

British Heart Foundation

Submission to the Comprehensive Spending Review

2020

Summary

- Heart and circulatory diseases still cause more than a quarter of all deaths in the UK – on average killing one person every three minutes.¹
- The Government has a critical opportunity in this Comprehensive Spending Review to invest in the prevention and treatment of heart and circulatory diseases, conditions which drive health inequalities in the UK.
- Addressing disparities in health outcomes is key to creating a more resilient population in the face of the challenges created by the coronavirus pandemic (Covid-19) and to increasing productivity, which remains the only path to sustainable, long-term economic growth.²
- Further investment in life-saving medical research, public health and the NHS is central to securing equality of economic opportunity and levelling up positive heart and circulatory health outcomes, which in turn will contribute to the health and wealth of the country³:
 - i) Medical research not only contributes to major advances in scientific discovery and patient care but also to the wealth of the UK; it's estimated that every £1 invested in medical research delivers a return equivalent to ~25p annually in perpetuity.⁴ Within this ecosystem, medical research charities are instrumental in building opportunities for innovation, boosting investment and increasing skills in every region. However, the ability to fund research and maintain this positive contribution to the economy has been threatened by the loss of income sustained by the medical research sector during Covid-19. To protect critical medical R&D capability in the UK over the next 3-4 years, medical research charities require co-investment by Government.
 - ii) Local authorities and the NHS play a vital role in detecting, preventing and treating heart and circulatory diseases and their risk factors⁵, thereby reducing the economic burden that would otherwise arise from ill health and loss of productivity caused by these conditions. Better health for all is a fundamental driver of increased productivity and economic levelling up: investment in the prevention of ill health represents value for money, with a £14 return to society on every pound spent on public health interventions.⁶ Similarly, however, these public services require urgent additional investment following the impact of Covid-19 to be able to carry out their respective roles and reduce disparities in health outcomes.

¹ BHF UK factsheet July 2020.

² Budget 2020 <https://www.gov.uk/government/publications/budget-2020-documents/budget-2020>

³ <https://www.yhealth4growth.info/>

⁴ King's Policy Institute (2017) Medical Research: What's it Worth? <https://www.kcl.ac.uk/policy-institute/research-analysis/medical-research-worth>

⁵ Department of Health and Social Care, [Advancing our health: prevention in the 2020s](#), July 2019

⁶ Department of Health and Social Care, [Advancing our health: prevention in the 2020s](#), July 2019; original review <https://jech.bmj.com/content/71/8/827>

Priority actions

We have identified the following key priorities for action that will help progress the Government's levelling up agenda:

- The Government should invest in a time-limited Life Sciences-Charity Partnership Fund ('the Fund') to protect critical medical research and development (R&D) capability in the UK over the next 3 financial years (2021/22 to 2023/24), commencing with a commitment in this Comprehensive Spending Review to an initial £310 million for the year 2021/22. This transitional funding will allow medical research charities to effectively return to pre-Covid-19 levels of funding and increase contributions to UK R&D thereafter.
- The Comprehensive Spending Review should also include a commitment to ensure that R&D investment is spread proportionately across disease areas, based on societal burden. To this end, we urge the Government to commit in this Comprehensive Spending Review to fill the estimated £650m gap⁷ in funding for UK cardiovascular research in the UK, to match its relative threat to the country's health and wealth.
- To maintain the UK's position as a global research superpower, the Government should signal its commitment to life sciences research in the UK and its role in the post-Covid-19 economic recovery by committing to a fixed non-industry investment in UK life sciences R&D target of £8 billion per year by 2027, alongside its long term commitment of ensuring 2.4% of GDP is invested in R&D by 2027.
- As outlined in the Life Sciences Industrial Strategy, protecting the critical partnerships that exist between universities and charities is essential to strengthening the UK's place in the world. To achieve this, the Government should commit to an increase in the Charity Research Support Fund to ensure it keeps pace with charity sector investment. This should be boosted to approximately £350m per year, based on 2017/18 Transparent Approach to Costing figures.⁸
- The Public Health Grant should be allocated an additional £1 billion a year, as an absolute minimum, to restore it to 2015/16 levels and ensure the delivery of vital preventative services.⁹ This will help build a healthier, more resilient nation, better able to overcome the impact of Covid-19. Further investment must be made to allow increased support for areas of greatest need and ensure improved health resilience across the UK.
- The NHS Long Term Plan must also be given an additional £4 billion by 2023/24 to realise the Government's ambitions of modernising the health service. £4 billion is the estimated gap in funding needed to fully realise the ambitions of the Long Term Plan, according to analysis by the Health Foundation prior to Covid-19.¹⁰ This is the minimum investment that should be made by 2023/24. On top of this, consideration should be given to further funding required to deliver the aims of the Long Term Plan in the current context, as the impact of Covid-19 continues to be felt by the NHS.
- A corresponding increase of £12.2 billion in social care funding is required, as a minimum, to restore access to 2010/11 levels of service. This estimated funding requirement is also based on analysis conducted before Covid-19 - further investment may be required to

