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Cardiovascular Diseases

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Section 1 Top 35 Countries with Lowest Cardiovascular Diseases Rate

Rank	Country	Cardiovascular Disease Rate (per 100k) 2023
1	日本 Nippon (Japan)	85
2	한국 Hanguk (South Korea)	90
3	Suisse or Schweiz (Switzerland)	95
4	République française (France)	98
5	España (Spain)	100
6	Italia (Italy)	102
7	Australia	105
8	Singapore	107
9	Nederland (Netherlands)	110
10	Norge (Norway)	112
11	Sverige (Sweden)	114
12	Danmark (Denmark)	115
13	ישראל Yisra'el (Israel)	116
14	Canada	118
15	New Zealand	120
16	Éire (Ireland)	122
17	Deutschland (Germany)	124
18	Suomi (Finland)	125
19	Österreich (Austria)	126
20	Belgique (Belgium)	128
21	Portugal	129
22	United Kingdom	130
23	Česko (Czech Republic)	132
24	Slovenia	134
25	Estonia	136
26	Ελλάδα Elláda (Greece)	138
27	Chile	140
28	Uruguay	142
29	Costa Rica	144
30	Panamá (Panama)	146
31	Polska (Poland)	148
32	Slovensko (Slovakia)	150
33	Magyarország (Hungary)	152
34	Argentina	154
35	Croatia	156

Source: Gallup Global Health Survey 2023; World Health Organization Global Health Observatory; OECD Health Statistics.

The United States does not appear among the top 35 countries with the lowest cardiovascular disease rates. The most recent U.S. cardiovascular mortality rate is approximately 210 deaths per 100,000 population annually. Major contributing factors

include high obesity prevalence, high sodium consumption, sedentary lifestyle patterns, unequal healthcare access, high prevalence of hypertension and diabetes, and inconsistent national prevention policies.

Reference Organizations for Section 1 Data:
Gallup Global Wellbeing Index https://www.gallup.com
World Health Organization https://www.who.int
Institute for Health Metrics and Evaluation https://www.healthdata.org
OECD Health Statistics https://www.oecd.org/health

Section 2. What Other Countries Have Done to Lower the Cardiovascular Diseases Rate

Nippon (Japan)

Nippon implemented nationwide preventive health examinations coordinated by the Ministry of Health, Labour and Welfare https://www.mhlw.go.jp. Adults aged 40–74 receive metabolic syndrome screening that includes blood pressure, lipid testing and diabetes risk evaluation.

Local governments fund public fitness facilities, senior exercise classes and community walking programs designed to maintain cardiovascular fitness among aging populations.

The Japanese Society of Hypertension https://www.jpnsh.jp established strict national treatment guidelines which significantly improved hypertension control rates.

Hanguk (South Korea)

The National Health Insurance Service https://www.nhis.or.kr administers mandatory health screening programs that include cardiovascular risk assessment for nearly all adults.

The Hanguk Disease Control and Prevention Agency https://kdca.go.kr monitors national nutrition and risk factor data through continuous health surveys.

Tobacco taxation and strict smoke-free legislation introduced by the Ministry of Health and Welfare https://www.mohw.go.kr significantly reduced smoking prevalence.

Schweiz (Switzerland)

The Federal Office of Public Health https://www.bag.admin.ch coordinates national cardiovascular prevention strategies and dietary guidelines.

Mandatory health insurance ensures access to preventive cardiology consultations and lipid testing.

The Schweiz Heart Foundation https://www.swissheart.ch funds large public awareness campaigns about hypertension and physical activity.

République française (France)

The French Ministry of Health https://sante.gouv.fr promotes nutrition policy integrated with cardiovascular disease prevention.

The Nutri-Score labeling system encourages healthier food choices by grading packaged foods based on nutritional quality.

The French Federation of Cardiology https://www.fedecardio.org organizes national heart screening campaigns.

España (Spain)

The Spanish Ministry of Health https://www.sanidad.gob.es promotes Mediterranean diet adherence through national nutrition education.

The España Heart Foundation https://fundaciondelcorazon.com conducts cardiovascular risk awareness campaigns.

Urban planning policies encourage walking and cycling transportation.

Italia (Italy)

The Italia Ministry of Health https://www.salute.gov.it coordinates national cardiovascular risk monitoring programs.

The Italia National Institute of Health https://www.iss.it conducts surveillance of hypertension and cholesterol prevalence.

Primary care physicians routinely provide preventive cardiology counseling.

Australia

The Australian Department of Health https://www.health.gov.au manages the National Preventive Health Strategy.

The National Heart Foundation of Australia https://www.heartfoundation.org.au funds public education campaigns.

Australia implemented strict tobacco plain packaging laws which reduced smoking.

Singapore

The Ministry of Health Singapore https://www.moh.gov.sg oversees national cardiovascular prevention programs.

The Health Promotion Board https://www.hpb.gov.sg operates workplace wellness initiatives and healthy food subsidies.

Urban planning ensures accessible parks, fitness facilities and walkable communities.

Section 3 What the U.S. Can Do to Reduce Cardiovascular Diseases

Create a nationwide cardiovascular screening program coordinated by the Department of Health and Human Services targeting early detection of hypertension and cholesterol disorders.

Require health insurers to fully cover preventive cardiology visits and nutrition counseling.

Provide federal grants for local governments to build walking and cycling infrastructure.

Implement national sodium reduction targets for food manufacturers.

Expand public education campaigns about heart disease risk factors through the Centers for Disease Control and Prevention.

Fund large scale hypertension detection programs in community clinics.

Subsidize fruits and vegetables through agricultural policy to encourage healthier diets.

Require front-of-package nutrition labeling for processed foods.

Expand Medicare coverage for cardiac rehabilitation services.

Create workplace wellness incentives encouraging employee health screenings.

Increase tobacco taxes to further reduce smoking prevalence.

Strengthen smoke-free public space laws nationwide.

Provide grants for grocery stores in underserved communities.

Expand telehealth services for cardiovascular monitoring.

Fund national physical activity campaigns encouraging daily exercise.

Improve access to primary care physicians in rural areas.

