

# Return to State of the Union Report

## Death Rates from Health Causes

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Section 1: Top 35 Countries with the Lowest Death Rates from Various Health Causes..... 1  
Section 2: What Other Countries Have Done to Decrease Their Death Rates from Various Health Causes ..... 4  
Section 3: What the U.S. Can Do to Decrease Its Death Rates from Various Health Causes..... 8  
Section 4: References..... 11  
Section 5: Draft of a House Bill..... 12

### Section 1: Top 35 Countries with the Lowest Death Rates from Various Health Causes

The following table ranks the top 35 countries with populations over 5 million people that have the lowest age-standardized death rates from various health causes. Data is sourced from the World Health Organization (WHO) Global Health Observatory and the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study (2021). Rates are age-standardized deaths per 100,000 population.

Rank	Country	Age-Standardized Death Rate (per 100,000)
1	日本 Nippon (Japan)	296.0
2	한국 Hanguk (South Korea)	307.5
3	Suisse or Schweiz (Switzerland)	315.2
4	España (Spain)	322.1
5	Italia (Italy)	333.4
6	Australia	338.7
7	ישראל Yisra'el (Israel)	342.3
8	République française (France)	348.9
9	Sverige (Sweden)	352.1
10	Norge (Norway)	355.4

<b>Rank</b>	<b>Country</b>	<b>Age-Standardized Death Rate (per 100,000)</b>
11	Nederland (Netherlands)	358.0
12	Canada	362.5
13	Suomi (Finland)	371.2
14	Portugal	378.4
15	New Zealand	381.0
16	Österreich (Austria)	385.6
17	Belgique (Belgium)	392.3
18	Deutschland (Germany)	398.7
19	Danmark (Denmark)	402.1
20	Ελλάδα Elláda (Greece)	411.5
21	United Kingdom	415.8
22	Éire (Ireland)	418.2
23	Česko (Czech Republic)	432.7
24	Chile	441.3
25	Singapore	448.0
26	Costa Rica	455.9
27	Cuba	461.2
28	Colombia	468.7
29	Polska (Poland)	472.3
30	Slovenia	479.1
31	Slovensko (Slovakia)	483.6
32	Panamá (Panama)	490.2
33	Argentina	495.8
34	Uruguay	502.3
35	United States	510.4

Source: World Health Organization Global Health Observatory (2021 data); Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study 2021.

The United States ranks 35th out of the 35 lowest-death-rate countries with a population over 5 million people, with an age-standardized death rate of 510.4 per 100,000. The U.S. ranks at the bottom of this group due to a combination of factors including high rates of chronic disease (cardiovascular disease, diabetes, obesity), limited universal access to health care, elevated rates of firearm-related mortality, drug overdose deaths (particularly the opioid epidemic), a fragmented health care system with significant socioeconomic disparities in access and quality of care, and lower public health infrastructure investment compared to peer nations.

In 2023 (the most recent full-year data), the U.S. overall age-adjusted death rate was approximately 733.8 per 100,000 standard population, reflecting ongoing challenges with chronic disease, substance use disorders, and preventable mortality. The U.S. continues to lag behind comparable high-income nations on most mortality metrics.

**Data Sources and References:**

World Health Organization - Global Health Observatory: <https://www.who.int/data/gho>

Institute for Health Metrics and Evaluation (IHME) - Global Burden of Disease: <https://www.healthdata.org/research-analysis/gbd>

CDC National Center for Health Statistics: <https://www.cdc.gov/nchs/>

OECD Health Statistics: <https://www.oecd.org/health/health-data.htm>

**Death Rates from Various Health Causes by World Region (Age-Standardized, per 100,000)**

Region	Age-Standardized Death Rate (per 100,000)
Australia	338.7
Canada	362.5
Western Europe (Excl. Россия Rossiya (Russia))	370.6
United States	510.4
中国 Zhongguo (China)	522.8
Central America	541.2
South America	558.7
México	589.3
Middle East	598.1
Asia (Excl. 中国 Zhongguo (China))	634.2
Other Regions	643.0
Россия Rossiya (Russia)	681.4
Africa	812.4

Note: Regional figures represent weighted averages of country-level data for countries in each region with populations over 1 million people. Data year: 2021. Source: WHO Global Health Observatory.

**Section 2: What Other Countries Have Done to Decrease Their Death Rates from Various Health Causes**

**The 8 Top Rated Countries with the Lowest Death Rates from Various Health Causes**

<b>Rank</b>	<b>Country</b>	<b>Age-Standardized Death Rate (per 100,000)</b>
1	日本 Nippon (Japan)	296.0
2	한국 Hanguk (South Korea)	307.5
3	Suisse or Schweiz (Switzerland)	315.2
4	España (Spain)	322.1
5	Italia (Italy)	333.4
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7	יִשְׂרָאֵל Yisra'el (Israel)	342.3
8	République française (France)	348.9

**Nippon (Japan)**

Nippon's remarkably low death rate results from a combination of cultural practices, government policy, and universal health care access. Nippon operates a universal health insurance system under the National Health Insurance (NHI) Act, requiring all residents to enroll.

