Cost Effectiveness of Stop Smoking Services in Wirral: 2012/13 Update

- We refreshed the smoking model with data for 2012/13 financial year.
- The number of people setting a quit date in 2012/13 was 5,403 of whom 42% quit at four weeks. The number of quits in 2012/13 was 2,259 compared with 3,379 the year before (so was one third lower).
- The number of quits in pregnant women had risen significantly from 21 in 2011/12 to 69 in 2012/13 which was very positive.
- The costs of the service, including NRT and drug costs, were 15% lower than the year before.
- Overall the cost per QALY gained was estimated at £14,882 per QALY gained which was higher (i.e. less cost effective) than the previous year but would still be considered to be cost effective. As with the previous year, using the results from the NICE economic model the interventions would come out as cost saving in the long term but other models use a higher long term quit rate than the 8% we have used.
- Since the first smoking report was produced NICE have produced guidance PH45 recommending a harm reduction approach for some smokers who cannot quit suddenly. This has not been implemented in Wirral as yet. This approach has the potential to get more smokers engaged with services, but also could be potentially less cost effective, as people would not be getting all the benefits they would if they stopped completely.
- One element with good evidence is temporary abstinence particularly for people who have been admitted to hospital; Wirral public health are currently working with Wirral University Hospitals Trust on helping to support staff and patients to abstain from smoking while in hospital.
- NICE Guidance around smoking cessation in acute, maternity and mental health services is due in November 2013 - a draft was produced in April 2013 which recommended that hospitals should reinforce their smokefree status, and support abstinence and quitting including through providing NRT and Champix.
- Electronic cigarettes have continued to get more popular, but there is little evidence on the long term safety of these products, and they are not recommended by NICE. From 2016 these products will be regulated by the MHRA (Medicines and Healthcare Products Regulatory Agency) so will be subject to more strict regulation.
- There is a new smoking cost effectiveness model that has been produced by McNeil, the company who make Nicorette, however we have not seen this yet, it seems to be based on similar data to the NICE model which we looked at in the original report.

Background

- Smoking is the single largest cause of health inequalities in Wirral. Reducing smoking in deprived populations through pricing, national policy measures, changing social norms and supporting people to quit, will significantly reduce health and social inequalities.
- Smoking prevalence in Wirral is 23%, compared to 21% nationally. In deprived areas, prevalence is more like 35%. There is a target to reduce national prevalence to 18.5% by 2015.
- Around 1 in 8 pregnant women in Wirral were still smoking at the time of delivery in 2011 (13.2%). There is a national target to reduce smoking in pregnancy to 11% or less by 2015.
- The cost of smoking to the Wirral economy was estimated to be £95m in 2012. It is estimated that Wirral smokers paid c. £78million in duty on cigarettes over the same period, so it is a myth that smokers pay for the consequences of their habit (and this is also true nationally).
- Economic modelling was used to estimate the impact of Public Health funded smoking cessation activity on health & economic outcomes for the financial year 2011/12 and 2012/13.
- The model showed that in the long term, smoking cessation activity would reduce disease prevalence, save the NHS money and increase life expectancy.
- Wirral spent just over £2.2million on stop smoking and tobacco control in 11/12 and £1.76million in 12/13 (not including all management, evaluation, environmental health and trading standards costs).
- The overall cost of Wirral smoking cessation services per **QALY (quality adjusted life year)** gained was £11,590 in 2011/12 and £14,882 in 2012/13. This figure is higher than other (published) smoking cessation services in the UK, but is still cost effective. NICE regard any prevention/ public health activities which result in a cost per QALY of £20,000 or less as a good use of resources.
- Using Wirral data, the **NICE Return on Investment Tool** predicts that over the lifetime (of those using smoking cessation services), interventions could produce a saving for the health sector.
- Triangulating this data with results from a **Value for Money tool** showed that smoking and tobacco control activity produce cost savings for local authorities and associated services (e.g Fire Service) through reduced need for social care, reduced litter and fewer fires.
- The Social Value Act (2012) requires public bodies to consider Social Return on Investment (SROI), which is the benefit generated to society, when they commission services. The SROI (Social Return on Investment) Ratio for smoking cessation in 2011/12 was between £1.71 and £2.43 for each £1 spent.
- The potential impacts of smoking cessation across the life course were outlined in the **Marmot review 'Fair Society, Healthy Lives'** and included improvements in:
    - **Child development:** Sudden Infant Death Syndrome (SIDS) and other childhood illnesses such as asthma and otitis media (glue ear) are associated with parental smoking. Children of smokers are more likely to smoke themselves, so parents quitting smoking breaks that link as well as providing immediate benefits to their child's health.
    - **Schooling:** Children of smokers are more likely to miss school through sickness and can teenagers who leaving school premises to smoke create an extra burden on teacher time, reducing smoking prevalence would help. Nine out of ten of smokers start before the age of 18.
    - **Employment:** Smoking interventions benefit employers and employees through improved productivity, reduced absenteeism caused by smoking related diseases and reduced fire risk.
    - **Income and benefits**: Smoking affects people's income due to money spent on cigarettes and lost income (smokers are more likely to be ill and off work). Up to 15% of the disposable income of smokers is spent on tobacco, so helping people to quit will ease financial pressures.

