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EFPIA position on Cardiovascular Health Checks

May 2026

WHAT IS A HEALTH CHECK?

A health check is a **routine appointment** with a primary care provider where key aspects of heart and metabolic health (e.g. blood pressure, cholesterol, blood sugar and weight) are reviewed. The aim is to **detect early signs of potential health risks**, and to guide **timely prevention or treatment.** If any of the results are outside of the recommended range, the healthcare provider will suggest a clear plan to address them, which may include lifestyle changes, treatment and follow-up care.

Health checks can be implemented as part of population wide programmes (like Greece's Prolamvano), opportunistic screening (as part of interactions between the citizen and the health system) and targeted screening programmes.

1 Why cardiovascular health checks: The case for EU action

Cardiovascular diseases (CVDs), which include heart disease and stroke, remain the leading public health challenge in the European Union (EU). They account for approximately 1.7 million deaths each year, affect around 62 million people, and generate economic costs exceeding EUR 282 billion annually.

Early detection and prevention should be viewed as long term investments in health system sustainability. Strong evidence shows that effective control of major modifiable cardiovascular risk factors - including hypertension, elevated LDL cholesterol, diabetes, smoking, and obesity - substantially reduces myocardial infarction, stroke, and cardiovascular mortality, while delayed detection is associated with acute events and hospitalisations that drive healthcare costs across Europe [1] [2] [3]

To effectively address this pressing burden, in December 2025 the European Commission launched the first ever EU Cardiovascular Health Plan - the Safe Hearts Plan. EFPIA welcomes the Plan and considers it an important step towards addressing CVDs in a comprehensive and structured manner, by establishing a more preventive life-course approach to cardiovascular health across the EU.

The Commission identifies prevention and early detection as underused levers in tackling CVDs, noting that risk factors and interconnected diseases (e.g., high blood pressure, high cholesterol, diabetes, obesity, arrhythmias) often remain undiagnosed and untreated. It further notes that current EU approaches are fragmented and lack a common protocol, leading not only to limited data comparability across Member States but also to variation in clinical care pathways, treatment standards, and follow up, which constrains scalability and equitable implementation.

EFPIA supports the Commission's plan to propose a **Council Recommendation on health checks for cardiovascular diseases** in 2026 and to pilot and launch an **EU protocol on health checks** to support a common approach for Member States in the development and implementation of national health checks. These initiatives will be supported by "Know Your Numbers" awareness campaigns and mobile and community-based outreach approaches to increase coverage.

The **Safe Hearts Plan defines EU-level ambitions to be achieved by 2035** for annual professional measurement of key cardiovascular risk factors in the population

- **Blood pressure:** At least 75% of people aged 25–64 and 90% of those aged 65 and over measured once a year [4].
- **Cholesterol:** At least 65% of people aged 25–64 and 80% of those aged 65 and over measured once a year [5].
- **Blood sugar**: At least 65% of people aged 25–64 and 80% of those aged 65 and over measured once a year [6].

EFPIA welcomes the inclusion of EU-level targets and believes that even greater ambition should be encouraged at national level. Achieving these objectives will require well-designed health checks and screening protocols. Member States should implement policies tailored to their national contexts, with the aim of reducing premature cardiovascular mortality and morbidity.

The sections below outline EFPIA's position and recommendations on cardiovascular health checks to help ensure that screening approaches across EU Member States are effective, harmonised, equitable, and actionable.

2 "Know Your Numbers by 35": setting the baseline (core "numbers")

2.1 Comprehensive baseline assessment at primary level

A Council Recommendation should include a clear commitment that e**very person receives a comprehensive cardiometabolic risk assessment by age 35** ("Know Your Numbers by 35"), with regular reassessment thereafter.

This baseline cardiometabolic risk assessment should be conducted at **primary care level and should cover the full set of routinely assessed cardiovascular and cardiometabolic parameters**, enabling earlier detection and prevention across the life course. At a minimum, the baseline assessment should include:

- **Lipid profile**, including LDL cholesterol (LDL-C).
- **Blood pressure** measurement according to proper measurement standards, with heart rate recorded at the time of measurement and a check for heart rhythm.
- **Blood glucose** or HbA1c to enable detection of both pre-diabetes and diabetes, and support integrated cardiometabolic risk assessment.
- **Measures of obesity and adiposity**, including body mass index (BMI) and assessment of waist circumference or waist-to-height ratio to assess overall and central adiposity [7].
- **Smoking status** and other relevant lifestyle risk factors.
- **Family history of premature CVD**, including major adverse cardiovascular events (MACE) such as myocardial infarction or stroke, and possible genetic predisposition.
- **Lipoprotein(a) (Lp(a))**, which should be measured at least once in every individual, as recommended in the ESC/EAS guidelines [8] for the management of dyslipidaemias.
- **Vaccination status against relevant respiratory infections**, as part of the individual's cardiovascular risk profile [9].