The Ministry of Health, Labour and Welfare (MHLW) ([www.mhlw.go.jp](http://www.mhlw.go.jp)) enforces stringent food safety regulations and nutritional labeling standards.

Nippon's Health Nippon 21 initiative promotes preventive care, mental health, and chronic disease management at the national level.

Municipal governments provide regular health screenings (tokutei kenshin) for residents over 40, enabling early detection of metabolic syndrome, cardiovascular disease, and cancer.

The traditional Japanese diet, characterized by low saturated fat, high vegetable consumption, and fish-based proteins, is closely linked to low cardiovascular mortality rates.

Nippon also has one of the highest rates of physician visits per capita and a robust ambulatory care system.

The National Cancer Center Nippon ([www.ncc.go.jp](http://www.ncc.go.jp)) coordinates cancer prevention and early detection programs.

Nippon's long-term care insurance system supports elderly residents, reducing mortality from neglected age-related conditions.

## **Hanguk (South Korea)**

Hanguk has achieved dramatic reductions in mortality through rapid expansion of universal health coverage under the National Health Insurance Service (NHIS) ([www.nhis.or.kr](http://www.nhis.or.kr)).

The government implemented the National Cancer Screening Program in 1999, dramatically improving early detection of stomach, colorectal, breast, cervical, and liver cancers.

The Hanguk Centers for Disease Control and Prevention (KCDC) ([kdca.go.kr](http://kdca.go.kr)) coordinates national infectious disease surveillance and chronic disease management programs.

Hanguk's Health Promotion Act mandates tobacco control, physical activity promotion, and nutrition programs.

The Ministry of Health and Welfare ([mohw.go.kr](http://mohw.go.kr)) oversees the National Health Promotion Fund, which finances anti-smoking campaigns, alcohol reduction programs, and mental health services.

Hanguk has invested heavily in digital health infrastructure, with electronic health records covering virtually all citizens and enabling data-driven public health interventions.

Occupational health regulations enforced by the Hanguk Occupational Safety and Health Agency (KOSHA) ([kosha.or.kr](http://kosha.or.kr)) have significantly reduced workplace-related mortality.

## **Schweiz (Switzerland)**

Schweiz's low death rate reflects a highly decentralized but comprehensive health care system combining mandatory private health insurance with strong federal regulation.

The Federal Office of Public Health (FOPH) ([www.bag.admin.ch](http://www.bag.admin.ch)) sets national health policy and oversees communicable disease prevention, environmental health, and health promotion.

Under the Federal Health Insurance Act (KVG/LAMal), all residents must carry basic health insurance, ensuring near-universal coverage. Schweiz invests heavily in primary care, with a strong general practitioner network that emphasizes preventive services and chronic disease management.

The Schweiz Cancer League ([www.krebsliga.ch](http://www.krebsliga.ch)) and Schweiz Heart Foundation ([www.swissheart.ch](http://www.swissheart.ch)) conduct national awareness and prevention campaigns.

Schweiz has stringent environmental protection standards under the Federal Office for the Environment (BAFU) ([www.bafu.admin.ch](http://www.bafu.admin.ch)), reducing mortality from air and water pollution.

The country's strong occupational safety laws are enforced by SUVA ([www.suva.ch](http://www.suva.ch)), the national accident insurance fund.

Schweiz has also implemented progressive tobacco legislation, including a comprehensive tobacco products act that restricts advertising and requires plain packaging.

## **España (Spain)**

España's public health system (Sistema Nacional de Salud, SNS) provides universal coverage to all citizens and legal residents, coordinated by the Ministry of Health ([www.sanidad.gob.es](http://www.sanidad.gob.es)).

España's Mediterranean diet, rich in olive oil, legumes, fish, fruits, and vegetables, is scientifically associated with reduced cardiovascular mortality and longer life expectancy.

The España National Health Survey monitors population health trends and guides preventive policy.

Regional governments (comunidades autonomas) operate primary health care centers (centros de salud) offering free preventive screenings, vaccinations, and chronic disease management.

España's tobacco control has advanced significantly under the Tobacco Control Law, which prohibits smoking in workplaces, public spaces, and near educational facilities.

The España Society of Cardiology ([www.secardiologia.es](http://www.secardiologia.es)) and the España Society of Oncology collaborate with government agencies on evidence-based prevention programs.

The National Epidemiology Center ([www.isciii.es](http://www.isciii.es)) conducts ongoing research linking environmental, behavioral, and genetic factors to mortality patterns.

## **Italia (Italy)**

Italia's Servizio Sanitario Nazionale (SSN) provides universal health care financed by general taxation and administered by 21 regional health authorities.

The Italian National Institute of Health (Istituto Superiore di Sanita, ISS) ([www.iss.it](http://www.iss.it)) directs national public health research and policy. Italia's adherence to the Mediterranean diet is one of the strongest contributors to its low cardiovascular mortality.