⁷ IPPR (2020) The science-based economy: The role of health research <https://www.ippr.org/research/publications/the-science-based-economy>. Using pre-COVID-19 data, the IPPR has predicted it would cost £1.27 billion to bring spend across all health research areas in the UK in line with their respective burden. Cardiovascular disease and stroke research alone required a £650 million investment per year, before cuts to funding related to Covid-19 were accounted for.

⁸ https://www.officeforstudents.org.uk/media/33c4dc91-705b-4321-a4a9-3f712f8a3fc8/annual-trac-2017-18_sector-summary-and-analysis-by-trac-peer-group.pdf

⁹ The Health Foundation and The King's Fund, [Urgent call for £1 billion a year to reverse cuts to public health funding. Joint press release from the Health Foundation and The King's Fund, 12th June 2019](#)

¹⁰ Health Foundation (2019) [Health and social care funding: Priorities for the new government](#).

stabilise the social care workforce and ensure better outcomes for everyone living with a heart and circulatory condition in the current circumstances, regardless of where they live in the country.

Context for this Comprehensive Spending Review (CSR)

Covid-19 has had an unprecedented impact on the economy and exacerbated existing health inequalities, including for those affected by heart and circulatory diseases.¹¹ This CSR is timely, as the Government can go a long way towards addressing these inequalities by delivering its commitment to 'levelling up' opportunity and prosperity when allocating departmental funding up to 2023/24.

There are more than seven million people living with heart and circulatory diseases in the UK today and millions more have risk factors for heart and circulatory conditions, such as high blood pressure, raised cholesterol, and type 2 diabetes. Healthcare costs relating to heart and circulatory diseases are estimated at £9 billion each year,¹² whilst the cost to the UK economy (including premature death, disability, and informal costs) as a result of these conditions is estimated to be £19 billion each year.¹³ Continued variation in the detection, diagnosis, treatment and provision of help with recovery for heart and circulatory diseases pose further challenges.

BHF-funded research has shown that Covid-19 affects the heart, not just the lungs, and we are concerned that even more people will be affected by heart and circulatory diseases in the future.¹⁴ In late March 2020, official data showed a 50% drop in the number of people attending A&E with suspected “myocardial ischaemia”¹⁵ (possible heart attacks). BHF-funded research further suggested that there were 5,000 fewer admissions for heart attacks than expected in England by the end of May 2020.¹⁶ Furthermore, people with heart failure have been unable to access services that help keep them well and avoid hospital admission. The long-term effects of not treating heart attacks and patients being unable to access cardiac rehabilitation services is likely to raise the future burden on the NHS, with ensuing costs to the economy.

In addition, Covid-19 has widened inequalities: a study of severe Covid-19 cases in hospitals across the UK showed that chronic cardiac disease was the most common comorbidity,¹⁷ and official data for England show that around 45% of Covid-19 deaths also mentioned cardiovascular (heart and circulatory) disease.¹⁸ The disproportionate burden caused by Covid-19 among people with heart and circulatory disease, combined with its effects on the NHS, has significantly increased the impact of these conditions for people in the UK. This, alongside regional disparities in public health funding for prevention services, could add to the costs borne by the NHS and the wider economy from treating heart and circulatory conditions.

¹¹ <https://www.bhf.org.uk/information-support/heart-matters-magazine/news/coronavirus-and-your-health/coronavirus-and-the-perfect-storm-for-heart-disease#Heading3>

¹² BHF UK factsheet July 2020.

¹³ *ibid*

¹⁴ *ibid*

¹⁵ <https://www.gov.uk/government/publications/emergency-department-weekly-bulletins-for-2020>

¹⁶ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31356-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31356-8/fulltext)

¹⁷ www.bmj.com/content/369/bmj.m1985

¹⁸ Public Health England, [Disparities in the risk and outcomes from COVID-19](#), June 2020, 63

In order to address the challenges set out above, the Government must review its research and health spending. It is essential that the UK harnesses its strengths in research, ensuring the pace of medical research is maintained in order to increase prosperity in every region and nation in the UK. The opportunity must also be seized in this CSR to level up funding for all health systems in order to close the gap in health outcomes caused by deprivation and variation in services regionally. Making the funding commitments for life saving medical research and public services, as outlined below, is imperative to boosting economic opportunities across the UK and improving social outcomes now and over the next five years.

