British Heart Foundation

Submission to the 2021 Comprehensive Spending Review and Budget

Summary and key recommendations

Today, 7.6 million people are living with cardiovascular diseases (CVD) across the UK and CVD still cause a quarter of all deaths in the UK; that's more than 160,000 deaths each year or one every three minutes. CVD is also a significant cause of ill health and inequality in the UK. The pandemic has only exacerbated this, impacting on every aspect of CVD, from the medical research that holds promise of the next big breakthroughs, to efforts to prevent the onset of disease, to how we treat and support people living with these conditions.

This CSR and Budget provides the Government an opportunity, as we emerge from the pandemic, to recognise that better health drives economic growth and is integral to the levelling up agenda. Without investment into cementing the UK's status as a science superpower, to clear the backlog of cardiovascular care and to address risk factors such as smoking and obesity, success in achieving Government ambition to improve the UK's health and wealth will be drastically depleted. While the impact of the pandemic has been bleak, it has highlighted the vital importance of the nation's health, and this CSR and Budget is a seminal moment as Government endeavours to build back a better UK health and research environment.

We therefore support the following key recommendations that will enable the Government to achieve this:

1. **Government should realise its goal to increase investment in the UK's world-leading R&D ecosystem**
    - The Government should publish a long-term plan and budget for meeting the 2.4% 2027 R&D intensity target, which includes support for the whole system. To this end, Government should set out a fully developed timetable this year outlining how the £22 billion public R&D investment commitment will be achieved.
    - The Government should work in partnership with medical research charities to preserve the distinct contribution of charity funding in the UK's research ecosystem – which has been hard hit by the Covid-19 pandemic - by bolstering the Charity Research Support Fund.
    - This Comprehensive Spending Review should also ensure R&D investment addresses the current underspend in some disease areas (in proportion to societal burden).[1] For example, the Government should outline how it intends to meet the Life Sciences Vision's ambition to 'deliver cutting edge research' that addresses the prevention of cardiovascular diseases.[2] This provides an opportunity to recognise and address the £650m gap in funding that currently exists for cardiovascular research in the UK.[3]
    - The critical role of the National Institute for Health Research (NIHR) in realising ambitions put forward in '*Saving and Improving Lives: The Future of UK Clinical Research Delivery*' should also be recognised – as such the NIHR budget must be uplifted in line with other parts of the research budget to ensure delivery of the outlined implementation plan.[4]

2. **The NHS faces a significant backlog of cardiovascular care and should be properly funded and resourced**
    - Substantial and long-term increased investment in the health and care system is needed to address the backlog of care and support transformation of services. At the minimum, the health service will need an increase in funding of 4% a year on average for the next ten years to bring pre-pandemic health spending in the UK in line with other G7 countries, as advised by the recent Lancet commission.[5]
    - The recent announcement of £10bn (up to 2024/25) to tackle the backlog of elective care is welcome, but it will not be sufficient. Health Foundation analysis indicates that close to £17bn would be needed to clear the backlog and return to the 18-week waiting time standard. Government action to reduce the backlog of care must also include a clear plan for cardiovascular services. This strategy must be long-term and sustainable, prioritising recruitment, training, and retention of skilled NHS workers.

3. **The prevention of ill-health is vital to levelling up our economy and helping to decrease the burden of disease on the NHS**
    - An additional investment of £1 billion a year must be the minimum investment to the Public Health Grant, restoring funding to 2015 levels. The Public Health Grant must also be maintained as a ring-fenced fund for local authority-commissioned public health activities and services.
    - Government should commit, in the 2021 Budget, to a Smokefree Fund, a levy on the tobacco industry, that would provide an estimated £700 million source of income to fund Government ambitions for a Smokefree 2030 in England including smoking cessation services.
    - This 2021 Budget should also commit to the introduction of a tax on sugar and salt, as proposed in the National Food Strategy. The revenue should allow increased spending on initiatives to increase the affordability of a healthy, balanced diet for families on low incomes.

