposes held by ASH and Dr Branston.

Summary

3. Half the difference in healthy life expectancy (HLE) between the richest and poorest in society is due to smoking,[1] so to deliver its commitment to halve this gap, the Government must address the differences in smoking prevalence. Reductions in smoking prevalence can deliver immediate benefits to the health and social care system as well as increasing the health and wealth of some of the poorest households[2] and the economic productivity of the most deprived areas.[3]

4. Significant declines in smoking prevalence were achieved under the last Labour Government through a three-pronged approach combining: i) ambitious legislation; ii) funding for mass media campaigns and smoking cessation; and iii) a comprehensive strategy, 'Smoking Kills', to set targets and milestones. The latest data (2023) shows, at least 6 million people in the UK still smoke, although the figure may be larger when including people who do not smoke cigarettes every day, smoke non-cigarette tobacco products (an extra 2 million people) and 'hidden populations' who are not sampled by national surveys (an extra 1 million people).[4] [5] [6]

5. This Government's commitment to a smoke-free Britain[7] can only be delivered if investment in measures to support smokers to quit are sustained, including those made by the last government, with the addition of the manifesto commitment to ensure all hospitals integrate 'opt out' smoking cessation interventions into routine care. However, there is strong case for further investment, over and above these commitments, to accelerate progress more rapidly, bringing about significant health and economic benefits

6. In 2024 smoking in England cost public finances £9.7 billion (bn), after tobacco excise tax income of around £10.1 bn and reduced pension payments of £0.2 bn are netted out. Most of the burden on public finances is due to the damage smoking does to the productivity of the nation. The total cost of smoking in England amounting to £43.7bn in 2024. [3]

7. Modelling by Landman Economics [3] and UCL Tobacco and Alcohol Research Group[8] shows that if the Government invests an *additional* £97mn annual investment in tobacco

control, alongside the £280mn committed to by the last government, then in 2030 an additional £894mn could be saved from public finances with returns in the intervening years not modelled here. Benefits are delivered through reduced burden on public services, lower welfare bill, and increased income taxes as a result of a fall in smoking of 1.2 percentage points (10% reduction). In 2035 this investment would improve public finances by £1.7bn a year. This figure is just for England and similar levels of investment UK-wide would deliver greater benefits for the whole country.

8. Additionally, reducing smoking through this level of investment will improve the wider economy. Reducing smoking means more people are fit to work. It is estimated that around 230,000 people are unfit to work due to smoking. It also generates UK jobs as very few jobs in this country are generated by tobacco with almost all products imported. When smokers switch their spending to other goods and services this has more benefit to the UK.

9. There is a strong return on investment case for investing in tobacco control measures as well as a moral one. Smoking kills people prematurely, robbing them on average of 10 years of life, but many more live in poor health undermining their quality of life. These deaths and poor health damage our society as well as our economy.

10. A 'polluter pays' health levy and system of price cap regulation on the wholesale prices charged by tobacco manufacturers would limit industry profits to the average level for UK manufacturing businesses, and allow greater control over prices which are currently manipulated by tobacco companies to keep people smoking. The excess profits the industry currently makes would be taken by government in the form of an additional excise tax. As well as raising funds, this would have the additional benefit of maintaining current high retail prices, which disincentivise smoking. Such a levy could raise £700mn annually, more than would be needed for tobacco control efforts. Excess funds could be used as a transformation fund to deliver on the Secretary of State for Health's priority to shift from treatment to prevention. Importantly, this would not place an additional tax burden on the public but on the companies themselves.

Summary of recommendations

Recommendation 1: Recommit to the £210.5mn package agreed to by the last government to reduce smoking and ensure NHS England spend ~£70mn to maintain quit support to smokers in the NHS.

- £142.5mn pa to ensure existing DHSC commitment to funding is maintained for the whole of the Parliament including:
    - £70mn additional funding for Stop Smoking Services (committed to for 25/26)
    - £5 mn for incentives for pregnant smokers plus additional commitment for partners
    - £22.5mn for 'Swap to Stop' campaign
    - £15 mnpa for communications and marketing campaigns
    - £30 mnpa additional funding to enforce the laws on underage sales and illicit trade in tobacco and vaping products. (committed to for 25/26)
- Return the Public Health Grant to 2015/16 levels in real terms to ensure local authorities can continue to invest an estimated £68mn to support smokers to quit.
- £70mn pa to safeguard funding to fully rollout the NHS Long Term Plan Tobacco Dependence Treatment programme and then embed in routine care.

