Smoking & economic recovery from COVID-19

Smokefree Councillor Network

Councillor Briefings

Key points:

- The COVID-19 pandemic has exposed and exacerbated pre-existing poor health and inequalities which left England on the back foot entering the pandemic
- Smoking is responsible for at least 50% of the difference in life expectancy between rich and poor in England putting the nation at a disadvantage entering the pandemic and stalling progress to recover from it
- Comprehensive tobacco control is key to equitable recovery from COVID-19 and future resilience building – it should be central to local, regional, and national recovery plans

Smoking, inequalities, COVID-19, and health

Entering the COVID-19 pandemic, England was in poor health. In March 2020, the Office for National Statistics stated that:

- improvements in life expectancy were slowing;
- health inequalities between the richest and poorest were widening; and
- "those living in the most deprived areas can expect to spend almost two decades less in good health than their counterparts in the least deprived areas."

Smoking remains the leading cause of preventable illness and death in the UK, seriously undermining the population's health and resilience. Smoking kills around 75,000 people every year in England alone, more than obesity, alcohol, drug misuse, HIV and traffic accidents combined. For those who smoke, no other aspect of their life will impact their health as significantly. On average, people who smoke die 10 years earlier and for every person killed by smoking, another 30 live with a serious smoking-related illness. People who smoke receive social care support 10 years earlier than never-smokers on average, at 63 years old, rely heavily on unpaid carers such as relatives and friends and are 2.5 times more likely to have unmet care needs.

The impact of smoking is not felt equally across society. Around 1 in 4 people in routine and manual occupations smoke, compared to 1 in 10 in managerial and professional occupations. Virtually every indicator of disadvantage is associated with higher smoking rates. Consequently, smoking is the leading cause of health inequalities, accounting for half the difference in life expectancy between the richest and poorest in society.

Smoking-related diseases which increase a person's risk of dying from COVID-19, such as diabetes, respiratory and cardiovascular diseases, are disproportionately common among those living in the most deprived areas, where smoking rates are highest. This

Annual costs of smoking in England:

- **£11.7bn** from unemployment and reduced earnings [1]
- **£2.4bn** in NHS treatment costs for health problems [2]
- **£1.2bn** in local authority social care costs [3]
- **£325m** in Fire and Rescue Service costs [2]

[1] ASH, Smoking, employability, earnings local breakdown, 2020 [2] ASH, Ready Reckoner, 2019 [3] ASH, The cost of smoking to the social care system, 2021

The above resources breakdown to local authority footprints, allowing you to see the cost of smoking to your community.

Produced by ASH, June 2021

likely in part explains why people living in the most deprived areas of the country are twice as likely to die from COVID-19. As a result of these inequalities, COVID-19 is recognised by public health experts not as a pandemic, but as a 'syndemic' - a co-occuring synergistic pandemic that is interacting with and increasing social and economic inequalities. Addressing these social and economic inequalities, of which smoking is a key driver, is integral to addressing the impact of COVID-19.

Poor health, poor communities

Communities cannot be productive unless they are healthy. By undermining the health of our communities, smoking also undermines economic security and prevents growth. As a result of disability and illness caused by smoking and controlling for other factors, long-term smokers are on average 7.5% less likely to be employed than non-smokers. Smokers still able to work earn an average of 6.8% less than non-smokers, equating to a loss of £1,424 per year. This is in addition to the average £1,355 annual cost of tobacco, giving a total average annual penalty of £2,759 per year for each employed person who smokes.

For disadvantaged smokers, this penalty is likely to be both greater in cost, given smokers from low socioeconomic groups face higher levels of addiction and smoke more, and greater in overall impact, as the income lost on tobacco will be a greater proportion of total income, compared to a smoker from a higher socioeconomic group. For example, on average, smokers living in social housing, who face some of the highest rates of smoking and levels of addiction, lose 14.6% of their disposable income to tobacco, whilst smokers who own their own homes lose 6.9%. For some, this penalty makes all the difference – almost half a million households, home to over 1 million people including 263,000 children, live in poverty across the UK as a direct result of income lost to tobacco addiction.

Supporting people to quit not only delivers substantial health benefits, but also immediate financial benefits in a way few interventions can - putting money directly back into the pockets of people in the community as soon as they start their quit attempt. Supporting smokers to quit also improves wider economic security through improved employment prospects - while long-term smokers are significantly less likely to be employed than non-smokers, ex-smokers are just 2.5% less likely to be in employment than non-smokers.

What can councillors do?

1. **Advocate for the delivery, funding, and prioritisation of comprehensive local tobacco control strategies** which set targets for reducing local smoking prevalence and maximising the proportion of local smokers making a quit attempt every year, in line with The End of Smoking guidance. Consider opportunities to work collaboratively with other local authorities across larger geographies to increase the cost-effectiveness of interventions such as mass media campaigns and illicit tobacco enforcement activity.
2. **Ensure that tobacco control activity forms a core part of local COVID-19 recovery** and that recovery strategies are joined-up with local tobacco control strategies. Make the case to colleagues responsible for local economies and growth that addressing smoking is vital for healthy, productive, resilient communities.
3. **Support national campaigns** for government to adopt recommendations made by the APPG on Smoking and Health needed to deliver the Smokefree 2030 ambition. Join national organisations, including medical royal colleges, the Association of Directors of Public Health, Faculty of Public Health, The Health Foundation, and others, by endorsing the APPG's recommendations as an individual and with your council.

Produced by ASH, June 2021