1. Government should realise its goal to increase investment in the UK's world-leading R&D ecosystem

Ensuring that the Government makes funds available, and re-commits to reaching the target of increasing public investment in research to £22 billion by 2024/25

The Government has committed to increase public funding for research and development (R&D) to £22 billion per year by 2024-25 as part of its goal to increase UK investment in R&D to 2.4% of GDP by 2027. This has been accompanied by bold visions on how to build the UK into a true science superpower (e.g., the R&D Roadmap, The Life Sciences Vision, Clinical Research Vision, the R&D People and Culture Strategy).

However, the sector now needs to see the details behind the Government's scientific superpower pledge; this Spending Review should include a detailed R&D budget trajectory to show how these ambitious funding targets will be met. As priority, the Government should re-commit to the £22 billion target for public R&D by 2024/25, publishing a clear investment timeline within the next year. This should be accompanied by a long-term plan for meeting the 2027 commitment to spend 2.4% of GDP on R&D.

While the economic context has changed since the 2020 Spending Review (when the £22bn commitment was made), the case for fulfilling the Government's commitment to increase public investment in research is more important than ever, given the reduction in this year's Department for Business, Energy and Industrial Strategy (BEIS) R&D budget (when UK's contributions to EU programmes were excluded) and the broader hit the R&D sector took from the pandemic. For medical research charities alone, the decrease in total estimated UK research spend for 2020-21 was £270 million. This drop was 7x greater than after the 2008 recession.[6]

Recommendation:

The Government needs to publish a long-term plan and budget for meeting the 2027 2.4% R&D intensity target as soon as possible, which includes support for the whole system. To this end, Government should set out a fully developed timetable outlining how the £22 billion increase will be achieved in order to deliver the 2.4% target.

Without this very clear re-commitment and detailed investment timeline, the UK risks falling further behind our international partners and losing its place as a science superpower. The UK currently invests a lower percentage of GDP in R&D than most of our competitors, many of whom have also launched specific strategies targeted at boosting their innovation performance, including increasing their R&D investment.[7]

Key to cementing the UK as a global science nation will be a recognition, and continued support, of the R&D sector's unique diversity. The UK has a diverse research and innovation ecosystem including academia, charities, and businesses – these players all bring unique strengths to the table, and together deliver substantial benefits to government, the economy and wider society. For the Government to achieve its ambitions for science, research and innovation, the UK's diverse R&D system will need to be considered holistically, with all players supported and championed.

Preserving the district contribution of charity funding in the UK's research ecosystem

As the Government outlines its plan to reach 2.4% of GDP investment in R&D by 2027, it should recognise the distinctive contribution that medical charities make in accelerating the transition of research findings into meaningful health impacts, as well as benefits to the economy.

Medical research charities are a unique and vital component of UK R&D. The Plan for Growth reaffirms that UK R&D expenditure is 'currently concentrated in a relatively small number of large firms based in particular regions of the country'.[8] However, medical research charities such as the BHF fund research in every region of the UK, enabling them to attract further investment and thereby supporting the Government's 'levelling-up' agenda. For example, between April 2015 and March 2020, the BHF awarded 549 new research grants worth over £180 million to research institutions outside the 'Golden Triangle' (I.e., London and the South East) for research and development. Charities invest in the UK's skills pipeline and have made long-term investments in research capacity and capability. In 2019, 17,000 researcher salaries were funded by AMRC members, including 1750 PhD students.[9]

Further, as acknowledged in the Build Back Better Plan for Growth,[10] public investment in R&D, including charitable funding, generates private investment. Every £1 spent on medical research by public and charitable funders delivers a return equivalent to around 25p every year, for ever[11]. For example, BHF funding is often leveraged by research institutions to attract additional funding. Analysis of the BHF's grant portfolio in 2019 showed that researchers leveraged approximately £1.27bn of additional funding from a BHF investment of £476m. The average return on investment from sources other than the BHF was £2.14 per £1 of BHF investment.

Medical research charities are inherently patient-centric and ultimately driven by patient benefit. They exist to meet the needs of their communities, with patient perspectives and priorities at the heart of their work to ensure their investment in R&D has the biggest impact. Given their independence, they can respond to patients' needs in an agile way and develop appropriate research strategies. They are therefore incredibly well placed to drive further improvements in health, particularly in parts of society in most need.