- **Healthy environment and green spaces:** A large proportion of litter is tobacco related, so reducing smoking prevalence not only reduces litter, it can also reduce the need for street cleaning. It also frees up resources to improve the living environment in other ways.
- **Transport:** There is evidence that smoking while driving contributes to traffic accidents and that people who smoke are less likely to wear seatbelts. The **British Medical Association** has called for smoking in cars to be banned.
- **Safety and crime:** Around 1 in 10 (11%) cigarettes smoked are smuggled into the UK illegally and the figure is much higher for hand rolled tobacco. Reducing smoking prevalence should therefore reduce spend on policing illegal tobacco sales. Helping young people to quit or not take up smoking could reduce the amount of money spent on policing underage sales.

Recommendations from 2011/12 report

1. Regional smoking services should be considered more often to ensure more efficient management and delivery of interventions.
2. Give services incentives to record quit status at 6 months and 12 months.
3. Incentives need to be weighted towards the most hard to reach and disadvantaged groups, including pregnant mothers and people with mental health, alcohol and drug problems.
4. All services should complete the database accurately, with redundant fields deleted and Fagerström dependence score recorded.
5. Recording of pharmacotherapy treatment (i.e. NRT, Champix and Zyban) should be made more consistent and detailed in the database.
6. Where appropriate, Wirral should consider learning from areas where smoking cessation rates are high (e.g Leeds).
7. More should be done to discourage smoking around mental health settings.
8. Pharmacists should be allowed to prescribe Champix directly to increase quit rates in the most deprived areas.
9. Services should be using new technologies to meet the needs of younger smokers.
10. Joint interventions that target cannabis and tobacco smoking at the same time should be considered.
11. Services should be tailored to meet the needs of carers who may find it hard to attend smoking cessation services, and may need additional help in finding alternative ways of coping with stress.
12. Wirral should preserve its investment in smoking cessation services, which achieve good cost effectiveness results resulting in increased quality and length of life for quitters, reducing health inequalities and cost savings to the NHS, local authorities, employers and individuals.
13. Wirral should do more to improve the quit rate amongst pregnant smokers. In 2011/12, it was just 23%, around half of the what is achieved nationally (45%).
14. Future interventions targeted at families smoking at home should consider the use of clinical markers (cotinine levels) to counter denial about the effect of smoking on family members.
15. The PbR (Payment by Results) Stop Smoking Service was relatively successful in attracting clients from target groups, so should be considered as a future service model.
16. Future PbR services need to be able to prescribe Champix as it results in the highest quit rates.
17. Senior officers in Wirral should, along with national organisations, use their voice to lobby for further smoking legislation to create an environment that decreases the social acceptability of smoking.
18. Wirral should investigate measures to discourage outdoor smoking particularly near schools, in parks, and in other areas where young people are likely to be.
19. Quitting smoking should be part of public sector culture.

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