September 2024

British Heart Foundation

Priority asks for Autumn Budget 2024

Introduction

The British Heart Foundation (BHF) is the nation's heart charity, representing the 7.6 million people living with heart and circulatory diseases in the UK. BHF currently supports £440 m of lifesaving research across the UK, as well as over 1,200 research staff.

Since BHF was established in 1961, the annual number of deaths from heart and circulatory disease has fallen by nearly half. Nevertheless, cardiovascular disease (CVD) remains a major cause of mortality in the UK, leading to around a quarter of all deaths. In more recent years, the picture has grown more alarming, as the rate and number of premature deaths from CVD has risen for three consecutive years. BHF analysis of national statistics shows that in 2022, over 39,000 people in England alone died prematurely (under the age of 75) of cardiovascular conditions, which is an average of 750 people each week – a 14-year high.

As NHS England's Long-Term Plan rightly set out in 2019, cardiovascular disease is the single biggest area where lives can be saved by the NHS. That is as true today as it was then. Sadly, the picture is worsening and we need to act immediately. As challenging as the issue may seem, action can be taken to try and reverse these trends and get heart care back on track.

The economic argument for tackling heart disease

Delivering game-changing health benefits by tackling cardiovascular disease will not only transform millions of lives and help contribute to an increase in healthy life expectancy, but it will also deliver a more prosperous nation. We welcome the commitment from the Government to tackle the biggest killers, including CVD, as well as the ambition to reduce deaths from heart attacks and strokes by a quarter over the next decade. These commitments could have a large, positive impact on people's lives across the UK. In fact, the cost of *not* acting is vast. Every year, the UK spends an estimated £12bn on cardiovascular disease healthcare costs, and the wider cost to the economy is £28bn.[1]

A significant proportion of this is driven by cardiovascular disease-related economic inactivity. More working-age people are reporting long-term health conditions than ever before,[2] with cardiovascular disease being the fifth most commonly reported condition among people economically inactive due to poor health in the UK.[3] Those with long-term health conditions and their carers may be less productive due to these conditions, requiring more time off for treatment or recovery, meaning potential long periods of time out of work.

Previously, the impact of mental health and arthritis on employment has been prioritised, but cardiovascular disease should also be a key focus, with Institute for Public Policy Research analysis showing that it increases the risk of exiting employment most sharply compared to other health conditions.[4] In fact, IPPR found that heart disease is the single largest factor behind people leaving the workforce due to ill-health, and that 30% of people who are economically inactive have a cardiovascular condition.[5] Addressing this over the course of this Parliament will bring greater productivity, economic benefits, and longer and healthier lives to people in the UK.

A sustained and strategic focus on lessening the impact of cardiovascular disease for good can deliver economic growth and a healthy nation, contributing significantly to the Government's aims to fix the foundations of the UK economy.

BHF's priority asks

To truly stop the heart care crisis in its tracks, reduce the cost of ill-health and facilitate economic growth in the process, we must:

- **Prioritise prevention** – We need to change the way we approach prevention, with a new strategy and new ways of working that address commercial determinants of ill health, embrace the digital age and empower patients and the public.
- **Tackle long waits for cardiac care** – The pandemic had a huge impact on non-covid care, but waiting lists were rising before then. We need a laser focus on supporting the NHS across England to bring long waits down, including by investing in the workforce.
- **Embrace and facilitate a revolution in technology and data** – We need to ensure the widescale adoption and use of new technologies that will transform the way we prevent, detect and treat heart disease.
- **Eradicate growing inequalities** – It is unacceptable that too many people see worse outcomes from heart disease because linked to their economic status, gender or ethnicity.
- **Invest in research** – No new cardiovascular treatments were licensed in the UK in 2023. We must double-down on our commitment to finding the cures and treatments of the future with research investment that matches the burden of disease.

Although some policies and investment in pursuit of the above will require a longer-term focus, there are things that can be done in the next year in order to improve everyone's cardiovascular health and begin bringing the associated financial burden down.