The BHF also funds high-risk, high-reward research that attracts and mobilises world-leading scientists, clinicians, innovators and entrepreneurs to tackle global cardiovascular health research challenges, significantly increasing the probability of developing solutions to some of the world's biggest killers. The BHF's Big Beat Challenge (BBC), for example, is a global competition that will culminate in a single research award of up to £30 million.

As a result of the pandemic, in 2020/21, BHF was forced to restrict research funding for new grants to £51.9m, down from £99.7m in 2019/20, and it could take several years to return to pre-pandemic levels of funding. The #ResearchAtRisk campaign highlighted the devastating impact of the pandemic on medical research charities and raised understanding within Government about their unique and vital role in the research ecosystem. This resulted in the £20 million Early Career Research Support Fund, to help protect the pipeline of charity funded researchers who will improve patient lives in the future. To build on this recognition, and help to mitigate the longer term impact of the pandemic, it will be important for the Government to continue to work in partnership with charities to ensure the sector can continue its unique function in the UK's R&D ecosystem.

In 2019, 87% of all AMRC charity-funded research took place in universities (amounting to £1.65 billion), and on average around 15% of all UK university research funding comes from charities.[12] In England, the Charity Research Support Fund (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.

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.[13] The CRSF has therefore not kept pace with growing charity investment in universities. Without this Government Fund, there would be undue pressure on universities to cover additional costs of research, subsequently endangering charity-funded research within universities.

The CRSF has historically been a welcome recognition from Government on how critical charities are to university research – there is clear opportunity to reaffirm Government commitments to working in partnership with charities by strengthening the CRSF.

Recommendation:

The Government should work in partnership with medical research charities to preserve the distinct contribution of charity funding in the UK's research ecosystem by bolstering the Charity Research Support Fund.

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

Further to investment in the R&D ecosystem, and the charity sector specifically, this CSR should be tasked with catalysing investment across underserved conditions and allocating funding where it will be most impactful.

Heart and circulatory conditions remain the world's biggest killers and account for a considerable burden of disability. The Government's Life Sciences Vision rightly outlines "Prevention and treatment of cardiovascular disease and its major risk factors including obesity" as a key mission.[14]

However, as evidenced in "The Science-Based Economy" report by the Institute for Public Policy Research (IPPR)[15], cardiovascular and stroke research is significantly underfunded compared to the impact of these conditions on society: 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 disability and the number of years of life lost). Relative underinvestment is also present in mental health, respiratory and musculoskeletal and immunological research.

Redressing these disparities in funding relative to disease burden is essential to the Government achieving its life sciences ambitions around tackling the major causes of death and disease through innovation and technical advancement.

The need for greater investment in cardiovascular research has been underscored by the Covid-19 pandemic and the finding that people with pre-existing cardiovascular diseases and many risk factors are more likely to develop severe complications from Covid-19.

Recommendation:

This CSR should outline how the Government intends to meet the Life Sciences Vision's key mission to deliver cutting edge research that addresses the prevention and treatment of cardiovascular diseases. Recognising and addressing the £650m gap in funding that currently exists for cardiovascular research in the UK is essential to spread R&D investment across disease areas, based on societal burden.

Investing adequately in science in the NHS

Clinical research is at the heart of driving improvements for patients, developing new ways to prevent, diagnose and treat disease.

The UK is already a global player in clinical research. In 2018/19, every single NHS Trust in England took part in research, with over 1 million clinical research participants. The evidence and innovations identified through such research are pivotal to the development of new types of care and treatment - ultimately leading to the prevention of ill health, earlier diagnosis, faster recovery and better outcomes.

As well as driving improvements for patients, there is growing evidence that research in the NHS is associated with increased staff retention, job satisfaction and financial benefits to the health system through commercial revenue.

Economic analysis has demonstrated that between 2016/17 and 2018/19, research supported by the NIHR Clinical Research Network generated an estimated £8bn of gross value added and 47,467 full time equivalent jobs for the UK.[16]

The Covid-19 pandemic only served to further highlight the importance of clinical research. For example, the RECOVERY trial was the first study to identify a drug (Dexamethasone) shown to improve survival in patients with severe respiratory complications of Covid-19. However, despite the UK's many successes, the pandemic has exposed areas that must be improved to bolster our future resilience, secure future investment, and deliver improved healthcare for patients. It is clear that increasing research delivery and participation is fundamental to addressing longstanding health inequalities and levelling up healthcare outcomes for patients right across the country.

