Finance Committee

Prevention

Submission from Cancer Research UK

Cancer Research UK and our work in Scotland

Cancer Research UK[1] is the world's largest independent organisation committed to research on cancer. In 2014/15, we spent £341 million on research with a view to improving our understanding of the causes of cancer, and to come up with strategies focused on prevention, diagnosis and treatment of different forms of the disease.

We spend over £31 million in Scotland every year on some of the UK's leading clinical and scientific research. Our researchers based in Edinburgh focus particularly on bowel, brain and women's cancers, whilst those based in Glasgow concentrate on pancreatic and bowel cancers, and chronic myeloid leukaemia. Or scientists in Glasgow first produced the brain cancer drug, Temozolomide, and Edinburgh drug discovery scientists recently pioneered a possible new means of delivering chemotherapy more precisely to tumours.

Our research strategy, launched in May 2014, makes a significant commitment to prevention research. This includes the establishment of a cancer prevention initiative, which includes a policy research centre for cancer prevention and separate funding committees to commission research into tobacco and e-cigarettes respectively. This initiative is overseen by Professor Linda Bauld (also Professor of Health Policy at the University of Stirling).

Cancer Research UK welcomes the opportunity to outline its position in relation to this inquiry on prevention spending recommendations by the Scottish Government.

The economic case for preventing cancer

More than four in ten cases of cancer diagnosed in the UK are attributable to lifestyle and environmental factors[1]. This includes 64,500 cases of cancer in the UK which are attributed to tobacco, and 49,100 which are attributed to overweight and obesity, not having a healthy, balanced diet and lack of physical activity.

Well-funded prevention research projects, coupled with strategic investment in service delivery and a long-term commitment to initiatives which address deep-rooted inequity in public health, must become national priorities for health policy.

Despite increases in funding to local authorities between 1999/2000 and 2014/15, a peak was reached in 2009/10[2] and by 2015/16 funding is expected to be at least 10% less than this peak, after adjusting for Fire and Police[3]. We envisage this has the consequential impact for cancer prevention that either (a) more will need to be

done with less and/or (b) alternative funding avenues will need to be sought to maintain service provision[4].

In the case of these funding pressures, it is critical that their impact must be managed responsibly to protect stop smoking services, health promotion and behaviour-change campaigns, and the provision of exercise and leisure facilities, to support people to stack the odds of not developing cancer in their favour.

Tobacco

Issue one: Tobacco use remains the UK's single greatest cause of preventable illness and avoidable death, with 100,000 people dying each year from smoking-related diseases, including cancer[5]. At 21.1%, smoking prevalence in Scotland is higher than the other UK nations[6]. This equates to an estimated 9.4 million UK adult cigarette smokers, whilst Scotland also has a lower 'never smoked' rate compared to England and Northern Ireland[7]. Households in Scotland spend £6.00 on cigarettes, compared to just £3.50 in England[8].

It is estimated that smoking causes nearly a fifth of all cancer cases in the UK, and more than a quarter of all cancer deaths[9,10]. Despite the long-term decline in smoking rates for over 40 years, smoking remains the leading cause of preventable death and disease in the UK.

The report of the Independent Cancer Taskforce in England has set out an ambition to reduce adult smoking prevalence to less than 13% by 2020 and less than 5% across all income groups by 2035[11], with the aspiration for a 'smoke-free Britain'[12] recognised by the Government. Scotland's tobacco control strategy, published in 2013, already sets out 5-year milestones to achieve an aim of 5% prevalence by 2034[13]. The progress of this target will be monitored through the Scottish Household Survey, with data for the 2016 milestone to be published in Autumn 2017.

Research from Action on Smoking and Health (ASH London) highlights that the total cost of tobacco use to society in England is £13.8 billion a year[14]. By comparison, tobacco duty receipts in England in 2013/14 were only £7.6 billion[15], meaning the societal costs of tobacco use in England alone is more than £6 billion, the situation in Scotland is likely to be similar. Of further concern is data from the Office of National Statistics (ONS) which shows that in 2013, there was marked national variation in the average weekly household expenditure on cigarettes.