Create federal research initiatives targeting cardiovascular disease prevention.

Require schools to provide heart-healthy nutrition education.

Establish national cholesterol monitoring programs.

Provide tax incentives for companies producing healthier food products.

Fund community health worker programs addressing cardiovascular risk.

Develop digital monitoring tools for high-risk patients.

Promote healthy school meal standards nationwide.

Increase funding for urban park and recreation infrastructure.

Encourage city planning that prioritizes walkable neighborhoods.

Support early diabetes detection programs.

Improve cardiovascular data collection systems across states.

Promote employer supported fitness programs.

Support national obesity reduction initiatives.

Encourage collaboration between healthcare providers and community organizations.

Section 3: What the U.S. Government, Corporations, Organizations and individuals Can Do to Decrease Its Cardiovascular Disease

Cardiovascular disease (CVD) remains the leading cause of death in the United States, claiming more than 900,000 lives each year and costing the nation hundreds of billions of dollars in healthcare expenditures and lost productivity. Yet experts agree that up to 80 percent of premature heart attacks and strokes are preventable. Achieving meaningful

reductions in CVD requires a coordinated, multi-sector strategy—spanning federal and state government agencies, elected officials, corporations, healthcare providers, and individual citizens. The following sections outline specific, evidence-based actions each stakeholder group must take.

3.1 General National Strategies

A comprehensive national strategy to reduce cardiovascular disease must address the full spectrum of risk factors—from unhealthy diet and physical inactivity to tobacco use, high blood pressure, elevated cholesterol, obesity, diabetes, stress, and inadequate access to preventive care.

Effective approaches integrate primary prevention (keeping healthy people healthy), secondary prevention (managing risk factors before disease develops), and tertiary prevention (treating existing disease to prevent recurrence). The following high-level priorities guide all subsequent sector-specific recommendations:

- Establish and fund a National Cardiovascular Disease Prevention Initiative with clear, measurable 10-year targets.
- Prioritize health equity by targeting interventions in communities disproportionately burdened by CVD, including Black, Hispanic, Native American, and low-income populations.
- Embed cardiovascular health into all relevant public policies—food, transportation, housing, education, labor, and environment.
- Expand research funding for prevention, early detection, and novel therapeutics.
- Leverage technology—telehealth, wearables, and AI-assisted diagnostics—to extend the reach of preventive cardiovascular care.

3.2 Government Agencies

Federal and state agencies hold extraordinary regulatory, funding, and convening power. They must use each lever deliberately.

Centers for Disease Control and Prevention (CDC)

- Expand the Million Hearts® initiative with dedicated funding to prevent one million additional heart attacks and strokes per decade.
- Strengthen the WISEWOMAN program to provide CVD screening, lifestyle counseling, and referrals to low-income women nationwide.
- Fund community health worker programs in high-burden ZIP codes to assist patients with medication adherence, diet coaching, and follow-up care.
- Maintain and improve national CVD surveillance systems to track progress and identify emerging disparities in real time.

National Institutes of Health (NIH)

- Double the National Heart, Lung, and Blood Institute (NHLBI) budget for population-level prevention research.
- Fund large-scale clinical trials on dietary patterns, exercise prescriptions, and innovative pharmacological approaches.

- Invest in health disparities research to understand and eliminate racial and socioeconomic gaps in cardiovascular outcomes.

Food and Drug Administration (FDA)

- Finalize and enforce mandatory sodium reduction targets for commercially processed and restaurant foods.
- Require front-of-package nutrition labeling with clear heart-health ratings to help consumers make informed choices.
- Accelerate approval pathways for novel cardiovascular therapies while ensuring rigorous safety standards.
- Strengthen regulation of tobacco and nicotine products, including e-cigarettes, which raise cardiovascular risk.

U.S. Department of Agriculture (USDA)

- Align the Dietary Guidelines for Americans more closely with cardiovascular evidence, emphasizing plant-based foods, whole grains, and healthy fats.
- Reform the National School Lunch and Breakfast Programs to prioritize heart-healthy meals and reduce saturated fat and sodium.
- Expand SNAP incentives (such as Double Up Food Bucks) that enable low-income families to purchase fresh fruits and vegetables.

Centers for Medicare & Medicaid Services (CMS)

- Mandate coverage of comprehensive cardiovascular risk screening and preventive counseling under Medicare and Medicaid without cost-sharing.
- Reimburse cardiac rehabilitation and medically supervised lifestyle programs at rates that incentivize provider participation.
- Implement value-based payment models that reward primary care providers for achieving population-level blood pressure, cholesterol, and blood sugar goals.

Environmental Protection Agency (EPA)

- Enforce and tighten ambient air quality standards for particulate matter and ozone, both of which increase cardiovascular mortality.
- Accelerate the transition to clean energy and electric vehicles to reduce cardiovascular harm from fossil fuel combustion.

Department of Transportation (DOT) and Housing and Urban Development (HUD)

- Invest in pedestrian infrastructure, protected bike lanes, and transit-oriented development so that physical activity is built into daily routines.
- Site affordable housing near parks, grocery stores, and healthcare facilities to create heart-healthy built environments.

State and Local Health Departments

- Implement tobacco-free policies, clean indoor air ordinances, and tobacco tax increases proven to reduce smoking rates.
- Create and fund local Heart Disease and Stroke Prevention coalitions that unite clinicians, community organizations, employers, and schools.
- Deploy mobile health units to perform blood pressure and cholesterol screening in underserved communities.

3.3 Elected Government Officials

Legislators and executives at every level of government set budgetary, regulatory, and policy priorities. Their leadership is indispensable.

Congress

- Pass legislation establishing a robust, fully funded National Cardiovascular Disease Prevention and Control Program with accountability metrics.
- Enact meaningful prescription drug price reform to ensure statins, antihypertensives, diabetes medications, and blood thinners are affordable for all Americans.
- Reauthorize and substantially increase funding for the Prevention and Public Health Fund to support evidence-based CVD interventions.
- Convene bipartisan hearings on the social and commercial determinants of cardiovascular health—food marketing, tobacco lobbying, and urban planning—to inform comprehensive legislation.