The UK now has an opportunity to build on its global reputation and Covid-19 successes by investing in NHS research outside of public health emergencies, tackling health issues that place consistent pressure on the NHS, such as heart and circulatory diseases.

In England, the Department of Health and Social Care funds health and care research through the NIHR, one of the largest national clinical research funders in Europe. The NIHR translates discoveries into practical products, treatments, devices and procedures, involving patients and the public in all its work. Through its infrastructure, NIHR also ensures that the NHS is able to support the research of other funders (including medical research charities), thereby encouraging broader investment in, and economic growth from, health research.

However, the impressive success of the NIHR has taken place in the context of several years of flat cash budget. In the November 2020 Spending Review, DHSC only received a one-year settlement, with £1.3bn for NIHR and Genomics England.

In 2021, the Life Sciences Vision and The Future of UK Clinical Research Delivery set out a collective commitment across the UK government, the NHS, regulators, industry and charities to create a digitally enabled and pro-innovation clinical research environment, which is more efficient, more resilient and has research embedded across the NHS as a core part of effective patient care. The BHF contributed to this important work through the Recovery Resilience and Growth (RRG) programme.

However, delivering on these overarching visions and making the UK a globally leading hub for clinical research will only be possible if the conditions—and additional, dedicated multi-year funding—are made available.

We believe that DHSC needs to be appropriate resourced to deliver on the Government's vision for the future of UK clinical research delivery. In particular, an uplift to the NIHR budget should be used to strengthen and expand our vital clinical research infrastructure. This includes increasing capacity for clinical research delivery across the NHS, for example by exploring giving more NHS staff contracts that include dedicated research time. An uplift could also allow the NIHR to invest more in upskilling the NHS workforce by funding training programmes that develop the confidence, expertise and capacity of NHS staff to deliver research.

Recommendation:

The CSR should recognise the critical role of NIHR in realising the UK's Clinical Research Vision of strengthening and expanding the UK's vital clinical research infrastructure and ensure the NIHR budget is uplifted in line with other parts of the research budget. This should include increasing capacity for clinical research delivery across the NHS.

The RRG Programme should hold responsibility for the monitoring and evaluation of delivery, to ensure that progress against commitments is measured and assessed.

It is important to recognise the current pressure NHS Staff and organisations are under following the pandemic response, with a sizeable backlog of care and workforce fatigue. However, clinical research, rather than being a burdensome addition, can play a major role in our health system recovery which supports not only patient outcomes, but staff satisfaction also.

2. The NHS faces a significant backlog of cardiovascular care and should be properly funded and resourced

Relieving pressure on the NHS workforce

Addressing the impact of Covid-19 on the healthcare system will also be crucial to realising the Clinical Research Vision. Although some clinical research studies, including trials, have resumed alongside resumption of non-Covid-19 related NHS services, many are still paused and some studies will never resume.

Further, while we can point to successes in areas such as Covid-19 research and learn from these experiences, they mask fundamental barriers to research in the UK that existed before the pandemic. Evidence over many years shows that a lack of time and capacity for healthcare staff to conduct or participate in research has significantly held the UK back.[17]

Pre-pandemic, staff even reported having to take annual leave to conduct research and funders report finding it harder to set up and run clinical trials. Pressure on time is only increasing as clinical trials become ever more complex due to advances in scientific understanding and persistent staff shortages across the health service.

