

Investing in Immunisation

Strengthening Europe's Competitiveness, Resilience and Global Health Security



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Executive summary

Europe is entering a more constrained economic phase, shaped by **ageing, high public debt, weaker growth prospects, rising geopolitical uncertainty and intensifying global competition**. These pressures make it important to assess public spending in terms of its capacity to reduce future fiscal, economic and social vulnerabilities. Health policy sits at the centre of this debate. A healthier population supports labour-market participation, productivity, resilience and long-term fiscal sustainability, while **pharmaceutical innovation acts as a broader economic and societal multiplier**, driving high-value employment, supporting productivity in ageing economies and reducing long-term pressure on health systems and public finances¹. Against this backdrop, strategic health industries — particularly the **innovative pharmaceutical industry** — should be recognised as a core pillar of Europe's innovation base, export strength and economic security.

The **innovative vaccine industry is especially relevant to Europe's competitiveness agenda**. Europe remains a global hub for vaccine R&D, advanced manufacturing and exports, combining high-value jobs, industrial know-how, supply-chain capabilities and scientific leadership. In a context of intensifying global competition in life sciences and shifting dynamics, vaccines **remain an area where Europe can still convert health policy into industrial strength**.

Preventive care is a strategic lever for Europe's future competitiveness and economic and social resilience. Immunisation and screenings **reduce avoidable disease, protect health-system capacity and limit downstream costs** from hospitalisations, emergency care, productivity losses, caregiver absences and welfare spending, while helping reduce inequalities and protect vulnerable populations. **Yet prevention remains structurally underfunded**: in 2024, representing only 3.1% of total public health expenditure in the EU-27, with immunisation at only 0.5%, reflecting a persistent mismatch between long-term value and short-term budget logic.

The cost of inaction extends beyond higher healthcare expenditure. Underinvestment in prevention **increases fiscal risk by shifting costs into the future**, often in more expensive and less predictable forms. It **weakens health-system resilience, reduces preparedness for future shocks, increases exposure to risks** such as antimicrobial resistance and **undermines the ability of citizens to remain active and productive for longer**. It can also weaken Europe's credibility as a global health leader: a Union that aims to shape global standards on preparedness, prevention and equitable access must demonstrate that it can sustain strong prevention systems internally.

The **New Economic Governance Framework** creates an important policy window to reframe prevention as a strategic investment. While it does not provide an automatic exemption for prevention spending, it **introduces a medium-term fiscal logic better suited to investments whose returns materialise over several years**. By linking fiscal sustainability to reforms and investments in resilience, growth and competitiveness, the framework allows Member States to include prevention in fiscal-structural plans and defend high-value expenditure within agreed expenditure paths. Early signals from countries such as Italy suggest that adult immunisation and screening **are beginning to be recognised as investments in social and economic resilience**, although this has yet to translate into a systematic budgetary model to protect preventive care from short-term cuts.

The main policy challenge is to **move from recognition to implementation**. EU institutions and Member States should protect prevention budgets from budget cuts, progressively expand funding for high-return interventions, embed prevention in fiscal planning and develop better metrics to capture its full value across

¹ IFPMA and WifOR Institute (2024), "The Economic Impact of the Global Pharmaceutical Industry."

health systems, labour markets and public finances. Stronger “**horizontal coherence**” is needed across EU fiscal, health, industrial, digital and preparedness policies, alongside stronger “**vertical coherence**” between EU priorities and national delivery. Prevention should no longer be treated as a residual expenditure item, but as a **core component of Europe’s strategy for fiscal sustainability, competitiveness, health security and long-term resilience**.

1. Europe's New Economic Reality: Ageing, Debt and Competitiveness Pressures

Europe is entering a new economic phase in which long-term growth can no longer be taken for granted. The **factors that supported European prosperity in previous decades** (expanding labour forces, global trade integration, relatively low energy costs and stable geopolitical conditions, ...) **are becoming less reliable**. The Draghi report on European competitiveness, among others, frames this shift clearly: Europe's long-term prosperity is under pressure, while the green and digital transitions require unprecedented levels of investment and innovation.