The National Prevention Plan (Piano Nazionale della Prevenzione, PNP) sets targets for reducing preventable chronic disease, cancer incidence, and premature mortality through evidence-based interventions.

Italia's tobacco control framework includes a ban on smoking in enclosed public spaces, restrictions on advertising, and mandatory health warnings.

The Italia Association for Cancer Research (AIRC) ([www.airc.it](http://www.airc.it)) funds cancer prevention, detection, and treatment research. Italia environmental protection laws, enforced by the Institute for Environmental Protection and Research (ISPRA) ([www.isprambiente.gov.it](http://www.isprambiente.gov.it)), limit population exposure to harmful pollutants.

Strong social cohesion and family support networks have been identified as protective factors against mental health-related and age-related mortality in Italian populations.

## **Australia**

Australia operates Medicare, a universal public health insurance system providing all citizens and permanent residents with access to subsidized medical services, managed by the Department of Health and Aged Care ([www.health.gov.au](http://www.health.gov.au)).

The Australian Institute of Health and Welfare (AIHW) ([www.aihw.gov.au](http://www.aihw.gov.au)) collects, analyzes, and reports health data to guide national policy.

Australia's National Preventive Health Strategy 2021-2030 focuses on addressing chronic disease risk factors including tobacco use, physical inactivity, unhealthy diet, and excessive alcohol consumption.

The Australian Cancer Council ([www.cancer.org.au](http://www.cancer.org.au)) operates nationally recognized cancer prevention and early detection programs, including the national bowel cancer screening program. Australia has one of the world's strictest tobacco control regimes, including standardized plain packaging legislation enacted in 2012 and enforced by the Department of Health. Environmental health protections under the Environment Protection and Biodiversity Conservation Act limit mortality from pollution.

The Australian Commission on Safety and Quality in Health Care ([www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)) sets national standards for clinical care quality to minimize preventable deaths.

## **Yisra'el (Israel)**

Yisra'el provides universal health care through four competing, non-profit Health Maintenance Organizations (HMOs) regulated under the National Health Insurance Law (1994).

The Ministry of Health ([www.health.gov.il](http://www.health.gov.il)) mandates a comprehensive benefits basket (sal habiut) covering preventive, curative, and rehabilitative services. Yisra'el's HMO system emphasizes preventive care, with high rates of vaccination, cancer screening, and chronic disease management.

Maccabi Health Services, Clalit Health Services, and other HMOs operate data-driven population health management programs that identify high-risk individuals and intervene proactively. Yisra'el has high rates of physician training and a robust research-driven medical culture supported by institutions such as the Weizmann Institute of Science ([www.weizmann.ac.il](http://www.weizmann.ac.il)) and Hebrew University-Hadassah Medical Center. Yisra'el's environmental health policies, coordinated by the Ministry of Environmental Protection ([www.gov.il/en/departments/ministry\\_of\\_environmental\\_protection](http://www.gov.il/en/departments/ministry_of_environmental_protection)), limit air and water pollution exposure.

Community-based social cohesion programs and a strong public health workforce contribute to Yisra'el's relatively low mortality across demographic groups.

## **République française (France)**

République française's Assurance Maladie system provides universal health insurance, with the government covering approximately 77% of total health care costs.

The Ministry of Health and Prevention ([sante.gouv.fr](http://sante.gouv.fr)) coordinates national health policy, supported by Sante publique République française ([www.santepubliquefrance.fr](http://www.santepubliquefrance.fr)), the national public health agency.

République française has implemented successive National Cancer Plans (Plan Cancer) since 2003, dramatically improving early detection and treatment outcomes.

The National Agency for Food, Environmental and Occupational Health and Safety (ANSES) ([www.anses.fr](http://www.anses.fr)) regulates food safety and environmental health risks.

République française's tobacco control strategy includes plain packaging requirements, sales restrictions to minors, and taxation to reduce consumption.

The République française National Nutrition and Health Program (PNNS) promotes balanced diet and physical activity to reduce cardiovascular and metabolic disease mortality.

République française has a dense primary care network with strong emphasis on preventive medicine, and benefits from the protective health effects of the Mediterranean-influenced French diet.

The High Authority for Health (HAS) ([www.has-sante.fr](http://www.has-sante.fr)) sets national clinical guidelines and evaluates health technologies to ensure evidence-based care delivery.

## **Section 3: What the U.S. Can Do to Decrease Its Death Rates from Various Health Causes**

The United States faces a complex, multifaceted mortality challenge driven by chronic disease, substance use, mental health crises, socioeconomic disparities, and a fragmented health care system. Comprehensive, coordinated action across government, private, and civil society sectors is required to meaningfully reduce preventable deaths.

### **Government Agencies:**

The Centers for Disease Control and Prevention (CDC) ([www.cdc.gov](http://www.cdc.gov)) must dramatically expand its public health infrastructure investment, increase chronic disease prevention funding, scale evidence-based community health programs, and improve national disease surveillance capabilities.

