Global
Heart Hub

Global Heart Hub Response to the EU Cardiovascular Health Plan Call for Evidence

September 11, 2025

Introduction & Our Unique Value Proposition

Cardiovascular disease (CVD) remains the **leading cause of death in the EU**, with **1.7 million lives lost each year**[1] and an estimated **€282 billion** in economic impact.[2] As the European Commission prepares its first EU Cardiovascular Health Plan, Global Heart Hub welcomes the opportunity to bring a **patient-led perspective** – one that centres on **prevention, equity, innovation and meaningful patient involvement.**

Global Heart Hub (GHH)[3] is the first **global non-profit organisation** established to provide a voice for those living with, or affected by, cardiovascular disease, uniting over **152 patient organisations** across **46 countries**. As a **patient-centred, patient-driven organisation**, we work to ensure that people living with heart conditions are equal stakeholders in shaping cardiovascular policy, care and innovation. GHH offers a perspective that complements but is distinct from clinical, institutional and research-driven stakeholders – anchoring cardiovascular policy in the realities of those it impacts most.

This response draws on the **lived experience, insights and evidence** from our patient community, focusing on **three priorities** where **EU and national action can drive meaningful change**:

1. **Early detection and screening:** to identify risk and disease earlier, enabling faster intervention.
2. **Women's cardiovascular health**: to address persistent gender gaps in research, recognition and care.
3. **Integration of care for related comorbidities:** recognising the complexity of CVD alongside related conditions such as **diabetes, obesity, kidney disease, liver disease and stroke**.

While healthcare remains a **national competence**, CVD is a **shared European challenge**. **A unified, patient-centred EU strategy** can **reduce inequalities, strengthen health system resilience** and **accelerate innovation** across Member States.

We therefore **welcome the European Commission's leadership** in developing a comprehensive EU Cardiovascular Health Plan and **urge a bold, inclusive approach** that embeds the **patient voice** from **strategy through to implementation**. This response is rooted in that commitment and includes **case studies** highlighting how GHH is making a difference to patients. It also sets out clear policy priorities – including a proposed ***Council Recommendation on Cardiovascular Health Checks*** – to help turn shared goals into tangible action across Europe.

Our Affiliate community in the EU brings together 68 CVD patient organisations:

Meine Herzklappe, Austria; IDF Europe, Belgium; Ligue Cardiologique Belge, Belgium; HCM Patient Foundation, Bulgaria; Nicosia Heart Patients' Association, Cyprus; Estonian Stroke Patients Society, Estonia; MTÜ Siirdatud Süda (NGO Transplanted Heart), Estonia; National Association of Familial Hypercholesterolemia, France; Association Vie Et Coeur, France; Alliance du Coeur, France; La Ligue contre la Cardiomyopathie, France; Herzsschwäche Deutschland, Germany; ICD Germany, Germany; ARVC-Selbsthilfe e.V., Germany; Initiative Herzklappe, Germany; Selbsthilfegruppe LipidHilfe-Lp(a), Germany; Selbsthilfegruppe "Herzlich Willkommen", Germany; Epioni, Greek Carer's Network, Greece; Panhellenic Heart Disease Association, Greece; Association of Heart Disease Sufferers among Naval Officers, Coast Guard Officers, and Friends, Greece; SzivSN Territorial Patient Society, Hungary; Diabetes Ireland, Ireland; Irish Coalition for People Living with Obesity, Ireland; Sligo Heart Failure Group, Ireland; Croí, Ireland; The Heartbeat Trust, Ireland; Heart & Stroke Voice Ireland, Ireland; Cuore Nostro, Italy; AICARM, Italy; Italian Society for Cardiovascular Prevention, Italy; Associazione Italiana Scompensati Cardiaci, Italy; Patient Organization "ParSirdi.lv", Latvia; Lithuanian Heart Association, Lithuania; Lithuanian Heart Failure Association, Lithuania; SVEIKA ŠIRDIS "The Healthy Heart", Lithuania; Cardiomyopathy Research The Netherlands, Netherlands; The Patient's Voice, Netherlands; Hartpatiënten Nederland, Netherlands; Stichting VrouwenHart , Netherlands; LMNA Cardiac Foundation, Netherlands; FH Europe, Netherlands; Hart In Shape, Netherlands; EcoSerce Association' National Association of Patients with Heart & Vascular Conditions, Poland; Polish Heart Failure Patients Association, Poland; ICDefibrylatorzy, Poland; Stowarzyszenie Metalowych Serc w Przemyślu, Poland; Polish Diabetes Association, Poland; Fundacja Diabeciaki, Poland; Serce na Banacha, Poland; Protective Association of Diabetics of Portugal, Portugal; Association to Support Patients with Heart Failure, Portugal; Portuguese Heart Foundation, Portugal; Da, si eu pot!, Romania; Asociația CardioGen, Romania; Solidarity for Health, Romania; Slovenian Heart Foundation, Slovenia; Coronary Club of Ljubljana, Slovenia; Asociación de Enfermedades Cardiovasculares Corazón sin Fronteras, Spain; AEPOVAC, Spain; European Coalition for People living with Obesity, Spain; Síndromes arrítmicos relacionados con la muerte súbita (SAMS), Spain; Patient Forum of the Spanish Heart Foundation, Spain; Cardioalianza, Spain; Spanish Federation of Diabetes, Spain; Asociación Española de Miocardiopatía Hipertrófica, Spain; Más Visibles, Spain; Hypertrofisk Kardiomyopatis Svenska Sällskap, Sweden; and FOKUS Patient, Sweden.