Prior to the pandemic, cardiology services already had significant staff vacancies across the UK. In England, there was one cardiologist per 41,335 of the population, with significant regional variation in access to cardiologist-led care.[18] According to the Getting It Right First Time (GIRFT) Cardiology report, consistent coverage at the level that currently exists in the north of England (one cardiologist per 36,000) would require the creation and successful appointment to 94 new cardiologist posts.[19]

There were also vacancies across the wider workforce, with suboptimal numbers of both advanced clinical practitioners (ACPs) and specialist nurses in England. According to the Alliance for Heart Failure, around 84% of heart failure services meet the current recommendation of one specialist nurse per 100,000. But many services are struggling with unmanageable caseloads due to the increased prevalence of heart disease since the current recommendations were drawn up, in 2002.[20] Current estimates are that between three and four heart failure specialist nurses or ACPs are needed per 100,000 population to deliver the requirements of the Long Term Plan.[21]

The health and care system was already working at reduced capacity in the years prior to the pandemic, due to a combination of high vacancy rates and increased caseloads. As a result, health and care services across the UK entered the Covid-19 pandemic with an already overworked and exhausted workforce.

The health and wellbeing of NHS staff was severely impacted by the pandemic. At the frontline of the Covid-19 crisis, their work became much more difficult and dangerous than usual and, as a result, many healthcare professionals became unwell with Covid-19, and some sadly died. The demands of delivering care during a pandemic compounded pre-existing workforce pressures and resulted in a concerning rise in work-related stress and burnout across the NHS workforce.[22]

Given the challenges that lie ahead, it is expected that some staff may decide to leave the NHS, compounding existing workforce shortages. Polling in May 2021 by YouGov of 1,009 NHS workers in England across all roles found that 1 in 11 (9%) are considering leaving the healthcare sector.[23] Worryingly, the number of UK doctors now considering early retirement has more than doubled in less than a year, with 32% of respondents to a British Medical Association survey saying they are considering leaving the NHS early.[24] This could have a detrimental impact on clinical leadership, at a time when significant changes are taking place in the health and care system.

The Government's commitment to recruit and train new NHS staff is welcome, as workforce pressures are likely to be one of the biggest hurdles to recovery from the pandemic. The Health Foundation estimate that, to tackle the backlog of care and meet future demand, the NHS workforce would need to grow by 20% by 2024/25.[25] But training new staff takes time, so targeted investment in the workforce is needed now – both to recruit and train new staff (including from overseas), and to retain and upskill existing staff.

Recommendation:

This CSR should include rapid investment to build more capacity into NHS England (NHSE) and relieve pressure on the workforce. It should prioritise recruitment, training, and retention of skilled NHS workers.

Increasing funding to tackle the backlog of care

Despite the unwavering efforts of NHS staff, there has been seismic disruption to cardiovascular care during the Covid-19 pandemic, with devastating consequences for many of the 7.6 million people who live with heart and circulatory diseases in the UK.

Even before the pandemic began, around 233,000 people in England were on waiting lists for heart diagnosis or treatment. The backlog of heart care caused by the pandemic is vast, and it continues to grow, exacerbating existing problems in the health and care system.

The latest NHSE statistics published in mid-September reveal that at the end of July 2021 in England, 260,403 people were waiting for heart tests and treatment, including invasive heart procedures and heart surgery – the highest number on record. The number of people waiting over a year decreased in July 2021 to 3,634 from a peak of 5,248 in March 2021, however, the figure is still 130 times higher than before the pandemic began in February 2020, when just 28 people had been waiting this long. As of the end of July 2021, there were 56 people in England who had been waiting over two years for a heart procedure or surgery.[26]

The BHF's modelling of waiting lists for cardiology treatment in England shows that it will take years for the heart care backlog to recover to pre-pandemic levels in England.[27] In the 'best case' scenario, where demand for services rises in line with Government investment in the NHS, the cardiology waiting list could peak at 352,660 in March 2022. In this scenario, returning to waiting lists equivalent to before the pandemic would take until around May 2024.

In the 'worst case' scenario, we estimate that it could take up to five years for the heart care backlog to recover to pre-pandemic levels. In this scenario, the number of people waiting for heart care and diagnosis could peak at 550,385 in January 2024, and it would take until around November 2026 to return to a waiting list equivalent to before the pandemic.[28] This disastrous scenario is possible if NHSE does not get enough investment and is under increased pressure from Covid-19 or a bad winter.

BHF analysis indicates that the bulk of cardiology waiting lists consists of people waiting for a diagnosis, so it will also be important for this CSR to prioritise investment in diagnostic hubs (including the infrastructure and specialist equipment they need) to tackle the backlog of cardiovascular care in the short and medium term.