Recommendation 2: Invest an additional £97mn in interventions that will target smokers experiencing disadvantage to accelerate reductions in smoking

- Put a comprehensive strategy in place to target resources so all GPs make opt out referrals, the swap to stop scheme is targeted at disadvantaged groups, and there is clear join up between local government and the NHS.
- Ensure NHS Tobacco Treatment Services have an additional £15mn to ensure services can be rolled out in community mental health services and a digital offer can be established.
- Invest £50mn, when fully established, to embed stop smoking support within Lung Health Checks.
- Invest £23mn to establish support for smokers within NHS Talking Therapies.
- Further increase mass media investment by £9mn to target inequalities

Investing this £97mn a year will deliver a return to public finances of £894mn in 2030 and £1.7bn in 2035, with additional returns in the intervening years.

Recommendation 3: Raise revenue to fund a shift to prevention through a scheme of price cap regulation of wholesale tobacco prices and create a ~£700mn levy on the tobacco industry that will place limits on industry's ability to manipulate prices and make excess profits.

- A 'polluter pays' levy could raise an initial estimated £700mn annually in revenue from tobacco companies rather than from the pockets of smokers.
- It could give Government the ability to prevent industry from manipulating the prices of products to keep people smoking and limit their ability to make excess profits.
- It provides more funding than is needed for a comprehensive tobacco control strategy, leaving £323mn for investment in wider prevention agenda.
- This is strongly supported with 79% of people in England backing a levy (5% oppose)[9]

Recommendation 4: Contribute £2mn pa Official Development Assistance (ODA) funding to support WHO Framework Convention on Tobacco Control (FCTC) implementation in low- and middle-income countries (LMICs)

- The UK has been a world leader in tobacco control and supported implementation of the FCTC by LMIC since 2017.
- In the UK's 20th year as a party to the treaty we should maintain our commitment to reducing smoking across the world rebuilding Britain's reputation on the international stage

The cost of smoking to the economy

11. The Office for Budgetary Responsibility recently concluded that: *"The health of the population is a key driver of the medium-term economic and fiscal outlook, and the costs of poor health pose one of the biggest risks to the long-term sustainability of the public finances."*[10] They note that three of the drivers for improving life expectancy since the second world war have been: "reduction in the prevalence of smoking, the development and deployment of antibiotics, and the establishment of the NHS".[11] However, since 2010 progress has slowed with health life expectancy in decline and health inequalities widening.

12. There are likely many causes for this but progress on reducing preventable illnesses caused by smoking (and other risk factors such as alcohol and obesity) can contribute to reversing this trend.

13. Most of the burden on public finances is due to the damage smoking does to the productivity of the nation, due to sickness, absenteeism, and premature death. People

who smoke need social care on average ten years earlier than non-smokers, and smokers are at least three times more likely to die while of working age than those who don't.[12]

14. Landman Economics estimates these costs to be £16.8 billion (bn) annually[3] made up of:
    - £1.8 bn to the NHS
    - £1.1 bn social care costs to local authorities
    - £13.8 bn (in reduced income tax and increased social security spending arising from lost productivity)

15. Landman Economics estimates that the net impact of smoking on public finances in England is over £9.7 billion (bn) in 2024, once tobacco excise tax income of around £6.8 bn and reduced pension payments of £0.2 bn are netted out. (See Table 7.2 in the Cost Benefit and Public Finance Report, January 2025).[3]

16. The overall costs of smoking in England to society as a whole are far higher, amounting to £43.7 bn annually (See Table 7.1 in the Cost Benefit and Public Finance Report, Jan 2025).[3] In addition to the public finance costs this includes:
    - £9.6 bn Reduced Gross Value Added (tobacco is not grown nor are tobacco products manufactured in the UK so the sector contributes fewer jobs and lower GVA, and widens the trade deficit)
    - £7.8 bn additional cost of informal social care
    - £5 bn additional cost of unmet need for social care
    - £0.3 bn cost of smoking-related fires

17. Landman Economics and ASH published modelling on the impact of smoking on public finances and the economy in May 2024. The costs were higher in our May estimates than in our most recent update (January 2025). This is mainly due to faster-than-anticipated reductions in smoking prevalence.

