THE COSTS OF SMOKING TO THE SOCIAL CARE SYSTEM IN ENGLAND
FOREWORD

This paper contains information of importance to every Council officer and Councillor concerned with providing social care services. It summarises new work which estimates that smoking costs the social care system £1 billion. This is made up of £600 million in costs borne by local authorities, with a further £450 million being spent by those who have to self-fund their care. It shows that current smokers, and to a lesser extent former smokers, are more likely than never smokers to need domiciliary care as they age, which in many cases will have to be paid for from Council funds.

The Care Act 2014 requires Councils with social care responsibilities to put in place preventive measures designed to reduce the need for care and support in the future. One important way in which this can be done is by helping to improve people’s health and wellbeing now, so that they are likely to require less paid for care in the future, or so that the time when they will need such care can be postponed. Therefore smoking, which remains by far the biggest single cause of preventable illness and death in the UK, is an issue that can and must be addressed in this context.

The work on which this report is based, estimates the social care costs of smoking at around £600 million. This is likely to be an underestimate because the data on which it is based does not include people aged under 50 who have relevant care needs. With Council budgets under great pressure, something which is forecast to continue for at least the next few years, planned action to cut smoking rates is likely to prove highly cost effective and improve many people’s quality of life as they age. Such action includes ensuring that stop smoking services are properly provided and funded in each Council area.

The detailed research on which the report is based contains anticipated costs for every Council. I hope that the report will be widely read by Councillors and officers and used to inform the preventive work that the Care Act now requires them to undertake. It also underlines the close relationship between the public health responsibilities that Councils now have, and their new duties under the Care Act.

Helping people to stop smoking is not just good for their health, but for the wellbeing of their families and friends. It is also good for reducing the costs of social care in the years to come, freeing much-needed public money that could be used for other key purposes. This is an important message that should be clearly understood in every Council that has responsibility for social care provision.

Paul Burstow MP
Chair: All Party Parliamentary Group on Smoking and Health
NOTE ON SOURCES

The information in this report summarises an analysis by Howard Reed of Landman Economics, for Action on Smoking and Health, entitled “The Cost of Smoking to the Social Care System in England” June 2014. The report can be downloaded at www.ash.org.uk/SocialCareCosts

Cost estimates are available for every top tier English local authority. The full information for each authority is available at: www.ash.org.uk/localtoolkit

SUMMARY OF KEY FINDINGS

<table>
<thead>
<tr>
<th>Cost to local authorities from increased social care needs</th>
<th>£600 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to self-funders from increased social care needs</td>
<td>£450 million</td>
</tr>
<tr>
<td>Increased number of people receiving social care support</td>
<td>47,000</td>
</tr>
<tr>
<td>Increased number of people receiving care from friends and relatives</td>
<td>846,000</td>
</tr>
<tr>
<td>Difference in age between when smokers and non-smokers need to access care</td>
<td>9 years</td>
</tr>
</tbody>
</table>

1 The report used data on smoking propensity and receipt of social care services in the English Longitudinal Study of Ageing (ELSA) to estimate the propensity of smokers and ex-smokers aged over 50 in England to receive domiciliary and residential social care compared with people who have never smoked. This information is combined with data on social care expenditure from the National Adult Social Care Intelligence Service (NASCIS), to estimate the proportion of public expenditure on social care which is attributable to smoking.
INTRODUCTION

The costs of smoking to the NHS and to the economy in general are well understood. However, there are also costs to the social care system, which are less well known, and have not previously been quantified.

These costs are not only those directly borne by local authorities but also the costs to those funding their own care needs and the burden on friends and family carers. All these costs need to be considered by local authority officers and members as part of their strategic approach to care issues. This is because:

- The Care Act 2014 places a duty on local authorities to enable access to services that reduce the need for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs.
- The Draft statutory guidance for the Act sets out how local authorities should implement the Act in April 2015. It includes guidance on how preventive services should be provided.

Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services.

Local authorities will also need to consider the relationship between their duties under the Care Act and those under the Health and Social Care Act 2012, which conferred new duties on local authorities to improve public health, and transferred public health functions to local authorities from the former NHS primary care trusts. Under this Act, local authorities must take such steps as they consider appropriate for improving the health of the people in their areas. Programmes such as the Better Care Fund further encourage local authorities and the NHS to work together to improve the wellbeing of communities.

However, local authorities in England are facing a particularly difficult financial position. According to the Community Care website, the overall budget available to local authorities in England fell in cash terms by 4.7% in 2011-12, 3.3% in 2012-13 and 1.7% in 2013-14. A further analysis of the 2014-15 budgets of 55 of the 152 local authorities in England with social services responsibilities found that planned spending on adult social services was 2% down in cash terms from the previous year. Allowing for inflation, this amounts to a reduction of 4% in real terms. This financial squeeze makes effective and targeted spending on preventive services all the more important.