Cardiology waiting lists do not give the full picture. There are potentially a large number of people who may not yet know they are at risk of becoming more unwell without any treatment, or who have existing conditions or symptoms but who have not yet come forward for diagnosis or treatment.

Even in the context of the pandemic, CVD continues to be a significant driver of ill health and inequality in the UK. But it does not have to be that way. CVD is often preventable, and most conditions can be treated successfully. If the Government acts now to invest in the NHS and address the backlog of cardiovascular care, it can avoid preventable deaths and improve the quality of life of the millions of people living with CVD in the UK.

The recent announcement of £10bn (up to 2024/25) to tackle the backlog of elective care is welcome, but in light of our prediction that waiting lists for vital heart care could more

than double within two years, it will not be sufficient.[29] Health Foundation analysis indicates that closer to £17bn of dedicated funding up to 2024/25 would be needed to clear the backlog and return to the 18-week waiting time standard.[30]

Recommendations:

This CSR should commit an additional £7bn of dedicated funding to clear the backlog of elective care, including vital cardiovascular care.

This CSR should take a far-sighted approach and commit substantial and long-term increased investment in the health and care system to put the NHS on a sustainable footing and meet future care needs. At the minimum, the NHS will need an increase in funding of 4% a year on average for the next ten years to bring health spending in the UK in line with other G7 countries, as advised by the recent LSE-Lancet Commission.

Funding allocations at the regional and local level should have a strong focus on the reduction of health inequalities associated with CVD, exacerbated by Covid-19.

Targeting waiting lists is one way to address the backlog of care, but it will also be important for this CSR to support the wider health and care system. In addition to supporting hospitals and other secondary care providers, this CSR should invest in primary and community services. These services have an important part to play in helping patients to stay well while they wait for hospital care, as well as mitigating future impact on secondary care. To enable the NHS to recover from the impact of the pandemic in the longer-term, additional investment is also needed to put the NHS on a sustainable footing. This will be crucial for delivering the goals of the NHS Long Term Plan, including the ambition to improve health outcomes through 150,000 heart attacks, strokes, and dementia cases by 2029.[31]

3. The prevention of ill-health is vital to levelling up our economy and helping to decrease the burden of disease on the NHS

Investing in better health for all through a strengthened Public Health Grant

Better health for all is a fundamental driver of increased productivity and economic levelling up. Analysis has shown that ill-health amongst the working-age population cost the economy an estimated £100 billion a year in 2015/16.[32] Investment in the prevention of ill health also represents value for money, with a £14 return to society on every pound spent on public health interventions.[33]

Covid-19 has made the need to improve population level health even more obvious. We know that those with an underlying health condition are at greater risk of serious illness from Covid-19; according to the King's Fund, 88% of those who died due to Covid-19 had a pre-existing condition such as dementia, diabetes or high blood pressure.[34] Analysis has also shown that having a body-mass index (BMI) classed as obese increases the risk of worse outcomes from Covid-19.[35]

As with Covid-19, improving the baseline health of the population can help to reduce the risk of heart and circulatory diseases. Two of the greatest risk factors for these conditions are smoking and living with obesity. In England, it's estimated that at least 12,000 deaths each year from heart disease and stroke can be attributed to smoking,[36] and there are around 25,000 heart and circulatory deaths attributable to excess weight and obesity every year - that's an average of 68 each day.[37] As well as the health burden associated with both smoking and obesity, there is a substantial economic cost. Lifetime costs to society of obesity have been estimated to be as high as 3% of GDP, equivalent to £60 billion in 2018,[38] and of tobacco at 3.6% of GDP, equivalent to over £70 billion per year in 2018.[39] A separate analysis places the immediate cost to UK society of smoking at £12.5 bn per year.[40]

Particularly concerning is that this impact is not spread equally. Obesity levels are higher in socio-economically disadvantaged areas: around 28 per cent of Year 6 children living in the most deprived areas of England have obesity compared to around 12 per cent of those living in the least deprived places.[41] Similar trends are seen in obesity prevalence in adults: the obesity prevalence gap between women from the most and least deprived areas was 17 percentage points in 2019 and for men was 8 percentage points[42], an increase from 11 percentage points for women and 2 percentage points for men in 2014.[43]

