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Making prevention work: an effective agenda for European resilience

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INTRODUCTION

Life expectancies across the EU continue to rise: by 2100, the European Commission projects they could exceed 90.[1] Healthy life expectancy, however, has not kept pace – meaning citizens spend more years in poor health. As the demographic transition reshapes EU labour markets, care systems and public budgets alike, this gap between lifespan and "healthspan"[2] risks becoming a central political pressure point.

To date, preventive health policies have largely relied on individuals' making behavioural changes – starting to eat better, move more, get enough sleep or attend screenings. This approach assumes a capacity that many people, especially those facing time and financial constraints, may lack. Layered on top of an already overburdened life, individual prevention demands can generate *cognitive overload*;[3] rather than producing healthier choices, they may lead to stress and disengagement.

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Taking a page out of climate science, we can conceptualise this as a tipping point[4] beyond which individual behavioural change may collapse. The individual is still the agent – but whether healthy choices are made is shaped by conditions they cannot easily control: affordable healthy food, safe neighbourhoods, predictable working hours and housing free of mould and similar issues. Making prevention work thus means creating the conditions that determine whether it feels within reach, rather than only demanding more behavioural change from individuals. Starting from this understanding, legislation must build the necessary infrastructure.

While COVID-19 led the EU to expand its efforts in healthcare, investments in prevention have barely changed, making up only 5.5% of member states' health budgets on average.[5] According to WHO, patients' overall health stems primarily from socioeconomic determinants rather than medical factors.[6] As healthcare costs rise, this makes the case for more efficient, horizontal allocations across policy areas – moving past treatment-outcome targets to consider prevention holistically. This requires realigning structural incentives with the evidence and dissolving policy siloes.

BACKGROUND

A prevention model that rests on individual behaviour change alone may be asking the most from those least able to bear such demands. The chronic stress burden is unequally distributed, with financial precarity, poor housing and insecure employment as key environmental stressors compounding non-communicable disease

risks in lower income populations, which are often overlooked in prevention frameworks.[7] Evidence from systematic reviews treats following health advice as work: recommendations carry accumulating financial, time, administrative and informational costs. Adherence to recommended lifestyle change is correspondingly low and uneven – pooled at around 27% among hypertension patients in one recent review.[8] No single, systematic review yet traces the full pathway, so designing prevention policy from this baseline should be paired with dedicated research and evaluation.

Structural disincentives in governance also matter, as health ministers who invest in prevention also generate gains flowing into other departments' budgets, such as labour, education and welfare. Member states and the EU's fiscal accounting tools may thus fail to capture them. While in the short term, prevention investments appear to be additional costs, they generate significant returns – in some cases, up to €14 in health and social value for every euro invested,[9] for example, by lowering disability spending.

In 2021, the cost of preventable illness to the EU economy reached approximately €282 billion for cardiovascular diseases alone.[10] The following year, over 700,000 deaths were estimated to have been preventable.[11] As cardiovascular diseases remain the EU's leading killer, claiming over 1.7 million lives annually, the European Commission responded in December 2025 by adopting the Safe Hearts Plan[12] to strengthen prevention and tackle the socioeconomic determinants of cardiovascular health. In short, there is an immense gap between today's prevention spending and the improved health outcomes more effective policies could bring.

Neurological disorders together account for a plurality of the overall disease burden in Europe.[13] Globally, 55 million people were living with dementia in 2020, a number expected to reach 153 million by 2050.[14] While population ageing is the primary driver of this growth, acting on socioeconomic determinants presents great potential to address the growing burden on societies.[15] As cognitive health and *brain capital*[16] are increasingly recognised as economic assets, the case for prevention is grounded in both the EU's social commitments and the cost of inaction. Improving mental wellbeing and brain function through skills and health education policies holds great potential to expand people's capacity and creativity, alongside economic spillover effects.

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Cross-sectoral approaches to prevention are not new. Already in 2006, Finland introduced the *Health in All Policies* approach during its EU presidency.[17] Starting in 2020, France's adoption of a Housing First[18] approach to mental healthcare foregrounded stable housing as an active component of prevention and recovery for the homeless. Later, the 2025 WHO conference statement on Mental Health in All Policies[19] called upon signatories to align funding and accountability across sectors and to promote social inclusion through improved public services and urban planning.