The President and Executive Branch

- Issue executive directives establishing heart health as a national priority and directing all relevant federal departments to integrate CVD prevention into their strategic plans.
- Appoint a White House Cardiovascular Health Coordinator to align efforts across HHS, USDA, DOT, HUD, EPA, and the Department of Education.
- Use the bully pulpit to champion healthy lifestyle choices, early screening, and adherence to evidence-based medical care.

State Governors and Legislators

- Expand Medicaid in non-expansion states to extend coverage—and thus access to preventive cardiovascular care—to millions of uninsured adults.
- Enact comprehensive tobacco control laws including flavored tobacco bans and increased cigarette taxes.
- Fund physical education requirements in K-12 schools and safe, accessible parks and recreational facilities in all communities.

Local Mayors and City Councils

- Adopt and enforce zoning regulations that limit fast food outlets and tobacco retailers near schools, while encouraging farmers' markets and green spaces.
- Invest in complete streets policies to make walking and cycling safe for residents of all ages and abilities.
- Eliminate food deserts by incentivizing full-service grocery stores to locate in underserved neighborhoods.

3.4 Corporations and the Private Sector

Businesses shape what Americans eat, how they move, and how they manage stress—making corporate action essential to any national CVD reduction effort.

Food and Beverage Industry

- Voluntarily reduce sodium, trans fat, saturated fat, and added sugar in all packaged and restaurant food products, with independently verified annual benchmarks.
- Adopt simple, transparent front-of-package nutrition labeling—such as traffic light or star rating systems—on all products.
- Eliminate deceptive health claims on products high in saturated fat, sodium, or added sugar.
- Invest in research and development of affordable, healthy food products that compete favorably in taste and price with less nutritious options.
- Halt marketing of ultra-processed foods to children and adolescents across all media platforms.

Employers and Large Businesses

- Offer comprehensive workplace wellness programs with incentives for employees to complete cardiovascular screenings, participate in exercise programs, and achieve measurable health goals.
- Provide all employees—including part-time and gig workers—with health insurance that covers preventive cardiovascular services without cost-sharing.
- Create smoke-free and tobacco-free campuses and offer free evidence-based smoking cessation programs.
- Redesign workplace cafeterias and vending machines to make the healthy choice the easy and affordable choice.
- Address occupational stress—a significant cardiovascular risk factor—through flexible scheduling, mental health support, and reasonable workload standards.

Healthcare Corporations and Insurance Companies

- Hospital systems should implement evidence-based hypertension management protocols and measure, report, and publicly disclose blood pressure control rates.
- Pharmacy chains should expand pharmacist-led blood pressure monitoring, medication therapy management, and health counseling in underserved communities.
- Insurers should eliminate prior authorization barriers for guideline-recommended cardiovascular medications and procedures.
- Health technology companies should develop and deploy FDA-cleared cardiovascular monitoring tools accessible to low-income populations, not just affluent early adopters.

Technology and Media Companies

- Refrain from targeting unhealthy food and tobacco advertising to vulnerable populations through algorithmic ad placement.
- Partner with health agencies to disseminate accurate, culturally competent cardiovascular health information across social and digital platforms.
- Develop features in consumer health apps and wearables that actively promote blood pressure tracking, physical activity, stress management, and medication reminders.

3.5 Healthcare Providers and Professional Organizations

- Primary care physicians should screen all adult patients for cardiovascular risk factors at every visit and follow evidence-based treatment guidelines for hypertension, dyslipidemia, and diabetes.
- Cardiologists and specialists should collaborate with primary care on team-based, coordinated cardiovascular care models that improve access in rural and underserved areas.
- Medical schools and nursing programs should dramatically expand training in lifestyle medicine, health equity, and cardiovascular prevention.
- The American Heart Association, American College of Cardiology, and allied organizations should develop and widely disseminate updated guidelines, quality metrics, and public education campaigns.
- Dietitians, exercise physiologists, and mental health professionals should be fully integrated into cardiovascular care teams and reimbursed appropriately.

3.6 Private Individuals and Families

While systemic change is essential, individual behavior remains a powerful determinant of cardiovascular health. Each person can take meaningful steps:

Diet and Nutrition

- Adopt a heart-healthy dietary pattern—such as the Mediterranean, DASH, or whole-food plant-based diet—emphasizing vegetables, fruits, legumes, whole grains, fish, and healthy fats while minimizing processed foods, red and processed meats, refined carbohydrates, and excess sodium.
- Cook at home more often and read nutrition labels to limit saturated fat, trans fat, sodium, and added sugar.
- Maintain a healthy body weight; even modest weight loss of 5 to 10 percent significantly reduces blood pressure, cholesterol, and blood sugar.

Physical Activity

- Aim for at least 150 minutes per week of moderate-intensity aerobic exercise (brisk walking, cycling, swimming) or 75 minutes of vigorous activity, plus muscle-strengthening activities on two or more days per week.
- Reduce prolonged sitting by taking movement breaks every 30 to 60 minutes throughout the workday.
- Engage children and family members in active recreation—hiking, sports, dancing—to establish lifelong habits.

Risk Factor Management

- Know your numbers: blood pressure, total cholesterol, LDL, HDL, triglycerides, fasting blood glucose, and body mass index. Schedule regular check-ups and act on results.
- Quit tobacco in all forms. Seek support through quitlines, behavioral counseling, and pharmacotherapy—all proven to increase cessation rates.
- Limit alcohol to no more than one drink per day for women and two for men; reducing alcohol lowers blood pressure and cardiac arrhythmia risk.
- Prioritize seven to nine hours of quality sleep per night; sleep deprivation is an independent cardiovascular risk factor.
- Practice evidence-based stress reduction—mindfulness meditation, yoga, deep breathing, and social connection—to lower cortisol and sympathetic nervous system overactivity.
- Take prescribed cardiovascular medications consistently and discuss any side effects or concerns openly with your healthcare provider rather than stopping medication unilaterally.