A 2014 report (part-funded by CRUK) found that of the £124bn Net Monetary Benefit gained from prioritised intervention resulting from cancer-related research (1991-2010) £80 billion (or 65%) arose from reductions in smoking: (the numbers for the increased proportion of the population who were non-smokers or ex-smokers is based on self-reported survey data)[16].

Policy recommendation one: To achieve its ambition of a tobacco-free Scotland by 2034, the Scottish Government needs effective strategies to reduce prevalence across all income quintiles, including:

- **A full refresh of Creating a Tobacco Free-Generation, reviewing and setting out the next steps required to meet the ambition of 5% smoking prevalence by 2034.**
- **Demonstrating leadership to ensure obligations and guiding principles of the WHO FCTC are met, including implementation of the measures in the revised Tobacco Products Directive as well as standardised packaging of tobacco products.**

Issue two: Tobacco-related health inequalities have proven persistent, despite the long-term successes of tobacco control strategies in driving down national smoking prevalence. Tackling inequality must be at the heart of any strategy to address the detriment of tobacco use. Without reducing smoking prevalence in the most disadvantaged groups, policies designed to reduce health inequalities will have limited success[17].

38% of adults in the most deprived quintile in Scotland smoked in 2011, compared to just 12% in the least deprived quintile[18]. Survey data from the Scottish Household Survey (SHS) suggests that adults in the 15 per cent most deprived areas of Scotland are twice as likely to be current smokers as those in the rest of the country (40% and 20% respectively).

The majority (55%) of Scots who are unemployed and seeking work are current smokers. With an unemployment rate of around 5.9%, or 162,000 people, this equates to around 89,000 unemployed people vulnerable to the lethal harms of tobacco[19 20]. Almost half (47%) of those in Scotland who are unable to work due to short-term ill-health, or those who are permanently sick or disabled (46%), are current smokers[21]. Households in the 15% most deprived areas of Scotland have a higher rate of no paid employment than the rest of Scotland. [22]

As one example, Glasgow remains as a striking example of regional inequality. A boy in the deprived Calton area of the city has a life expectancy of 54, compared with a boy from the Lenzie area (just 12km away) who could expect to live to live to 82[23]. While reasons are not entirely understood, numerous studies note both the significantly higher smoking rates and rates of 'heavy smoking' in Glasgow as a major contributory factor to the poor health outcomes in the area[24,25]. In Renfrew and Paisley, a study collating data over a 28-year period shows that never smokers in the lowest social classes had better survival outcomes than smokers in the highest social classes, suggesting the impact of smoking on health inequality compared with social position[26].

An analysis by the National Cancer Intelligence Network undertaken with Cancer Research UK demonstrated that economic inequality is linked to around 15,000 extra cases of cancer and around 19,000 extra cancer deaths every year in England[27]. Over half of those deaths, 11,000 each year were linked to lung cancer. 86% of lung cancer cases in the UK are attributable to smoking[28]. Lung cancer risk is more dependent on smoking duration (i.e. the number of years) than amount smoked (number of cigarettes smoked each day)[29,30,31]. Smokers who quit - even well into middle age - avoid most of their subsequent risk of lung cancer. Quitting before middle age avoids more than 90% of the risk attributable to smoking[32].

Tobacco industry pricing strategies undermine policies to reduce health inequalities. In recent years 'Ultra Low Price' (ULP) cigarette brands have proliferated in the UK market[33]. Examining the real price of individual ULP brands shows that some have fallen by as much as 5%[34] giving smokers access to cheaper tobacco. Research shows that between 2006 and 2009, the ULP market doubled[35]. There has been an increase in the sales volumes of economy brand cigarettes and the use of hand rolling tobacco which is undermining efforts to reduce smoking rates[36].