Below we make policy recommendations to be implemented in the upcoming Budget, as well as longer terms asks that we believe the Government should implement throughout this Parliament and in the upcoming Comprehensive Spending Review (CSR).

Better prevent heart disease and stroke

Most cases of cardiovascular disease are preventable – 70% in the UK can be attributed to modifiable risk factors including obesity, tobacco and air pollution.[6] The goal of any Government must be to create an environment where everyone can live in good health for longer, delaying the onset of disease, and helping to create a stronger, more resilient population.

As well as being the right thing to do for people's health and wellbeing, this would help the economy. Spending on disease prevention at a population level is cheaper than treating individuals when they become ill. It costs around £3,800 to give an additional year of good health to someone's life using public health measures, compared to around £13,500 using NHS interventions.[7]

At a time when public finances are increasingly stretched, and the NHS in particular is at risk of dominating the entire economic picture, investing in prevention is fundamental to reducing the size of the healthcare burden, whilst boosting economic productivity and improving people's lives.

1. Maximise the potential of the Soft Drinks Industry Levy

The Soft Drinks Industry Levy (SDIL) has been highly effective, reducing sugar levels in soft drinks by 46% between 2015 and 2020,[8] and reducing daily consumption of free sugars by 4.8g in UK children and 10.9g in UK adults.[9] Furthermore, the SDIL raises an average £300 m each year[10] which has previously been used to fund a national breakfast programme, a holiday hunger programme and school PE premiums.

However, there are some limitations within the current structure of the SDIL that are stopping it from being even more effective. Firstly, milk and milk-alternative based drinks remain out of scope of the current SDIL. Whilst there has been some progress in voluntary sugar reduction of milk and alternative milk-based drinks in the pre-packaged retail sector, the last figures for out-of-home open cup milkshakes showed a 12.7% increase in sugar content and a 12.2% increase in calories per single serving from baseline[11]. Secondly, unlike tobacco and alcohol duties, the SDIL has never been uprated with inflation. Lastly, most manufacturers have reformulated their drinks to the current thresholds, but even at the lower threshold of 5g sugar per 100g, a drink still fails the Nutrient Profiling Model and is considered high in fat, salt and/or sugar (HFSS) in government

advertising and promotional regulations. Whist acknowledging the progress made, lowering the threshold would bring SDIL in line with the current nutrient profiling model (NPM) and drive further reductions in sugar content and/or increases in revenue.

Recommendations: In the forthcoming Budget, HM Treasury should announce the extension of SDIL to sugary milk- and alternative milk-based drinks across the whole soft drinks category, to be introduced no later than April 2025.

HM Treasury should also strengthen the SDIL to incentivise further product reformulation and increase revenues for investment in children's health. This includes:

- Announcing an intention to uprate the liability under the Levy starting no later than April 2025.
- Initiating a review of the current tiered approach to the Levy, and options for incentivising further sugar reduction and/or maximising its revenue potential.
- Maintaining a stated commitment to ensuring revenues from SDIL and any further healthy food and drink levies support government investment in programmes to support children's health.

BHF is a member of the Recipe for Change coalition[12] and refers to their submission for further details on these recommendations.

2. Open a call for evidence on measures to incentivise healthier food and drink production beyond the Soft Drinks Industry Levy, including use of further financial levers

Despite existing policies and programmes, average sugar and salt consumption in the UK is above recommended levels for both adults and children. Overconsumption of sugar is associated with the onset of obesity, which costs the UK economy £98 bn each year[13], and accounts for approximately 1 in 6 heart and circulatory disease deaths.[14] Overconsumption of salt is directly linked to hypertension, which is associated with half of all heart attacks and strokes in the UK.[15]

Despite success in the early 2000s, progress under the previous Government's voluntary salt reduction programme has stalled. Only half of all the average in-home salt reduction targets set in 2014 were met by 2017 and no progress report has been published since.[16] BHF modelling found that, if all adults met UK and World Health Organization guidelines for salt consumption by 2030, we could avoid up to 1.4 million cases of high blood pressure and save the UK economy up to £11.4bn by 2035. While reformulation alone won't take us to these guidelines, it is a vital part of a wider strategy to improve dietary health across the population, which will lessen future pressures on frontline health services.