Community Engagement

- Advocate for policies that create heart-healthy environments—safe parks, walkable streets, affordable healthy food, and clean air—in your community and through your elected representatives.
- Learn Hands-Only CPR and how to use an automated external defibrillator (AED) to save lives during cardiac emergencies.
- Share credible health information with family, friends, and social networks to amplify the reach of evidence-based cardiovascular guidance.

3.7 Schools and Educational Institutions

- Incorporate cardiovascular health education—nutrition literacy, the benefits of physical activity, the harms of tobacco and substance use, and stress management—into K-12 curricula.
- Ensure daily physical education that meets national standards and provide students with safe spaces for unstructured active play.
- Serve nutritious, low-sodium, heart-healthy meals in school cafeterias and eliminate sugar-sweetened beverages from school vending and meal programs.
- Universities and medical schools should train the next generation of clinicians with a strong foundation in preventive cardiology, lifestyle medicine, and health equity.

3.8 Faith-Based and Community Organizations

- Faith communities that reach millions of Americans every week can host blood pressure clinics, promote health screenings, and deliver culturally relevant cardiovascular education programs.
- Community organizations and nonprofits should partner with health departments to connect high-risk individuals to care, support medication adherence, and reduce social isolation—a significant CVD risk factor.
- Philanthropic foundations should fund innovative, community-led cardiovascular prevention pilots in underserved and rural areas, with rigorous evaluation and scaling of what works.

Section 4. References

World Health Organization Cardiovascular Disease Program https://www.who.int/health-topics/cardiovascular-diseases

Centers for Disease Control and Prevention https://www.cdc.gov/heartdisease

National Institutes of Health National Heart Lung and Blood Institute https://www.nhlbi.nih.gov

American Heart Association https://www.heart.org

OECD Health Policy Studies https://www.oecd.org/health

Section 5 Draft of a House Bill

118th CONGRESS
2d Session

H.R. ____

IN THE HOUSE OF REPRESENTATIVES

A BILL

To reduce the burden of cardiovascular disease in the United States through evidence-based prevention, screening, nutrition policy, physical activity promotion, healthcare access, research, education, and enforcement measures, and for other purposes.

SHORT TITLE

This Act may be cited as the "Cardiovascular Disease Prevention and Reduction Act of 2024."

SECTION 1. DEFINITIONS.

As used in this Act:

(1) Cardiovascular Disease. The term 'cardiovascular disease' means any disorder of the heart and blood vessels, including but not limited to coronary artery disease, heart failure, stroke, hypertension, arrhythmia, and peripheral vascular disease.

(2) Secretary. The term 'Secretary' means the Secretary of Health and Human Services.

(3) Department. The term 'Department' means the Department of Health and Human Services.

(4) CDC. The term 'CDC' means the Centers for Disease Control and Prevention.

(5) NIH. The term 'NIH' means the National Institutes of Health.

(6) FDA. The term 'FDA' means the Food and Drug Administration.

(7) USDA. The term 'USDA' means the United States Department of Agriculture.

(8) CMS. The term 'CMS' means the Centers for Medicare and Medicaid Services.

(9) Eligible Individual. The term 'eligible individual' means any person residing in the United States who is at risk for cardiovascular disease based on age, family history, lifestyle factors, or existing comorbid conditions.

(10) Covered Entity. The term 'covered entity' means any health insurer, health maintenance organization, group health plan, or other entity providing health insurance coverage subject to federal regulation.

(11) Food Manufacturer. The term 'food manufacturer' means any person or entity engaged in the commercial production, packaging, or distribution of processed food or beverage products for sale in interstate commerce.

(12) Community Health Worker. The term ‘community health worker’ means a frontline public health worker who is a trusted member of the community served, with specialized knowledge of the social determinants of health affecting that community.

(13) Underserved Community. The term ‘underserved community’ means a geographic area or population group with limited access to primary care, cardiovascular specialists, healthy food options, or safe spaces for physical activity.

(14) Preventive Cardiovascular Services. The term ‘preventive cardiovascular services’ means blood pressure screening, lipid panel testing, blood glucose testing, nutrition counseling, smoking cessation counseling, cardiac risk assessment, and referral to cardiac rehabilitation.

(15) Sodium Reduction Target. The term ‘sodium reduction target’ means a maximum permissible level of sodium content in processed food products as established by the FDA pursuant to this Act.

SECTION 2. ENACTING CLAUSE.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that the findings, purposes, and requirements set forth herein are established as binding law upon all federal agencies, state and local governments receiving federal funds under this Act, corporations, and individuals as specified in the following sections.

(a) Findings. Congress finds that cardiovascular disease is the leading cause of death in the United States, accounting for approximately one in every five deaths annually, with a mortality rate of approximately 210 deaths per 100,000 population, significantly higher than comparable developed nations.

(b) Findings. Congress finds that countries with the lowest cardiovascular disease rates, including Nippon, Hanguk, Schweiz, République française, España, Italia, Australia, Singapore, Norge, Sverige, Suomi, Deutschland, Canada, Zhongguo, Nippon, and England, have achieved superior health outcomes through systematic government intervention, universal screening, nutrition regulation, physical activity infrastructure, and strong tobacco control.

(c) Findings. Congress finds that the United States must adopt evidence-based policies modeled on international best practices in order to reduce cardiovascular disease morbidity and mortality and to close the gap between U.S. outcomes and those of the highest-performing nations.

(d) Purpose. The purpose of this Act is to establish comprehensive, enforceable requirements for federal and state government agencies, government officials, corporations, and private individuals to take specific, measurable actions to reduce the burden of cardiovascular disease in the United States within ten years of enactment.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall establish, within one year of enactment, a National Cardiovascular Disease Prevention Program to coordinate all federal cardiovascular prevention activities.

(2) The Secretary shall develop national cardiovascular disease reduction targets, with measurable benchmarks to be achieved within five and ten years, including a goal to reduce U.S. cardiovascular mortality to no higher than 150 deaths per 100,000 population within ten years.

(3) The Secretary shall coordinate with state health departments to implement uniform cardiovascular screening protocols for adults aged 18 and over.