2 http://careandsupportregs.dh.gov.uk/category/prevention/
BACKGROUND TO THE RESEARCH

The research, commissioned by ASH and carried out by Landmark Economics, compared the care needs of current and former smokers with those of never smokers. Risk ratios were derived for adults in receipt of domiciliary care and residential care separately. This analysis was used to estimate the greater extent to which local authority-funded social care services were used, as well as the costs to those funding their own care and the number of people requiring support from family and friends.

Data for this calculation was taken from the English Longitudinal Study of Ageing (ELSA). ELSA is a large scale longitudinal panel survey of people aged 50 and over and their partners. The last wave of ELSA data available to us was completed in June 2011. The ELSA data was then combined with figures on social care spending taken from the National Audit Social Care Intelligence Service (NASCIC).

The ELSA survey only looks at adults aged over 50. It was therefore not possible to calculate the proportion of social care spending on adults aged under 50 that is attributable to smoking. It was also not possible to take account of all costs that might be incurred for those over 50, for example, the cost of aids and adaptations and the cost of assessing people for care. As such this research is likely to indicate a low estimate for the social care costs attributable to smoking.

ELSA does not ask specifically whether the social care received by the individuals it surveys was paid for by the local authority or the individual care recipient. However, it is possible to use ELSA data on income and wealth to ‘simulate’ the means test applied to receipt of care funded by local authorities, and therefore to derive an estimate of the proportion of care costs that is met from local authority funds.

The data available for people in residential care was limited. Our analysis found no statistically significant difference between the proportions of smokers, ex-smokers and never smokers receiving residential care. However, further research is needed to gain a better understanding of the possible impact of smoking on residential care costs.
INCREASED CARE NEEDS CAUSED BY SMOKING

The burden on smokers as a result of illnesses caused by their addiction is significant. In the past it has been estimated that for every smoker who dies, 20 are living with a smoking-related illness. This research shows that smokers are likely to need care on average nine years earlier than non-smokers. It also found that being a smoker doubled the chances of receiving care of any sort and increased the risk for ex-smokers by 25%.

The research looked at the increased likelihood that smokers and ex-smokers would need help with 13 activities:

- Walking across a room
- Bathing or showering
- Eating
- Getting in and out of bed
- Using the toilet
- Using a map
- Preparing a hot meal
- Shopping for groceries
- Making telephone calls
- Taking medication
- Doing work around the house or garden
- Managing money

The results show that current smokers are more likely than never smokers to have difficulties with 10 of the 13 activities listed. The exceptions are: using the toilet; taking medication; and managing money. Ex-smokers have more difficulty than never smokers with two of the 13 activities: dressing; and doing work round the house or garden. Therefore, current smokers, and to a lesser degree former smokers, are more likely than never smokers to require domiciliary care.

5 Cigarette Smoking-Attributable Morbidity --- United States, 2000. MMWR September 5, 2003 / 52(35);842-844
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5235a4.htm
The increased likelihood of a smoker needing help with specific activities compared with never smokers is shown below.

**Smokers increased likelihood of needing support with specific activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making telephone calls</td>
<td>181%</td>
</tr>
<tr>
<td>Preparing a hot meal</td>
<td>120%</td>
</tr>
<tr>
<td>Shopping for groceries</td>
<td>107%</td>
</tr>
<tr>
<td>Getting in and out of bed</td>
<td>83%</td>
</tr>
<tr>
<td>Walking across a room</td>
<td>74%</td>
</tr>
<tr>
<td>Dressing</td>
<td>73%</td>
</tr>
<tr>
<td>Using a map</td>
<td>70%</td>
</tr>
<tr>
<td>bathing or showering</td>
<td>68%</td>
</tr>
<tr>
<td>Eating</td>
<td>65%</td>
</tr>
<tr>
<td>Doing work around house/garden</td>
<td>36%</td>
</tr>
</tbody>
</table>

As a result of smoking **47,000 more people are receiving care** provided by a local authority or private provider. A further **436,000 are receiving care from a relative or friend**. If ex-smokers are included in the number of additional people being cared for by friends and relatives this goes up 846,000 people. As the personal stories in this report show, smoking-related illnesses place a burden not only on services but on individuals and their family life.

The increased likelihood of smokers receiving care from different sources is shown below.