Government should invest in the life sciences sector, and charity-funded research specifically, to level up economic opportunity and productivity across the UK

Preserving the distinct contributions of medical research charities to the UK's research base by committing to a Life Sciences-Charity Partnership Fund

As acknowledged in the Budget earlier this year, the only sustainable way to drive economic growth and improve living standards in every corner of the country is to boost productivity. Medical research provides a vital mechanism for ‘uniting and levelling up our country, giving people opportunity and hope’¹⁹: not only does it contribute to major advances in scientific discovery and patient care, but also to the wealth of the nation - every £1 invested in medical research delivers a return equivalent to ~25p annually in perpetuity.²⁰ Within this ecosystem, medical research charities are instrumental in building opportunities for innovation, boosting investment and increasing skills in every region. For example, BHF funding is often leveraged by research institutions to attract additional funding. In 2019, researchers leveraged approximately £1.27bn of additional funding from a BHF investment of ~£476m and the average return on investment from sources other than the BHF was £2.14 per £1 of BHF investment.

However, the BHF's ability to deliver its core mission as a medical research funder has been threatened by the Covid-19 pandemic; the significant loss of retail and fundraising income has forced us to cut our research spend this year in half, from £100 million to around £50 million. We do not expect income streams—and therefore research spend—to return to pre-pandemic levels for some years, reflecting a combination of societal and economic disruption being felt across the sector. The Association of Medical Research Charities (AMRC) – the membership organisation of over 150 leading medical and health research charities in the UK – has forecast a £310 million shortfall in sector spend on research in FY20/21 and is anticipating it will take charities 4-5 years for their research spend at UK universities and hospitals to recover to pre-pandemic levels.²¹

There are currently no clear support mechanisms for medical research charities within Government support schemes. The £750 million of extra funding announced in April for charities providing ‘essential services’ in response to Covid-19 cannot be used for medical research, and the university research support package announced in June is not a long-term solution to the challenges currently facing medical research charities.

¹⁹ Budget 2020 <https://www.gov.uk/government/publications/budget-2020-documents/budget-2020>

²⁰ King's Policy Institute (2017) Medical Research: What's it Worth? <https://www.kcl.ac.uk/policy-institute/research-analysis/medical-research-worth>

²¹ <https://www.amrc.org.uk/Handlers/Download.ashx?IDMF=1cf57b61-5794-46ff-b3a6-0814bc6e9127>

To ensure medical research can continue to contribute to the creation of economic opportunities and innovation in every region and nation of the UK, the Government should invest in a time-limited Life Sciences-Charity Partnership Fund to protect critical medical R&D capability up to 2023/24. This should commence with a commitment in this CSR to an initial £310 million funding for the year 2021/22.

Investing in the Fund will help protect the vital contributions of the medical research sector in support of the Government's levelling up agenda:

➤ ***Delivering greater research capacity in regions outside the Golden Triangle so that health improvements are realised in every corner of the country***

It has long been recognised that publicly-funded biomedical research in the UK is strongly concentrated in London and in the South East of the country, the 'Golden Triangle' for research and development. As highlighted in "The Missing £4 Billion" Nesta report, these regional disparities narrow the scope for private investment in R&D, hindering progress towards the Government's ambition of reaching R&D expenditure of 2.4% of GDP by 2027. Charity-funded research can help to address these disparities – for example, AMRC members fund research in every region of the UK. The BHF also recognises the importance of funding excellent science regardless of geographical location, building on regional strengths and national collaborations. For example, between April 2015 and March 2020, we awarded 549 new research grants worth over £180 million to research institutions outside the Golden Triangle. And in 2018/19, five of the top 10 institutions that received the most funding by the BHF were from outside the Golden Triangle - the University of Leeds, University of Manchester, University of Leicester, University of Edinburgh and University of Glasgow.²²

➤ ***Protecting critical research jobs across the UK***

Charities invest in the UK's skills pipeline and have made long-term investments in research capacity and capability. Last year, 17,000 researcher salaries were funded by AMRC members, including 1,750 PhD students. The BHF is currently funding the salaries of approximately 1,700 research staff working on projects across the UK, including 440 early-career researchers through career development awards. We understand that nurturing promising talent is vital in strengthening the UK's place in the world, and that creating equal opportunities across every region requires a variety of roles to harness talent across the R&D ecosystem. To that end, we fund a wide variety of researchers, including technicians, statisticians, programmers and midwives.