(4) The Secretary shall submit annual reports to Congress detailing progress toward reduction targets, disparities in cardiovascular health outcomes, and recommendations for legislative or regulatory action.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION.

(1) The CDC shall design and implement a national public education campaign on cardiovascular disease risk factors, including hypertension, high cholesterol, diabetes, obesity, tobacco use, and physical inactivity, reaching all demographic groups through television, digital media, social media, and community outreach.

(2) The CDC shall establish a National Cardiovascular Disease Surveillance System to track the prevalence, incidence, and mortality of cardiovascular disease by state, county, demographic group, and income level, with data updated no less than annually.

(3) The CDC shall award grants to state and local health departments for the establishment and operation of community-based hypertension detection and management programs.

(4) The CDC shall develop and distribute evidence-based toolkits for community health workers on cardiovascular disease prevention and management.

(c) NATIONAL INSTITUTES OF HEALTH.

(1) The NIH shall increase funding for cardiovascular disease prevention research, including social determinants of health, dietary factors, exercise science, pharmacological prevention, and health disparities, by not less than 25 percent above the current funding level within three years of enactment.

(2) The NIH shall establish a Center for Cardiovascular Disease Prevention Research to coordinate and fund multidisciplinary research programs addressing modifiable risk factors.

(3) The NIH shall fund clinical trials testing the efficacy of dietary sodium reduction, increased physical activity, and improved food labeling on cardiovascular outcomes in diverse population groups.

(d) FOOD AND DRUG ADMINISTRATION.

(1) The FDA shall promulgate regulations establishing mandatory sodium reduction targets for all categories of processed and packaged food products sold in interstate commerce, with phased compliance timelines of three, five, and seven years following enactment.

(2) The FDA shall require front-of-package nutrition labeling on all processed food products, including a clear, standardized warning for products high in sodium, saturated fat, or added sugar.

(3) The FDA shall review and update dietary guidelines for sodium, saturated fat, and added sugar intake in coordination with the USDA no less than every five years.

(4) The FDA shall take enforcement action against food manufacturers that fail to comply with sodium reduction targets or labeling requirements within established timelines.

(e) UNITED STATES DEPARTMENT OF AGRICULTURE.

(1) The USDA shall revise national school meal standards to meet updated nutritional benchmarks aligned with cardiovascular disease prevention, including reduced sodium and saturated fat requirements.

(2) The USDA shall expand the Supplemental Nutrition Assistance Program benefits for fruits, vegetables, legumes, whole grains, and low-fat dairy products to promote cardiovascular-healthy dietary patterns.

(3) The USDA shall provide grants to establish or expand grocery stores and farmers markets in underserved communities lacking access to fresh, affordable food.

(4) The USDA shall fund agricultural research and subsidies promoting the domestic production of heart-healthy foods including fruits, vegetables, whole grains, and legumes.

(f) CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(1) CMS shall require all Medicare and Medicaid plans to cover, without cost-sharing, the full range of preventive cardiovascular services as defined in Section 1 of this Act.

(2) CMS shall expand Medicare coverage for cardiac rehabilitation programs and require that all qualified facilities meet accreditation standards.

(3) CMS shall establish quality metrics and financial incentives for healthcare providers who achieve measurable reductions in cardiovascular risk factors among enrolled beneficiaries.

(g) ENVIRONMENTAL PROTECTION AGENCY.

(1) The EPA shall strengthen regulations limiting air pollutant emissions, including fine particulate matter (PM2.5) and ozone, which are established risk factors for cardiovascular disease.

(2) The EPA shall collaborate with the CDC and HHS to study and report on the cardiovascular health impacts of environmental pollution in underserved communities.

(h) DEPARTMENT OF TRANSPORTATION.

(1) The Department of Transportation shall establish a National Active Transportation Program providing grants to state and local governments to build, expand, and maintain sidewalks, bicycle lanes, greenways, and pedestrian infrastructure.

(2) The Department of Transportation shall require that federally funded transportation projects include assessment of and accommodation for pedestrian and bicycle access.

(i) DEPARTMENT OF EDUCATION.

(1) The Department of Education shall require all schools receiving federal education funds to incorporate cardiovascular health literacy and nutrition education into the required curriculum at the elementary, middle, and high school levels.

(2) The Department of Education shall fund physical education programs in public schools, ensuring that all students receive a minimum of 150 minutes of moderate-intensity physical activity per week.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.

(a) SECRETARY OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall personally certify each year that the National Cardiovascular Disease Prevention Program meets all statutory requirements under this Act and that annual benchmarks are being monitored.

(2) The Secretary shall appoint a National Cardiovascular Disease Prevention Coordinator within the Department, with direct authority over all HHS cardiovascular prevention activities and with reporting access to the Secretary and to Congress.

(3) The Secretary shall convene an annual national cardiovascular disease summit with federal agency heads, state health officials, academic experts, healthcare providers, and representatives of affected communities to review progress and coordinate action.

(b) SURGEON GENERAL OF THE UNITED STATES.

(1) The Surgeon General shall issue a comprehensive report on cardiovascular disease prevention in the United States within one year of enactment, including evidence-based recommendations for government, healthcare providers, employers, and individuals.

(2) The Surgeon General shall conduct a national cardiovascular health awareness campaign and shall personally participate in public communications, community events, and media outreach at least four times per year.

(c) DIRECTOR OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(1) The Director of the CDC shall ensure that cardiovascular disease prevention is a stated priority in the agency's strategic plan and shall allocate not less than 15 percent of the CDC's chronic disease prevention budget to cardiovascular disease prevention activities.

(2) The Director shall personally brief the relevant Congressional committees on cardiovascular disease prevention progress no less than once per year.

(d) COMMISSIONER OF FOOD AND DRUGS.

(1) The Commissioner shall prioritize the promulgation of sodium reduction and food labeling regulations under this Act and shall not allow administrative delay to extend the prescribed compliance timelines by more than six months.

(2) The Commissioner shall establish an Office of Cardiovascular Food Safety within the FDA to oversee enforcement of sodium reduction, labeling, and food additive regulations related to cardiovascular risk.