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Early Detection & Screening: A Patient-Led Imperative

CVD is still too often detected only after a major, life-altering event such as a heart attack or stroke. Earlier detection not only saves lives and reduces healthcare costs – it also helps prevent serious deterioration in health and quality of life. For example, cardiomyopathy may go undiagnosed until it progresses to heart failure, when treatment becomes more complex and outcomes worsen. Yet many of these cases could be identified earlier through structured cardiovascular health checks.

Opportunities to detect risk are routinely missed – particularly in underserved or high-risk populations – where earlier diagnosis could make the biggest difference.

GHH believes the level of ambition shown in **Europe's Beating Cancer Plan**[4] should be mirrored in tackling CVD. Just as Europe is investing in cancer prevention and screening, similarly **bold and coordinated action** is urgently needed to reduce the burden of cardiovascular disease across Member States.

This call is echoed by the **European Alliance for Cardiovascular Health (EACH)**, whose roadmap urges Europe to match its ambition on cancer with equivalent action on CVD and prioritise systematic CVD risk assessments to enable earlier intervention.[5] Likewise, GHH's *'Achieving early detection and diagnosis of cardiovascular disease: A manifesto for change'* calls for a coordinated, patient-centred EU strategy on early detection, grounded in equity, access and shared learning between countries.[6]

Updated global estimates from the **Global Cardiovascular Risk Consortium** suggest that 57.2% of CVD cases in women – and 52.6% in men – are attributable to five key modifiable risk factors (body-mass index, systolic blood pressure, non–HDL cholesterol, smoking and diabetes).[7] This marks a significant shift from earlier assumptions that up to 80% of CVD was due to modifiable risk factors, underscoring the limits of primary prevention alone and the urgent need to implement **structured cardiovascular screening** to detect disease earlier and reduce avoidable deaths.

This reflects the growing recognition that genetics, congenital, commercial or environmental determinants, and gaps in care play a major role in cardiovascular risk. While promoting healthier lifestyles remains vital, these findings highlight the need for **system-level solutions**: structured cardiovascular health checks, equitable access to diagnostics and integrated care must be central pillars of the EU Cardiovascular Health Plan.

Early and accurate diagnostics – from comprehensive family history reviews and routine stethoscope exams to advanced digital risk assessments (using validated algorithms and AI-supported tools) and, where appropriate, targeted genetic and family screening – must be part of a **systematic approach to cardiovascular risk assessment**. Taking **a full family history** enables clinicians to better understand inherited risk and interpret silent warning signs in the context of the whole patient. Innovations in early detection, including identifying heart valve disease, heart failure and inherited conditions such as cardiomyopathy, can transform outcomes when combined with patient-informed screening protocols. For heart valve disease in particular, systematic stethoscope checks and timely access to echocardiograms are critical – yet remain underutilised across Europe, contributing to avoidable late diagnoses and preventable deaths.

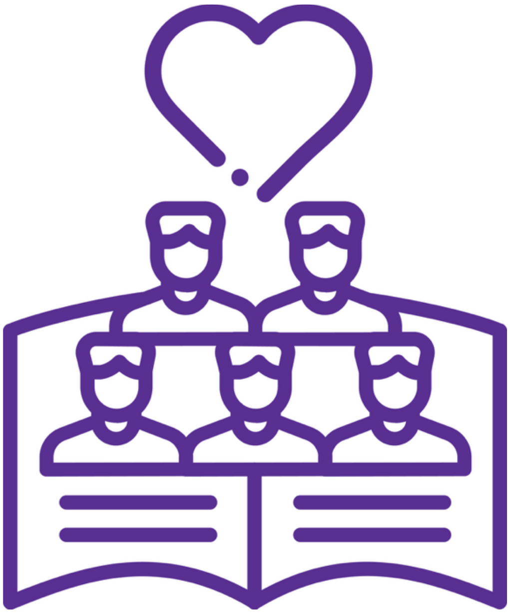
Global Heart Hub Proposal:
A Family Cardiovascular Risk Passport

GHH proposes the development and piloting of a Family Cardiovascular Risk Passport – a simple, patient-held tool to capture family history of cardiovascular conditions such as heart failure, cardiomyopathy, familial hypercholesterolaemia and elevated lipoprotein(a). This passport would empower patients, support clinicians in identifying inherited risk earlier and enable more targeted follow-up, especially in primary care settings.