Similarly, the voluntary sugar reduction programme, which began in 2015 and was extended until 2025, has so far seen mixed results. No category has yet met the 20% target, and there was only a 3.5% overall reduction in the average total sugar per 100g in products sold for in-home consumption and a 0.2% reduction in out-of-home products.[17] A voluntary approach is insufficient to drive progress at the pace and scale needed.

The SDIL has demonstrated that mandatory measures can shift industry practice where voluntary schemes have failed to deliver sufficient results. There is an urgent need for a broader fiscal measure, to reduce salt and sugar levels in products across the supply chain and create a level playing field across the food and drinks industry. The National Food Strategy proposed a wholesale tax on sugar and salt which could save up to 97,000 years of healthy life lost in the UK each year and raise up to £3.9 bn per year for HM Treasury.[18] A mandatory measure along these lines, or even a more focused levy targeting categories already included in existing legislation such as the 9pm watershed and online advertising restrictions, would drive further reformulation and accelerate progress towards a healthier, more productive nation.

Recommendation: As a first step towards a longer-term ambition, issue an HM Treasury and Department for Health and Social Care (DHSC) joint call for evidence on measures to incentivise healthier food and drink production beyond the Soft Drinks Industry Levy, including use of further financial levers. Government should then explore the development of these measures at the upcoming CSR.

BHF is a member of the Obesity Health Alliance[19] and supports the recommendations made within its submission.

3. Reinforce existing commitments to achieving a Smokefree UK

The BHF warmly welcomes the Government's commitment to reintroduce the Tobacco and Vapes Bill to raise the age of sale of tobacco, introduce new measures to reduce the appeal of e-cigarettes to young people, and reduce the impact of second-hand smoke on population health.

Smoking is still one of the leading preventable causes of disease and premature death in the UK, with at least 15,000 attributable heart and circulatory disease deaths a year, and a significant contributor to health inequalities.[20] Indeed, around half of the difference in life expectancy between the least and most deprived in society is due to smoking.[21] Passing and implementing the Tobacco and Vapes Bill as quickly and effectively as possible to drive progress towards a Smokefree UK, including by raising the age of sale of tobacco, is critical. But there is still more to do.

Recommendation: The Budget must reinforce this legislation by honouring and sustaining existing investment commitments of £142.5 m per annum for stop smoking services, anti-smoking mass media campaigns, and enforcement of underage and illicit trade.[22] In addition, at least £85 m per annum additional funding must be secured to fully roll out and integrate the NHS Long Term Plan commitments to tobacco dependence treatment into routine care, in line with Labour's manifesto commitment on smoking cessation.

BHF is a core funder of Action on Smoking and Health (ASH)[23] and supports the taxation recommendations outlined in their submission to reduce the affordability of smoking and to discourage young people and non-smokers from vaping.

4. Invest in a long-term tobacco control strategy

Alongside the measures contained in the Bill, a comprehensive tobacco control strategy is urgently needed to build on current steps to prevent uptake of smoking and support people to quit and make the Government's ambition of a Smokefree UK a reality.

It is estimated that £11 bn is raised annually from tobacco taxation in the UK, while the full cost of smoking to the UK is estimated at £15.6 bn per year.[24] Given that the four biggest tobacco manufacturers each make on average £900 million a year in the UK, with a net operating profit margin of 50%, it is reasonable to expect such a harmful industry to pay for the damage its products cause through a levy on their profits.[25]

A "polluter pays" levy on the tobacco industry, also known as a Smokefree Fund, could raise an estimated £700 m per year to fund a strategic approach that will deliver vital tobacco control measures and stop smoking services.[26]

Recommendation: To help fund a long-term and comprehensive tobacco control strategy, HM Treasury should use the Budget to introduce a 'polluter pays' tobacco levy to enable investment in vital smoking cessation and enforcement measures.