Individual level smoking cessation interventions, unless specifically targeted to address inequalities, are at risk of widening health inequalities. NHS stop smoking services are successful at preferentially enrolling those of lower socio-economic status providing balance for the fact that success rates for quit attempts are lower in these groups[37]. Given that behavioural support and prescription medication from the NHS stop smoking services offer the best possible chance of smoking cessation, it is of concern that popularity has decreased over the previous two years[38], with the rise in the popularity of e-cigarettes.

Tax induced price rises are one of the most effective ways of reducing tobacco consumption, something the tobacco industry itself admits[39]. The benefit of a tax induced 5% year-on-year increase in the weighted average price of cigarettes would be up to £485 million in the first year and £7.4 billion over the next five years[40].

In July 2015, following *Tackling illicit tobacco: from leaf to light*[4142], HMRC received additional funding to tackle illicit tobacco fraud of £95 million by 2018-19[43]. These resources are vital to enable HMRC to take a tough approach against illicit tobacco smuggling – including the role of manufacturers in its facilitation[4445].

Policy recommendation two: A strategy to reduce smoking related health inequalities should include the following:

- **Advocating for the UK Government to implement a minimum consumption tax for tobacco products, as consulted in 2014, coupled with a tax escalator on cigarettes of 5% above inflation and 10% above inflation for hand rolling tobacco**
- **Sustained support for smoking cessation programmes to ensure that 'gold standard' NHS stop smoking services are and available and delivered to support all smokers interacting with the services**

Issue three: The massive health and economic benefits which can be realised by driving down smoking rates is threatened by a strain on the resources of competent authorities. It is predicted that funding to local authorities could be 10% less in 2015/16 than it was in 1999/2000[46]. Local authorities must be resourced to ensure they can provide smokers with 'gold standard' stop smoking services. The combination of behavioural support and prescription medication offered through stop smoking services offers the best possible chance of quitting[47,48]. It is of concern that their attendance in Scotland has decreased by 13% between 2012 and 2013, perhaps partly due to the rise in e-cigarette use[49]. According to the National Institute for Clinical Excellence (NICE), every £1 spent on smoking cessation saves £10 in future health care costs[50].

A levy on tobacco manufacturers and importers could raise £500 million per annum to fund stop smoking services; mass media campaigns and increased resources to tackle the illicit trade. The money would come directly from the tobacco companies – it is not an additional tax on the product – the proportion of payment would be based on the market share of each company. In July 2015, following consultation[51], the UK Government missed an opportunity to plug a gap in health finances by not introducing a levy and failing to set out an alternative mechanism to ensure these vital services are maintained[52].

Policy recommendation three: Funding for, and investment in, tobacco control can be achieved through the following:

- **Supporting the introduction of a financial levy for tobacco manufacturers and importers, hypothecated for the provision of public health in particular, stop smoking services and tobacco control mass media campaigns**
- **Funding for the responsible agencies to effectively tackle the illicit tobacco trade and enabling the UK to meet the requirements of the *Illicit Trade Protocol*[53] - which should be ratified without delay**
- **Investment to ensure that local authorities are sufficiently resourced to guarantee delivery of standards consistent with NICE guidance[54,55,56]**

Obesity

Issue: Obesity represents a serious and growing threat to the NHS, causing 18,100 cases of cancer each year, as well as a range of serious health conditions. It is estimated that excessive weight costs the NHS £5.1bn directly per annum[57], and broader costs to society approximately £16bn[58].

Scotland continues to have the worst weight outcomes of any of the UK nations. Almost two-thirds (64.6%) of Scots are overweight or obese, compared to 62.1% in England. Similarly, 27.1% of people in Scotland are obese, compared to 24.9% in England. Scotland has the lowest household expenditure on fresh fruit and vegetables of any UK nation, at £6.00 per week compared to £7.60 in England[59].