This competitiveness challenge is increasingly connected to Europe's ability to **protect and scale strategic sectors that combine innovation, industrial capacity, export strength and economic security**. The innovative pharmaceutical sector is a clear example. It is identified in the Draghi report as a high-value strategic asset for the European economy, accounting for around 11% of EU exports, while facing growing competitive pressure in the life sciences landscape.² This strategic role is underpinned by the sector's exceptional level of investment in research and development. OECD evidence shows that the **pharmaceutical industry reinvests nearly 30% of its gross value into R&D**, significantly exceeding other innovation-intensive sectors such as electronics, aerospace and manufacturing.³ This makes health-related industries central not only to public health, but also to Europe's broader growth, innovation and strategic autonomy agenda.

Europe retains important strengths that should not be taken for granted. The EU continues to demonstrate strong pharmaceutical manufacturing investment growth, with a 15% CAGR between 2018 and 2022, outpacing growth observed in other major manufacturing hubs, including China (around 11%), while maintaining a significant trade surplus. Within this broader ecosystem, vaccines stand out as a uniquely strategic European asset: **Europe is the world's leading exporter of vaccines, a global hub for R&D and advanced manufacturing, and a contributor to innovation, high-value jobs and supply chain resilience**.

Europe's worrying economic environment matters because it comes at a time when fiscal space is already constrained. Public debt remains high in several Member States, and the return to a rules-based fiscal framework requires Governments to place debt on a sustainable path while still financing strategic priorities. In 2025, general government gross debt stood at 81.7% of GDP in the EU; in some large Member States the ratio was significantly higher, **including Italy at 137.1%, France at 115.6% and Spain at 100.7%**⁴.

² For context, global clinical trial activity has shifted significantly: in 2024 the U.S. accounted for 35% of global trial starts, China 30% (up from 1% in 2009), while the EU's share fell from 44% to 21% in the same period. China is also the world leader in patent filing across technologies, including a 9.3% increase from 2023 to 2024. IQVIA (2025), "Global Trends in R&D 2025"; WIPO (2025), "World Intellectual Property Indicators" and WIPO (2025), "Facts and Figures 2025".

³ OECD (2023), "Health at a Glance Report". This compares to electronics (23.5%), aerospace (14.7%), and manufacturing (8.4%).

⁴ Eurostat, 2026.

Country	Deficit (% of GDP), 2025	Debt (% of GDP), 2025	Population Aged 65 and older (%), 2025	Projected Population Aged 65 and Older (%), 2035
European Union	-3.1	81.7	22.0	25.7
Austria	-4.2	81.5	20.2	23.3
Belgium	-5.2	107.9	20.2	25.0
Bulgaria	-3.5	29.9	24.0	26.4
Croatia	-3.0	56.3	23.3	25.9
Cyprus	3.4	55.0	18.3	22.0
Czechia	-2.1	44.3	20.7	22.9
Denmark	2.9	27.9	20.9	23.6
Estonia	-2.0	24.1	20.9	23.9
Finland	-3.4	88.5	23.6	25.6
France	-5.1	115.6	21.9	25.1
Germany	-2.7	63.5	22.7	27.0
Greece	1.7	146.1	23.7	28.4
Hungary	-4.7	74.6	20.9	22.5
Ireland	1.8	32.9	15.7	19.2
Italy	-3.1	137.1	24.7	30.1
Latvia	-2.5	46.9	21.9	25.9
Lithuania	-1.8	39.5	20.9	25.6
Luxembourg	-2.0	26.5	15.2	18.4
Malta	-2.2	46.4	18.4	18.2
Netherlands	-1.6	44.4	20.8	24.0
Poland	-7.3	59.7	21.0	23.4
Portugal	0.7	89.7	24.3	28.6
Romania	-7.9	59.3	20.3	22.9
Slovakia	-4.5	61.4	18.8	22.3
Slovenia	-2.5	65.7	22.1	26.1
Spain	-2.4	100.7	20.7	25.2
Sweden	-1.3	35.1	20.8	23.3

Table 1. Economic and Demographic Characteristics of EU Member States - Source: TEHA Group on Eurostat data, 2026

Demographic ageing will make public finance sustainability harder to achieve. The proportion of people aged over 65 in the EU is **projected to rise from 22.0% in 2025 to 25.7% by 2035⁵**. This will affect public finances through several channels at once: higher pension expenditure, greater demand for health- and long-term care, and a smaller relative share of the population contributing to employment, production and tax revenues.