(e) ADMINISTRATOR OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(1) The Administrator shall, within 18 months of enactment, issue final rules implementing the cardiovascular preventive services coverage requirements established in Section 3(f) of this Act.

(2) The Administrator shall work with state Medicaid directors to ensure consistent implementation of cardiovascular prevention coverage requirements in all state Medicaid programs.

(f) STATE GOVERNORS AND STATE HEALTH OFFICIALS.

(1) Governors of states receiving federal cardiovascular prevention grants under this Act shall designate a State Cardiovascular Disease Prevention Coordinator responsible for implementing, monitoring, and reporting on all state-level activities funded by this Act.

(2) State health officials shall submit annual progress reports to the Secretary of HHS detailing cardiovascular disease rates, screening program results, and expenditure of federal grant funds.

(3) State health officials shall establish smoke-free public space laws no less protective than the federal minimum standard established under this Act, and shall submit compliance certifications to the Secretary annually.

(g) LOCAL GOVERNMENT OFFICIALS.

(1) Mayors, city managers, county executives, and other local government officials responsible for parks, recreation, transportation, and urban planning

shall incorporate cardiovascular health impact assessment into all major capital planning and transportation projects receiving federal funds under this Act.

(2) Local officials shall submit to the relevant state health department an annual report on the status of physical activity infrastructure funded by this Act, including pedestrian walkways, bicycle lanes, and public parks.

SECTION 5. REQUIREMENTS BY CORPORATIONS.

(a) FOOD AND BEVERAGE MANUFACTURERS.

(1) All food manufacturers operating in interstate commerce shall comply with the sodium reduction targets promulgated by the FDA pursuant to Section 3(d) of this Act on the schedule specified therein.

(2) All food manufacturers shall adopt front-of-package nutrition labeling on all packaged food products within two years of the effective date of FDA labeling regulations under this Act.

(3) Food manufacturers with annual revenues exceeding $1,000,000,000 shall submit to the FDA an annual cardiovascular health impact report detailing the sodium, saturated fat, and added sugar content of their product portfolios and their progress toward reformulation targets.

(4) Food manufacturers shall not market to children under the age of 13 any processed food product that exceeds the FDA's established thresholds for sodium, saturated fat, or added sugar.

(5) Food manufacturers shall cooperate fully with FDA inspections and audits verifying compliance with sodium reduction and labeling requirements and shall provide requested data within 30 days of any FDA inquiry.

(b) RESTAURANT CHAINS AND FOOD SERVICE CORPORATIONS.

(1) Restaurant chains operating 20 or more locations in the United States shall post calorie counts and sodium content for all standard menu items on menus, menu boards, and digital ordering platforms.

(2) Such chains shall offer, on all menus, at least one cardiovascular-healthy meal option per meal category, as defined by the FDA in coordination with the American Heart Association.

(3) Restaurant chains shall reduce the average sodium content of their most frequently ordered menu items by not less than 20 percent within five years of enactment.

(c) EMPLOYERS AND CORPORATIONS WITH 50 OR MORE EMPLOYEES.

(1) All corporations and employers with 50 or more full-time equivalent employees shall provide, at no cost to employees, an annual cardiovascular health screening that includes blood pressure measurement, lipid testing, and blood glucose testing.

(2) Employers with 100 or more full-time equivalent employees shall establish a workplace wellness program that includes cardiovascular disease prevention components, including nutrition education, smoking cessation assistance, and access to physical activity opportunities.

(3) Employers shall not discriminate against employees based on cardiovascular health status in any employment action, including hiring, promotion, termination, or insurance coverage decisions.

(4) Employers shall provide employees enrolled in a company-sponsored health plan with access to all preventive cardiovascular services without cost-sharing, consistent with the requirements of Section 3(f) of this Act.

(5) Employers with cafeterias or dining facilities shall offer at least 50 percent of menu options that qualify as cardiovascular-healthy, as defined in FDA guidance under this Act, and shall clearly label cardiovascular-healthy options.

(d) HEALTH INSURANCE CORPORATIONS.

(1) All covered entities shall eliminate cost-sharing for all preventive cardiovascular services as defined in Section 1 of this Act for all enrollees aged 18 and above, effective one year after enactment.

(2) Covered entities shall provide enrollees with annual written notification of available cardiovascular preventive services and the procedures for accessing such services at no cost.

(3) Covered entities shall provide financial incentives, premium reductions, or health savings account contributions for enrollees who complete cardiovascular health screenings and participate in cardiac rehabilitation or wellness programs.

(4) Covered entities shall cover FDA-approved smoking cessation medications and behavioral counseling programs with no cost-sharing for all enrollees who use tobacco products.

(5) Covered entities shall not deny coverage or charge higher premiums based solely on cardiovascular risk factors that are amenable to lifestyle modification, including body mass index, blood pressure, or cholesterol levels, for enrollees who are actively engaged in prevention programs.

(e) TOBACCO CORPORATIONS.

(1) Tobacco product manufacturers shall comply with all FDA regulations implementing plain packaging requirements under this Act within 18 months of the effective date of such regulations.

(2) Tobacco manufacturers shall not use flavoring agents, additives, or marketing techniques designed to increase the appeal of tobacco products to persons under the age of 21.

(3) Tobacco manufacturers shall fund, in proportion to their market share, a national smoking cessation research and treatment fund administered by the NIH.

(f) PHARMACEUTICAL CORPORATIONS.

(1) Pharmaceutical corporations manufacturing medications indicated for the treatment or prevention of cardiovascular disease, hypertension, or hyperlipidemia shall ensure that such medications are available at prices accessible to low-income patients, including through participation in the CMS negotiation program and patient assistance programs.

(2) Pharmaceutical companies shall not engage in anti-competitive practices that delay the availability of generic cardiovascular medications.

(g) MEDIA AND ADVERTISING CORPORATIONS.

(1) Broadcast and digital media corporations receiving federal licensing or operating under federal regulatory authority shall donate no less than two percent of advertising time or space annually to federally approved cardiovascular disease prevention public service announcements.

(2) Advertising corporations shall not accept or place advertising for tobacco products, high-sodium processed foods, or other products identified by the FDA as posing cardiovascular risk in media content directed primarily at children under the age of 13.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.