Piloting the passport through **national programmes or EU-funded initiatives** could support earlier detection, improve outcomes for families at risk and enhance equity by addressing silent and inherited drivers of cardiovascular disease.

Early intervention is not only clinically effective but also cost-effective – both for health systems and for patients. Failure to detect cardiovascular conditions in time or to provide timely access to treatment, results in avoidable deaths, worsening health outcomes and unnecessary costs.[8]

GHH strongly supports the European Commission's focus on early detection and screening, as outlined in the *Call for Evidence*,[9] including the recommendation for an EU protocol on cardiovascular health checks. We strongly recommend the adoption of a **Council Recommendation on Cardiovascular Health Checks** to guide and align national implementation – building on the model set by the Council Recommendation on Cancer Screening (2022), which advanced a coordinated, population-based approach.[10] The Council Conclusions on Cardiovascular Health (2024) also call for the implementation of European Cardiovascular Health Checks.[11]



A Council Recommendation on Cardiovascular Health Checks should include:

- **Structured cardiovascular health checks**, integrated into routine and opportunistic primary care. These should include systematic screening for key risk factors such as hypertension, dyslipidaemia, diabetes (e.g. HbA1c), obesity and chronic kidney disease. Clinicians should also assess **'red flag' symptoms** such as oedema and breathlessness, and **consider cardiovascular risk factors related to pregnancy**, including a history of **gestational diabetes, pre-eclampsia or hypertensive disorders of pregnancy**, as early indicators of future CVD risk.
- **Comprehensive family history review** – a key, non-invasive tool to help identify individuals at risk of inherited cardiovascular conditions such as cardiomyopathy, elevated lipoprotein(a) [Lp(a)], or familial hypercholesterolaemia. Family history should be routinely captured in primary care to support early diagnosis, cascade screening and targeted follow-up.
- **Pilot a Family Cardiovascular Risk Passport** – a patient-held tool to systematically record family history and inherited risk across generations. This passport would support early diagnosis, personalised risk assessments and family-wide prevention strategies, especially in primary care. Pilots could be supported through EU4Health or Member State innovation funds, with a view to scaling up across Europe.
- **Heart auscultation (stethoscope check)** at key life stages[12] to support early detection of heart valve disease and other conditions.
- **Timely access to high-quality echocardiograms**, ideally within two weeks of detecting a heart murmur, to enable early diagnosis and avoid progression of undetected heart valve disease.[13]
- **Screening for advanced biomarkers** such as **lipoprotein(a) [Lp(a)]**, via a **simple, one-off blood test** to reveal inherited cardiovascular risk.[14] **Where relevant, genetic and family screening for inherited conditions such as cardiomyopathy should also be considered.**
- **The use of NT-proBNP testing** – a simple blood test **to support early detection of heart failure and cardiomyopathy** – as a first-line diagnostic tool**,** with EU-level guidance to ensure its availability, accessibility and reimbursement across both **primary and secondary care** settings across all Member States.[15]
- **Clear age- and risk-based protocols for implementation,** including non-invasive clinical checks (e.g. blood pressure, lipid profiles, pulse checks), digital risk tools and lifestyle risk assessments. These protocols should include structured critical pathways for early detection of **heart failure and atherosclerotic cardiovascular disease (ASCVD),** integrated within primary care.[16] **Cascade screening protocols** should be integrated into national cardiovascular strategies, particularly for inherited conditions. Identifying one individual at risk can help protect entire families through targeted testing and early intervention.
- **Proactive outreach to high-risk groups**, including women (particularly during and after pregnancy), older people, underserved communities and individuals living with comorbidities. Risk assessments should account for life-stage and sex-specific factors such as gestational diabetes, early menopause, pregnancy-related complications and autoimmune conditions.
- **Use of digital tools and AI-supported models** to extend reach, personalise risk profiling and support early detection in under-resourced or remote settings. This should include **innovative technologies**[17] to support the patient journey – such as **digital communications, digital stethoscopes and portable echocardiograms** – ensuring timely access to diagnostic services closer to home.
- **EU-wide benchmarks or targets** – such as the percentage of eligible adults reached by 2030 and 2035 – to drive uptake, track progress and reduce inequalities.

Case Study Spotlight: Reducing Missed Diagnoses in Cardiomyopathy

Cardiomyopathies are the most common inherited heart conditions and a leading cause of heart failure,[18] sudden cardiac death in young people[19] and heart transplantation.[20] Despite this, they remain **widely underdiagnosed or misdiagnosed** across Europe – often due to a lack of awareness, access to appropriate diagnostics and clear care pathways.