The CDC's Office of Public Health Preparedness and Response should increase coordination with state and local health departments.

The National Institutes of Health (NIH) ([www.nih.gov](http://www.nih.gov)) must prioritize funding for research on preventable mortality causes including cardiovascular disease, cancer, diabetes, and substance use disorders.

The Food and Drug Administration (FDA) ([www.fda.gov](http://www.fda.gov)) must strengthen nutritional labeling requirements, accelerate approval of life-saving therapeutics, enforce stricter regulations on addictive substances including tobacco and alcohol, and expand oversight of the food supply to reduce harmful additives.

The Centers for Medicare and Medicaid Services (CMS) ([www.cms.gov](http://www.cms.gov)) must expand Medicaid eligibility, increase reimbursement rates for preventive services, mandate coverage of evidence-based screening programs, and reduce administrative barriers to care access.

The Health Resources and Services Administration (HRSA) ([www.hrsa.gov](http://www.hrsa.gov)) must fund expansion of Federally Qualified Health Centers (FQHCs) to serve underserved communities, and increase the primary care workforce pipeline.

The Department of Veterans Affairs (VA) ([www.va.gov](http://www.va.gov)) must continue expanding mental health services, suicide prevention programs, and comprehensive chronic disease management for veterans.

The Environmental Protection Agency (EPA) ([www.epa.gov](http://www.epa.gov)) must enforce and strengthen air quality standards to reduce pollution-related respiratory and cardiovascular mortality.

The Substance Abuse and Mental Health Services Administration (SAMHSA) ([www.samhsa.gov](http://www.samhsa.gov)) must expand access to medication-assisted treatment (MAT) for substance use disorders and scale mental health crisis intervention infrastructure.

### **Government Officials:**

The President and executive branch must designate reducing preventable mortality as a top national priority, directing interagency coordination and sustained budget increases for public health.

The Secretary of Health and Human Services must convene a National Commission on Preventable Mortality to develop evidence-based recommendations and measure progress annually.

Members of Congress must pass legislation expanding the Affordable Care Act to achieve universal coverage, fund Medicaid expansion in all states, enact comprehensive tobacco and e-cigarette regulations, strengthen mental health parity enforcement, and authorize sustained investment in public health infrastructure.

State governors and legislatures must expand Medicaid in holdout states, fund community health programs, pass tobacco control legislation, strengthen environmental protections, and implement evidence-based opioid response strategies.

County and municipal officials must invest in social determinants of health including affordable housing, food access, safe recreational spaces, and economic opportunity programs that reduce mortality-associated poverty and inequality.

### **Corporations and Private Sector:**

Employers must expand employee health benefits to include comprehensive preventive care, mental health services, substance use treatment, and chronic disease management programs.

Major food and beverage manufacturers must voluntarily reduce sodium, sugar, and trans-fat content in products and adopt front-of-package nutritional labeling systems aligned with public health recommendations.

Health insurance companies must eliminate cost-sharing barriers for preventive screenings, expand telehealth access, and develop value-based payment models that reward health outcomes over service volume.

Pharmaceutical companies must invest in affordable chronic disease medications, expand patient assistance programs, and collaborate with federal agencies on evidence-based prescribing guidelines to reduce opioid overprescription.

Technology companies must develop and deploy digital health tools, remote monitoring platforms, and AI-driven population health management systems that enable earlier identification of high-risk individuals.

Media and entertainment corporations must promote health literacy, combat health misinformation, and adopt responsible standards for advertising unhealthy products, particularly to children and adolescents.

### **Private Individuals and Civil Society:**

Individual Americans must be empowered to make health-promoting choices through accessible, culturally competent health education.

Community organizations, faith communities, and civic groups must engage in peer health education, social support networks, and advocacy for equitable health resources.

Academic and research institutions must collaborate with government and community partners to develop, evaluate, and disseminate evidence-based health promotion interventions.

Non-profit health organizations including the American Heart Association ([www.heart.org](http://www.heart.org)), American Cancer Society ([www.cancer.org](http://www.cancer.org)), and American Diabetes Association ([www.diabetes.org](http://www.diabetes.org)) must scale community-based prevention programs, policy advocacy, and public awareness campaigns.

Medical and public health professional associations must advocate for evidence-based policy, eliminate health care disparities, and lead continuing medical education efforts focused on preventive care and chronic disease management.

Individuals from all walks of life must participate in community health initiatives, advocate to elected officials for public health funding, and support policies that create equitable conditions for health for all Americans.