⁵ Ibid.

The issue is not only that Europeans are living longer, but that many of the additional years are not spent in good health. Despite life expectancy **climbing to 81.5 years in the EU in 2024**, healthy life years have **declined to 63.1 years in 2023 from 64.6 before the COVID-19 pandemic**⁶. This has direct implications for health systems, but also for labour markets and welfare systems: poor health can reduce labour participation, increase absenteeism, raise demand for informal care and accelerate exit from the workforce.

Recent crises have also shown that health is not only a social policy issue, but a dimension of economic security. Pandemic preparedness, surveillance capacity, resilient supply chains and the ability to respond to emerging health threats are now part of Europe's strategic agenda. While preparedness has improved since the pandemic, gaps remain. Antimicrobial resistance is another example of this vulnerability, **causing around 35,000 deaths per year in the EU and with annual costs estimated at €11.7 billion**⁷.

Taken together, these pressures change the way public expenditure should be assessed. In a context of low growth, high debt, demographic ageing, growing health-security risks and intensifying global competition, the central question is not only how much Governments spend, but whether spending decisions reduce or increase future economic and fiscal vulnerabilities. This includes whether they support the conditions that make Europe more competitive: a healthier and more productive population, more resilient health systems, stronger preparedness capacity and strategic industrial ecosystems in areas such as vaccines and pharmaceuticals. The new fiscal environment makes this question more urgent: Member States will need to protect debt sustainability, but doing so through short-term compression of high-value expenditure could weaken the very foundations of long-term resilience and competitiveness.

2. Preventive care as a Strategic Lever to Address Europe's Structural Challenges

The pressures described above **require a broader way of thinking about health policy**. In an ageing Europe with constrained fiscal space, the challenge is not only to expand access to treatment, but to reduce avoidable demand for care, preserve healthy life years and maintain people's ability to participate in society and in the labour market. **Preventive care is central to this shift** because it intervenes before health risks translate into hospitalisations, productivity losses and higher healthcare expenditure, helping protect economic capacity and reduce exposure to future shocks. The returns of prevention and early intervention are well documented: **every €1 invested in preventive care can generate up to €14 in health and social returns**,⁸ while a 10% increase in prevention can reduce health spending on chronic disease by 0.9%.⁹

Preventive care should not be understood as a narrow set of public health activities. It includes primary prevention, such as immunisation; secondary prevention, such as screenings; and interventions that help people manage risks before they generate more severe disease. These measures differ in design and target population, but they share the same logic: they **reduce the probability that health risks become higher-cost events for health systems, employers, households and public budgets**.

Immunisation is one of the clearest examples: a **life-course approach** — ensuring vaccination across all stages of life — is particularly important in ageing societies, where risks accumulate over time and **adult populations remain under-protected**. It reduces the incidence and severity of infectious diseases, protects

⁶ Ibid.

⁷ OECD (2023), "Fighting Antimicrobial Resistance in EU and EEA countries. Embracing a One Health Approach".