Family history is critical. For individuals with a known family history of sudden cardiac death or heart failure, early diagnosis can save lives – not only for the individual but for relatives who may also be at risk. Yet too often, cardiomyopathy is only diagnosed after an acute event. **Incorporating family history reviews and red-flag prompts into routine cardiovascular health checks** would support earlier recognition and targeted follow-up.

Improved screening within primary care – including **life-course prompts, funded genetic testing with cascade screening, timely access to echocardiography and cardiac MRI and NT-proBNP testing to support early detection and differential diagnosis** – can dramatically improve outcomes and reduce preventable deaths.

GHH's **Cardiomyopathy Patient Network** is working to address these missed opportunities by:

- Advocating for **clear diagnostic pathways** and clinical timelines.
- Promoting access to **genetic testing and cascade screening.**
- **Supporting the development of cardiomyopathy-specific care pathways** across primary and specialist care.

The **EU Cardiovascular Health Plan** should explicitly support national efforts to **improve early diagnosis** of inherited cardiovascular diseases like cardiomyopathy – through EU-level guidance, equitable access to diagnostics and integration into national cardiovascular strategies. **Patient-led insight and experience** must inform the design of these systems to ensure effectiveness and equity.

Case Study Spotlight: Driving Early Detection and Multidisciplinary Care in Heart Failure

Heart failure affects over 15 million people in Europe[21] and is a **leading cause of hospitalisation in adults over 65**.[22] Yet early symptoms are often vague or overlooked, resulting in **delayed diagnosis and poorer outcomes.**

Timely detection and coordinated care are essential to reduce hospitalisations and improve quality of life. **NT-proBNP testing** – a simple blood test that measures a hormone released by the heart when it's under stress – offers a fast, cost-effective way to detect heart failure early, especially in **primary care,** but it must be available, accessible and reimbursed across both **primary and secondary care settings.**[23] When combined with clear referral pathways and **rapid access to echocardiography**, early intervention becomes possible.

Equally critical is **multidisciplinary care**. People living with heart failure benefit from **integrated teams** – including cardiologists, nurses, pharmacists and mental health professionals – who can offer evidence-based treatment, **rehabilitation and support tailored to patient needs**.[24]

GHH is actively working to advance early diagnosis and coordinated care for heart failure across Europe, including through its *Heart Failure Patient Charter (2022)*[25] and *Heart Failure Patient Guide (2023)*.[26] These tools empower patients, raise awareness and advocate for policy and practice changes to embed timely testing, referral and multidisciplinary management as standard components of national cardiovascular strategies. This underscores the importance of embedding **early diagnosis, NT-proBNP testing** and **integrated care pathways** into national cardiovascular plans – with **EU-level support** to drive consistent, equitable implementation.

An EU-wide approach to cardiovascular health checks should adopt a **life-course perspective**, recognising that cardiovascular risk evolves over time – from early adulthood through mid-life and older age – and that specific life stages, such as pregnancy and menopause, require particular attention. Tailoring screening and prevention to these stages would ensure earlier detection and more equitable outcomes for all.

Many patients consistently describe the **trauma of delayed or missed diagnoses** – too often, a heart attack, stroke or advanced disease is the first sign that something is wrong. Early detection must therefore connect seamlessly to integrated care pathways, ensuring no patient is left behind.

> *"During a completely routine visit, without any symptoms at all, my cardiologist suggested further testing simply because of my age. That first step – a standard check-up that anyone can access – became the red flag that eventually led to the CT coronary angiography and the discovery of my rare condition.* ***It shows how vital regular, simple screenings are:*** *even a basic stethoscope exam or an age-appropriate test can trigger the right follow-up and save lives."*
>
> ***– Antonios Psaroudakis, Vice President of the Hellenic Association of Cardiac Patients Officers of Armed Forces and Friends of Greece, Greece***

Preventive strategies should also build on evidence that vaccination against respiratory viruses can reduce cardiovascular complications and events, particularly in high-risk populations.[27]

Systematic cardiovascular checks – implemented through primary care – **offer an efficient, feasible and equitable opportunity** to shift from reactive care to preventive action. To maximise impact, these checks must be embedded within **well-coordinated pathways that improve coordination across primary care and specialist providers** – supporting high-quality care, timely follow-up and ongoing management for individuals at risk.

We urge the Commission to **embed early detection and screening as a foundational pillar** of the EU Cardiovascular Health Plan – backed by EU policy tools and national commitment – to ensure no patient is left behind. We also urge the EU to **support patient engagement in cardiovascular research and innovation** – ensuring that lived experience informs priorities, trial design, and the development of new screening tools and treatments that can then be adopted by Member States.

Women's Cardiovascular Health: A Policy Priority for the EU

CVD is the **leading cause of death in women across the EU** – accounting for **35% of all deaths in women**, with a **20% higher risk of mortality following a heart attack** compared to men (*Council Conclusions on Cardiovascular Health*, 2024).[28] Despite this, gender disparities in prevention, diagnosis, treatment and outcomes persist across Member States.