## Section 4: References

The following organizations and sources provided data, research, and policy guidance used throughout this document:

World Health Organization (WHO) - Global Health Observatory: <https://www.who.int/data/gho>

Institute for Health Metrics and Evaluation (IHME) - Global Burden of Disease:

<https://www.healthdata.org/research-analysis/gbd>

Centers for Disease Control and Prevention (CDC): <https://www.cdc.gov>

National Institutes of Health (NIH): <https://www.nih.gov>

OECD Health Statistics: <https://www.oecd.org/health/health-data.htm>

Commonwealth Fund - International Health Policy Survey: <https://www.commonwealthfund.org>

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

American Cancer Society: <https://www.cancer.org>

American Diabetes Association: <https://www.diabetes.org>

Sante publique République française (French Public Health Agency):

<https://www.santepubliquefrance.fr>

Health Resources and Services Administration (HRSA): <https://www.hrsa.gov>

Substance Abuse and Mental Health Services Administration (SAMHSA):

<https://www.samhsa.gov>

Australian Institute of Health and Welfare (AIHW): <https://www.aihw.gov.au>

National Cancer Center Nippon: <https://www.ncc.go.jp>

Korean Centers for Disease Control and Prevention (KCDC): <https://kdca.go.kr>

Italian National Institute of Health (ISS): <https://www.iss.it>

Federal Office of Public Health Schweiz (FOPH): <https://www.bag.admin.ch>

Ministry of Health España: <https://www.sanidad.gob.es>

Yisra'el Ministry of Health: <https://www.health.gov.il>

High Authority for Health République française (HAS): <https://www.has-sante.fr>

## Section 5: Draft of a House Bill

117th CONGRESS

2nd Session

H.R. \_\_\_\_\_

IN THE HOUSE OF REPRESENTATIVES

**A BILL**

To reduce death rates from various health causes in the United States through comprehensive public health improvements, universal preventive care access, chronic disease management, and coordinated government and private sector initiatives, and for other purposes.

### SHORT TITLE

This Act may be cited as the "National Health Mortality Reduction and Prevention Act of 2024" (NHMRPA).

### SECTION 1. Definitions

As used in this Act:

1. "Age-standardized death rate" means the number of deaths per 100,000 population adjusted to account for differences in the age structure of populations, enabling valid comparisons across countries and time periods.
2. "Chronic disease" means a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living, or both, including but not limited to cardiovascular disease, diabetes, cancer, chronic respiratory disease, and chronic kidney disease.
3. "Death rate" means the number of deaths occurring in a defined population during a specified time period, expressed as a rate per 100,000 persons.
4. "Evidence-based intervention" means a health promotion or disease prevention program, practice, or policy supported by peer-reviewed scientific research demonstrating effectiveness in reducing mortality or disease burden.
5. "Health disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by socially disadvantaged populations defined by factors such as race, ethnicity, gender, income, geography, disability, or sexual orientation.
6. "Preventable mortality" means deaths that could have been averted through evidence-based medical care, public health interventions, or policy changes.
7. "Primary care" means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

8. "Social determinants of health" means the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
9. "Universal health coverage" means a system in which all individuals and communities receive the health services they need without suffering financial hardship.
10. "Secretary" means the Secretary of Health and Human Services.

## **SECTION 2. Enacting Clause**

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that:

- (a) The Congress finds that the United States has among the highest preventable death rates of all high-income nations, driven by chronic disease, substance use disorders, mental illness, socioeconomic inequality, and inadequate access to preventive health care.
- (b) The Congress further finds that evidence from comparable nations demonstrates that universal health coverage, robust preventive care programs, coordinated chronic disease management, and sustained public health investment are associated with significantly lower mortality rates.
- (c) The Congress declares that it is the policy of the United States to reduce preventable mortality through comprehensive, coordinated action by federal and state governments, the private sector, and civil society.
- (d) The purposes of this Act are to:
  - (1) Expand access to evidence-based preventive health care services for all Americans regardless of income or insurance status;
  - (2) Establish national targets for reducing age-standardized death rates from the leading preventable causes of mortality;
  - (3) Require coordinated federal agency action to address the leading preventable causes of death in the United States;
  - (4) Create accountability mechanisms to monitor progress toward national mortality reduction goals; and
  - (5) Authorize appropriations sufficient to achieve the purposes of this Act.

## **SECTION 3. Requirements by Government Agencies**

- (a) Centers for Disease Control and Prevention. The Director of the Centers for Disease Control and Prevention (CDC) shall:
  - (1) Develop and implement a National Preventable Mortality Reduction Plan within 180 days of enactment of this Act, establishing measurable targets and evidence-based strategies for reducing death rates from cardiovascular disease, cancer, diabetes, substance use disorders, respiratory disease, and mental health conditions;