⁸ The European House, Ambrosetti (2024), "The value of prevention for economic growth and the sustainability of healthcare, social care and welfare systems".

vulnerable groups and helps limit avoidable pressure on health services. It also contributes to the prevention of some non-communicable diseases, as **certain vaccines can reduce the risk of cancer** – in Australia in 2025 there were no cases of HPV related cancer in vaccinated young women – and plays a critical role in **protecting individuals with chronic conditions** from complications linked to vaccine-preventable diseases, particularly respiratory infections, which remain under-utilised despite posing significant risks to ageing populations.¹⁰ For example, adults with cardiovascular disease are 10 times more likely to suffer a heart attack after contracting influenza.¹¹ Premature mortality from non-communicable diseases **is estimated to cost EU economies around €437.7 billion annually** through lost productivity, a significant share of which is linked to preventable complications and can be mitigated through stronger immunisation uptake. The economic case is also strong: adult immunisation programmes can deliver benefits worth up to 19 times their initial investment.¹²

Screening and early detection play a complementary role. Their value lies in identifying disease at a stage where treatment is more effective, less complex and often less costly. In cancer policy, this logic is already embedded in the EU approach: **Europe's Beating Cancer Plan is structured around prevention**, early detection, diagnosis and treatment, and quality of life. Expanding the approach to other areas of prevention, such as immunisation, can significantly improve outcomes for the population and economic returns.

Despite its positive impact on all levels, preventive care remains structurally underfunded. In 2024, **public preventive care expenditure represented only 3.1% of total public health expenditure in the EU-27**, with wide variation across Member States. Germany, Italy and Croatia were the highest spenders, at 4.5%, 4.2% and 4.0% respectively, while several countries allocated around 2% or less, including France, Belgium and Poland. The ranking should not obscure the broader message: even countries at the top of the distribution are still allocating only a small fraction of public health expenditure to prevention.

There is no single EU-wide benchmark defining the optimal share of health expenditure that should be allocated to prevention. However, the fact that preventive care¹³ represents only 3.1% of public health expenditure in the EU-27 — and remains around 4-4.5% even among the highest-spending Member States — **points to a structural underinvestment problem**. The academic literature estimates that the optimal budget for health prevention is close to 1.2% of GDP¹⁴, which would put the optimal allocation of the total healthcare budget for prevention **closer to a 15%-20% range**, well above the current average. Investment in immunisation is even lower and stands at around 0.5% of national healthcare budgets on average across the EU¹⁵.

The strategic value of preventive care also extends to resilience. A population with higher vaccination coverage and stronger screening systems is less exposed to avoidable health shocks. **Prevention also strengthens preparedness** by reducing baseline vulnerability: fewer preventable complications, better surveillance, earlier detection and stronger public trust can all improve the ability of health systems to respond when pressure rises. **Health shocks are also economic and security shocks**, reinforcing the need

⁹ OECD (2025), "The Economic Benefit of Promoting Healthy Ageing and Community Care."

¹⁰ The Health Policy Partnership (2025), "From protection to prevention: The power of immunization for people living with noncommunicable diseases".

¹¹ World Heart Federation (2025), "Influenza and Cardiovascular Disease".

¹² Steuten, H. E. B., et al. (2024), "Socio-Economic Value of Adult Immunisation Programmes".

¹³ The range of activities classified as "preventive care" may vary from country to country and a precise definition has not yet been achieved for the EU.

¹⁴ Wang F. et al. (2021), "Investing preventive care and economic development in ageing societies: empirical evidences from OECD countries". Health Economics Review.

¹⁵ Ethgen O et al. (2018), "Vaccination Budget in Europe: An Update".

to reduce baseline vulnerability through sustained investment in prevention. While the COVID-19 pandemic may already feel distant in public and political debate, it remains a reminder that preparedness is harder to build in the middle of a crisis and must be sustained before the next shock occurs.

3. The NEGF as a Policy Window: Reframing Preventive Care as Strategic Investment

The **New Economic Governance Framework (NEGF)** changes the context in which Member States make fiscal choices. It does not remove the need for budgetary discipline, nor does it create an automatic exemption for health expenditure. Its relevance lies elsewhere: it creates a **more structured opportunity to connect fiscal sustainability with reforms and investments** that strengthen Europe's medium-term growth, resilience and competitiveness. This is particularly important for preventive care, which is often treated as a short-term budget cost even though its benefits materialise through lower future risks, healthier ageing and stronger labour-market participation.

