ESIP Statement

on the
EU Cardiovascular Health Strategy

European Social Insurance Platform (ESIP)

20-05-26

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The European Social Insurance Platform (ESIP) representing European social security institutions in their role as healthcare payers, welcomes the European Commission's Safe Hearts Plan (COM(2025)1024) and supports the direction of the European Parliament's Draft Report on an EU Cardiovascular Diseases Strategy (2025/2132(INI)). The costs of cardiovascular diseases (CVDs) are borne in large part by social security systems through healthcare expenses, disability pensions, sickness benefits, and early retirement.[1] ESIP urges both the Commission and the Parliament to ensure that the implementation of the Safe Hearts Plan and the formulation of compromise amendments follow the best available scientific evidence. This is a prerequisite for policy that credibly serves an efficient prevention and care strategy, along with the long-term sustainability of European health and social security systems. In what follows, ESIP sets out its positions on those issues where the financial exposure of social security institutions is most direct, where the science-policy mismatch is highest, and where the Safe Hearts Plan requires strengthening.

Governance: Conflict-of-interest safeguards are a prerequisite

Effective cardiovascular health policy depends on governance structures that protect decision-making from undue commercial influence. When industry participation in health policy is not subject to structured conflict-of-interest safeguards, outcomes systematically shift away from effective public health measures, a pattern well documented across tobacco, alcohol and food policy.[2,3] Formulations that equate commercial stakeholder input with independent scientific evidence undermine this protection. The WHO FCTC Article 5.3 standard is the established baseline for managing this risk.

Advisory or stakeholder engagement in health policy matters should include transparent conflict-of-interest declarations and exclude entities with direct commercial interests from the formulation of evidence-based recommendations.

Alcohol: Fiscal and regulatory measures across the full consumption spectrum

Social security institutions directly bear hospitalisation, disability pension and early retirement costs attributable to alcohol-related CVDs. The WHO recommends increasing alcohol excise taxes, restricting availability and implementing comprehensive bans on advertising as "best buy" interventions for reducing the burden of non-communicable diseases.[4] These instruments are a cost-management mechanism for ESIP members: fiscal measures such as minimum unit pricing have demonstrated reductions in alcohol-attributable hospital admissions of 2 to 9% annually in real-world settings, with the strongest effects in the socioeconomic groups that generate the highest social security costs.[5] The scope of those instruments should encompass all usage levels, as cardiovascular risk is by now well-established across the full consumption spectrum.[6,7]

Fiscal, labelling and availability measures should apply to the full range of alcohol products and consumption levels, in line with WHO best buy recommendations.

Tobacco and nicotine: A comprehensive regulatory framework

The Safe Hearts Plan sets the objective of reducing tobacco use to below 5% of the EU population. Achieving this target requires the full deployment of evidence-based regulatory instruments. As set out in ESIP's response to the revision of the Tobacco Taxation Directive (October 2025),[8] the regulatory framework should include: reducing the affordability of all tobacco and nicotine products, including heated tobacco products and e-liquids through raising minimum taxes;[9] tax equivalence between novel and conventional products to prevent substitution towards lower-cost entry products; an EU-wide ban on advertising, promotion and sponsoring for all novel nicotine products analogous to existing restrictions on traditional tobacco; a ban on characterising flavours that serve primarily to attract young users; and mandatory plain packaging for e-cigarettes and refill containers. Novel nicotine products should undergo pre-market health impact assessment and regulatory transitional periods should be shortened so that health benefits, especially for young consumers, are realised without delay.

The upcoming revision of the EU tobacco legislation should implement the full set of financial, availability and marketing instruments needed to reach the below-5% target, including mandatory pre-market health impact assessment for novel nicotine products before any regulatory differentiation is considered.

Food environment: Binding measures are a fiscal necessity

The food environment creates costs that ESIP members carry directly. Two-thirds of obesity-related excess mortality is attributable to CVDs[10] and avoidable healthcare costs from inadequate diet are estimated at EUR 16.8 billion per year in Germany alone, based on modelled disease-cost estimates.[11] Structural and fiscal measures - namely binding reformulation targets, mandatory front-of-pack labelling and marketing restrictions for products high in fat, sugar and salt (HFSS) - deliver health gains across the full socioeconomic distribution, whereas approaches focused primarily on individual behaviour systematically widen cardiovascular inequalities.[12,13]

ESIP therefore regrets that the Commission's initiative for a sustainable EU food system - which was expected to provide a framework for measures including food labelling - has not been taken forward and calls on the European Commission to reconsider this decision. The absence of such a framework makes binding sectoral action even more urgent.