We refer to the representation from Action on Smoking and Health, to which BHF provides core funding, for further details.

5. Define an adequate and sustainable model of funding to support a prevention-first approach and address health inequalities

The current approach to public health investment is sub-optimal: money is not ring-fenced, and the long-term benefits are undervalued. We know that vital public health services, such as weight management and stop smoking support, are not available to everyone who needs them. Health Foundation analysis shows a 28% real terms drop in the Public Health Grant that funds these services between 2015/16 and 2023/24, with cuts disproportionately affecting more deprived areas.[27] Numerous organisations, including the BHF, have long called for an uplift the to the grant of at least £1 bn per year, and for a more sustainable solution to be found.[28]

This is particularly important to addressing inequalities. CVD remains inextricably linked to the wider health inequalities of the UK. Heart and circulatory diseases alone account for around a fifth of the life expectancy gap between the most and least deprived communities in England and is a significant driver of lower healthy life expectancy in deprived areas.[29] The alarming rise of premature deaths from heart and circulatory diseases in recent years has not been felt equally across society. It is falling most acutely on the poorest, with the most deprived areas of England experiencing a rate of early deaths from CVD that is 2.5 times higher than the rate seen in the least deprived areas.[30]

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What's more, inequalities in health outcomes from CVD are determined before people even fall ill. The modifiable risk factors driving the onset of preventable CVD are also more prevalent in the most deprived parts of the UK. The prevalence of obesity is 15 percentage points higher in the most deprived decile than the least, with similar levels of physical inactivity reported.[32] Smoking prevalence, having dropped in recent years, is still more than three times higher in the most deprived areas compared to the least deprived. This embeds CVD as a major barrier to achieving economic growth, as underlying inequalities in preventing and managing CVD burdens large swathes of the working-age population with increasing morbidity and early mortality.

As such, Government's shift to a prevention-first approach is welcome, but it must also place addressing inequalities at its heart. Such an approach will pay off in the longer term but will require significant initial and sustained investment. Many of the proposed policies outlined above can help provide a source of the required upfront revenue, shifting the financial burden of some of the commercial determinants of our unhealthy environment – namely the marketing, promotion and abundance of health-harming commodities – towards the manufacturers of these products. Many organisations, including the Tony Blair Institute for Global Change[33] and the Health Foundation[34] have proposed models for increasing and ring-fencing government spending on prevention. It is the BHF's position that Government should review these models and adopt the proposals they deem most appropriate.

Recommendations: In this Budget, an uplift of at least £1bn per annum is required to restore the Public Health Grant to historic levels and ensure that local authorities can provide support that meets their population's needs.

Government must also immediately initiate work, overseen by its Health Mission Board, to define a new, sustainable and equitable funding model for promotion across Government, the healthcare system and at local level, to inform the upcoming Comprehensive Spending Review. The work of the Board must be centred on the principle that spending on health promotion is a vital long-term investment.

Prioritise NHS heart care to minimise the time it takes for people to get help

Timely, specialist care is critical to prevent disability and premature death from CVD. However, a perfect storm of record high NHS waiting times, missed opportunities to identify and treat cardiovascular disease risk factors, and an overstretched cardiac workforce are all putting countless lives at risk.

At the end of June 2024, cardiac waiting lists in England were at their highest total on record at over 426,000,[35] and record numbers of people are waiting over 18 weeks for potentially lifesaving elective heart tests and treatment.[36] We believe that rising waiting lists are being driven by an increased need for care and are compounded by an NHS that can't keep up, with the cardiac workforce facing burnout, shortages, and a lack of the infrastructure and equipment they need. Getting to grips with this heart care crisis must be a priority if we are to reduce the physical and economic burden on the NHS.

