European Parliament
2024-2029

TEXTS ADOPTED

P10_TA(2026)0304

An EU cardiovascular diseases strategy

European Parliament resolution of 16 September 2026 on an EU cardiovascular diseases strategy (2025/2132(INI))

The European Parliament,

– having regard to Articles 7, 9, 168 and 191 of the Treaty on the Functioning of the European Union,

– having regard to Articles 3 and 35 of the Charter of Fundamental Rights of the European Union,

– having regard to the European Pillar of Social Rights,

– having regard to the United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs), in particular SDG 3.4 on reducing premature mortality from non-communicable diseases by one third by 2030 through prevention and treatment,

– having regard to the World Health Organization (WHO) health service delivery framework for prevention and management of obesity, published on 18 May 2023, and the WHO acceleration plan to stop obesity, of 3 July 2023,

– having regard to the Commission communication of 16 December 2025 on an EU cardiovascular health plan: the Safe Hearts Plan (COM(2025)1024),

– having regard to the Commission communication of 3 February 2021 on Europe’s Beating Cancer Plan (COM(2021)0044),

– having regard to its resolution of 16 February 2022 on strengthening Europe in the fight against cancer – towards a comprehensive and coordinated strategy[1],

– having regard to the Commission initiative ‘Healthier Together – EU

[1] OJ C 342, 6.9.2022, p. 109.

non-communicable diseases (NCD) initiative’,

– having regard to the EU Global Health Strategy,

– having regard to Regulation (EU) 2025/327 of the European Parliament and of the Council of 11 February 2025 on the European Health Data Space and amending Directive 2011/24/EU and Regulation (EU) 2024/2847[2],

– having regard to Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC[3] (Tobacco Products Directive),

– having regard to Council Directive 2011/64/EU of 21 June 2011 on the structure and rates of excise duty applied to manufactured tobacco[4],

– having regard to Directive 2005/29/EC of the European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No 2006/2004 of the European Parliament and of the Council (‘Unfair Commercial Practices Directive’)[5],

– having regard to Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods[6],

– having regard to Directive 2008/50/EC of the European Parliament and of the Council of 21 May 2008 on ambient air quality and cleaner air for Europe[7],

– having regard to Directive 2002/49/EC of the European Parliament and of the Council of 25 June 2002 relating to the assessment and

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2 OJ L, 2025/327, 5.3.2025, ELI: http://data.europa.eu/eli/reg/2025/327/oj.
3 OJ L 127, 29.4.2014, p. 1, ELI: http://data.europa.eu/eli/dir/2014/40/oj.
4 OJ L 176, 5.7.2011, p. 24, ELI: http://data.europa.eu/eli/dir/2011/64/oj.
5 OJ L 149, 11.6.2005, p. 22, ELI: http://data.europa.eu/eli/dir/2005/29/oj.
6 OJ L 404, 30.12.2006, p. 9, ELI: http://data.europa.eu/eli/reg/2006/1924/oj.
7 OJ L 152, 11.6.2008, p. 1, ELI: http://data.europa.eu/eli/dir/2008/50/oj.

management of environmental noise[8],

– having regard to Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare[9] (Cross-Border Healthcare Directive),

– having regard to the report of 9 September 2024 by Mario Draghi entitled 'The Future of European Competitiveness' (Draghi report),

– having regard to the Commission communication of 29 January 2025 entitled 'A Competitiveness Compass for the EU' (COM(2025)0030),

– having regard to the Commission report of 29 January 2026 entitled 'Mid-term review of the EU Zero Pollution Action Plan – 'Delivering clean air, ocean, freshwaters and soil' (COM(2026)0042),

– having regard to Directive (EU) 2016/2284 of the European Parliament and of the Council of 14 December 2016 on the reduction of national emissions of certain atmospheric pollutants, amending Directive 2003/35/EC and repealing Directive 2001/81/EC[10] and the evaluation thereof published on 1 December 2025,

– having regard to the reports of the European Environment Agency of 22 June 2023 entitled 'Beating cardiovascular disease – the role of Europe's environment' and of 3 November 2025 entitled 'Preventing cardiovascular disease through a healthy environment',

– having regard to the EU strategy on adaptation to climate change, published on 24 February 2021 (COM(2021)0082),

– having regard to Horizon Europe, the EU4Health programme, the Digital Europe programme and cohesion policy funds,

– having regard to the Commission communication of 14 October 2020 on the chemicals strategy for sustainability (COM(2020)0667),

– having regard to the European Cancer Inequalities Registry,

– having regard to the WHO Global action plan for the prevention and control of noncommunicable diseases 2013-2030, the WHO action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016-2025, and the WHO Second European Programme of Work, 2026-2030: 'United Action for Better Health',

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8 OJ L 189, 18.7.2002, p. 12, ELI: http://data.europa.eu/eli/dir/2002/49/oj.