Ensuring proportionate R&D investment across disease areas, based on societal burden

This CSR should be tasked with catalysing investment across underserved conditions and allocating funding where it will be most impactful. Heart and circulatory diseases are the biggest cause of death worldwide and account for a considerable burden of disability. However, as evidenced recently in "The Science-Based Economy" report by the Institute for Public Policy Research (IPPR)²³, 'cardiovascular and stroke' research is the most underfunded area of health research in the UK: it receives only 9% of UK health R&D investment, considerably below the 19% that should be invested based on disease burden, as measured by disability adjusted life years (DALYs; a measure of overall disease burden that combines the number of years lived with

²² BHF Research Evaluation Report 2018-19 <https://www.bhf.org.uk/for-professionals/information-for-researchers/managing-your-grant/research-evaluation>

²³ <https://www.ippr.org/research/publications/the-science-based-economy>

disability and the number of years of life lost). Relative underinvestment is also present in mental health, respiratory and musculoskeletal and immunological research.

Addressing these disparities in funding relative to disease burden is essential to the Government achieving its mission to add 5 years of healthy life expectancy by 2035, which will in turn contribute to productivity levels. Furthermore, the need for greater investment in cardiovascular research has been underscored by the Covid-19 pandemic and the finding that people living with pre-existing heart and circulatory diseases and many of their risk factors are more likely to develop severe complications from Covid-19.

This CSR should include a commitment to help fill the £650m gap in funding²⁴ that currently exists for UK cardiovascular research in the UK, to match its relative threat to the nation's health and wealth. This will ensure that R&D investment is spread proportionately across disease areas, based on societal burden.

Signalling a commitment to life sciences research by committing to a fixed non-industry R&D target

Having a world-beating science and research base is one of the UK economy's many strengths.²⁵ Life sciences R&D is more important than ever and has a key role in supporting the UK's post-Covid-19 economic and social recovery, in turn levelling up opportunity across the UK.

The Government's commitments to increase the UK's investment in R&D to 2.4% of GDP by 2027 and to increase Government R&D spending to £22 billion by 2024/25 are vital steps in strengthening the UK's place in the world - both have been widely welcomed across the medical research sector. However, the BHF is concerned that GDP-based targets are likely to lose value in periods of economic instability. Statistics published by the ONS estimate that the UK's GDP fell by 20.4% in Quarter 2 2020.²⁶ If the economy does not recover to pre-Covid-19 forecasts by 2027, we are concerned that lower than expected levels of investment in R&D by 2027 may be experienced, thus limiting the UK's growth as a global science superpower.

In the recent "The Science-Based Economy" report by the IPPR,²⁷ pre-pandemic estimates of GDP growth were used to predict real monetary investment in the life sciences through to 2027. The authors found that achieving the Government's 2.4%-by-2027 commitment would require an annual £8 billion spend in non-industry life sciences R&D by 2027, roughly doubling current levels. IPPR modelling also highlighted that total non-industry life sciences R&D spend would reach £6.7 billion per year by 2027, based on pre-Covid-19 GDP trajectories. This leaves a shortfall of £1.3 billion compared to the £8 billion required to reach the Government's 2.4%-by-2027 target. Action should be taken to address this gap in funding, with additional funding being concentrated on under-served conditions.

²⁴ IPPR (2020) The science-based economy: The role of health research <https://www.ippr.org/research/publications/the-science-based-economy>: Using pre-COVID-19 data, the IPPR has predicted it would cost £1.27 billion to bring spend across all health research areas in the UK in line with their respective burden. Cardiovascular disease and stroke research alone required a £650 million investment per year, before cuts to funding related to Covid-19 were accounted for.

²⁵ Budget 2020 <https://www.gov.uk/government/publications/budget-2020-documents/budget-2020>

²⁶ Office for National Statistics (2020) GDP first quarterly estimate, UK: April to June 2020 – decrease on previous quarter <https://www.ons.gov.uk/economy/grossdomesticproductgdp/bulletins/gdpfirstquarterlyestimateuk/apriltojune2020>

²⁷ IPPR (2020) The science-based economy <https://www.ippr.org/research/publications/the-science-based-economy>

To maintain the UK's position as a global research superpower, the Government should signal its commitment to life sciences research in the UK and its role in the post-Covid-19 economic recovery by committing to a fixed non-industry investment in UK life sciences R&D target of £8 billion per year by 2027 alongside ensuring 2.4% of GDP is invested in R&D by 2027.