Evidence from England demonstrates that obesity is starkly linked to deprivation for adults[60], whilst children from the most deprived backgrounds are up to twice as likely to be overweight or obese as the least[61].

In 2010, the Scottish Government introduced a *Route Map Towards Healthy Weight,* which sets out a long-term strategy to tackle overweight and obesity. It has set a national indicator "to increase the proportion of healthy weight children"[2] alongside a number of interventions and initiatives supported by £200 million investment in sports and health budgets.[62] The Scottish Government has developed a vision for becoming a *Good Food Nation by 2025* and has produced *Supporting Healthier Choices: a framework for Voluntary Action* to shape healthier diets in Scotland.

Tackling obesity will make a demonstrable cost saving. To echo a recent report into the economic impact of obesity policies, the Scottish Government should aim to do 'as much as possible as soon as possible' through comprehensive policy

[2] *Percentage of children aged 2-15 years whose Body Mass Index lies within a healthy range (between the 2nd and 85th percentile of the UK growth reference charts)*

interventions[63]. We welcome proactive measures by the Scottish Government to address this, including expressing support for introducing restrictions on junk food and alcohol marketing to children on television before the 9pm watershed[64].

Policy Recommendation: The Scottish Government should lobby the UK Government to implement the following measures, or do so themselves where they fall within devolved competencies:

- **Measures to restrict the marketing of unhealthy food, including a pre-9pm watershed ban on TV junk food adverts, a review of online marketing of unhealthy foods and drinks products to children and tighter rules to significantly restrict the placement and content of unhealthy food marketing online**
- **A new accountability framework with food businesses to deliver reformulation and reduced portion sizing to reduce free sugars, saturated fat and calories in the food supply. This should follow government-led national standards, being transparent and involving rigorous monitoring and evaluation.**
- **Fiscal measures to tackle the drivers of unhealthy diets such as the introduction of a 20p/litre duty on sugar-sweetened beverages, to tackle the issue that teenagers consume 30% of their 'free' sugars from sugar sweetened beverages. This should extend to examining the case for further fiscal measures on foods high in sugar, salt and fat where appropriate, and improving the affordability of healthier alternatives.**
- **Measures to promote physical activity including sustained investment in active travel options such as cycling and walking, and supporting local authorities to ensure appropriate access to recreation facilities and open space, particularly for deprived groups**

Alcohol

Issue: The health harms from alcohol place a significant burden on the economy and the NHS. Estimates from the Scottish Government show that the cost of alcohol misuse to the NHS was about £270m a year, and the cost to the economy was £3.6bn per year (at 2007 prices)[65]. Across the UK, the direct cost to the NHS is estimated to be £3.5bn a year and the cost of alcohol-related cancers alone is estimated at £728m[66 67]. Alcohol is a highly modifiable risk factor for cancer.

Alcohol consumption is strongly linked to health inequalities, with people from deprived groups suffering far greater harm from alcohol than those from higher socio-economic groups. In Scotland, there are over 6 times as many alcohol-related deaths in the lowest socio-economic quintile compared to the highest quintile[68]. Scotland has the highest household expenditure on alcohol of any UK nation, at £14.90 per week compared to £11.90 in England[69].

We are concerned that alcohol is now 61% more affordable than it was in 1980[70]. There is a relationship between alcohol related mortality and socioeconomic status in England and Wales with progressively higher rates in more deprived areas[71]. It has also been found that tobacco and alcohol related cancers in the UK are 2-3 times more common in areas of the most deprivation than the least[72]. There is clear

evidence that policy interventions focused on price increases translate to both reduced consumption and reductions in alcohol-related harm[73].

Policy Recommendation: A comprehensive alcohol harm reduction strategy should be implemented, including:

- **Measures to tackle the price, marketing and availability of alcohol as detailed in *Health First*[74], including implementing a minimum price of 50p per unit of alcohol with a mechanism to regularly review and revise this price**
- **Better health information on alcohol products**
- **Sustained funding for evaluated health marketing campaigns**

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