The framework entered into force in April 2024 with two objectives that are directly relevant to this debate: **strengthening Member States' debt sustainability** and **promoting sustainable and inclusive growth** through reforms and priority investments. The Commission identified four priority areas for investment: green and digital transition, defence and economic and social resilience. The latter is a broad concept that includes health prevention.

This creates an opening for prevention because the framework is built around **medium-term fiscal-structural plans** rather than annual fiscal adjustment alone. Member States are asked to set out fiscal targets together - in terms of a maximum annual increase in net public expenditure¹⁶ - together with **priority reforms and investments over a multi-year horizon**. This is a better fit for preventive care than traditional annual budgeting, because prevention rarely produces its full value within a single fiscal year¹⁷.

The most concrete element of flexibility is the possibility of **extending the fiscal adjustment period** when Member States commit to reforms and investments **from 4 to 7 years**. In practical terms, this can make the adjustment path less abrupt and help Governments preserve selected investments while still committing to debt reduction. This opportunity has already been exploited by Finland, France, Italy and Spain as a result of a commitment to investment in the 4 priority areas identified by the Commission¹⁸.

The **annual implementation process also matters**. Member States present annual progress reports on the commitments included in their plans, and the Commission assesses whether they are delivering on the agreed fiscal path and reform-investment agenda. The Commission's own description of the framework **emphasises that annual progress reports are intended to focus on the implementation of commitments** laid out in national plans. This does not mean that preventive spending can be increased without regard to expenditure ceilings. It does mean, however, that the quality and composition of expenditure become part of the policy conversation. A budget that protects high-value prevention while remaining consistent with the agreed net expenditure path can be more defensible than one that cuts prevention to meet short-term targets.

¹⁶ General government expenditure net of interest expenditure, discretionary revenue measures, expenditure on EU programmes fully matched by EU funds revenue, national co-financing of EU-funded programmes, cyclical unemployment expenditure, and one-off or temporary measures.

¹⁷ The European House – Ambrosetti (2024), "The value of prevention for economic growth and the sustainability of healthcare, social care and welfare systems", realised in partnership with IFPMA and Vaccines Europe.

¹⁸ OECD (2025), "National fiscal plans under the new European Union fiscal rules: An initial assessment".

This means that the NEGF can create a **more favourable environment for preventive care**, but it does not yet fully solve the problem. There is no escape clause for prevention investment similar to the one introduced for defence expenditure in 2025¹⁹. There is **no automatic exclusion of immunisation**, screening or public health spending from fiscal indicators. And once the medium-term plan has been agreed, the framework does not provide an open-ended annual mechanism to increase preventive spending outside the agreed expenditure path.

This is where the framework still needs further development. **If Europe accepts that prevention contributes to productivity, resilience and fiscal sustainability, then fiscal governance should become better at identifying and protecting this type of expenditure.** Today, preventive care can benefit from the NEGF mainly when it is included in a credible national strategy, linked to reforms and investments, or supported by EU funding and co-financing. What remains missing is a more explicit treatment of prevention as a form of future-oriented expenditure.

The NEGF should therefore be seen as a **policy window rather than a complete solution**. It gives Member States and EU institutions a stronger language to connect prevention with debt sustainability, growth and resilience. It also creates procedural moments — medium-term plans, annual progress reports and budgetary assessments — in which the composition of public spending can be evaluated more strategically. But further steps are needed to ensure that preventive care is protected in budget decisions.

4. The Cost of Inaction: Why Underinvesting in Preventive Care Increases Fiscal Risk

Underinvesting in preventive care does not result in savings for the healthcare budget. It shifts costs into the future, often in more expensive and less predictable forms. When immunisation, screening and broader prevention systems are weak, preventable diseases are more likely to translate into hospitalisations, emergency demand, productivity losses, social care needs and fiscal shocks. The result is not only poorer health outcomes, but greater pressure on public finances.

Europe is already facing a long-term rise in age-related expenditure. Public long-term care (LTC) spending alone is projected to almost double by 2050, rising to 2.8% of GDP²⁰. In this context, failing to prevent avoidable diseases increases the probability of health and care systems becoming more expensive, less resilient and more difficult to finance over time.