Protecting the critical partnerships between universities and charities by ensuring the Charity Research Support Fund (CRSF) keeps pace with charity investment

Strengthening the university research system in the UK is also essential to maintaining the UK's place as a global research superpower. Medical research charities are a vital component of this system; in 2019, 87% of all AMRC charity-funded research took place in universities²⁸ (a significant contribution at approximately £1.65 billion), and on average around 15% of all UK university research funding comes from charities. In England, the CRSF is a key part of this system, underpinning charity investment by enabling researchers who receive charitable funding to recover the indirect costs of research that charities do not pay. Without this government funding, there would be undue pressure on universities to cover additional costs of research, subsequently endangering charity-funded research within universities.

However, the CRSF is currently underfunded. Between 2010/11 and 2020/21, it has remained relatively constant, only increasing from £198 million to £204 million per year; conversely, between 2010/11 and 2018/19, charity research spend in universities increased steadily from £686 million to £1,015 million per year.²⁹

To protect the critical partnerships between universities and charities, as recommended in the Life Science Industrial Strategy, the Government should commit to an increase in the Charity Research Support Fund to ensure it keeps pace with charity investment. The Fund should be boosted to approximately £350m per year, based on 2017/18 Transparent Approach to Costing figures.³⁰

Government must increase investment in the public sector to improve heart and circulatory disease outcomes across the country

Restoring the Public Health Grant

Better health for all is a fundamental driver of increased productivity and economic levelling up. Investment in the prevention of ill health also represents value for money, with a £14 return to society from every pound spent on public health interventions.³¹ But to be truly effective, Government must commit to further investment in the Public Health Grant.

There are strong but complex connections between obesity, type 2 diabetes and heart and circulatory diseases. In 2017, 16.5% of UK cardiovascular deaths were attributable to excess

²⁸ AMRC (2020) Medical research charities: our sector's footprint in 2019

<https://www.amrc.org.uk/Handlers/Download.ashx?IDMF=ad9acc0a-f186-4415-bb13-43d04ea9a6d0>

²⁹ AMRC (2019) Charity Research Support Fund (CRSF) <https://www.amrc.org.uk/charity-research-support-fund-crsf>

³⁰ https://www.officeforstudents.org.uk/media/33c4dc91-705b-4321-a4a9-3f712f8a3fc8/annual-trac-2017-18_sector-summary-and-analysis-by-trac-peer-group.pdf

³¹ Department of Health and Social Care, [Advancing our health: prevention in the 2020s](#), July 2019

weight,³² with an estimated 63% of adults in the UK having a weight classed as overweight or obese³³. In 2017, 22.3% of healthy years lost across the UK population due to heart and circulatory diseases were attributable to obesity.³⁴ Overall, lifetime costs to society of obesity have been estimated at 3% of GDP, equivalent to £60 billion in 2018.³⁵ Government action on obesity, including funding for weight management services, could increase equity of economic opportunity by reducing the number of these DALYs which affect the number of years people are able to work and thus contribute to the public purse.

There is also a strong association between socioeconomic disadvantage and obesity. The 2018 Health Survey for England established a connection between adult obesity and neighbourhood deprivation.³⁶ In the least deprived areas, 20% of adults had obesity, compared to 36% of adults living in the most deprived areas.³⁷ The survey also revealed a clear regional inequality in obesity rates after accounting for age: the lowest levels of obesity were in the South East and London and the highest levels were in the West Midlands, the North East and Yorkshire and the Humber. However, according to analysis by the IPPR, the ten most deprived local authorities in England saw a 50% cut to their budget for obesity services between 2014/15 and 2019/20, compared to a 37% cut in the ten least deprived.³⁸

Comprehensive action to address obesity will be a key part of ‘unleash(ing) Britain’s potential’,³⁹ driving productivity and spreading opportunity. The new obesity strategy provides England with the opportunity to become world-leading in reducing obesity rates, which currently stand amongst the highest in Europe.⁴⁰ The same commitment demonstrated for smoking cessation must be given to weight management services, backed with further investment. The BHF welcomes the obesity strategy’s commitment to expanding weight management services available through the NHS to enable more people to access support to lose weight. Crucially, these services need to be adequately funded and universally available. While services in the NHS are important, Tier 1 and 2 services provided at local authority level cannot be forgotten.

Further investment in the Public Health Grant must enable commissioning of accessible, tailored and varied services to ensure they work for the whole population, with an uplift in provision of all tiers, and data and evaluation embedded more strongly in programmes. Tailored services will be paramount in addressing inequalities in obesity prevalence and to realising the levelling up agenda.