This set of parameters represents the **minimum dataset** that should be feasible at a general practitioner's office. When readings do not meet recommended thresholds, the assessment should trigger the initiation of a **control plan with defined follow-up**. More specialised or second-level tests should be specified in subsequent sections of the protocol.

Given the specificities of inherited **cardiometabolic** risk, pathways should also be in place to identify inherited conditions such as familial hypercholesterolemia (FH) and cardiomyopathies. Member States should establish systematic early detection screening and diagnosis for FH for all citizens, with appropriate care programmes focused on childhood identification and treatment [10].

2.2 Risk stratification with validated European tools

The EU protocol should require risk stratification using validated European cardiometabolic risk tools, such as SCORE2 [11] or SCORE2-OP [12], or similar composite risk scores that integrate cardiac, kidney, and metabolic dimensions. Ultimately, the risk scores employed should integrate multiple risk factors and guide the intensity of follow-up and intervention, rather than addressing single parameters in isolation.

Additional assessments that should be included to refine risk stratification and enable early intervention include:

- **Pulse and palpitations:** A simple and effective method to detect irregular heart rhythms, enabling timely referral and early stroke-prevention interventions.
- **N-terminal pro B-type natriuretic peptide (NT-proBNP)**: Useful for identifying asymptomatic or early-stage heart failure risk and refining overall cardiovascular risk assessment.
- **Kidney function tests**: Estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR) to detect early kidney damage and associated vascular risk.
- **Inflammatory cardiovascular risk assessment** using the prognostic biomarker high-sensitivity C-reactive protein (hs-CRP) [14].

These measures, combined with comprehensive baseline assessments and validated risk tools, ensure that **cardiometabolic** risk is evaluated holistically, supporting timely and tailored preventive interventions.

3 Who needs earlier and more frequent checks: Defined high-risk groups

The Safe Hearts Plan highlights that screening should not only follow defined population approaches but also be **targeted at subgroups with higher risk** due to family history, medical conditions, lifestyle, or environmental factors. A Council Recommendation should therefore explicitly identify high-risk groups who require earlier and more frequent testing, including:

- **Family history of:**
  - **premature Atherosclerotic Cardiovascular Disease (ASCVD)** suspected or confirmed inherited risk, or cardiomyopathies. Assessment should begin from age 18.
  - **Familial Hypercholesterolemia (FH**), with cascade screening for first-degree relatives and structured detection initiatives supported by EU instruments and cohesion funds where appropriate. Assessment should be done in childhood.
  - **elevated Lp(a).**
- **Subclinical atherosclerosis** detected opportunistically or via coronary artery calcium (CAC) imaging.
- **History of stroke**, as a strong independent risk factor for further cardiovascular events.
- **Chronic kidney disease**, including dialysis.
- **Hypertension**, with higher frequency follow-up and initiation of a control plan for resistant hypertension.
- **Diabetes** (including pre-diabetes), **obesity, or metabolic syndrome**, requiring tailored monitoring and intervention.
- **Atherosclerosis-related checks**, including blood tests for blood sugar, cholesterol (HDL, LDL), C-reactive protein (CRP), and electrocardiograms (ECG/EKG).
- **Chronic inflammatory diseases** associated with higher ASCVD risk.
- **People living with HIV**, due to increased long-term ASCVD risk from chronic inflammation and therapy exposure.
- Individuals with a **history of gestational diabetes**.
- People at high or very high risk of **cancer therapy-related cardiotoxicity**.
- **Smokers and socioeconomically** vulnerable groups with elevated lifetime risk and lower access to prevention.

The Council Recommendation should also require EU Member States to define, within national programmes, how early cardiovascular health checks should begin for these high risk groups and how their frequency should increase according to risk tier, using the EU protocol as the operational framework.

4 Screening and early detection are not enough: Integrated follow ups and care pathways to improve patient outcomes across Europe

The Safe Hearts Plan emphasises that early detection and screening can prevent disease progression and avoid costly emergency care, but it also highlights the **challenge of fragmented pathways and lack of common standards** across Member States.

To be effective, an EU protocol should therefore define not only what to screen for but also what happens next. This should include:

- **Follow-up diagnostic evaluations** after abnormal screening results, including detection of subclinical atherosclerosis using CAC scoring [15].
- **Referral pathways to specialist care**, where indicated, such as lipid/FH services, hypertension clinics, diabetology, endocrinology, specialist obesity management services, nephrology, cardiology, or neurology.
- **Patient education** to clarify cardiovascular risk resulting from overlapping cardiovascular, kidney, and metabolic conditions (e.g., chronic kidney disease and its impact on heart disease, long-term cardiovascular consequences of type 2 diabetes) and the importance of early action.
- **Evaluation of treatment adherence**, including checklists for healthcare professionals and patients to assess compliance with prescribed interventions.