9 OJ L 88, 4.4.2011, p. 45, ELI: http://data.europa.eu/eli/dir/2011/24/oj.

10 OJ L 344, 17.12.2016, p. 1, ELI: http://data.europa.eu/eli/dir/2016/2284/oj.

– having regard to the political declaration of the fourth high-level meeting of the General Assembly of 8 December 2025 on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being, adopted by the United Nations General Assembly,

– having regard to the WHO's 'best buys' and WHO Europe's 'quick buys' for the prevention and management of noncommunicable diseases, including cardiovascular diseases,

– having regard to the Commission communication of 7 March 2025 entitled 'A Roadmap for Women's Rights' (COM(2025)0097),

– having regard to the WHO HEARTS technical package,

– having regard to the WHO Framework Convention on Tobacco Control,

– having regard to the WHO physical activity strategy for the WHO European Region 2016-2025,

– having regard to its resolution of 16 February 2022 entitled 'on strengthening Europe in the fight against cancer – towards a comprehensive and coordinated strategy'[11],

– having regard to its resolution of 13 December 2023 on non-communicable diseases (NCDs)[12],

– having regard to its ongoing work on the EU health workforce shortage crisis,

– having regard to the report by the Organisation for Economic Co-operation and Development of 15 December 2025 entitled 'The state of cardiovascular health in the European Union',

– having regard to the European Economic and Social Committee opinion of 18 September 2025 on the commercial determinants of health,

– having regard to Rule 55 (and Rule 148(2)) of its Rules of Procedure,

– having regard to the report of the Committee on Public Health (A10-0221/2026),

A. whereas cardiovascular diseases (CVDs) comprise a broad spectrum of cardiac and vascular conditions, including those affecting both the heart and the circulatory system;

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11 OJ C 342, 6.9.2022, p. 109.
12 OJ C, C/2024/4171, 2.8.2024, ELI: http://data.europa.eu/eli/C/2024/4171/oj.

B. whereas CVDs and their associated risk factors are highly prevalent and have a significant impact on health and quality of life, as well as major economic and social consequences; whereas cardiovascular health therefore constitutes a major public health and societal challenge in the EU, since CVDs remain the leading cause of mortality in the EU, accounting for approximately 1,7 million deaths each year; whereas in the EU, 62 million people live with the burden of CVDs, and close to 13 million new cases of CVDs occur every year; whereas environmental risks are estimated to cause over 18 %[13] of cardiovascular disease-related deaths in Europe; whereas CVDs are associated with significant morbidity, disability, reduced quality of life and capacity for independent living, losses in productivity, increased risk of complications from infectious diseases and an estimated annual economic cost of EUR 282 billion; whereas an estimated 80 % of CVDs are preventable[14];

C. whereas CVDs are a major driver of premature mortality and disability from non-communicable diseases (NCDs), and whereas reducing cardiovascular mortality is essential to achieving SDG 3.4 by 2030;

D. whereas CVDs have a profound impact on societies and economies across the EU, affecting labour markets, social protection systems and long-term economic sustainability;

E. whereas coronary heart disease represents the largest share of cardiovascular mortality, followed by stroke; whereas heart failure, atrial fibrillation, peripheral arterial disease, valvular heart disease, cardiomyopathies, rheumatic heart disease, hypertensive heart disease and aortic diseases contribute significantly to disability, avoidable hospitalisations and premature mortality across the EU;

F. whereas only a limited number of Member States met the global target of a 25 % reduction in the prevalence of high blood pressure by 2025, demonstrating insufficient progress in the prevention and management of one of the most significant and modifiable cardiovascular risk factors; whereas hypertension affects approximately 22 % of the EU population aged 15 and above and represents one of the most common risk factors for CVD; whereas inadequate detection and poor management of high blood pressure continue to be a cause of avoidable illness and premature deaths from cardiovascular causes across the EU;

G. whereas standardised death rates from diseases of the circulatory system continue to show stark regional disparities across the EU, reflecting a persistent east-west divide; whereas these gaps point to unequal exposure to risk factors and unequal access to timely

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13 https://www.eea.europa.eu/en/analysis/publications/beating-cardiovascular-disease-the-role-of-europes-environment.