Reducing smoking rapidly in this Parliament

18. The measures in the Tobacco and Vapes Bill are very welcome, but the benefits to the public finances and the economy will be small to start with and grow over time. The DHSC estimate that by 2050 smoking rates among 18–30-year-olds will effectively be 0, as a result of phased out sale of tobacco. While there is uncertainty in this estimate and the full impact could be swifter, in the short term the impact on overall smoking rates will be limited as the impacted population will be small relative to the whole population. UCL estimates that by 2035 the measure will have reduced smoking rates among 18–28-year-olds by 2 percentage points to 3.4% % (in addition to the background downwards trend) but this is only a 0.08% reduction in overall prevalence.

19. Supporting current smokers to quit whatever their age can have rapid benefit to individuals. While not all the health harms can be avoided by quitting later in life, there are still substantial benefits to be had[13]. In recent years we have seen drops in smoking rates that are greater among younger people than older, with smoking rates among over 65s almost unchanged through the last decade.[14]

20. There are challenges in engaging older adults who smoke and have high levels of addiction.[15] But models, such as embedded support in the NHS, are more likely to benefit this population. The government must have a strategic focus on reducing

smoking in middle age as well as creating a smokefree generation with likely rapid benefits to both productivity and demands on the NHS.

21. To bring rates down more rapidly the government must invest in initiatives that will help those who currently smoke to quit. This investment will have a rapid dividend that will grow over time. A one percentage point reduction in smoking in 2025 would save public finances (at 2024 prices):
    - £690m per annum in 2026
    - £787m per annum by 2030
    - £906m per annum by 2035

22. It would also have a direct impact on the wider economy through two important mechanisms. First, through ill health that is avoided in the population of working age. This improves productivity and the gains grow over time. A one percentage point reduction in smoking in 2025 would mean 20,000 more jobs.

23. However, there is another, more immediate, impact on the economy. Tobacco creates almost no UK jobs with tobacco products being almost entirely imported so when smokers switch their spending away from tobacco towards other goods and services this is a boost to the UK economy. Therefore, a reduction in smoking by one percentage point in 2025 means a boost to the labour market of 16,000 in 2026 and thereafter.

Detailed recommendations

RECOMMENDATION 1: Recommit to the £210.5mn package put in place by the last Government to reduce smoking, including ensuring NHS spending of £70mn is maintained on tobacco.

24. The government must sustain the funding committed to by DHSC:
    - £70 mn for Stop Smoking Services (committed to for 25/26) in addition to £68mn spent through PH Grant (£138mn in total)
    - £22.5 mn for 'Swap to Stop' campaign
    - £5 mn for incentives for pregnant smokers plus additional commitment for partners
    - £15 mn pa for communications and marketing campaigns
    - £30 mn pa additional funding to enforce the laws on underage sales and illicit trade. (committed to for 25/26)

See Appendix 1 for a detailed account of the evidence underpinning these investments. UCL's Smoking Toolkit Study which tracks rates of smoking and quitting behaviour in the population is already seeing the impact of this additional investment on quitting activity. In 2024 the use of stop smoking services as an aid to quitting grew by ~50% after a decade of stagnation.[16] As this is the most effective way to stop smoking these are promising impacts.

25. As part of the NHS Long Term Plan, smoking quit services have also been established in the NHS. An estimated £70mn is being spent to deliver these services in acute, mental health, and maternity settings. These services can facilitate the government's desired 'shift to prevention' in the NHS and respond to the critique from the Public Accounts Committee that insufficient focus has been given to preventative approaches in the NHS. However, with so many other pressures on the NHS these services are currently at risk.

26. DHSC estimate that increasing funding for local authority stop smoking services by £70mn to £138mn a year will increase the number of people supported to quit smoking for at least 4 weeks, to rise to 198,000 a year (likely contributing a 0.1% reduction to

smoking prevalence in 2030). Improving the reach of services can also support wider partnerships and initiatives. To maximise the impact of this investment government should have a national roadmap to ensure local and system level strategies align with national ambitions. (for more on the evidence see appendix 1)

27. Expanding services requires the current public health grant to be sustained and returned to the level if was in 2015/16 in real terms. We support the submission to the spending review made by the Association of Directors of Public Health on the future level and structure of the Public Health Grant. Funding stability is as important as funding level (both for local government and the NHS) and a clear multi-year settlement for prevention is necessary as establishing services and interventions to deliver change can take more than a single year to fully deliver.