Furthermore, despite strong evidence that exercise-based cardiac rehabilitation significantly lowers mortality risk after a heart attack – with even greater benefit in women than in men,[29] women are still referred at much lower rates than men.[30] Ensuring equitable access to rehabilitation and follow-up care must be a key component of gender-sensitive cardiovascular strategies.

"CVD in women remains significantly understudied, under-recognised, underdiagnosed and undertreated." *— Global Heart Hub, commentary in The Lancet Regional Health – Europe* (2025)[31]

We welcome the European Commission's recognition that CVD is too often viewed as a "men's issue" and agree that greater knowledge, investment and action on women-specific risk factors is urgently needed *(Call for Evidence – EU Cardiovascular Health Plan, 2025).*[32]

GHH's own reports – *Global Heart Hub International Roundtable Discussion on Late, Missed and Misdiagnosis of Heart Disease in Women* (2024)[33] and *Shaping the Future for Women with Heart Valve Disease* (2025)[34] – highlight widespread gaps in cardiovascular research, clinician awareness, persistent delays in diagnosis and the ongoing challenges many women face in having their cardiovascular symptoms recognised, investigated and taken seriously in a timely way. A stronger commitment is needed to sex-disaggregated analyses in cardiovascular research, clinical trial design and data reporting – to better understand how CVD affects women and ensure treatment guidelines are truly evidence-based. This includes ensuring the inclusion of women in proportion to their disease burden and presentation across CVD trials.

Women remain significantly underrepresented in cardiovascular research. Between 2010 and 2017, women accounted for less than 39% of participants in CVD clinical trials.[35] This underrepresentation limits the development of sex-specific strategies and evidence-based recommendations tailored to women's unique cardiovascular risk and presentation.

These realities are echoed in **global findings**. The **Lancet Commission on Women and Cardiovascular Disease** (2021)[36] warns that women's heart health continues to be deprioritised in research, clinical pathways and funding – despite being the leading cause of death in women worldwide.

Delayed diagnosis of cardiovascular events in women is all too common, whose symptoms may be dismissed or misattributed.

> *"At 22, I was **misdiagnosed with migraines** for six months when I actually had a Cerebral Venous Sinus Thrombosis. My local hospital had no MRI, causing a 12-hour delay that left me in a coma with serious complications, and I was very lucky to have survived. My hope for the future of healthcare across Europe is that all regional hospitals should have access to scanning equipment or be able to transfer patients who urgently need a vital scan to save their life."*
>
> *– Chloe Greene, Patient Advocate and Stroke Survivor, Ireland*

There is now growing international recognition – including from the **World Economic Forum** – that closing the gender health gap is both a human rights imperative and smart policy.[37,38, 39] Across Europe, women spend more years in poor health than men, often due to late or missed diagnoses and persistent gaps in care. The **cost is not only personal – it is economic**, driving lost productivity and increased pressure on families and health systems.

Momentum is building for change. In a historic milestone, the **2025 European Society of Cardiology (ESC) Guidelines**[40] now include dedicated sections on sex and gender differences across all new guidance documents – from mental health and dyslipidaemia to pregnancy, myocarditis and valvular heart disease. This marks a strong shift toward gender-sensitive cardiovascular medicine.

Yet patients continue to face the real-world consequences of gender bias and exclusion – sex-specific treatment recommendations remain limited, due to the ongoing underrepresentation of women in clinical trials. This underscores the urgency of the **EU Cardiovascular Health Plan** taking a bold, system-wide approach to embed gender equity across research, prevention, diagnosis and care – and to ensure that women's voices and experiences help shape solutions from the start. The **EU Cardiovascular Health Plan** should address these long-standing disparities and embed equity as a core principle – from strategy to delivery.

We recommend:

At EU level:

- **Mandate** sex- and gender-disaggregated data collection, analysis and reporting across all EU-funded cardiovascular research and programmes.
- **Require that EU-funded research includes strategies to improve gender parity** in clinical trial design, recruitment and analysis – including mandatory sex-disaggregated data reporting.[41]
- **Fund research into cardiovascular conditions and risk factors that disproportionately affect women**, such as autoimmune diseases, pregnancy-related risk and menopause-related changes.
- **Ensure EU-funded digital health tools, AI models and innovation initiatives are gender-responsive by design**, with safeguards to prevent algorithmic bias.
- **Support professional and public awareness campaigns** on women's cardiovascular symptoms and risk factors – particularly through EU health promotion and prevention programmes.[42]
- **Embed women's cardiovascular health within broader EU policy frameworks**, including the EU Gender Equality Strategy, EU NCD Initiative and EU4Health Programme.