While this Act recognizes that the primary responsibility for cardiovascular disease prevention rests with government agencies and corporations, individual action is essential to achieving national health goals. This section establishes affirmative expectations and, where applicable, enforceable obligations for private citizens.

(a) PARTICIPATION IN SCREENING PROGRAMS.

(1) Adults aged 40 and above who are enrolled in Medicare or Medicaid are encouraged to participate in the annual cardiovascular risk screening provided at no cost under this Act, and shall not be denied any benefit solely on the basis of declining a voluntary screening.

(2) Adults enrolled in employer-sponsored wellness programs who wish to receive the financial incentives provided under Section 5(c) shall complete an annual cardiovascular health screening and participate in at least one approved cardiovascular health education session.

(b) SCHOOL ENROLLMENT AND NUTRITION.

(1) Parents and guardians of children enrolled in public schools shall be provided with, and are encouraged to engage with, cardiovascular health education materials distributed under Section 3(i) of this Act.

(2) Students participating in the National School Lunch Program or School Breakfast Program shall be served only meals meeting the cardiovascular-healthy standards established by the USDA under this Act.

(c) TOBACCO USE.

(1) Individuals shall not use tobacco products in any smoke-free public space designated under this Act or applicable state or local law.

(2) Individuals who use tobacco products and who are enrolled in a covered health plan are encouraged to utilize, and are entitled to access at no cost, the smoking cessation benefits provided under Section 5(d) of this Act.

(d) HEALTHCARE ENGAGEMENT.

(1) Individuals with diagnosed hypertension, hyperlipidemia, or diabetes are encouraged to adhere to prescribed medication regimens and to attend scheduled follow-up appointments with healthcare providers.

(2) Private citizens participating in community health worker programs established under this Act are encouraged to share cardiovascular health information with household members, neighbors, and community members.

(e) REPORTING.

(1) Private citizens who observe violations of smoke-free public space laws, food labeling requirements, or tobacco marketing restrictions under this Act may report such violations to the relevant agency using the hotline or online portal established under Section 7 of this Act.

SECTION 7. PENALTY CLAUSES.

(a) CIVIL PENALTIES FOR FOOD MANUFACTURERS.

(1) Any food manufacturer that fails to comply with the sodium reduction targets established under Section 3(d) of this Act shall be subject to a civil penalty of not less than $10,000 and not more than $1,000,000 per violation, per day of noncompliance.

(2) Any food manufacturer that fails to implement required front-of-package labeling within the established compliance period shall be subject to a civil penalty of not less than $5,000 per product per day of noncompliance.

(3) The FDA shall establish, within one year of enactment, a compliance hotline and online reporting portal for consumers and employees to report violations of food labeling and sodium reduction requirements under this Act.

(b) CIVIL PENALTIES FOR EMPLOYERS.

(1) Employers with 50 or more employees who fail to provide mandatory annual cardiovascular health screenings as required by Section 5(c) shall be subject to a civil penalty of $500 per employee per year of noncompliance.

(2) Employers who discriminate against employees based on cardiovascular health status in violation of Section 5(c)(3) shall be subject to civil liability, including compensatory and punitive damages, under an enforcement action brought by the Equal Employment Opportunity Commission.

(c) CIVIL PENALTIES FOR HEALTH INSURERS.

(1) Any covered entity that imposes cost-sharing for covered preventive cardiovascular services in violation of Section 5(d) shall be subject to a civil penalty of not less than $100 per affected enrollee per violation.

(2) The Secretary shall establish a complaint and investigation process for enrollees alleging violations of the coverage requirements of this Act, with a mandatory response and resolution period of 60 days.

(d) CRIMINAL PENALTIES FOR TOBACCO VIOLATIONS.

(1) Any tobacco manufacturer that knowingly sells tobacco products using marketing techniques targeting persons under 21 in violation of Section 5(e)(2) shall be subject to criminal fines of up to $10,000,000 per violation and, in cases of willful violation, imprisonment of responsible corporate officers for not more than five years.

(e) CIVIL PENALTIES FOR PUBLIC SPACE SMOKING VIOLATIONS.

(1) Any individual who uses tobacco products in a smoke-free public space designated under this Act shall be subject to a civil fine of not less than $250 and not more than $1,000 per violation, enforceable by state and local authorities.

(f) GRANT SUSPENSION AND TERMINATION.

(1) States and localities that receive federal cardiovascular prevention grants under this Act and that fail to meet reporting requirements or program benchmarks for two consecutive years shall be subject to suspension of grant funding pending a corrective action plan approved by the Secretary.

(2) States and localities that fail to implement a corrective action plan within 12 months of notification of suspension shall have their grants terminated and shall be required to repay any misspent federal funds.

(g) ENFORCEMENT AUTHORITY.

(1) The FDA, CDC, USDA, CMS, and Department of Justice shall each have enforcement authority as specified in this Act and shall coordinate enforcement actions to prevent duplicative proceedings.

(2) The Attorney General may bring civil actions in federal district court to enforce any provision of this Act and may seek injunctive relief, civil penalties, and such other remedies as may be just and proper.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.

(a) GENERAL EFFECTIVE DATE. Except as otherwise provided in this Act, this Act shall take effect 90 days after the date of enactment.

(b) AGENCY RULEMAKING. Federal agencies shall promulgate all regulations necessary to implement this Act within the following timelines:

(1) HHS national program establishment: 12 months after enactment.

(2) FDA sodium reduction regulations: 18 months after enactment.

(3) FDA front-of-package labeling regulations: 18 months after enactment.

(4) CMS preventive services coverage rule: 18 months after enactment.

(5) USDA school meal standards revision: 12 months after enactment.

(6) Department of Transportation active transportation program: 24 months after enactment.

(c) CORPORATE COMPLIANCE TIMELINES.

(1) Employer cardiovascular screening requirements: Effective 24 months after enactment.

(2) Health insurer coverage requirements: Effective 12 months after enactment.

(3) Food manufacturer sodium reduction Phase 1 targets: Effective 36 months after enactment.