This also applies for smoking cessation services. Although local authorities have made efficiencies through better commissioning, cuts are having a devastating impact on frontline prevention services. Research conducted by Action on Smoking and Health (ASH) and Cancer

³² British Heart Foundation analysis of Global Health Data Exchange, Global Burden of Disease (GBD) Results Tool, <http://ghdx.healthdata.org/gbd-results-tool>

³³ BHF analysis of latest UK health surveys: <https://www.bhf.org.uk/what-we-do/our-research/heart-statistics/heart-statistics-publications/cardiovascular-disease-statistics-2020>

³⁴ BHF analysis, Global Health Data Exchange, Global Burden of Disease (GBD) Results Tool, <http://ghdx.healthdata.org/gbd-results-tool>

³⁵ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/837907/cmo-special-report-childhood-obesity-october-2019.pdf

³⁶ NHS Digital, [Health Survey for England 2018](#), Overweight and obesity in adults and children, December 2019

³⁷ *Ibid.*

³⁸ IPPR, ‘[Hitting the poorest worst? How public health cuts have been experienced in England’s most deprived communities](#)’, November 2019

³⁹ [Conservative Party 2019 Manifesto](#)

⁴⁰ [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi-30-\(crude-estimate\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi-30-(crude-estimate)-(-))

Research UK found that, following year-on-year reductions to the Public Health Grant since 2015, stop smoking services have been persistently cut across local authorities.⁴¹ By 2019, only

59% of local authorities were able to offer a stop smoking service to all smokers in their area. Among the local authorities that still had a budget for stop smoking services, 35% had cut this budget between 2018/19 and 2019/20.⁴² It is vital that all local authorities are able to provide specialist, universal stop smoking services, as well as tailored services for groups where need is greatest, with communications and outreach capacity to reach smokers in need of support. This is because smoking is also a leading driver of health inequalities: in 2019, the ONS estimated that 13.9% of adults in England were regular cigarette smokers (14.1% across the UK),⁴³ with prevalence in Blackpool, an area of high deprivation, at 23%, compared to 8% in Richmond upon Thames, which is in the least deprived decile.⁴⁴ Stubborn smoking rates persist in more deprived areas, amongst those in routine and manual professions (23%, compared to 9% for those in managerial and professional roles)⁴⁵ and for adults with a mental health condition, 29% of whom smoke.⁴⁶ Tobacco also remains a leading cause of preventable illness and death in the UK, leading to around 100,000 deaths each year from conditions including heart and circulatory diseases, cancer and respiratory diseases. In 2017, an estimated 16% of healthy years lost across the population due to heart and circulatory diseases were attributable to smoking.⁴⁷ This enormous health burden translates into a vast economic burden: estimates place the immediate cost to UK society of smoking at £12.5bn per year.⁴⁸ Furthermore, separate analysis has placed the lifetime costs of tobacco at 3.6% of GDP, equivalent to over £70 billion per year in 2018.⁴⁹

To reduce the societal cost arising from the regional disparities in obesity and smoking services and prevalence, the Public Health Grant must be restored equitably in this CSR to ensure local authorities have adequate resource to carry out their public health responsibilities and improve population-level health. Based on 2019 analysis by the Health Foundation and the King's Fund, even prior to the pandemic investment of at least an additional £1 billion a year was required to restore the Grant to former levels and ensure the delivery of vital preventative services.⁵⁰ Further analysis by the Health Foundation outlines why this is the case: the Public Health Grant, which currently amounts to £3.2 billion a year,⁵¹ is now 22% lower on a real-term per capita basis than initial allocations in 2015/16.⁵² This was in spite of a 2.6% real term increase to the Public Health Grant earlier this year. However, the £80 million above inflation increase for the year 2020/21 falls short of restoring the grant to its former level.⁵³ Moreover in 2018, the Health Foundation found that to achieve equitable funding, and ensure proper delivery of services in areas of

⁴¹ Action on Smoking and Health & Cancer Research UK. [A changing landscape](#): Stop smoking services and tobacco control in England

⁴² Action on Smoking and Health & Cancer Research UK. [A changing landscape](#): Stop smoking services and tobacco control in England

⁴³ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019> - NB national health surveys present higher prevalence figures, averaging 17% for the UK

⁴⁴ Public Health England, Fingertips

⁴⁵ Public Health England Local Tobacco Control Profiles 2019

⁴⁶ Public Health England, Fingertips: Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS) 2018/19

⁴⁷ BHF analysis, Global Health Data Exchange, Global Burden of Disease (GBD) Results Tool, <http://ghdx.healthdata.org/gbd-results-tool>

⁴⁸ Action on Smoking and Health Ready Reckoner- <https://ash.org.uk/ash-ready-reckoner/>