- (2) Expand funding for the Prevention and Public Health Fund to support state and local health department capacity, disease surveillance, and community health programs;
  - (3) Establish a National Chronic Disease Prevention Center to coordinate evidence-based screening, early intervention, and management programs;
  - (4) Implement a national public health data infrastructure to enable real-time mortality surveillance and rapid public health response;
  - (5) Fund community health worker programs in medically underserved areas to reduce health disparities contributing to excess mortality; and
  - (6) Report annually to Congress on national progress toward mortality reduction targets.
- (b) Centers for Medicare and Medicaid Services. The Administrator of the Centers for Medicare and Medicaid Services (CMS) shall:
- (1) Eliminate cost-sharing for all evidence-based preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) under Medicare and Medicaid;
  - (2) Expand Medicaid coverage to ensure coverage of comprehensive preventive care, behavioral health services, substance use disorder treatment, and chronic disease management;
  - (3) Develop and implement value-based payment models that reward health care providers for achieving measurable improvements in population health outcomes and mortality reduction;
  - (4) Require accredited hospitals and health systems to implement evidence-based protocols for cardiovascular disease, cancer, diabetes, and substance use disorder management; and
  - (5) Establish a National Health Equity Initiative to reduce racial, ethnic, and socioeconomic disparities in mortality rates.
- (c) Food and Drug Administration. The Commissioner of Food and Drugs shall:
- (1) Require front-of-package nutrition labeling on all processed food and beverage products indicating levels of sodium, added sugar, saturated fat, and caloric density using a standardized, evidence-based format;
  - (2) Implement and enforce comprehensive regulations on tobacco products and electronic nicotine delivery systems, including prohibiting flavored products targeting youth and requiring graphic health warning labels;
  - (3) Accelerate review and approval processes for life-saving medications for chronic diseases with unmet therapeutic needs;
  - (4) Strengthen post-market surveillance of pharmaceuticals associated with increased mortality risk, including prescription opioids; and
  - (5) Restrict marketing of foods, beverages, alcohol, and tobacco products to children and adolescents through all media platforms.
- (d) National Institutes of Health. The Director of the National Institutes of Health (NIH) shall:

- (1) Increase funding for research on the prevention and treatment of the leading preventable causes of mortality, prioritizing studies of under-resourced populations and health disparities;
  - (2) Establish a Center for Preventive Medicine Research to support translation of basic science findings into evidence-based preventive care practices;
  - (3) Fund clinical trials of novel behavioral, pharmacological, and structural interventions to reduce mortality from cardiovascular disease, cancer, diabetes, and substance use disorders; and
  - (4) Promote dissemination of research findings to clinicians, public health practitioners, policymakers, and the general public.
- (e) Environmental Protection Agency. The Administrator of the Environmental Protection Agency (EPA) shall:
- (1) Strengthen and enforce National Ambient Air Quality Standards to reduce premature mortality from air pollution-related cardiovascular and respiratory disease;
  - (2) Accelerate cleanup of contaminated water sources contributing to preventable disease and death in low-income and minority communities;
  - (3) Require cumulative health impact assessments for major industrial facilities in environmental justice communities; and
  - (4) Coordinate with state environmental agencies to implement evidence-based pollution controls targeting the highest-mortality-risk environmental exposures.
- (f) Substance Abuse and Mental Health Services Administration. The Administrator of SAMHSA shall:
- (1) Expand access to medication-assisted treatment (MAT) for opioid use disorder by increasing the number of certified providers and eliminating administrative barriers to prescribing buprenorphine and other FDA-approved treatments;
  - (2) Fund a national network of community mental health centers providing integrated behavioral health services, including crisis intervention, in all regions of the United States;
  - (3) Implement evidence-based suicide prevention programs in schools, workplaces, veteran communities, and other high-risk settings; and
  - (4) Require mental health parity compliance by all federally regulated health insurance plans.

#### **SECTION 4. Requirements by Government Officials**

- (a) The President of the United States shall:
- (1) Issue an Executive Order within 90 days of enactment designating reduction of preventable mortality as a national priority and directing all relevant federal agencies to incorporate mortality reduction goals into their strategic plans;

- (2) Establish a White House Task Force on National Health Mortality Reduction, chaired by the Secretary of Health and Human Services, to coordinate interagency efforts and report to the President annually; and
  - (3) Include in each annual budget submission to Congress sufficient appropriations to achieve the purposes of this Act.
- (b) The Secretary of Health and Human Services shall:
- (1) Convene a National Commission on Preventable Mortality within 120 days of enactment, composed of experts in public health, medicine, epidemiology, health equity, economics, and patient advocacy;
  - (2) Establish national targets for reducing age-standardized death rates for the ten leading preventable causes of mortality within 5 and 10 years of enactment;
  - (3) Submit an annual report to Congress detailing progress toward mortality reduction targets, identifying barriers, and recommending legislative action; and
  - (4) Coordinate with state governors to ensure uniform implementation of evidence-based public health programs.
- (c) Members of Congress shall be encouraged to:
- (1) Enact legislation expanding eligibility for federal health insurance programs to achieve universal health coverage;
  - (2) Authorize increased appropriations for the CDC Prevention and Public Health Fund and NIH research programs focused on preventable mortality;
  - (3) Strengthen and enforce mental health parity requirements for all insurance plans operating in interstate commerce; and
  - (4) Conduct annual oversight hearings on federal agency progress toward national mortality reduction targets.
- (d) State Governors and State Health Officers shall be encouraged to:
- (1) Expand Medicaid eligibility to all income-eligible adults under the Affordable Care Act;
  - (2) Implement evidence-based tobacco control laws, including comprehensive indoor clean air acts and restrictions on e-cigarette sales;
  - (3) Fund state and local public health departments at levels adequate to implement national preventive health programs; and
  - (4) Establish state-level chronic disease prevention plans aligned with national mortality reduction targets.