28. The Swap to Stop campaign was partly modelled on a pilot programme in social housing. UCL Tobacco and Alcohol Research Group modelled the impact of a similar programme in social housing and estimated that it could contribute to a 0.34% reduction in smoking prevelance by 2030 and 0.63% reduction by 2035. Other programmes where a similar approach has been taken include COSTED trial which provided vapes to smokers accessing A&E and found strong quit outcomes. (for more on the evidence see appendix 1)

29. There is a strong international and domestic evidence base for mass marketing campaigns. These stimulate quit attempts and can enhance prevention strategies. They can have very wide reach and as such high return on investment. Unfortunately they have been seen as areas which can be easily cut and in 2010 the incoming coalition government fully cut all campaigns. As a result quit attempts fell.[17] (for more on the evidence see appendix 1)

30. The NHS Tobacco Dependence Treatment programme was established using a model developed in Ottawa. This bedside treatment model can reach smokers who may otherwise be missed and engage them at a highly salient moment when they have been hospitalised. The reach of this programme could be particularly important with older smokers who may not have been engaged by services in the community. ASH's impact model for treatment services uses assumptions from the Ottawa model to understand the impact of these services.[18] While the NHS remains committed to continue to provide these services, ASH has concerns that in practice other priorities in the system may put current delivery at risk. Action is needed to ensure that they are maintained and can support the government's shift to prevention.

31. DHSC and NHSE should also consider where it may need to retain some of the funding for delivery at national or regional level to enable delivery. Localities need flexibility in their spending but also require support to ensure they have robust local approaches in line with the evidence. Areas which have had sustained programmes at regional level to reduce smoking have also seen bigger drops.[19] This is in part due to the additional capacity lent by regional level experts to help support implementation.

RECOMMENDATION 2: Invest an additional £97mn in interventions that will target smokers experiencing disadvantage and accelerate progress

32. In addition to maintaining current funding levels for tobacco control as set out above, further investment should be made to capitalise on the passage of the Tobacco and Vapes Bill and turbo-charge progress towards creating a smokefree country with a particular focus on reducing health inequalities.

33. The proposed interventionsbelow are in areas where there is sufficient data to model the impact and assess the possible costs. We have included our estimate of the cost of a fully established programme here, but it is likely that any programmes would require phasing. There are other interventions which could also deliver prevalence reductions targeted towards disadvantaged groups. For example, there is innovative work happening engaging smokers in A&E opportunisticly with results showing you can nearly double the likelihood someone will quit compared to no intervention with greater chance of reaching disadvantaged groups.[20]

34. The interventions:
    - **Opt out referral by GPs**: Providing smokers with opt out referral to support when they come into contact with primary care, will accelerate quitting. Such a referral will increase the likelihood of smokers accessing specialist quit support (see appendix 1) but also increase the likelihood of independent quitting. This is an intervention which can reach all smokers. While there are no new financial costs of this intervention, it is contingent on stop smoking services being fully in place and clear direction being provided to primary care. A comprehensive roadmap to a smokefree country could deliver such direction.
    - **Targeted support in community mental health services**: Smoking rates are exceptionally high among people with mental health conditions and estimated to be around 40% among those with Serious Mental Illness (SMI). Trials over many years have shown that targeting evidence based support for this population will increase the rate of quitting.
    - **Targeted support in IAPT (Talking Therapies) settings**: Smoking rates among those accessing IAPT services are estimated to be around 24%. Trials have shown that counsellors in Talking Therapies have the skills and willingness to deliver stop smoking behaviour change support and this can increase rates of quitting. The cost estimates below are speculative as there has been limited piloted work outside of research studies.
    - **Mass media campaigns**: In addition to the £15mn in the existing envelope of funding above, further targeted mass media campaigns targeted in specific parts of the country for key populations can provide further benefits. Detailed evidence for mass media campaigns is in appendix 1
    - **Support integrated in Lung Health Checks**: Those invited to Lung Health Checks are done so on the basis of their current and past smoking behaviour. However, there is no standard treatment embedded into these checks to reduce smoking. There is ample evidence from the UK and around the world that doing so could substantially reduce smoking in this key at risk older population[21]. The cost estimates here are based on research studies and may overestimate the real world costs.

35. Working with UCL and Landman Economics we have modelled the impact of investment in the interventionsabove in para 35 to show their impact over time, the cost to the government and the benefits to public finances over the next 5 years of this additional investment. The costs of these new programmes are estimates as many of them are novel.

Intervention	**Reductions in smoking rates by 2030**	**Reductions in smoking rates by 2035**	**Estimated cost to government per year**
Opt out referral by GPs	0.52%	0.91%	No additional costs requirement through QoF

Targeted support in community MH	0.01%	0.02%	£15m
Targeted support in IAPT settings	0.14%	0.26%	£23mn
Mass media C2DE	0.14%	0.22%	£9mn
Mass media ABC1	0.04%	0.11%	
Support integrated in Lung Health Checks	0.31%	0.50%	£50m
Cumulative	1.16%	2.02%	£97mn

36. The £97mn annual investment will lead to an impact on public finances in 2030 of £894mn and by 2035 of £1.7bn. Without this investment, smoking rates are unlikely to fall at this accelerated rate and Government would therefore forgo the benefits to public finances.