Long-term national strategies show that this recognition, though slow, can take hold. France has run successive cancer plans since 2003,[20] when they first paired treatment investment with enhanced breast-cancer screening. The 2009–2013 and 2014–2019 plans added a focus on personalised medicine, organised colorectal screening and a sharper focus on avoidable-risk mortality. Most recently, the 2021–2030 strategy,[21] launched with €1.74 billion for its first five years, foregrounded prevention and was co-designed through a national citizens' consultation. At EU level, the Beating Cancer Plan (2021) first adopted the same logic, pairing a dedicated lifestyle intervention pillar with a cancer screening scheme.[22]

Further, social isolation and a lack of shared public spaces are recognised risk factors for dementia[23] and Alzheimer's,[24] which are among the most burdensome neurological conditions. Social media, virtual echo chambers and an always-online society also exacerbate this and related risks, with additional potential health consequences tied to mis- and disinformation,[25] particularly during emergencies.

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STATE OF PLAY

Public health prevention campaigns often set targets that may be difficult to meet. For instance, in 2019 only one in eight EU adults ate the WHO-recommended five daily portions of fruit and vegetables.[27] When health recommendations exceed what people can sustain, participation is documented to fall,[28] and stress may increase. Left unaddressed, these pressures may increase *allostatic load*, the cumulative physiological toll, as the body chronically faces stressful situations – itself a risk factor for chronic diseases.

Prevention design should thus work with this constraint. Threshold-based and default-shifting measures targeting companies, for example, ask less of individuals: tiered sugar taxes in the United Kingdom, France and Portugal prompted reformulation and measurable falls in the sugar content of drinks. Universal school meals can raise nutritional quality for every child without adding to households' daily workload – in Sweden, for instance, a study found that school meals provided around half of children's daily vegetable intake.[29] Lowering average alcohol strength can also cut total consumption more than simply adding alcohol-free products.[30]

The COVID-19 pandemic led to the considerable expansion of the EU's multi-year Health Programme, named EU4Health[31] in its fourth iteration, under the 2021–2027 Multiannual Financial Framework (MFF), and to the establishment of the Health Emergency Preparedness and Response Authority (HERA). Recent years have seen continued EU attention to the subject, from the Safe Hearts Plan noted above to the EU Biotech Act proposal,[32] demonstrating appetite for further progress to reduce health inequalities and elevate healthcare and research to a competitiveness priority. With negotiations for the 2028–2034 MFF underway, this represents the most immediate opening to expand the prevention agenda.[33]

While at €5.3 billion for 2021–2027, the outgoing EU4Health Programme was the largest of its kind, this level of support may now be in question. Under the Commission's July 2025 proposal, EU4Health is one of 14 instruments folded into the new European Competitiveness Fund, where health, biotechnology, agriculture and the bioeconomy share a single envelope of roughly €22.6 billion within a broader €410 billion proposal.[34] While the Commission maintains that all actions previously financed under EU4Health remain eligible, resources now ring-fenced for health systems risk redirection towards industrial and biotech priorities. After the European Parliament called[35] for this fund to be enlarged in an April 2026 report, reaffirming that EU4Health should be separately earmarked within it, the Council in June agreed[36] to leave prevention to wider negotiations, expected to run to late 2026.

Moreover, the European Semester Country Specific Recommendations (CSRs) process remains non-binding and unevenly applied. Member states spending well below evidence-based health benchmarks need more than guidance. As the EPC has previously argued,[37] countries spending below 5% of healthcare budgets on prevention should receive tailored, evidence-based recommendations. Reform remains slow; in 2025, only three member states' CSRs referenced preventive care. While this rose to 10 in 2026, much progress remains to be made.

Another issue is the political cycle: investment in prevention today may only deliver returns beyond the current electoral cycle. The financial instruments needed to bridge this gap do not yet exist at EU scale. Outcome-based instruments – social or health impact bonds and blended public-private structures to de-risk early investments – could let returns that mature over a decade or more be financed today, provided outcomes are measured consistently across systems. Innovative therapies, such as GLP-1 products for diabetes, illustrate the logic: high upfront costs weighed against health and productivity gains that accrue over many years.[38]

Research and innovation can also make prevention more feasible for individuals. New approaches for the next EU Framework Programme, under the *societal readiness* pilots across climate, energy and mobility, aim to show how to reduce barriers to engagement and improve take-up of behavioural change.[39] Extending these to health projects would put the everyday feasibility of prevention measures at the centre of what the Programme funds.

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Wearable technologies also hold potential to make the invisible visible. Monitoring, risk-scoring and real-time diagnostics supported by machine learning and AI generate a breadth of data that, under appropriate privacy and security safeguards – and without overwhelming users – can improve individuals' understanding of their health profiles. This also presents opportunities to tackle gender data gaps.[40] Women are under-represented in the datasets behind many clinical risk models, so tools developed using male-dominant data can under-estimate their risk. Feeding sex-stratified wearable data into these models supports earlier and more accurate detection and, therefore, prevention.