⁴⁹ https://www.mckinsey.com/~media/McKinsey/Business%20Functions/Economic%20Studies%20TEMP/Our%20Insights/How%20the%20world%20could%20better%20fight%20obesity/MGI_Overcoming_obesity_Full_report.ashx (report compares the economic burden of obesity with other health risk factors, including smoking)

⁵⁰ The Health Foundation and The King's Fund, [Urgent call for £1 billion a year to reverse cuts to public health funding. Joint press release from the Health Foundation and The King's Fund, 12th June 2019](#)

⁵¹ UK Government, [Public health grants to local authorities: 2020 to 2021](#), published 17th March 2020

⁵² The Health Foundation, [Response to the public health grant allocations](#), 17th March 2020

⁵³ <https://www.health.org.uk/news-and-comment/blogs/invest-in-public-health-now-or-store-up-problems-for-the-future>

greatest need, substantial further investment was necessary.⁵⁴ The coronavirus pandemic has put further considerable stress on local authority budgets and public health, hence proper analysis is needed to determine the level of additional funding that is required to support the levelling up agenda and make significant health gains across all areas of the UK.

In light of the substantial additional burden that Covid-19 has placed on local authority budgets, an additional investment of £1 billion a year must be the absolute minimum increase to the Public Health Grant required to restore it to former levels. However, further investment must be made to allow increased support for areas of greatest need and ensure improved health resilience across the UK.

Further income generation to support local tobacco control efforts could be possible through a 'polluter pays' tobacco levy. Tobacco manufacturers are highly profitable and the principle of 'polluter pays' dictates that they should bear responsibility for paying for the cost of tobacco control.⁵⁵ To that end, we support the proposal from ASH to use legislative mechanisms set out in the Health Act 2006 to implement a 'polluter pays' tobacco levy.⁵⁶ More detail on this and further measures to support tobacco control can be found in the Smokefree Action Coalition's Roadmap to a Smokefree 2030 and in ASH's submission to the CSR.⁵⁷ As a steering group member of the Obesity Health Alliance, we also support the fiscal calls outlined in their submission to the CSR.

The forthcoming transition to a new model of public health via the creation of the National Institute of Health Protection also provides an opportunity for Government to ensure sustainable, long-term investment in the prevention agenda, facilitating leadership, expertise and evidence-based practice across all levels of Government and across the health system. The Public Health Grant is a substantial part of ensuring that local authorities can carry out their public health responsibilities, but any increase in local authority responsibilities in light of these changes must come with sufficient resource.

Increased funding for the Long Term Plan

NHS England's Long Term Plan identified action on heart and circulatory diseases as a significant way in which it can improve health outcomes, stating it is the single biggest area in which it can save lives over its ten-year cycle and prevent 150,000 heart attacks, strokes and cases of vascular dementia. Moving beyond this year's winter pressures, it will be important that HM Treasury adequately finances the Long Term Plan to achieve its long-term ambitions in the context of Covid-19 and beyond.

Sustainable investment in health and care services, including substantial investment in public health, workforce, education and training and capital will help outcomes for people with heart and circulatory diseases and deliver the ambitions of the Long Term Plan.

In England, the NHS Long Term Plan is underpinned by a funding settlement up to 2023/24, with average annual increases of 3.3% a year. However, this will only allow for the maintenance of current levels of care, without budget included for workforce education and training, capital

⁵⁴ The Health Foundation, [Taking our health for granted](#), October 2018

⁵⁵ Branston, J. R. and Gilmore, A. [The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy](#). 2015, University of Bath.

⁵⁶ Health Act 2006. Annex 2: Scheme Powers of the Secretary of State Deriving from the NHS Act 2006.

⁵⁷ <https://smokefreeaction.org.uk/wp-content/uploads/2020/01/Roadmap-to-a-Smokefree-2030-FINAL.pdf>

and public health. When these are included, investing in and modernising the health service as set out in the NHS Long Term Plan requires an increase of approximately 4.1% a year.⁵⁸

Substantial investment is also needed to address the problem of digital exclusion to ensure that difficulties in accessing technology do not exacerbate existing health inequalities. Consideration should be given to further funding required to deliver the aims of the Long Term Plan in the current context, as the impact of Covid-19 continues to be felt by the NHS.

Going forward, it is more important than ever that the NHS Long Term Plan delivers on its ambitions and is given adequate resource to deliver its aims both during and beyond the new reality imposed by Covid-19. Health and care services cannot simply be 'switched back on' – there is a need for new and altered spaces for care that are safe and socially distanced. Health and care services will need to find new ways of diagnosing and managing conditions. It will also be important to ensure that new models of services do not create or deepen inequalities. This will require the full support of Government, including ensuring enough funding is in place for the NHS and the wider health and care system to deliver on the ambitions in the Long Term Plan.