37. In addition to the public finance benefits, the additional reductions in smoking rates could create an estimated 42,800 jobs in 2030 in the labour market and 76,600 in 2035 through improved productivity and the boost to the economy of smokers switching their spending to goods and services that generate more UK jobs. The benefits would be weighted towards disadvantaged areas with higher levels of smoking.

'Polluter pays' levy on tobacco manufacturers

RECOMMENDATION 3: Raise revenue to fund a shift to prevention through a scheme of price cap regulation of wholesale tobacco prices and create a ~£700mn levy on the tobacco industry that will place limits on industry's ability to manipulate prices and make excess profits.

38. Tobacco companies make excessive profits because of their monopoly-like pricing power. Imperial Brands and Japan Tobacco International (JTI) together control 81% of the UK market for factory made cigarettes and together with Philip Morris International (PMI) and British American Tobacco (BAT) account for about 95% of the tobacco market.[22] These four companies are the largest of the tobacco transnationals known globally as 'Big Tobacco'.

39. In other UK markets where monopoly-like pricing power could be an issue, we tend to regulate the prices the relevant companies can charge, for example for water, gas, and electricity. These are life enhancing products, yet we think it appropriate to limit their profits by regulating prices; why not also do so for tobacco.

40. This should be carried out in two stages.
    - **Step 1** A corporation tax surcharge, as applied to banks, could be implemented immediately through the Finance Bill. It has been estimated that a corporation tax surcharge on profits could raise £74 million from tobacco transnationals.[43]
    - **Step 2** Implement legislation to cap industry wholesale prices, and hence profits, while maintaining the retail price through additional taxation, which has been estimated could raise up to £700 m a year.

41. The government imposes a corporation tax surcharge on energy companies and banks to address their excess profitability. However, tobacco companies make proportionally far greater excess profits selling cigarettes which, unlike energy and banking, have only detrimental impacts on society. For example, Imperial Brands made a net operating profit margin of 66.5% in the UK in 2023,[23] while BP's net operating profit in September 2023 was estimated to be 11.1%.[24] The average for UK manufacturing is under 10%.[25]

42. Step 1 should be the imposition in the forthcoming Budget of a corporation tax surcharge on the profits of the Big Four tobacco transnationals. This could be implemented immediately through the Finance Act, but would be a temporary measure which would only be needed until the following recommendation for price cap regulation and a 'polluter pays' levy comes into effect. As a temporary measure it would be unlikely the industry would try to restructure their operations to avoid it, given the time and costs involved to do so.

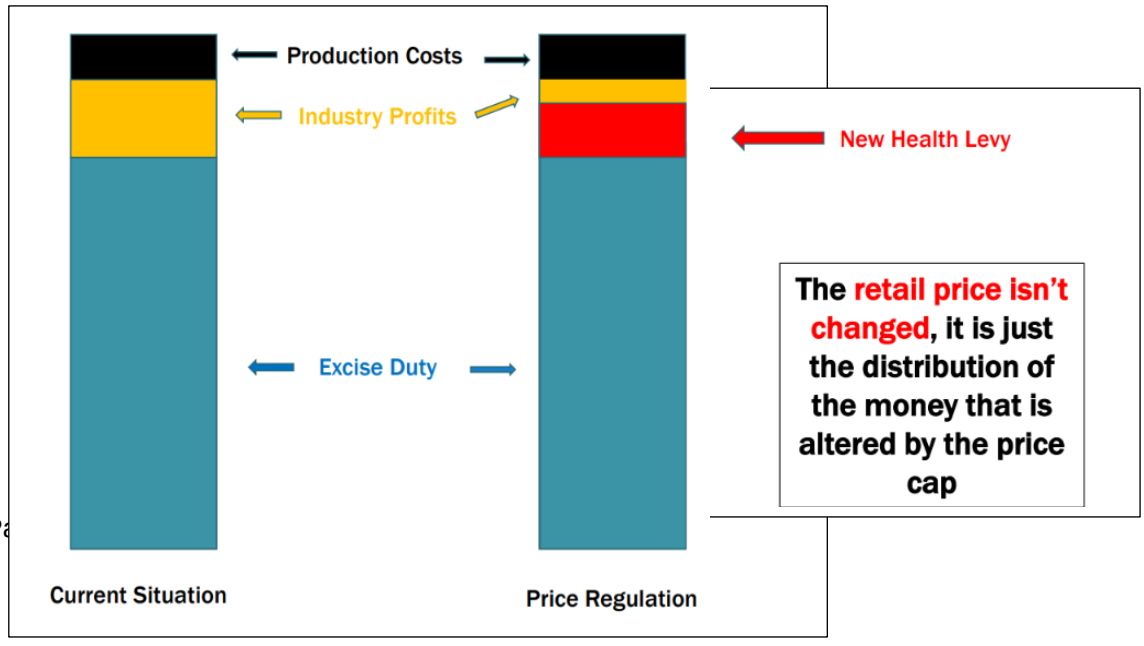
43. However, a corporation tax surcharge would not sufficiently address the industry's excess profitability. Detailed analysis has revealed that between 2009 and 2016 Imperial Brands, the British company which is the market leader in the UK, received £35 million more in corporation tax refunds/credits than it paid in tax.[26]