Assessments should trigger a personalised management plan whenever results exceed recommended thresholds or are not close to achieving guideline-directed goals, in line with the current ESC/EAS guidelines on CVD prevention in clinical practice [16]. Embedding these elements ensures that each time a parameter crosses a defined threshold, there is a mandatory and standardized next step to follow, linking early detection directly to effective patient care.

5 Establish guideline implementation and treat-to-target

The Safe Hearts Plan highlights that suboptimal use of cardiovascular medications and the lack of common standards across Member States contribute to **inequalities and inefficiencies**, reinforcing the need for **EU-level standardisation tools** within the protocol. A Council Recommendation should therefore encourage Member States to adopt the **ESC CVD prevention guidelines [17] as the benchmark** for cardiovascular prevention and risk factor management within national health-check pathways.

Health check pathways should explicitly support **treat-to-target management and systematic follow-up**, including structured adherence support and escalation whenever targets are not achieved, in line with the “treat-to-target” prevention approach outlined in detailed proposals.

6 Operational delivery model: Combining opportunistic and programme-based screening ('make every contact count')

EFPIA's earlier consultation input [18] on the Safe Hearts Plan highlights that cardiometabolic health checks should be automatically integrated whenever routine bloodwork is ordered in primary care for adults, thereby increasing uptake and normalising preventive care. The Safe Hearts Plan similarly supports community-based screening initiatives and mobile outreach programmes to achieve high coverage, particularly in rural or underserved areas, and envisages EU support for piloting such approaches.

Accordingly, the Council Recommendation should support Member States in implementing a blended approach that combines:

- **Systematic cardiovascular health checks**, offered through structured, age-based invitations to eligible populations (e.g., adults aged 35–65 years), delivered at regular intervals and following a standardised protocol to ensure consistent coverage and equitable access [19].
- **Opportunistic cardiovascular health checks**, triggered by routine healthcare contacts, including primary care visits and bloodwork, ensuring that every interaction with the health system can serve as an opportunity for early detection [20].

This blended model ensures both proactive, population-wide screening and the flexibility to capture individuals during routine healthcare interactions, maximising coverage and early detection across diverse populations.

7 Reaching every citizen: Targeted outreach and inequality reduction

The Safe Hearts Plan highlights major inequalities across Member States and within populations, driven by socioeconomic status, geography, and gender, and commits to an inequalities' dashboard modelled on the Cancer Inequalities Registry [21]. Health-check programmes should therefore **include targeted outreach strategies and adapted delivery models**, such as community-based services, mobile clinics, and culturally sensitive communication, to reach underserved groups (e.g., migrants, rural populations, lower socioeconomic groups) and reduce inequities in access to screening, follow-up care, and specialist services. Programmes should also strengthen primary care capacity to manage patients effectively with minimal specialist input.

8 Monitoring and accountability: EU-level indicators and dashboards

The Safe Hearts Plan identifies gaps in data availability and interoperability and stresses the need for EU-level coordination to enable comparable monitoring and data-driven improvement. A Council Recommendation should **support transparent monitoring through EU-level indicators and dashboards tracking** at a minimum:

- **Annual measurement rates for key risk factors.**
- **Proportion of the population screened by age.**
- **Detection and follow-up outcomes for major risk factors and inherited conditions, such as FH.**

The Safe Hearts Plan explicitly links targets to the design of early detection programmes and protocols and emphasises data and digital enablement, including alignment with the European Health Data Space (EHDS) [22], supporting the inclusion of interoperable reporting standards in the protocol.

9 Implementation urgency and timeline

A Council Recommendation should be designed for **rapid implementation after adoption,** ensuring that national pathways become operational without delay. This aligns with the Safe Hearts Plan's ambition to deliver tangible benefits and reduce preventable cardiovascular burden. A concrete operational readiness goal for all Member States is set for the first half of 2027 at the latest, reflecting the urgency of preventable mortality and the need to translate the protocol and Recommendation into national practice quickly. The European Commission should also ensure that adequate funding through various sources of the MFF (cohesion funds, etc.) is available to member states to implement health checks and screening programmes.

For more information on effective implementation of health checks, please consult the PwC report Unlocking the Value of Cardiovascular Health Checks (May 2026).