1. Focus on secondary prevention and case-finding

Millions of people are living with risk factors for CVD like hypertension, high cholesterol, and atrial fibrillation; many of whom do not know it and are consequently not having their condition appropriately managed.[37] These people risk ending up on the ever-growing waiting lists for elective care, or worse, experiencing a life-threatening emergency such as a heart attack or stroke.

The potential gains from increasing the number of people diagnosed with a risk factor and managing their condition appropriately are vast. UCL Partners estimate that if just 80% of people in England with diagnosed high blood pressure were on optimal treatment, around 16,000 heart attacks and strokes would be prevented in just three years with savings to the NHS of £180 m[38].

There are examples of how CVD risk has been successfully prioritised in recent years: NHS England's Core20PLUS5 approach to inequalities includes hypertension and cholesterol as clinical priorities; the BP@Home remote management programme has shown promising improvements for some patients;[39] the CVDPREVENT audit of primary care is supporting local systems to deliver targeted support to areas of unmet need;[40] and the Community Pharmacy Blood Pressure Checks service is enabling hypertension case-finding in community pharmacies, closer to the patients who need it, with estimates that this could prevent more than 1,350 heart attacks and strokes in the first year alone.[41] Newly announced blood pressure checks in dentistry and optometry settings, and rollout of the NHS Health Check to certain workplaces are also welcome, as is piloting of the new Digital NHS Health Check. This proactive approach is particularly important, as we know that Health Check uptake is consistently low in the eligible population.[42]

However, these programmes are often locally implemented and limited by short-term funding cycles, an inability to scale more widely, a lack of public awareness around risk factors, and infrastructure and workforce challenges. Sustained funding for local systems is needed to enable them to tailor programmes for their area. Funding for CVD Prevention leadership must also be protected: these roles ensure oversight and alignment of the delivery of the CVD plan for their Integrated Care System (ICS) with overarching NHS priorities.

Beyond optimising and supporting these programmes, the time is right for the UK Government to support an approach that embraces advances in technology, capitalising on innovations in data science, behavioural sciences, and digital technology and AI to stimulate development of a new, more efficient model of care in cardiovascular prevention. Looking outside of primary care, and learning from low-cost innovations seen internationally, often in low-income countries, we see huge potential to transform the detection and management of these risk factors and deliver transformative change.

Recommendations: Government should, through this Budget, ensure sustained funding for local systems and NHSE to implement, evaluate and build on programmes to find people living with

cardiovascular risk factors and ensure that their health is appropriately managed to avoid a heart attack or stroke.

Longer-term, we urge HM Treasury to work with DHSC and NHS England (NHSE) to support a new, transformative model of care in CVD prevention.

2. Maximise capacity to reduce the cardiac elective backlog

Long waits for care are dangerous and can cause permanent disability and even death. Many patients are also telling us that they are not being sufficiently supported while they wait for care. This can result in those waiting becoming more unwell and likely requiring additional and more complex care or leaving them out of work longer, potentially increasing the burden on the health system, and causing wider cost to the economy.

Increases in cardiac waiting lists *and* waiting times are driven by complex and interconnected drivers, including an ageing population. The stubbornly high need for cardiac services is reflected in high referral rates (bucking the trend of overall referrals decreasing), and patients aren't moving efficiently through the pathway.[43] While we lack the granular data across the cardiac pathway to confidently identify specific pinch points in waiting lists, there are indications that diagnostic supply and demand is likely one driver behind delays to care. The number of people waiting for an echocardiogram, although slowly improving, remains stubbornly high, and significantly higher than pre-pandemic.[44]

We welcome recent developments such as the introduction of Community Diagnostic Centres (CDCs) and the Government's manifesto promise to double NHS scanners. If well resourced, these could speed up diagnosis of heart conditions, though further evaluation of CDCs will be needed to assess their true impact on diagnosis rates within the cardiac pathway.