44. To address this, for the longer-term, we propose a 'polluter pays' levy scheme to cap producer prices and hence profits. Prior to leaving the EU such a scheme was prohibited by EU legislation, which meant that a levy could only be imposed as a form of excise tax which could be passed on to consumers. That is why after consulting on a levy on tobacco manufacturers in 2014[27] [28] HM Treasury decided not to proceed,[29] having concluded that manufacturers and importers would fully pass the levy on to consumers by raising retail prices.

45. We are no longer subject to EU legislation, and the polluter pays model we propose can now be implemented. The primary legislation necessary was tabled as amendments to the Health and Social Care Bill.

46. The straightforward 'polluter pays' model, explained in the ASH policy paper 'Establishing a Smokefree Fund'[30] overcomes these problems by:
    - Capping wholesale prices, thereby preventing the industry from passing the levy on to consumers (EU exit dividend – previously prevented by the EU Tobacco Tax Directive)
    - Ensuring consumer prices don't fall, which could stimulate increased smoking - the difference between current wholesale prices and capped prices would be taken as a health promotion levy.

47. Analysis carried out for the APPG on Smoking and Health has estimated that a 'polluter pays' levy could raise £700m in year one, if tobacco industry profits were limited to a maximum of 10%, not unreasonable given the margins for UK manufacturing.[31] [32] This could be implemented through primary legislation, backed up by more detailed regulations. The levy could apply throughout the UK and therefore the appropriate proportion should be allocated to the devolved nations. The diagram below demonstrates how this would work, with each bar representing the wholesale price.



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48. A new health levy imposed by HMT would ensure that retail prices remained the same after wholesale prices were capped with the difference accruing to government revenues.

49. Furthermore, it would provide a greater stimulus to tobacco manufacturers to move out of selling tobacco; the excess profit currently made from selling combustible tobacco products is a major incentive to continue to actively sell and promote these products.

50. A scheme for tobacco could limit the wholesale price that manufacturers can charge, thereby limiting profits, while also preventing price being used as a marketing tool, which unfortunately tax policy, despite the introduction of a minimum excise tax (MET), has been unable to do. A new health levy would be needed to make sure retail prices did not drop.

51. DHSC has the expertise to monitor company profits to set the price and close loopholes. There is a team in place which already does something similar for medicines, with many more manufacturers and a large and diverse product range. The tobacco market is much simpler, with two main commodity products - factory made cigarettes and handrolled tobacco - and four manufacturers responsible for 95% of the market. Approximately one full time equivalent is all that would be needed to carry out the work required to monitor the tobacco market.

Funding for International Tobacco Control: £2 mn pa Official Development Assistance (ODA) funding to support WHO FCTC implementation in low and middle-income countries (LMICs)

52. The last Labour government was instrumental in the development and adoption of the first WHO health treaty, the Framework Convention on Tobacco Control (FCTC), helping to negotiate a strong and meaningful treaty and ensuring the UK was among the first countries to ratify the FCTC. Next year will mark the UK's 20th anniversary of joining the Convention and we have been an exemplar for how implementing the treaty can reduce smoking rates. We have also supported implementation of the Treaty by low and middle-income countries (LMICs).

53. In 2017 the UK invested £15 million over five years to set up the FCTC 2030 project[33] to support LMICs to achieve the Sustainable Development Goals.[34] The project, delivered by the FCTC Secretariat with support from WHO and UNDP, focuses on policy change and capacity building for both government and civil society actors, making available UK experience and expertise in implementing strong tobacco control.