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A Life-Course Approach to Cardiovascular Health Checks

CHILDHOOD

Early detection of inherited conditions (e.g. Familial Hyper-cholesterolemia)

AGE 18+

Early assessment for individuals with elevated risk

KNOW YOUR NUMBERS BY AGE 35

- Lipid profile (including LDL cholesterol)
- Blood pressure (with heart rate and rhythm check)
- Blood glucose (or HbA1c)
- BMI and waist-to-height ratio assessing adiposity
- Smoking status and lifestyle risk factors
- Family history of premature CVD
- Lipoprotein(a) (measured once in adulthood)
- Vaccination status

AGES 35–64

Reassessment in intervals driven by risk

AGE 65+

Annual or more frequent monitoring based on risk and comorbidities

WHY IT MATTERS: ADDRESSING THE BURDEN OF CVD IN THE EU

- 1.7 million deaths annually
- Up to 80% of CVD cases preventable through early detection and risk-factor control

The EU Safe Hearts Plan aims to reduce cardiovascular premature mortality by 25% by 2035, with 2022 as the baseline year

ACTION AFTER ALL CHECKS
Trigger follow-up, treatment initiation and specialist referral where indicated

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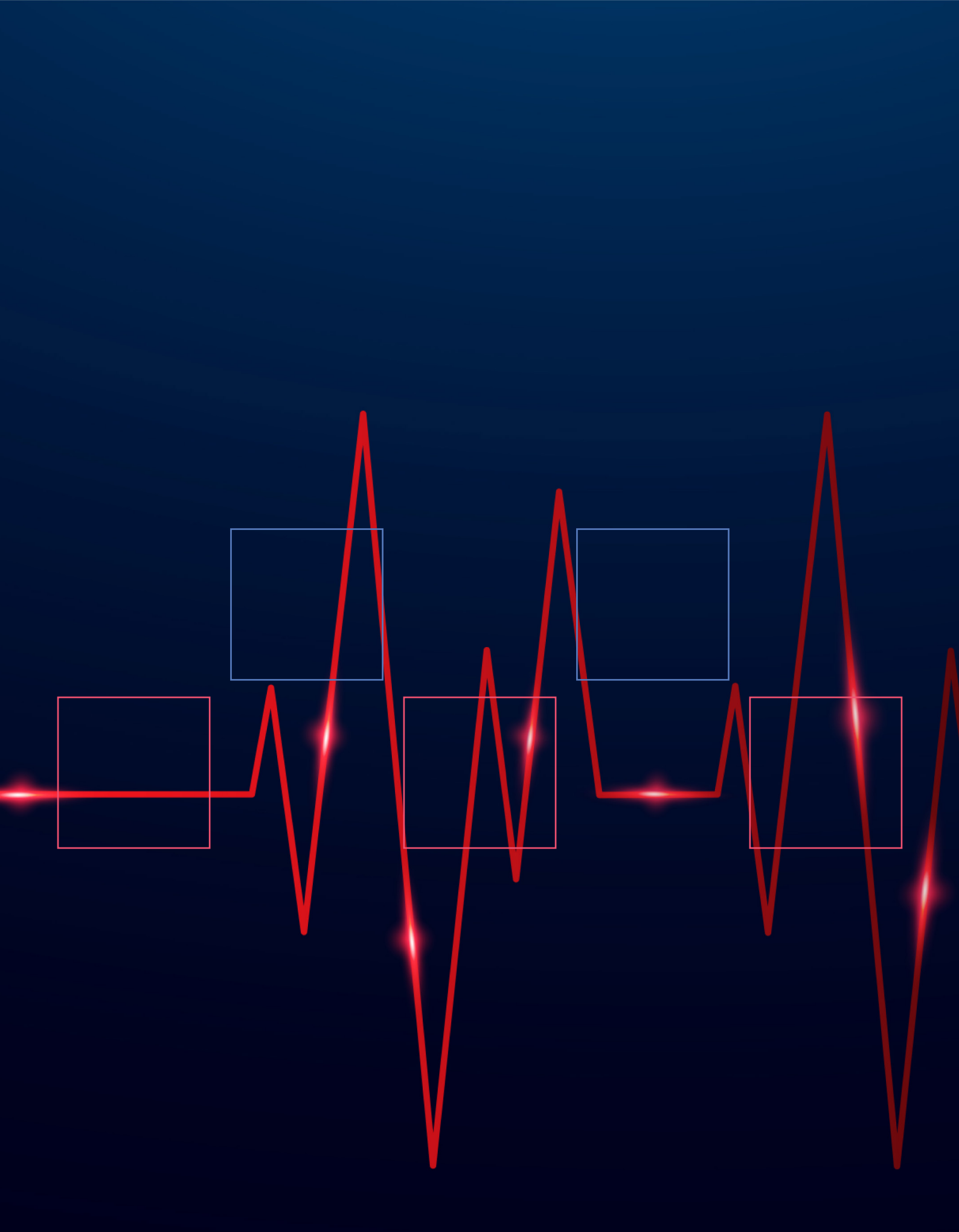

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