Tobacco use is also a key driver of health inequalities, with the Marmot Review noting that approximately half the difference in life expectancy between the richest and poorest in society can be attributed to smoking.[44] In 2019, smoking prevalence in Blackpool, an area of high deprivation, was 23 per cent, compared to 8 per cent in Richmond upon Thames, which is in the least deprived decile.[45]

Reducing rates of smoking and obesity in the UK would almost certainly reduce the incidence of heart and circulatory diseases, reduce the costs to society of treating the resultant ill health burden and impact on productivity, and contribute to the Government's critical work on levelling up. A key factor in achieving this will be the provision of universally accessible weight-management and stop-smoking services. Both are primarily funded by the Public Health Grant, which provides vital resource for local authorities to commission crucial preventative services.

The 2021-22 Public Health Grant of £3.3bn provided a slight increase (£45 million) on the previous year's grant but, in real terms, this represents a 24% cut since initial allocations were made in 2015–16.[46] Moreover, analysis has shown that cuts to the public health grant have disproportionately affected the most deprived communities: the Institute for Public Policy Research (IPPR) found that almost £1 in every £7 cut from public health services has come from England's ten most deprived communities - compared to just £1 in every £46 in the country's ten least deprived places.[47]

Cuts to Public Health Funding are having a significant impact on the provision of services. 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.[48]

The £30.5 million invested in local authority weight management services in 2021/22 was a welcome step, and we were particularly pleased to see the commitment to monitoring and evaluating these services to enable learning and sharing of best practice, as well as ensuring that "underserved population groups have access to weight management services and how services can be tailored to meet specific needs."[49] This evaluation and

learning must be built on and used to direct resources to ensure that all local authorities have adequate, sustainable funding, for their local need.

Stop smoking services have been equally affected. Tobacco control public health funding saw cuts of more than 20 per cent between 2016/17 and 2021.[50] Recent analysis by Action on Smoking and Health and Cancer Research UK has shown that, in 2020/21, only 62% of local authorities surveyed provided a universal specialist stop smoking offer, while 77% provided a specialist service.[51] Evidence shows that stop smoking services are cost-effective: for every £1 invested in Stop Smoking Services, an estimated £2·37 will be saved on treating smoking-related diseases and reduced productivity.[52] Both universal and tailored services for communities with the highest rates of smoking are required to ensure that all smokers have access to the support they need.

As we look to restoration of services post-Covid, it is vital that all local authorities have sufficient funds to meet demand in their area. According to the Health Foundation, £1bn is the minimum amount required to stabilise the Public Health Grant and restore funding to 2015 levels. A further £2.6 billion should be invested in the Grant to reduce inequalities in funding across different regions.[53]

Recommendation:

An additional investment of £1 billion a year must be the minimum investment to the Public Health Grant, restoring funding to 2015 levels. The Public Health Grant must also be maintained as a ring-fenced fund for local authority-commissioned public health activities and services.

Moreover, the Public Health Grant must be maintained as a ring-fenced fund for local authority-commissioned public health activities and services following the transition to ICSs. We welcome the focus of Integrated Care Systems (ICSs) on population health and inequalities, and the ability afforded by the Health and Care Bill for ICSs to pool and direct their resources flexibly.

However, designated public health funding must be preserved and should not be redirected to help fund other aspects of health and care at the expense of local, community services that are universal and designed to meet the needs of the local population. Instead, adequate funding must be provided to each part of the system to allow it to properly discharge its prevention duties and the Health and Care Bill should create the conditions that support collaboration, resource-sharing and activities that meet the need of local populations.

The NHS Long Term Plan also made commitments to the prevention of ill health, notably:

1. The rollout of NHS-funded tobacco treatment services to all people admitted to hospital who smoke by 2023/24;
2. Specific aims to increase access to weight management services to people living with obesity and at increased risk of heart and circulatory diseases due to diabetes and high blood pressure.[54]

The NHS settlement must include funding to support full rollout of these programmes, to help drive progress towards the Plan's aims of improving health outcomes, including up to

150,000 fewer heart attacks, strokes and dementia cases over the next 10 years[55], and the Government's broader pledge to achieve 5 extra healthy years of life for everyone by 2035.