The cost of inaction has three main layers: at health-system level, underinvestment means more avoidable demand and greater pressure on already scarce capacity; at macro-fiscal level, it means more sick days, lower productivity, lower tax receipts and higher welfare or care-related expenditure; and at strategic level, it translates into weaker preparedness, greater exposure to antimicrobial resistance and outbreaks, and less predictable demand for vaccine innovation and production.

¹⁹ The National Escape Clause for defence expenditure is a temporary flexibility under the EU fiscal rules that allows a Member State to increase defence spending without this automatically triggering corrective action under the Stability and Growth Pact.

²⁰ OECD (2026), "Future long-term care expenditure trajectories across OECD countries".

This is why the cost of inaction should not be interpreted only as future healthcare spending, but rather as a wider economic, social and strategic risk. The policy implication is straightforward: cutting or underfunding prevention may appear fiscally convenient in the short term, but it can increase fiscal risk over the medium and long term. If Europe wants to manage ageing, debt and competitiveness pressures, prevention should be treated less as a discretionary line item and more as a form of risk management for public finances.

Layer of inaction	What happens if preventive care is underfunded	Why prevention funding matters
Health-system costs	More preventable infections, higher emergency demand, more hospitalisations, greater winter pressure and deferred elective care.	Preventive care protects scarce capacity and reduces avoidable operating pressure.
Macro-fiscal costs	More sick days, caregiver absences, productivity losses, lower tax receipts and higher transfer payments.	The value of vaccination is partly outside the health budget and must be captured by fiscal assessment methods.
Strategic costs	Weaker preparedness, greater exposure to AMR and outbreaks, less predictable demand for vaccine innovation and production.	Immunisation is part of resilience and economic security, not only public health.

Table 2. The systemic costs of underfunding preventive care – Source: TEHA Group, 2026

5. Why Preventive Care Remains Underfunded: A Structural Misalignment in Public Spending

The persistence of underinvestment in preventive care is not primarily a problem of insufficient evidence, nor of insufficient resources. The reason lies in communication and awareness: prevention creates value in ways that are not fully recognised by the way health systems, budget processes and political incentives are organised.

The first barrier is the short-term focus of public budgeting. Governments are often required to demonstrate savings within the budget year, while the benefits of immunisation and screening can emerge over longer time horizons. This creates a disadvantage for prevention in annual spending rounds. Hospital activity, medicines, emergency services and workforce pressures are immediate, visible and politically difficult to defer. By contrast, the value of preventive care is often reflected in events that never occur: infections avoided, cancers avoided and detected at earlier stages, complications prevented, hospital admissions reduced, and productivity maintained.

This makes prevention difficult to defend with conventional budget logic. A treatment that responds to an existing need has an identifiable patient, provider and cost. A preventive intervention has a target population, an upfront allocation and a probabilistic future benefit. Even when the long-term case is strong, it can therefore lose out to services whose pressure is more visible in the short term.

A second barrier is that the impact of prevention is underestimated. The costs of immunisation, screening and broader prevention programmes are usually concentrated in health budgets and appear immediately. Their benefits, however, materialise over time and across different sectors: fewer hospitalisations, fewer sick

days, higher labour participation, reduced caregiver burden, lower welfare spending and stronger productivity. Traditional budget processes often fail to capture these wider returns. Funding alone, however, is not sufficient: realising these benefits depends on achieving high coverage, which requires effective implementation and uptake.

The treatment-centric design of health systems represents a third barrier. Most systems are still organised, financed and evaluated around the delivery of care once illness has already occurred. Hospitals, specialist services, pharmaceuticals and waiting lists naturally attract political attention because their pressures are immediate and measurable. Prevention sits in a different space: it requires outreach, public trust and continuous engagement with people who may not yet feel ill and that therefore tend to be less engaged and interested in the importance of prevention.