At Member State level:

- **Integrate** sex-specific risk factors into national clinical guidelines and cardiovascular risk assessment tools.
- **Embed women's cardiovascular health in medical education and continuing professional development –** including sex- and gender-specific symptom recognition, risk profiles and communication training.[43]
- **Promote** gender-sensitive care pathways, including during pregnancy, menopause and in the presence of coexisting conditions like autoimmune disease.
- **Prioritise cardiovascular health screenings for women** in primary and community care, particularly for underserved and high-risk populations, supported by proactive outreach and EU-level good practice exchange.[44]
- **Strengthen the participation of women in cardiovascular clinical research** by supporting recruitment from primary care, addressing barriers to participation and ensuring diverse representation in national trials and registries.

These recommendations are grounded in GHH's patient-led research and align with broader EU policy frameworks. The upcoming ***Global Heart Hub Unite 2025 Summit on Women's Cardiovascular Health – Turning Insight into Action***[45] will further spotlight these patient-centred calls to action, drawing together ***advocates, researchers and policy leaders*** to demand meaningful change.

Heart valve disease in women, and CVD more broadly, remains understudied, under-recognised, underdiagnosed and undertreated. One study reported that only 22% of primary care providers and 42% of cardiologists felt well prepared to assess CVD risk in women.[46]

Case Study Spotlight: Shaping the Future for Women with Heart Valve Disease

In a **ground-breaking GHH report** launched on **1 September 2025,** we reveal the **striking evidence of gender gaps** in cardiovascular care – specifically in **heart valve disease.**

Drawn from in-depth interviews and a multi-disciplinary roundtable, the findings show that:

- Many women with heart valve disease experience **significant delays in diagnosis.**
- Symptoms are frequently **dismissed or misattributed** – often to stress, anxiety or ageing.
- Women often feel they must **advocate repeatedly** to be heard and taken seriously.
- Diagnosis often comes at **a later stage**, requiring more invasive interventions or emergency care.

The report, *Shaping the Future for Women with Heart Valve Disease (2025)*,[47] calls for **sex-specific care pathways,** greater awareness of how heart valve disease presents in women and **timely access to diagnostics** such as echocardiograms.

The **EU Cardiovascular Health Plan** should encourage and support Member States to embed **gender-sensitive screening protocols,** ensure **equitable access to diagnostic tools** and strengthen **professional education** on sex- and gender-specific symptoms of cardiovascular disease.

It is time for cardiovascular health policy to see women, serve women and save women's lives.

Integration of Care for Related Comorbidities

For millions of Europeans living with CVD, the challenge does not stop at one diagnosis. **Stroke, diabetes, kidney disease, liver disease and obesity frequently co-occur**, creating a complex web of risks – yet our systems remain fragmented and siloed. As highlighted in both the Council Conclusions on Cardiovascular Health (2024)[48] and the European Commission's Call for Evidence (2025), there is growing recognition that CVD cannot be tackled in isolation.[49]

Many conditions are intrinsically connected, for instance, people living with chronic kidney disease (CKD) exhibit an elevated cardiovascular risk manifesting as coronary artery disease, heart failure, arrhythmias and sudden cardiac death.[50]

Patients with multiple long-term conditions face **repeated assessments, conflicting advice and gaps in care.** Too often, health systems treat **each condition in isolation**, leading to **delays, duplication, poorer outcomes and lower quality of life** – while placing greater strain on already-stretched services. Multimorbidity leads to increased healthcare expenditures due to more frequent hospitalisations, specialist consultations and extended treatment plans.

> *"People with multiple long-term conditions have a higher usage of healthcare, face poorer quality of life and more impaired functioning, more hospital admissions and more adverse outcomes.* ***We need to change this.*** *And the way to change is to deliver* ***an integrated care approach*** *– but that requires quite* ***a seismic change*** *in the way we deliver healthcare, because it's always been traditionally delivered in a silo or a disease-based approach."*
>
> *-* ***Dr. Susan Connolly, Consultant Cardiologist, Galway University Hospital, Ireland*** *(Unite for Change Report, 2024)*[51]

> *"As a 53-year-old woman living with hypertrophic cardiomyopathy for over 25 years, I have been forced to manage my own care across* ***fragmented public and private systems****, with little coordination or follow-up. Even with a clear diagnosis,* ***chronic conditions were dismissed early symptoms of other****, and critical complications and connected factors like my undiagnosed bleeding disorder and entering menopause were overlooked. This* ***siloed approach to women's*** *health leaves patients like me* ***untreated, unseen and at constant risk."***
>
> *-* ***Angela Turrin, Asociación Española de Miocardiopatía Hipertrófica (AEMCH), Spain***

GHH's 2024 report, *Unite for Change: Transforming Cardiovascular Care for People Living with Multiple Conditions*,[52] brings patient voices to the fore – illustrating how health systems often fail to coordinate care across interconnected conditions. Patients highlighted **duplicated tests, inconsistent diagnoses, treatment delays and** the **mental toll** of constantly navigating between providers.

Comprehensive rehabilitation services – including **physical, psychological, educational** and **social support** – are also vital to restoring quality of life after major cardiovascular events. **Mental health services must also be embedded as a standard component of care**, addressing the psychological impact of diagnosis, treatment and recovery.