54. The UK's contributions have been from DHSC's ODA budgets. Funding has been sustained after the first five years, but at a lower level, reduced from £3mn to £1mn for the financial year 2024/5. We recommend that this project continues to be supported at a rate of £2mn a year. Given the project's record of delivery, and the global profile in tobacco control that it gives the UK, this is a small investment with a big impact, which should be sustained.

55. In 2020 the United Kingdom was awarded a 2020 United Nations Inter-Agency Task Force Award for the FCTC2030 project.[35] An independent evaluation of the project at the end of the first 5 years concluded that the FCTC 2030 programme provided value for

money and the financial inputs led to substantial changes and progress in respective countries.[36]

56. Globally, tobacco kills more than 8 million people each year, including an estimated 1.3 million non-smokers who are exposed to second-hand smoke. This is 15% of all deaths,[37] causing a greater number of deaths than air pollution, obesity, or alcohol. Annual deaths from tobacco are higher than that from COVID in the peak pandemic years of 2020 and 2021.[38] Globally, unless action is taken, tobacco could kill as many as 1 billion this century, the overwhelming majority of whom will live in the global south.[39]

Appendix 1: Evidence underpinning current funded initiatives

Stop Smoking Services

57. Specialist treatment for tobacco dependence combining behavioural support with pharmacological interventions and provided by local authority stop smoking services, is one of, if not the most cost-effective healthcare interventions and is cost-saving, not just cost-effective.[40]

58. Success rates are on average three times as high for smokers using the stop smoking services than quitting unaided.[41] It has been estimated that for every £1 invested in Stop Smoking Services, £2.37 will be saved on treating smoking-related diseases and reduced productivity.[42]

59. Stop Smoking Services are atypical in not conforming to the inverse care law. In fact, although throughput has fallen following cuts in funding for the services and their promotion, in 2023/24, 24% of those setting a quit date came from people working in routine and manual occupations compared to 10% from those working in professional and managerial jobs.[43]

60. Although a higher proportion of routine and manual workers smoke (22.8% compared to 8.3% for professional and managerial workers), **Error! Bookmark not defined.** more than a third of t he population aged 16+ work in professional and managerial jobs, compared to fewer than a quarter in routine and manual employment (33.1% compared to 23.3%).[44] When these two countervailing factors are taken into account it is still the case that more routine and manual smokers quit using Stop Smoking Services than those in professional and managerial occupations.

61. If the government is to deliver on its commitment to reduce inequalities, the additional funding commitment of £70 mn pa for the next five years for the local authority-provided stop smoking services must be maintained in addition to the £70mn LA are currently spending.[45]

Financial incentives for pregnant smokers

62. Smoking cessation support for pregnant smokers has already delivered substantial benefits. Smoking is the leading modifiable risk factor for poor birth outcomes, including miscarriage, premature and stillbirth, and sudden infant death. Between 2015 and 2019, after cuts in real terms funding of 41% to local authority Stop Smoking Services,[46] smoking prevalence at time of delivery barely changed, averaging 10.6%.[47]

63. In 2019 the NHS began rolling out treatment for all pregnant smokers through maternity services. Since the start of the programme, smoking prevalence at time of delivery has fallen from 10.4% to 7.4%.[47] If rates had stayed at 2019 levels there would have been an additional 16,800 women smoking at time of delivery last year.

64. Financial incentives will increase the rate of decline and are a highly cost-effective intervention, with a long-term cost per QALY of £482 and an estimated return on investment of £4 for every £1 invested.[48] [49] Funding for financial incentives for pregnant women and their partners, currently only committed to the end of 2024/5, should be sustained throughout this parliament.

Swap to Stop

65. The most popular, cheapest, and effective aid to quitting are nicotine-containing e-cigarettes, which have been found to be nearly twice as effective as traditional nicotine replacement therapy such as patches and gums, and as effective as the most effective prescription smoking cessation treatments, varenicline and cytisine. [50]

66. The ‘Swap to Stop’ campaign, which provides free vapes to smokers trying to quit through the stop smoking services, was piloted in social housing in Salford with support from Stop Smoking Services provided by community pharmacies. Throughput to the Services increased fourfold year-on-year, with 5 times as many successful quits for the most deprived quintile. After the pilot finished quitting rates reduced back to previous low levels. Despite the additional cost of the e-cigarette kit, the increased success rate meant that the Swap to Stop pilot was less than half the cost per quit than the standard stop smoking service offer including NRT.[51]

67. In the light of the evidence of effectiveness and cost-effectiveness set out above, the existing two-year programme, to roll out 1 million free vapes by the end of F/Y 2024/5,[45] should be sustained for the whole of the current parliament.