Another barrier is that prevention is easier to postpone than treatment. When fiscal pressure increases, Governments may find it administratively and politically simpler to delay prevention programmes and reduce public health. The consequences of underfunding prevention are real, but they are often delayed. This makes prevention particularly exposed in a tighter fiscal environment, where short-term consolidation pressures can override longer-term value.

This is why budgetary protection matters. Without dedicated mechanisms, prevention risks becoming a residual item: praised in strategies but squeezed in implementation. The issue is not only how much is allocated to preventive care, but whether these allocations are stable enough to support planning, coverage expansion, workforce capacity, data systems and public engagement. Immunisation and screening programmes cannot deliver their full value if they are funded episodically or treated as optional add-ons to the health budget.

A final barrier is fragmented governance. Preventive care depends on multiple actors, and this fragmentation makes it harder to align objectives, budgets and accountability. This governance challenge is especially relevant in Europe, where EU-level strategies can set direction, but delivery often depends on national and subnational implementation. European plans, recommendations and guidance can help define priorities, but they do not automatically translate into budget lines, workforce capacity or coverage improvements. This is why prevention requires both “horizontal coherence” across EU initiatives and “vertical coherence” between European policy objectives and national implementation.

The underfunding of preventive care is therefore not simply a failure to recognise its importance. It reflects a deeper **mismatch between the way prevention creates value and the way public budgets allocate resources**. Prevention works across time horizons, sectors and institutions; public budgeting often remains annual, siloed and focused on visible short-term pressures. Until this mismatch is addressed, immunisation and screening will continue to be treated as strategic priorities in principle, but often as residual expenditure in practice.

6. From Framework to Practice: Early National Signals After the NEGF

The New Economic Governance Framework is still in its first cycle of implementation, and it is **too early to conclude whether it has already produced a structural increase in prevention budgets** across Member States. Its practical relevance should therefore be assessed more carefully: not by asking whether countries

have already used the framework to create a dedicated fiscal space for immunisation and screening, but whether they are beginning to **frame prevention investment in a way that is compatible with the new medium-term fiscal logic**²¹.

Italy provides one of the clearest early examples of how preventive care can be positioned within this logic. In the parliamentary discussion on the **2025 Public Finance Document** submitted to the European Commission, adult immunisation and screening were recognised as strategic investments for social and economic resilience. This is relevant because it moves prevention **beyond the language of routine health expenditure** and **links it to the medium-term fiscal planning framework** introduced by the NEGF. The reference remains a political and programmatic signal rather than a fully operational budgetary mechanism, but it creates a basis for a possible future definition of prevention as an investment rather than an expenditure.

Other countries have also included prevention in their fiscal-structural plans, although the signals are still uneven. **Lithuania** provides a concrete example: its plan links health-sector recommendations to system resilience, service quality and access, adequate financing, and the **strengthening of primary and preventive healthcare**. It also identifies prevention-related measures such as centralised invitations to early diagnosis programmes, expanded target age groups, new cancer-prevention directions, and additional tests and procedures financed from 2025 through the Compulsory Health Insurance Fund.

This is a critical point. The early national evidence **does not yet show a mature “NEGF prevention model”, but it points to an emerging opportunity**. Some countries are beginning to use the framework’s wording - resilience, sustainability, priority investment, medium-term planning - in ways that help frame preventive care as something that **generates an economic and social return on investment**. However, this has not yet translated into a systematic practice of protecting or expanding prevention budgets through dedicated budget lines, performance indicators or fiscal assessment methods.

The annual implementation process could become important in this respect. Under the NEGF, annual progress reports allow the Commission to assess whether Member States are delivering on the reforms and investments included in their plans. This does not reopen fiscal space every year, nor does it exempt prevention from the agreed expenditure path, but it **creates a recurring policy moment in which the composition of public spending can be assessed. The NEGF should be seen as an enabling framework**, not as a finished solution. It can help **reframe preventive care as a strategic investment**, but this depends on how Member States use their plans, how the Commission evaluates spending quality, and whether **national budget processes develop better tools to track the fiscal and economic returns of prevention**. The next step is to move from recognition to implementation: prevention should be made visible in fiscal-structural plans, linked to measurable outcomes, and protected in annual budget decisions.