A shift towards integrated, person-centred care is both necessary and possible – supported by action at EU and national levels.

We recommend:

At EU level

- **Prioritise** integrated care as a cross-cutting priority in EU health strategies and funding – including EU4Health, Horizon Europe and other relevant programmes.
- **Develop** EU-level guidance and promote national best practices – such as **Ireland's chronic disease community hubs.**
- **Accelerate the adoption of interoperable electronic health records and digital tools** – aligned with the ambitions of the **European Health Data Space** – to improve continuity of care and reduce duplication.
- Support innovation through **EU-funded pilots and cross-country twinning schemes** that enable the development, testing and scaling of **multidisciplinary care models – including solutions to strengthen the health workforce.**
- **Promote** Member State implementation of comprehensive rehabilitation services and mental health integration through EU best practice exchange and funding support.
- **Embed** patient and carer co-design in EU-funded programmes and evaluations.

At Member State level

- **Implement** integrated care pathways for CVD and related conditions – including stroke, diabetes, kidney and liver disease and obesity. This should also take into account inherited cardiovascular diseases such as cardiomyopathy, with structured cascade screening and access to genetic counselling.
- **Invest** in care coordination roles (e.g. nurse navigators, patient liaisons) and multidisciplinary teams.
- **Address health workforce shortages** by expanding the roles of allied health professionals and supporting multidisciplinary care models.
- **Align** national funding, workforce planning and performance metrics around outcomes-based, integrated care.
- **Develop** public awareness campaigns to help patients understand and navigate complex care journeys.
- **Establish** national frameworks for patient engagement in service design, delivery and continuous improvement.
- **Ensure access to comprehensive rehabilitation services** – including physical, psychological, educational and social support – as a core component of integrated cardiovascular care.
- **Embed mental health services** as a standard part of diagnosis, treatment and recovery pathways for people living with CVD.

Integrated care is **better for patients** and essential for **sustainable health systems.** As Europe faces rising multimorbidity and chronic disease, the **EU Cardiovascular Health Plan must champion joined-up, person-centred care** as a defining feature of 21st-century healthcare.

Policy Hooks & Final Recommendations

GHH welcomes the European Commission's commitment to developing an **EU Cardiovascular Health Plan** and affirms our strong support for a **bold, inclusive and patient-led approach.**

Our response is grounded in **three core advocacy priorities** drawn from lived experience, evidence and patient-led dialogue across Europe and beyond:

1. **Early detection and screening**
2. **Women's cardiovascular health**
3. **Integration of Care for Related Comorbidities**

To support action across these areas, we draw on our **five joint policy asks**, outlined in *Unite for Change: Transforming Cardiovascular Care for People Living with Multiple Conditions (2024)*:[53]

1. **Multidisciplinary Care & Navigation for People with Lived Experience**
2. **Early Detection & Community-Based Screening**
3. **Innovation & Digital Health Solutions**
4. **Equity Across Gender, Geography and Socioeconomic Groups**
5. **Prevention, Empowerment & Mental Health Integration**

We call for these principles to **guide the development and implementation** of the EU Cardiovascular Health Plan – ensuring it delivers both **ambition** and **accountability.**

Case Study Spotlight: Closing the Participation Gap in Cardiovascular Research

Despite growing **regulatory requirements to embed patient involvement** throughout the clinical research lifecycle, **awareness and access remain major barriers.** Many patients only learn of clinical trials if they are treated at specialist centres – and even then, only if their clinician is directly involved in research. This limits both the **diversity and equity** of trial participation, particularly among women, older adults, minorities, individuals with multiple conditions and underserved populations – particularly those who are economically disadvantaged.

GHH is tackling this challenge head-on through a new global initiative aimed at increasing **patient engagement in cardiovascular research.** The initiative:

- **Raises awareness** among patients and the general public about clinical research, including its benefits and risks.
- Provides **accessible, patient-friendly educational resources.**
- Offers a **searchable clinical trial portal,** enabling patients to find relevant cardiovascular trials by disease area and location.
- Advocates for **patient co-design** of research protocols and dissemination, ensuring research reflects lived experience.

To increase inclusivity, **participation strategies should actively target underrepresented populations** – while supporting accessibility through digital tools, language adaptation and financial or logistical support for participation. This initiative reflects GHH's commitment to ensuring that **research reflects the lived experience and priorities of cardiovascular patients** and that innovation reaches all those it is intended to serve.

Call to Action at EU Level:

We urge the European Commission to prioritise patient engagement in cardiovascular research as part of the **EU Cardiovascular Health Plan** – including through awareness-raising campaigns, support for national trial registries and Horizon Europe calls that fund inclusive, patient-informed research design. The **Horizon Europe Cancer Mission**[54] provides a useful precedent, demonstrating how EU research programmes can drive citizen engagement, public awareness and co-creation of research priorities.