Communications and marketing campaigns

68. Although most people who smoke say they want to quit, because it is so addictive, on average smokers take thirty attempts before they successfully quit.[52] Smokers can only successfully quit if they are motivated to make an attempt, and to keep trying until they succeed, and multi-media behaviour change campaigns are the most effective and cost-effective way to motivate them.

69. The Chancellor announced that one of the immediate savings being considered in the current and subsequent financial years was to *“review the hundreds of millions spent each year across government on communications and marketing campaigns, with a view to making reductions.”* [53] Clearly such spending should be reviewed, but it would be the falsest of false economies to cut the £15 million a year budget recommended by the Khan review,[54] and committed in the last parliament for *“new national campaigns to explain the legal changes, the benefits of quitting and the support available.”* [45]

70. Mass media anti-smoking campaigns play a key role in motivating smokers to quit and succeed.[55] In 2008, 40% of adult smokers in England had tried to quit in the past year, in 2018 this had fallen by a quarter to only 30%. Over the same time period government funding for mass media campaigns had fallen by 90% in monetary terms from £23.3 million in 2008/9,[56] to around £2.16 million in 2018/19.

71. In 2012, the annual Public Health England anti-smoking campaign, Stoptober, was estimated to have generated an additional 350,000 quit attempts in England and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group.[57] A further evaluation of subsequent campaigns indicated a prolonged effect over the first six years of Stoptober campaigns in England with greater impact when campaign budgets were higher. [58] When due to funding cuts the national spend on anti-smoking behaviour change campaigns, Stoptober, only ran on digital media in 2016, there was a reduction in campaign recognition from 71% the previous year to 48% and the campaign was less effective at reaching older and poorer smokers.[58] The evidence is clear that exposure to campaigns is needed to drive awareness; digital and social media alone are not effective.

72. In the North East of England where mass media campaigns continued, run by Fresh, the tobacco control programme funded by the region, the campaigns have been associated with faster rates of decline in smoking prevalence and greater reductions in smoking rates in routine and manual workers. In 2005 when Fresh was set up, smoking rates were 20% higher than the England average and the disparity was growing. The central pillar of Fresh’s strategy has been regional health behaviour change campaigns, which been associated with the fastest rate of declines in the whole of England. In 2005, smoking rates

were 21% higher than the average for England (29% compared to 24%);[59] in 2022 they were only 3% higher (13.1% compared to 12.7% for England).**Error! Bookmark not defined.**

73. There is also good evidence internationally that behaviour change mass media campaigns are effective, but that there is a threshold level for mass media campaigns which need to have sufficient intensity and be sustained over time if they are to translate into population reductions in smoking prevalence.[60] There is also a dose response relationship.[58] [61] This is no surprise; it is why big commercial brands sustain their advertising campaigns year in year out and continue to advertise on broadcast media to drive awareness. Broadcast media (TV and radio) are also the most trusted media, while trust in the Internet and social media is low.[62]

74. Detailed analysis of campaign impact in the US and Australia demonstrates that population behaviour change can be driven by mass media campaigns delivered with sufficient and sustained intensity.[63] [64] Such campaigns have immediate impact and can be targeted with precision at disadvantaged smokers, which is essential given their higher smoking rates, higher levels of addiction and lower success in quitting.[65] [66] [67] [68]

75. Behaviour change campaigns like this are both effective and cost-effective. The FDA's Tips from Former Smokers campaign,[69] [70] delivering 11 ads a quarter to the target audience from 2012-15, led to over half a million sustained quits during 2012–2015.

76. The campaign, indirectly funded by the tobacco manufacturers through the government's user fee legislation, has been sustained.[71] The US Centers for Disease Control and Prevention estimates that from 2012–2018 more than 16.4 million people who smoke have attempted to quit, and approximately one million have successfully quit because of the Tips campaign. The campaign was equally effective by subgroups of race/ethnicity, education and mental health and the effects have been durable over time.[72]

77. A comprehensive evaluation of the campaign between 2012 and 2018, which factored in smoking relapse, inflation, and advertising and evaluation, demonstrated that the campaign was associated with healthcare cost savings of $11,400 per lifetime quit, and $5,300 per quality-adjusted life year gained.[73] [74]

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