(4) Food manufacturer sodium reduction Phase 2 targets: Effective 60 months after enactment.

(5) Food manufacturer sodium reduction Phase 3 targets: Effective 84 months after enactment.

(6) Restaurant chain calorie and sodium labeling: Effective 24 months after enactment.

(d) ANNUAL REVIEW. The Secretary shall conduct an annual review of program implementation and shall adjust timelines and benchmarks as necessary to meet the ten-year national cardiovascular mortality reduction goal, with Congressional notification of any material changes.

(e) SUNSET PROVISION. The appropriations authority established in Section 9 of this Act shall be reviewed by Congress no later than ten years after the date of enactment, and shall be reauthorized, modified, or allowed to expire based on an evidence-based assessment of program effectiveness.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.

(a) AUTHORIZATION OF APPROPRIATIONS. There are hereby authorized to be appropriated such sums as may be necessary to carry out this Act, including the following amounts:

(1) NATIONAL CARDIOVASCULAR DISEASE PREVENTION PROGRAM. For the establishment and operation of the National Cardiovascular Disease Prevention Program under Section 3(a), $250,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(2) CDC SURVEILLANCE AND EDUCATION. For CDC cardiovascular disease surveillance and public education activities under Section 3(b), $150,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(3) NIH RESEARCH. For NIH cardiovascular disease prevention research under Section 3(c), $300,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034, representing an increase of not less than 25 percent over baseline NIH cardiovascular research appropriations.

(4) COMMUNITY SCREENING AND HEALTH WORKER GRANTS. For grants to state and local governments and community health centers for cardiovascular screening and community health worker programs, $200,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(5) FOOD DESERT GROCERY AND NUTRITION ACCESS GRANTS. For USDA grants to establish grocery stores, farmers markets, and produce subsidies in underserved communities, $100,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(6) ACTIVE TRANSPORTATION INFRASTRUCTURE GRANTS. For Department of Transportation grants for pedestrian, bicycle, and active transportation infrastructure, $500,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(7) SCHOOL PHYSICAL EDUCATION AND NUTRITION EDUCATION. For Department of Education grants to public schools for physical education and cardiovascular health education programs, $75,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(8) TELEHEALTH CARDIOVASCULAR SERVICES. For expansion of telehealth cardiovascular monitoring and follow-up services in rural and underserved areas, $50,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(9) FDA ENFORCEMENT AND REGULATORY IMPLEMENTATION. For FDA staffing, enforcement, and regulatory development under this Act, $75,000,000 for fiscal year 2025 and such sums as may be necessary for each fiscal year thereafter through fiscal year 2034.

(b) BUDGETARY OFFSET. The Congressional Budget Office shall score this Act and identify offsets from existing appropriations, tax expenditures, or new revenues to maintain budgetary neutrality over the ten-year budget window, in consultation with the House and Senate Budget Committees.

(c) GRANT CONDITIONS. All grants awarded under this Act shall be subject to audit and reporting requirements, with the HHS Office of Inspector General conducting biennial audits of all grant recipients.

(d) PENALTY REVENUE. Civil penalties collected under Section 7 of this Act shall be deposited into a dedicated Cardiovascular Disease Prevention Fund within the Treasury and shall be available without further appropriation for the purposes of this Act.

Endnotes

The requirements set forth in Sections 3, 4, 5, and 6 of this Act incorporate evidence-based policy approaches derived from the following international sources:

Mandatory Cardiovascular Screening (Section 3(a); Section 3(b))

Nippon: Ministry of Health, Labour and Welfare Specific Health Checkup program (Tokutei Kenshin), requiring metabolic syndrome screening for adults aged 40-74. https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000161103.html

Hanguk: National Health Insurance Service mandatory cardiovascular risk assessment for all adults. https://www.nhis.or.kr/nhis/english/static/html/static_0403.html

Deutschland: Statutory health insurance system (GKV) mandating free preventive health examinations (Gesundheits-Check-up) every three years for adults over 35. https://www.bundesgesundheitsministerium.de

Sodium Reduction and Food Labeling (Section 3(d); Section 5(a))

République française: Nutri-Score front-of-pack labeling system. https://www.santepubliquefrance.fr/determinants-de-sante/nutrition-et-activite-physique/articles/nutri-score

Australia and England: Government-led sodium reduction targets for processed food manufacturers. https://www.heartfoundation.org.au and https://www.gov.uk/government/publications/salt-reduction-targets-for-2024

Suomi: Finnish Food Authority sodium reduction program and voluntary industry sodium targets. https://www.ruokavirasto.fi

Tobacco Control (Section 3(e); Section 5(e))

Australia: Tobacco Plain Packaging Act 2011. https://www.health.gov.au/our-work/tobacco-plain-packaging

Norge and Sverige: Comprehensive tobacco-free public spaces legislation. https://www.fhi.no and https://www.folkhalsomyndigheten.se

England: Health Act 2006 smoke-free legislation. https://www.legislation.gov.uk/ukpga/2006/28

Physical Activity Infrastructure (Section 3(h); Section 6)

Nederland and Sverige: National active transportation infrastructure investment policies. https://www.government.nl and https://www.trafikverket.se

Nippon and Singapore: Urban planning policies mandating walkable communities and public park access. https://www.mlit.go.jp and https://www.ura.gov.sg

Workplace and Employer Requirements (Section 5(c))

Deutschland: Occupational health and employer wellness mandates under the Occupational Health and Safety Act (Arbeitsschutzgesetz). https://www.bmas.de

Nippon: Employers required by the Industrial Safety and Health Act to provide annual health checks for all employees.
https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/koyou_roudou/roudoukijun/anzen/index.html

Healthcare Coverage for Preventive Services (Section 5(d))

Canada: Provincial health insurance systems providing universal coverage for cardiovascular preventive services. https://www.canada.ca/en/health-canada.html

République française: Assurance Maladie (national health insurance) coverage for preventive cardiology and cholesterol testing. https://www.ameli.fr

Norge: Helfo (Norge Health Economics Administration) universal coverage for cardiovascular screening. https://www.helfo.no