**Smokers increased likelihood of needing care**

<table>
<thead>
<tr>
<th>Source</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other relatives</td>
<td>197%</td>
</tr>
<tr>
<td>Friends or neighbours</td>
<td>152%</td>
</tr>
<tr>
<td>Local authority/social services</td>
<td>94%</td>
</tr>
<tr>
<td>Any other person</td>
<td>32%</td>
</tr>
<tr>
<td>Spouse or partner</td>
<td>31%</td>
</tr>
<tr>
<td>Privately paid help</td>
<td>18%</td>
</tr>
</tbody>
</table>
**DEBBIE’S STORY**

After being diagnosed with smoking-related Chronic Obstructive Pulmonary Disease (COPD) in his mid-50s, Denham Thomas, from Hartlepool, has had to rely on the caring support of his partner, Debbie Myles.

Now 62-years-old, Denham’s health has continued to deteriorate. He can no longer do the things that we sometimes take for granted. For Debbie, who celebrates her 50th birthday in October, she no longer has a life outside of caring for Denham.

“I first met Denham when he’d just been diagnosed with COPD. At the time, he was still a physically active man and was able to go to work as normal. He’d just have to do things that little bit slower that’s all, as he would get out of breath really quickly.

“Since then though, his health has really deteriorated. It’s been heart-breaking to watch him get worse over the years and when I look at him sat in his wheelchair struggling to breathe through his oxygen tank, it’s hard to believe that he was once this strong young man who loved sports. He gets really depressed sometimes and I can see in his eyes how angry he is with what smoking has done to him.

“It’s really sad to say, because I wouldn’t want anyone else to take care of him, but I’m not his partner anymore - I’m his carer and I’ve got to look after his every personal need. He still prefers to clean himself, but I do everything else from helping him to put on his clothes, making his meals, washing his hair and driving him around. It can be extremely tiring.”
PETER’S STORY

Peter Hunt is 67 and has needed the support of his wife and the local authority for a number of years as a result of smoking related illness. He pays for part of the care himself and the local authority pays the remainder.

“I used to work as a lorry driver, driving all round Europe. Cigarettes are cheaper over there, sometimes £1 a pack, and black-market tobacco is available in all the pubs and clubs. I smoked 60-70 cigarettes a day.

“Three years ago, I had a bad accident in the lorry and damaged one of my legs and my spine. Doctors couldn’t operate straight away due to a heart condition, for which I was fitted with a stent. After the stent was put in, I had to wait six weeks before having another operation, but by this time it was too late to repair the damage as my leg had seized up. I walk with a Zimmer frame and I can’t be operated on because my medical conditions make it too dangerous – I might not wake up. I also suffer from COPD and this and my heart condition are as a result of smoking.

“I’ve received support from the council for two years and the care is vital – I really couldn’t do it without them. My carer comes in every morning to help me with washing, shaving and changing and my wife helps out too – she has to, I can hardly do anything for myself. I can make a cup of tea myself but I can’t carry it anywhere. I also have a walk-in shower and a ramp to help me get into the house. I pay for as much of my care as I can and the local authority provides what’s left.

“I stopped smoking 14 months ago with the help of the local Stop Smoking Service. If I hadn’t packed it in then, I’d be dead by now. Stopping has made a real difference to how I feel and I can breathe more easily now.

“My advice would be to anyone who does smoke, try and pack it in. Go and see some of the people in hospitals who struggle to breathe. I think that would choke a lot of people.”
COSTS OF SMOKING TO THE CARE BUDGET

The social care costs of smoking to local authorities are about **£600 million a year**. This figure is probably an underestimate. It does not include any additional domiciliary care costs for current or former smokers aged under 50, nor has it been possible to include all local authority costs.

The National Audit Office estimates that the total care spending managed by local authorities is around £19 billion. It is estimated that in 2014, £14.6 billion was spent by local authorities from their own funds. This research estimates that local authority social care spending in 2012 on adults over 50 was about £4.0 billion for residential care and £5.5 billion for domiciliary care. This means that smoking-related social care costs account for about 6% of the local authority social care spend on the over 50s. By comparison, the total cost of smoking to the NHS in England has been estimated by the National Institute for Health and Care Excellence (NICE) at around £1.8 billion – this accounts for less than 2% of the total NHS budget.

The research also estimates the cost to people who do not meet the local authority means test and have to fund their own care. The cost to self-funders is estimated to be about £450 million a year. On average this means that smokers who do not meet the local authority means test are spending £28,063 per year to meet their care needs. However, for the reasons above, and because self-funders may well opt for more expensive services, this estimate is expected to be low.
CONCLUSION

This study shows that smoking is placing a significant financial burden on local communities beyond that of previous estimates. It is both a financial and an emotional burden that affects many thousands of people in every community.

Reducing smoking prevalence has a significant role to play in easing future cost pressures on the social care system. This report also shows that local authorities should include work on reducing smoking prevalence such as stop smoking services as part of their range of preventive services required under the Care Act 2014.
THE COSTS OF SMOKING TO THE SOCIAL CARE SYSTEM IN ENGLAND