Additional solutions that have been proposed to tackling waiting lists including increased use of private sector capacity, surgical hubs – which have been found to increase treatment volumes and shorten hospital stays[45] - and maximising staff and hospital theatre time through evening and weekend work. These are all welcome moves in the short term, but there are caveats to their use. With CDCs and 'high-intensity' theatres relying on the currently available pool of workforce, it's clear that sustainable NHS investment and the necessary workforce planning will be necessary[46].

Alongside this, local systems must be supported to build on pockets of innovation, such as use of remote monitoring to support patients while they wait,[47] ensuring they are fit for treatment and avoiding unnecessary cancellations and delays.

Recommendations: Government must prioritise cardiac waiting lists, supporting immediate initiatives to improve efficiency and maximise capacity through the cardiac pathway. This includes resourcing CDCs and utilising private sector capacity where appropriate, with evaluation of these programmes a necessity.

For the longer-term, we urge HMT to make immediate assessment of the need and provide systems with sustained funding for the resource, infrastructure, workforce and leadership needed to ensure timely, high-quality care for all cardiovascular patients.

3. Invest in the cardiovascular workforce, including local leadership

Numerous recent reports have highlighted that cardiology services are experiencing widespread capacity issues across a variety of roles, and significant shortages in certain areas.[48] In 2023, BHF ran a first-of-its-kind census of core roles within the specialist cardiac workforce in secondary care in England.[49] Key areas of concern that emerged in cardiology include low staff numbers within specific cardiac subspecialties, demographic inequalities within the workforce and potential retirement hot spots. For example, 1 in 5 consultant cardiologists were aged 56 and over, with

higher proportions in certain subspecialties, such as interventional cardiology. These are areas where consultants may be more likely to retire within the next 5 to 10 years. Planning and appropriate funding are required to attract and train people in these areas to avoid an even more significant shortfall in the near future.

We need to see sustainable, long-term funding to accompany the implementation of the NHS Long Term Workforce Plan. The 2023 Plan committed £2.4 bn of funding for expansion of medical training, running to 2028/29. However, this funding commitment does not consider the significant cost implications of an increase in NHS staff (i.e. wages, medical infrastructure, IT, medicines etc.). Government should work with NHSE to outline an updated costing of full implementation of the Plan over the next 15 years, as previously outlined by the Public Accounts Committee.[50] This should include ongoing staff costs, training and recruitment costs, and the costs and underlying assumptions of necessary wider enablers such as technology and innovation, social care, and infrastructure.

Alongside this, the next iteration of the Plan must include a structured proposal to train, retain and develop the careers of staff across the entire cardiovascular workforce. Accessible, detailed information on both supply and demand is vital for workforce planning, and can help to illuminate shortages, potential retirement hotspots, inform the funding allocated for the Workforce Plan, and help us to design measures to train and retain an appropriate pipeline of clinicians.

Alongside investment across the workforce nationally, we urge Government to support local cardiac leadership. NHSE's Cardiac Transformation Programme and the Cardiac Networks, which provide strategic leadership and support across a range of long-term heart conditions at ICS level, have made notable strides in aligning national priorities, collaborating with existing programmes, and monitoring progress. However, the longevity of these roles is often under question because of short-term funding cycles. We would like to see funding for Cardiac Networks protected to enable local systems to embed their priorities and build on progress in a sustainable manner.

Recommendations: Government must set out, in this Budget, sustainable, long-term funding for full implementation of the NHS Long Term Workforce Plan, beyond funding already committed to 2028/29.

Government should also provide the necessary resource to NHSE to enable long term support for Cardiac Networks and leadership at a local level, helping to embed cardiovascular priorities within local systems.