## **SECTION 5. Requirements by Corporations**

- (a) Employer Health Benefit Requirements. All employers with 50 or more full-time equivalent employees subject to the requirements of this Act shall:
- (1) Provide comprehensive health insurance coverage that includes, without cost-sharing, all preventive services recommended by the U.S. Preventive Services Task Force;

- (2) Offer employee wellness programs incorporating evidence-based physical activity promotion, nutritional counseling, tobacco cessation support, and mental health resources;
  - (3) Provide access to employee assistance programs (EAPs) offering confidential mental health counseling and substance use disorder referrals; and
  - (4) Report to the Secretary of Health and Human Services annually on employee health outcomes and participation in wellness programs.
- (b) Food and Beverage Industry Requirements. Corporations engaged in the manufacture, processing, or distribution of food and beverage products sold in interstate commerce shall:
- (1) Reduce sodium content in packaged foods by a minimum of 10 percent within 3 years and 25 percent within 7 years of enactment, in accordance with targets established by the Food and Drug Administration;
  - (2) Eliminate industrially produced trans fatty acids from all products within 2 years of enactment;
  - (3) Display front-of-package nutrition labeling on all products using a standardized format approved by the Food and Drug Administration; and
  - (4) Refrain from marketing products with excessive sodium, sugar, saturated fat, or caloric density to children under the age of 13 through any medium.
- (c) Pharmaceutical Industry Requirements. Corporations engaged in the research, development, manufacture, or distribution of pharmaceutical products shall:
- (1) Participate in government-negotiated pricing programs for chronic disease medications to ensure affordability and access;
  - (2) Implement and maintain robust pharmacovigilance programs to identify and report mortality risks associated with their products;
  - (3) Provide expanded patient assistance programs for individuals unable to afford essential chronic disease medications; and
  - (4) Adhere to evidence-based marketing standards prohibiting promotion of opioid analgesics and other high-risk medications beyond FDA-approved indications.
- (d) Health Insurance Industry Requirements. Health insurance corporations and managed care organizations shall:
- (1) Cover all evidence-based preventive services without cost-sharing, including cancer screenings, cardiovascular risk reduction interventions, diabetes prevention programs, and substance use disorder treatment;
  - (2) Implement population health management programs using data analytics to identify high-risk enrollees and connect them with preventive and chronic disease management services;
  - (3) Comply fully with mental health parity requirements under the Mental Health Parity and Addiction Equity Act; and
  - (4) Develop and implement value-based payment arrangements with health care providers that incentivize reduction of preventable mortality.

## **SECTION 6. Requirements by Private Citizens**

- (a) Health Education and Engagement. The Secretary of Health and Human Services shall establish a National Health Literacy Initiative to:
  - (1) Develop and disseminate culturally and linguistically appropriate health education materials to all Americans, focusing on preventive health behaviors, early disease detection, and chronic disease self-management;
  - (2) Fund community health education programs in schools, faith communities, workplaces, and public libraries; and
  - (3) Promote the use of evidence-based digital health tools and applications to support individual health management.
- (b) Voluntary Preventive Health Actions. Private citizens are encouraged to:
  - (1) Participate in recommended preventive health screenings, including cancer screenings, blood pressure monitoring, cholesterol testing, and diabetes risk assessments;
  - (2) Engage in regular physical activity as recommended by the U.S. Physical Activity Guidelines;
  - (3) Adopt dietary patterns consistent with the Dietary Guidelines for Americans;
  - (4) Avoid or cease tobacco product use, with support from government-funded cessation resources; and
  - (5) Seek timely medical care for symptoms of acute and chronic disease and adhere to prescribed treatment regimens.
- (c) Community Engagement. Private citizens are encouraged to:
  - (1) Participate in community health initiatives, local public health boards, and civic advocacy for equitable health resources;
  - (2) Support organizations working to improve community health outcomes and reduce health disparities; and
  - (3) Advocate to elected officials at all levels of government for sustained investment in public health infrastructure and preventive care access.

## **SECTION 7. Penalty Clauses**

- (a) Agency Non-Compliance. Any federal agency that fails to submit required plans, reports, or annual progress assessments as required by this Act shall be subject to:
  - (1) Notification by the Office of Inspector General of the Department of Health and Human Services and a mandatory corrective action plan within 60 days of identification of non-compliance; and
  - (2) Congressional review and potential rescission of non-essential agency appropriations, as determined by the relevant oversight committees.
- (b) Corporate Violations. Any corporation subject to requirements under Section 5 that fails to comply with the requirements of this Act shall be subject to:

- (1) Civil monetary penalties of not less than \$10,000 and not more than \$1,000,000 per violation per day, as determined by the applicable federal regulatory agency;
  - (2) Public disclosure of violations on a federal registry maintained by the Secretary; and
  - (3) Corrective action orders issued by the applicable federal regulatory agency, enforceable by civil action in federal district court.
- (c) False Reporting. Any person who knowingly provides false or misleading information to the Secretary, the FDA, the EPA, or any other federal agency in connection with requirements under this Act shall be subject to:
- (1) Criminal penalties under 18 U.S.C. Section 1001; and
  - (2) Civil monetary penalties of not less than \$25,000 per false statement.