²¹ The European House – Ambrosetti (2024), “The value of prevention for economic growth and the sustainability of healthcare, social care and welfare systems”, realised in partnership with IFPMA and Vaccines Europe.

7. Policy Asks for EU and National Decision-Makers: Protecting and Expanding Preventive Care Budgets

The case for investing in prevention is clear: immunisation and screenings can reduce avoidable disease, protect health-system capacity, support labour-market participation and strengthen resilience to future shocks. Yet the evidence alone is not sufficient. Prevention remains vulnerable because its benefits are perceived as long-term, dispersed across sectors and poorly captured by traditional budget processes. **The policy challenge is therefore to translate strategic recognition into stable financing, implementation capacity and accountability.** This also requires clearer recognition of the broader innovation and industrial ecosystem underpinning prevention, particularly the role of the innovative pharmaceutical industry in supporting competitiveness, economic growth and health security.

European policy already provides important foundations. The New Economic Governance Plan represents a first step towards a unified European budgetary process that, while still promoting sound and responsible fiscal policy, protects investment in key priority areas such as preventive care.

Full implementation of this goal requires **stronger coherence in two directions**. First, **“horizontal coherence”** is needed across EU policies: fiscal governance, health policy, industrial strategy, preparedness, digital health and research policy should all recognise the economic and strategic value of prevention. Second, **“vertical coherence”** is needed between EU-level priorities and national implementation: Member States should translate European prevention objectives into budget lines, delivery plans, measurable targets and monitoring systems.

Specific policy asks should include:

- **Protect preventive care budgets from short-term cuts.**

EU institutions and Member States should recognise immunisation, screening and broader prevention as high-value expenditure that should not be disproportionately compressed during fiscal consolidation. Prevention budgets should be protected because cutting them may reduce short-term spending while increasing medium- and long-term fiscal risk.

- **Progressively expand prevention funding where evidence shows clear returns.**

Member States should move from support to actual budgetary prioritisation, especially for interventions with strong evidence of health, fiscal and economic value. This includes adult immunisation and cancer screening.

- **Embed prevention in national fiscal planning.**

Preventive care should be included more systematically in medium-term fiscal-structural plans, national health strategies and annual budget laws. Under the NEGF, Member States should use the language of resilience, productivity and long-term sustainability to justify prevention as a strategic investment, not as residual current expenditure.

- **Develop better metrics to capture the full value of prevention.**

Fiscal and budgetary assessments should go beyond immediate health-budget costs and include avoided hospitalisations, fewer sick days, higher labour participation, reduced caregiver burden, lower welfare spending, higher tax receipts and improved preparedness. Shared EU-level methodological guidance could help Member States assess prevention more consistently.

- **Improve horizontal coherence across EU policies.**

Prevention should be reflected not only in health policy, but also in EU work on fiscal sustainability, competitiveness, strategic autonomy, health security, digital infrastructure and research. This is particularly important for immunisation, where public health objectives intersect with vaccine innovation, manufacturing capacity and supply-chain resilience.

- **Improve vertical coherence between EU guidance and national delivery.**

EU recommendations and plans should be matched by national implementation mechanisms. This requires coordination between health ministries, finance ministries, regional authorities, public health agencies and service providers, so that prevention objectives are not lost between strategic guidance and budget execution.

- **Use EU funding and co-financing strategically to support effective implementation.**

EU programmes should be used to support prevention infrastructure, including registries, invitation systems, digital tools, surveillance capacity, workforce training and outreach models — which are critical to achieving high coverage rates and realizing the full value of life course immunization investment. Since EU programmes and national co-funding are excluded from net expenditure, this represents an opportunity to increase investments in prevention.

- **Maintain prevention as a continued policy dialogue.**

The roundtable should not be treated as a one-off discussion, but as the starting point for a structured dialogue among EU institutions, national governments, experts, industry, patient organisations and public health actors. The goal should be to build a shared agenda on how to make prevention a stable pillar of Europe's economic and health strategy.



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