Supercharge research to unlock future treatments and cures

It has long been accepted that the UK's life sciences sector significantly contributes to economic growth, while helping drive the discovery of lifesaving treatments and cures. Medical research charities like the BHF are a key component of the UK's rich research ecosystem. The BHF is the largest independent funder of cardiovascular research in the UK, with over £430m of BHF-funded research in progress. In 2023-24, BHF awarded £119.3 million in new research grants and in total, is supporting 703 active grants, 449 lead researchers, 298 students and 1,262 research staff in 49 institutions across the UK. To continue harnessing the value of charity funders, Government must ensure that the environment in which they operate continues to thrive.

1. Enhance Government support for the Charity Research Support Fund to help make university research more sustainable

Medical research charities such as the BHF fund projects and researchers in every region of the UK, with the majority of this research taking place at universities. The Charity Research Support Fund (CRSF) is an essential partnership between charities, Government and universities that enables this research to thrive, by underpinning some of the indirect costs of charity-funded research in universities, including estates, IT and HR costs.

However, the Fund has not kept pace with rising charity investment or the increased cost of research due to inflation, threatening the sustainability of charity-funded research at universities. When it was launched by the last Labour Government in 2006, the CRSF stood at £135.5 m, with a commitment to increase it to £270 m by 2010-11.[51] This was never honoured, and today, it stands at only £219 m. In the same time, charitable research investment has doubled, increasing from £557 m in 2007 to £1.8 bn in 2023.[52] In real terms, the CRSF has therefore significantly declined in value. Against a backdrop of financial uncertainty for universities, supporting the breadth of investment into university research, including that by charities, must be a priority.

As the Government outlines its ambitions to unlock economic growth with a thriving life sciences economy, HM Treasury should work alongside charities, who play a vital role in the sector, to ensure the long-term financial sustainability of the CRSF and help support the future of charity-funded research in the UK.

Recommendation: The BHF supports the Association of Medical Research Charities' call for the Government to increase the CRSF so that it keeps pace with charitable funding. To achieve this, the fund must be almost doubled. Using charity investment in 2022-23 as an example, this represents an increase of £194.5 m.

2. Increase investment in UK research and development and ensure funding for cardiovascular research matches its impact on society

The UK is lagging behind its international competitor science nations in terms of overall research and development (R&D) investment.[53] This has been exacerbated by inflation, which has almost negated increases in government spending on R&D since 2021.[54] Without a significant increase in the levels of R&D funding by the next Government, the UK will be unable to match its ambitions to be a leading nation within the G7 for science and innovation.

How R&D funding is invested is also important. Looking at overall funding, CVD has suffered from an historic lack of investment relative to disease burden. In 2019, CVD, stroke, and blood disorders accounted for just over 13% of all years lived with a disability or lost to premature death in the UK. Despite this, together they received only 7% of public and charity research funding in 2022[55]. We see how this translates into treatments for patients: 15 new drugs were approved by MHRA in 2023, 6 for oncology, none for CVD.[56]

BHF is the largest independent funder of cardiovascular research, investing over £100 m in new research every year, but we cannot solve the growing challenge of CVD alone. 2024 BHF analysis revealed that cardiovascular disease research funding faces a shortfall of more than a quarter of a billion pounds between 2025 and 2035.[57] And that due to inflation, Government will need to invest an extra £259m over the decade just to maintain research spending at 2022 levels.

As Government develops a new Industrial Strategy and fleshes out its plans to set 10-year budgets for certain R&D institutions, it must work with funders to define a plan to increase cardiovascular disease research funding. A joined-up approach, clearly outlining cardiovascular disease as a priority area, is needed to ensure there is no shortfall over the next decade and to safeguard the future of UK cardiovascular research and drive advances against some of the country's biggest killers.

Recommendation: In this Budget, Government should commit to increasing public investment in R&D, to be brought in line with its G7 competitors.

Longer term, Government should work with research councils and other research funders to define a plan to increase CVD research funding by at least £259m over the next 10 years, within the development of a new Industrial Strategy.

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