Funding tobacco control via a Smokefree 2030 Fund

In December 2020, the Public Health Minister confirmed that a new Tobacco Control Plan for England is due to be published, with an aim of achieving a Smokefree 2030[56]- a smoking prevalence of 5% or less by 2030. We are hugely supportive of this aim but recognise that it will take bold action and significant investment in tobacco control efforts.

Alongside restoration of the Public Health Grant, a mechanism for further supporting spending on tobacco control has been proposed by the All Party Parliamentary Group on Smoking and Health in their June 2021 report outlining priorities for the new Tobacco Control Plan for England[57]. This is a Smokefree Fund, constituted as a levy on the tobacco industry. This could provide a sustainable source of income, estimated at £700 million, which is significantly more than the estimated £266 million required to deliver a Smokefree 2030 in England,[58] and makes the Government's aim substantially more achievable.

Tobacco manufacturers are highly profitable and the principle of 'polluter pays' dictates they should bear responsibility for paying for the cost of tobacco control. In 2018, it is estimated that tobacco manufacturers made over £900 million in profits in the UK alone.

Yet despite their enormous profitability, the major tobacco manufacturers pay little profit tax in the UK.[59] The Government's ultimatum for industry to make smoked tobacco obsolete by 2030 will only be delivered if it becomes less profitable to sell combustible tobacco products. A statutory scheme could achieve this by imposing a targeted, tobacco-manufacturer profit cap, utility-style price controls and raise funds from the industry through a charge based on sales volumes.

Recommendation:

In the 2021 Budget, Government should commit to a Smokefree Fund, a levy on the tobacco industry, that would provide an estimated £700 million source of income to fund Government ambitions for a Smokefree 2030 in England.

Introducing a reformulation levy on the food industry to fund initiatives to improve access to healthy diets

Sugar and salt consumption in the UK are consistently above the recommended levels, with long-term health implications. The most recent figures show that average salt intake in UK adults[60] remains well above the guideline level of 6g per day, set by the Scientific Advisory Committee on Nutrition (SACN) in 2003,[61] with 5,000 deaths from heart and circulatory diseases associated with high sodium intake in the England every year.[62]

While voluntary Government salt reduction programmes have had significant benefit since the early 2000s, progress has stalled. Only half (52%) of all the average in-home salt reduction targets set in 2014 were met by 2017.[63] Similarly, the UK's voluntary sugar reduction programme has had limited success. An Autumn 2020 progress report showed that, despite a sugar reduction target of 20% by 2020, a reduction of only 3% was

achieved three years into the programme, while sales of sugary products such as chocolate confectionery have increased.[64] Contrastingly, the Soft Drinks Industry Levy has led to a 35% reduction in sugar sales from soft drinks between 2015 and 2019, despite increased sales of soft drinks.[65]Analysis suggests that the SDIL has led to 36,000 fewer cases of obesity in children and teenagers in England.[66]

It is clear that a mandatory approach to reformulation can meaningfully drive progress and deliver health benefits. The recently published National Food Strategy proposes the introduction of a tax of £3/kg on sugar and £6/kg on salt at wholesale level, in order to incentivise manufacturers to reduce the salt and sugar content of their products.[67] Modelling of this policy showed significant potential benefits, saving up to 97,000 years of healthy life lost in the UK each year, and raising £2.9bn-£3.4bn per year for the Treasury.

The strategy proposes that the revenue should be spent on initiatives to increase the affordability of a healthy, balanced diet for families on low incomes, including expanding eligibility for free school meals and Healthy Start vouchers and providing greater access to fruit and vegetables. Through a mandatory approach to reformulation of food in combination with appropriate support for people through weight loss services and smoking cessation services, we can make meaningful gains towards the 'five extra years of healthy life by 2035' ambition committed to in the 2019 Conservative Party manifesto.

Recommendation:

The 2021 Budget should commit to the introduction of a reformulation tax, like that proposed in the National Food Strategy. The revenue should allow increased spending on initiatives to increase the affordability of a healthy, balanced diet for families on low incomes.

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