Successful technology-enabled prevention efforts, however, hinge on a trustworthy data infrastructure. The European Health Data Space (EHDS)[41] provides a regulatory and technical foundation for the wider analysis of health data across the EU and should ensure the integration of wearable data, elevating their role in medical research.

Technological progress can also shrink the feedback loop between prevention investments and their economic returns. McKinsey estimates[42] that, by 2050, scaling proven interventions could add about $12.5 trillion to annual global output – a return of roughly four to one – with most avoidable disease burden addressable through prevention and early intervention. AI-enabled screening is one example: EU-funded projects such as AI-Mind[43] have developed tools to flag dementia risk years earlier than was previously possible. Meanwhile, the Commission's Apply AI Strategy has set out to build a network of advanced screening centres for cancer and cardiovascular disease. Digital behaviour-change tools embedded in primary care show how earlier, easily integrated support could be delivered at scale.

EU-funded projects such as AI-Mind have developed tools to flag dementia risk years earlier than was previously possible.

PROSPECTS

In light of this discussion, the EU would benefit from a preventive health reform, financing and research agenda that accurately captures the complexity of individuals' experience, limiting the social and economic burden of non-communicable diseases in particular.

1. Make burden reduction a condition of EU-funded prevention efforts.

The outcomes of future EU4Health, Framework Programme and Competitiveness Fund initiatives relating to behavioural change or disease screening should be evaluated, for the administrative, cognitive and time burden effects they place on stakeholders involved. These measures should consider individuals' unequal capacity to absorb certain demands, disaggregating by region and socioeconomic group, and feed into the MFF performance framework. The EU Social Scoreboard should also track such burdens and mental wellbeing[44] alongside narrow measures of health outcomes, building on recent calls to complement illness indicators with other measures of resilience.

2. Extend the EU Framework Programme's Societal Readiness pilots to prevention.

The next Framework Programme should apply the Societal Readiness approach to health, funding prevention research that is designed for easier uptake, by lowering the burden on individuals. Already used in national strategies, co-design with patients should be a standard condition for access to funding. To inform this, a dedicated research and evaluation stream should also look into the cognitive impacts of preventive health recommendations, investigating stress and disengagement over time.

3. Ring-fence health and prevention in the European Competitiveness Fund.

Within the fund's health, biotechnology, agriculture and bioeconomy envelope, the European Parliament and Council should carve out a dedicated prevention subenvelope with its own budget line and reporting, rather than leaving prevention to compete inside a broad competitiveness cluster. Retaining EU4Health's identity would preserve a visible, protected home for disease prevention, health promotion and health-system resilience across the 2028–2034 MFF.

4. Explore long-horizon financing instruments for prevention.

Working with the European Investment Bank, the European Commission should pilot, on a closely evaluated basis, outcome-based instruments – social and health impact bonds and blended public-private structures – that allow prevention returns maturing beyond one electoral cycle to be financed now. Any pilot depends on consistent outcome metrics, which the Social Scoreboard and the EHDS could provide, and on observing the value of long-cycle cases over several years.

5. Give the European Semester teeth on prevention.

Country-Specific Recommendation (CSRs) should be binding standards rather than guidance. Progress towards higher spending targets, as EPC has previously argued,[45] should receive tailored recommendations, tracked through a health and prevention scoreboard within the Social Convergence Framework. Recognising prevention as a productive investment in medium-term fiscal-structural plans, as is the case for R&D spending, would let states reallocate towards this without penalty. Where member states underspend year after year, the European Commission must ask them to justify the gap against the evidence.

6. Make the European Health Data Space prevention-ready.

Implementation of the EHDS should integrate validated wearable data, stratified by sex and age to close data gaps and place stewardship obligations on health systems rather than on individuals, so that monitoring supports prevention without becoming a new source of stress. Interoperable, disaggregated data of this kind can power monitoring of inequality,[46] reaching beyond the Safe Hearts Plan's encouragement of "responsible" consumer-monitor use. This way, digital infrastructure may better supply the outcome data needed for the Semester scoreboard and long-horizon financing instruments.

CONCLUSION

A prevention agenda for an ageing, always-on Europe cannot rely on asking more of already overstretched individuals; it must change the conditions in which they live, work and are asked to change their behaviour. Treating health as a strategic investment rather than a residual cost means protecting pre-existing efforts, giving the European Semester a real prevention standard and building financing instruments that can wait for returns measured in decades. It also means designing prevention around people rather than at them: measures that lower the everyday burden on individuals, draw on citizens' own knowledge of what they can sustain and understand prevention programmes themselves as potential stressors, using data and technology to lighten the load rather than add to it.

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NOTES

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