Binding front-of-pack labelling requirements, mandatory reformulation targets and binding restrictions on HFSS marketing to children should be used to achieve the Plan's ambitious goals. Binding restrictions on the marketing of HFSS products to children should be addressed through the forthcoming revision of the Audiovisual Media Services Directive.[14] Voluntary industry commitments have historically not reduced this burden.

Screening: Evidence before targets

The Safe Hearts Plan proposes population-wide screening targets of 75 to 90% for blood pressure and 65 to 80% for cholesterol and blood glucose. ESIP supports evidence-based early

detection as a complement to primary prevention, but notes that the proposed targets are not yet underpinned by high-quality outcome studies. The available evidence supports risk-stratified follow-up for individuals with known risk factors, such as hypertension, diabetes or family history, rather than untargeted population-wide screening.[15] Population-wide screening without demonstrated net benefit carries risks of overdiagnosis, unnecessary follow-up interventions and overmedicalisation, costs that fall directly on ESIP members. This applies particularly to children and adolescents, where the evidence base for routine lipid or blood pressure screening remains insufficient.[16,17]

EU screening recommendations should clearly distinguish between risk-based early detection, supported by ESIP, and untargeted large-scale population screening programmes. Population-wide screening should be implemented only when supported by the best available evidence of net clinical benefit and where the feasibility within national health systems has been demonstrated. Screening targets should be recommended on the basis of the available evidence and only once they have been assessed against the implementation capacity of national care systems.

Rehabilitation and return to work

CVDs are among the leading causes of disability pensions across EU Member States. In Germany alone, approximately 15% of all new disability pensions in 2023 were attributable to CVD.[18] While for those with established CVDs, low occupational class more than doubles the disability retirement risk.[19] Investment in rehabilitation is crucial and has shown to deliver positive returns: in Germany returns of up to five euros per euro invested within the first two years.[20] The Safe Hearts Plan should explicitly foresee adequate measures and financing for rehabilitation and return-to-work programmes, while safeguarding employability and linking health policy with labour market and social policy.

The Safe Hearts Plan and derived legislation should strengthen rehabilitation, vocational reintegration and employability as integral elements of Europe's cardiovascular health strategy.

Socioeconomic and environmental determinants: A social security fiscal risk

CVD burden falls hardest on those with the lowest incomes, least secure employment and poorest housing.[21] The workplace is a critical but underrepresented prevention setting: occupational exposures such as heat, physical strain, noise and psychosocial stress directly increase cardiovascular risk and generate costs that social security systems bear. Environmental exposures compound this gradient: environmental risk factors account for approximately 18% of CVD deaths in the EU, concentrating harm in lower-income areas.[22] The Safe Hearts Plan acknowledges environmental risks but addresses them primarily as data gaps for risk prediction rather than as drivers requiring concrete prevention and adaptation strategies. Addressing these determinants requires a Health in All Policies approach extending well beyond the health sector.

Actions following the Safe Hearts Plan should understand socioeconomic, occupational, and environmental determinants of cardiovascular health as crucial drivers of disease burden and translate them into actionable cross-sectoral measures.

In conclusion, ESIP urges the European Commission and the European Parliament to ensure that the Safe Hearts Plan and its legislative follow-up support national and EU approaches to prevention rooted in evidence and sound governance and free from undue commercial influence. This should include a comprehensive regulatory framework for tobacco and nicotine, the integration of targeted evidence-based screening programmes into national healthcare systems, rehabilitation and return to work, as well as structural measures addressing the well-documented social, occupational and economic determinants of cardiovascular health. Finally, implementation should also ensure that EU initiatives on non-communicable diseases are aligned around shared risk factors. This approach is financially sound and necessary to strengthen our solidarity-based healthcare systems.

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About the European Social Insurance Platform (ESIP)

The European Social Insurance Platform (ESIP) represents 46 national statutory social insurance organisations in 19 EU Member States and Switzerland, active in the field of health insurance, pensions, occupational disease and accident insurance, disability and rehabilitation, family benefits and unemployment insurance. The aims of ESIP and its members are to preserve high profile social security for Europe, to reinforce solidarity-based social insurance systems and to maintain European social protection quality. ESIP builds strategic alliances for developing common positions to influence the European debate and is a consultation forum for the European institutions and other multinational bodies active in the field of social security.

ESIP members support this position insofar as the subject matter lies within their field of competence.

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