The NHS Long Term Plan must receive an additional £4 billion by 2023/24 as a minimum, according to analysis by the Health Foundation,⁵⁹ with scope to increase this to ensure that the innovations brought about by Covid-19 such as remote access to cardiac rehabilitation and virtual consultations with general practitioners and cardiac specialists are adequately financed and can be embedded across the country to reduce regional variations in service provision.

In the face of ongoing pressures created by Covid-19, it is important that the funds used by health and care providers for the initial Covid-19 response are replaced so that the ambitions of the Long Term Plan can be realised. In April 2020, HM Treasury approved £6.6 billion of support to our health services through the Covid-19 pandemic. More recently, the Government unveiled £1.5 billion funding for hospital maintenance and building (including expanding emergency care capacity) together with an additional £3 billion to restore as much capacity as possible for this winter and help the system prepare for a potential 'second wave' surge in cases. This financial support is welcome as it will help maintain the additional capacity that was put in place in recent months. But there will be many calls on these funds, and HM Treasury must be prepared to provide an additional funding boost to the amount already approved over the next four years to support health and care services as challenges emerge over the coming months and the impact of Covid-19 becomes clearer.

To avoid a surge in potentially avoidable long-term cardiovascular conditions, like heart failure, it is vital that the Government acts now to provide the necessary investment in services to address the backlog in cardiac care. HM Treasury must also provide additional funding to local systems to ensure that they can embed innovative new practices developed during the pandemic, as set out in the Government's letter to NHS trusts on 31 July 2020.

⁵⁸ Health Foundation (2019) [Health and social care funding: Priorities for the new government](#).

⁵⁹ Health Foundation (2019) [Health and social care funding: Priorities for the new government](#).

Increasing investment in social care

With health and care systems working together to deliver the Long Term Plan, sustainable funding across the system will be critical to transforming and levelling up outcomes for people with heart and circulatory diseases. Community-based services, including those provided by social care, play an important part in supporting people with heart and circulatory diseases to stay well, but are also key to relieving pressure on the broader health and care system by keeping people out of hospital and facilitating early discharge.

During the pandemic, access to specialist services in the community has been depleted due to redeployment of staff for the Covid-19 response. A range of specialist heart and circulatory services have been affected, and insight gathered from the health service and from calls to our Heart Helpline has confirmed a significant and varied impact on community services needed to support people with long-term cardiac conditions, like heart failure. The true impact of this loss of services cannot yet be quantified, but it could lead to more hospital admissions, extra demand on hospitals, and greater pressure on community services that are already preparing for likely winter pressures, including a potential second wave of Covid-19.⁶⁰

It is vital that barriers to effective cross-sector work are removed. Where strong relationships and new ways of working have been developing across primary, secondary, and community care boundaries, these should be maintained to help improve long-term continuity of care. Where appropriate, this should entail sharing budgets.

The Government has said that the NHS is its number one spending priority,⁶¹ but if the health and care system is going to be resilient to a second wave of Covid-19 and outcomes improved for cardiovascular disease patients, social care must be treated as an equal partner to the NHS in an interdependent system,⁶² and provided with adequate funding to deliver the aims of the Long Term Plan.

Based on analysis by the Health Foundation, this CSR should commit to a minimum increase of £12.2 billion for councils to spend on social care above the current estimates of funding available in 2023/24,⁶³ in order to return funding to previous peak 2010/11 levels.

This will help address pay and retention issues in the social care workforce, ensuring that it is adequately equipped to deal with future pressures. As the UK begins to plan beyond the immediate crisis, this £12.2 billion uplift in funding for social care is urgently needed, as a minimum, to ensure better outcomes for everyone living with a heart and circulatory condition, regardless of where they live in the country. Given £12.2 billion was estimated as the extra amount needed for social care prior to Covid-19, consideration must be given to any further investment the sector may need to deal with future increase demand for state funded adult social care.

⁶⁰ <https://www.bhf.org.uk/informationsupport/heart-matters-magazine/news/coronavirus-and-your-health/coronavirus-and-the-perfect-storm-for-heart-disease#Heading4>

⁶¹ Budget 2020 <https://www.gov.uk/government/publications/budget-2020-documents/budget-2020>

⁶² <https://www.kingsfund.org.uk/press/press-releases/covid-19-support-social-care-too-little-too-late>

⁶³ <https://www.health.org.uk/news-and-comment/charts-and-infographics/social-care-funding-gap>