Aligning with EU & Global Health Policy Frameworks

The Plan should **not sit in isolation**, but act as a **driver of coherence and integration** across existing European, national and global health strategies. While healthcare delivery remains a national competence, the EU has a vital role to play in guiding shared priorities, supporting implementation and reducing health inequalities across Member States.

We strongly recommend that the EU Cardiovascular Health Plan aligns with:

Strategic Alignment Across EU, National and Global Frameworks

- **Europe's Beating Cancer Plan and the Council Recommendation on Cancer Screening** – as models for structured screening and multistakeholder collaboration.
- The **EU NCD Initiative** and **EU4Health** – advancing prevention and innovation across chronic conditions.
- Existing and future **national cardiovascular strategies and programmes** – ensuring **EU-level support for country-specific delivery.**
- **Global targets**, including **UN and WHO efforts on NCDs** and **Sustainable Development Goal 3.4** – with an EU Cardiovascular Health Plan helping Member States meet their shared commitment to **reduce premature mortality from NCDs.**

Gender Equality and Equity

- The forthcoming **Gender Equality Strategy (2026–2030)** – embedding sex and gender considerations into CVD policy and research.
- Exploring the creation of an **EU Inequalities Registry for CVD**, coordinated by the **Joint Research Centre**, to improve data on underserved populations and integrate existing cardiovascular registries across Europe.

Research and Innovation

- **Horizon Europe** – ensuring CVD research funding reflects disease burden and promotes equitable innovation.
- The **Strategy for European Life Sciences** – integrating **patient needs** into R&D pipelines, access frameworks and health system resilience.

Digital Health and Data

- The **European Health Data Space, AI Act** and the **forthcoming Applied AI Strategy** – ensuring digital tools are ethically deployed and **patient-centred.** To be effective, digital health tools and apps should be **co-designed with patients** to ensure usability, personalisation and integration into care pathways. Policymakers must also **set standards to ensure digital health innovations are accessible, affordable and user-friendly for all patient groups**, with particular focus on older adults and digitally underserved communities. This should include **digital literacy initiatives, public coverage of digital tools as essential healthcare benefits** and safeguards to prevent exclusion based on age, income or geography.

Access and Assessment

- **Seamless cross-border access to specialised cardiovascular care** should be ensured when local options are unavailable. Timely access to treatment in another Member State can be life-saving and should be **supported under EU frameworks.**
- **Strengthening patient involvement in Health Technology Assessments (HTAs).** While cardiovascular medicines will not be fully assessed through **EU-level Joint Clinical Assessments** until **2030, high-risk medical devices – many of which relate to cardiovascular care – will be included from 2026.** We therefore urge Member States to embed patient perspectives in their national HTA processes now, ensuring equitable access to innovative cardiovascular medicines, technologies and interventions.

Environment and Cardiovascular Health

- **Environmental and climate health strategies** – recognising that environmental risk factors such as air and noise pollution significantly contribute to preventable CVD deaths. The EU Cardiovascular Health Plan should align with WHO air quality guidelines and EU environmental frameworks, encouraging Member States **to integrate environmental health targets and emissions reduction into national CVD prevention plans.**[55]

Tackling Inequalities in Cardiovascular Health

An **EU Cardiovascular Health Plan** should explicitly support efforts to **reduce inequalities in cardiovascular care** – so that **survival and quality of life are not determined by socioeconomic status or geography.**

To support this aim, the EU should:

- **Encourage Member States** to allocate **targeted funding and resources** for public health interventions and healthcare access in disadvantaged communities.
- **Promote legislative frameworks** that guarantee **universal coverage** of essential CVD diagnostics, treatment and follow-up – with **accountability measures** for closing care gaps.
- Invest in **stronger data collection,** including consideration of a dedicated **EU Inequalities Registry for CVD,** coordinated by the **Joint Research Centre.**

Governance and Social Participation

In line with the **WHA77 Resolution on Social Participation for Universal Health Coverage** (May 2024),[56] the EU Cardiovascular Health Plan should embed meaningful patient involvement throughout its development and implementation. This includes:

- Institutionalising patient and civil society participation in governance structures.
- Ensuring early and ongoing engagement in policy, research and care design.
- Allocating resources to support inclusive, representative participation.

Consultation & Co-Creation

As the **only global patient alliance** focused on cardiovascular health, GHH welcomes the opportunity to support the development of the EU Cardiovascular Health Plan and looks forward to **contributing directly** to ensure **patient priorities are embedded throughout.** We also welcome opportunities to contribute as part of the **European Alliance for Cardiovascular Health (EACH),**[57] working with EU institutions, Member States and civil society partners.

For this strategy to succeed, the **patient voice should be integrated at every stage** – from design and decision-making to delivery and evaluation. **Together, we can ensure the EU Cardiovascular Health Plan reflects the real-world needs, realities and aspirations of the millions of people it is designed to serve.**

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