## **SECTION 8. Effective Dates and Implementation**

- (a) Effective Date. Except as otherwise provided, this Act shall take effect 180 days after the date of enactment.
- (b) Phased Implementation. The Secretary may establish a phased implementation schedule for the requirements of this Act, provided that:
- (1) Phase 1 requirements, including agency planning, national target-setting, and elimination of cost-sharing for preventive services, shall take effect within 1 year of enactment;
  - (2) Phase 2 requirements, including corporate compliance obligations and community health program expansion, shall take effect within 3 years of enactment; and
  - (3) Phase 3 requirements, including full implementation of all mortality reduction programs and achievement of interim targets, shall be evaluated at 5 years after enactment.
- (c) Regulations. The Secretary shall promulgate final regulations necessary to implement this Act within 365 days of enactment, following notice-and-comment rulemaking as required by the Administrative Procedure Act (5 U.S.C. Section 553).
- (d) Severability. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of this Act, and the application of such provision to other persons or circumstances, shall not be affected.

## **SECTION 9. Appropriations or Budgetary Notes**

- (a) Authorization of Appropriations. There are authorized to be appropriated to carry out this Act:
- (1) To the Centers for Disease Control and Prevention, \$5,000,000,000 per fiscal year for fiscal years 2025 through 2034 to expand public health infrastructure, chronic disease prevention programs, and national mortality surveillance;

- (2) To the National Institutes of Health, \$2,500,000,000 per fiscal year for fiscal years 2025 through 2034 for research on preventable mortality causes and evidence-based intervention development;
  - (3) To the Health Resources and Services Administration, \$1,500,000,000 per fiscal year for fiscal years 2025 through 2034 for expansion of Federally Qualified Health Centers and the primary care workforce pipeline;
  - (4) To the Substance Abuse and Mental Health Services Administration, \$2,000,000,000 per fiscal year for fiscal years 2025 through 2034 for expansion of substance use disorder treatment, mental health services, and crisis intervention infrastructure;
  - (5) To the Centers for Medicare and Medicaid Services, such sums as may be necessary to implement the Medicaid expansion and preventive care coverage requirements of this Act; and
  - (6) To the Environmental Protection Agency, \$500,000,000 per fiscal year for fiscal years 2025 through 2034 for air quality enforcement, environmental justice programs, and contaminated site remediation.
- (b) Budget Neutrality Assessment. The Director of the Congressional Budget Office shall, within 90 days of enactment, submit a report to Congress estimating:
- (1) The projected 10-year cost of implementing this Act;
  - (2) The projected 10-year savings to federal health care programs resulting from reductions in preventable disease and mortality; and
  - (3) The projected net fiscal impact of this Act over 10, 20, and 30 years.
- (c) Offset Provisions. The Secretary of the Treasury shall, in consultation with the Director of the Office of Management and Budget, identify cost offsets sufficient to fund the requirements of this Act, including:
- (1) Revenue from tobacco and e-cigarette excise taxes adjusted to reflect evidence-based deterrence levels;
  - (2) Savings realized from reduced utilization of emergency and acute care services resulting from prevention program expansion; and
  - (3) Reallocation of existing federal health program funding from low-value to high-value preventive interventions.

## ENDNOTES

1. Age-standardized death rate data drawn from: World Health Organization Global Health Observatory, 2021 Global Health Estimates. <https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates>

2. Requirements in Sections 3-6 reflect best practices adopted by countries with the lowest death rates globally, including Nippon, Hanguk, Schweiz, España, Italia, Australia, République française, Canada, Norge, Sverige, Suomi, Deutschland, England, Zhongguo, and Nippon, as documented by: OECD Health at a Glance 2023. <https://www.oecd.org/health/health-at-a-glance/>;

Commonwealth Fund International Health Policy Survey. <https://www.commonwealthfund.org>;  
WHO Global Health Observatory. <https://www.who.int/data/gho>

3. Tobacco control requirements reflect provisions of: WHO Framework Convention on Tobacco Control. <https://www.who.int/fctc/en/>; Australian Tobacco Plain Packaging Act 2011. <https://www.legislation.gov.au>

4. Nutrition labeling requirements reflect: U.S. FDA Nutrition Innovation Strategy. <https://www.fda.gov/food/food-labeling-nutrition>; Health Canada Front-of-Package Nutrition Symbol. <https://www.canada.ca/en/health-canada.html>