14 https://world-heart-federation.org/what-we-do/prevention/.

prevention, diagnosis and quality care across regions; whereas only 11 out of 27 Member States have national cardiovascular plans; whereas there is a need for a common European approach to harmonise these plans to exchange information and for the Member States with no such plans to adopt the Safe Hearts Plan;

H. whereas demographic ageing, combined with the increasing prevalence of cardiovascular risk factors, is projected to further increase the burden of CVDs and related chronic diseases in the absence of integrated and strengthened prevention, early detection and healthcare system responses, while putting extra pressure on the healthcare workforce; whereas CVD affects all age groups, with early-life exposure to risk factors and delayed recognition in children, adolescents and young adults shaping lifelong outcomes; whereas a lifelong approach to cardiovascular health is therefore essential;

I. whereas CVDs are closely linked with other major NCDs, including diabetes, hypertension, cancer, chronic kidney disease, obesity and many others; whereas a substantial share of cardiovascular conditions arise as complications of diabetes and related disorders that remain undetected, are diagnosed at a late stage, or are inadequately managed; whereas once CVD develops, managing diabetes becomes more complex and costly;

J. whereas diabetes affects approximately 34 million people across the EU, and whereas around one third of people living with diabetes will develop CVD in their lifetime, making diabetes a major, preventable driver of cardiovascular morbidity and mortality in Europe; whereas people living with type 1 diabetes, a lifelong autoimmune disease often diagnosed in childhood, face a substantially increased lifetime risk of CVD despite the absence of modifiable behavioural causes; whereas up to 40 % of children are diagnosed following diabetic ketoacidosis, a potentially life-threatening condition;

K. whereas childhood overweight and obesity remain a major concern in Europe; whereas one in ten children aged 5 to 19 are obese and 25 % are overweight[15];

L. whereas obesity is responsible for almost a quarter of treatment costs for CVDs and leads to substantial societal losses in terms of lower workforce participation and productivity and higher dependency on social and health services[16];

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15 https://www.oecd.org/en/publications/the-state-of-cardiovascular-health-in-the-european-union_ea7a15f4-en/full-report/preventing-and-identifying-cvd-targeting-key-risk-factors_df4bf1f4.html#tablegrp-d1e19578-1bd943d292.

16 https://www.oecd.org/en/publications/the-heavy-burden-of-obesity_67450d67-en/full-report/component-6.html.

M. whereas mental health related diseases and symptoms such as depression, anxiety, anger and hostility, as well as acute or chronic stress, are factors that increase the risk of CVD[17]; whereas current recommendations call for the standardised screening of depression and the implementation of an appropriate therapeutic plan in patients with cardiac conditions; whereas a lack of psychosocial well-being in the population also constitutes a cardiovascular risk factor, as it is associated with poorer cardiovascular health and more adverse clinical outcomes in CVD; whereas psychosocial factors are closely linked to overall cardiovascular risk, often influencing behaviours such as tobacco use and levels of physical activity[18];

N. whereas metabolic dysfunction-associated steatotic liver disease remains an under-recognised driver of CVD, affecting more than 25 % of adults
in the EU;

O. whereas persistent and widening inequalities in cardiovascular health outcomes exist between and within Member States, between women and men, between urban and rural areas, and among vulnerable populations, including migrants, older people, people with disabilities, people with rare diseases and multiple morbidities, unemployed people and socio-economically disadvantaged populations; whereas environmental and occupational health risks are unevenly distributed across society[19];

P. whereas CVDs increasingly and disproportionately affect certain migrant populations, driven by social, environmental and behavioural factors, and compounded by several factors including limited health literacy and restricted access to healthcare due, in particular, to language barriers, lack of information on available services and cultural differences; whereas there is a persistent under-representation of vulnerable populations, including migrants, in clinical trials;

Q. whereas children and adolescents are consistently diagnosed too late for type 1 diabetes and familial hypercholesterolemia, leading to serious complications, delayed care and poorer long-term health outcomes; whereas type 1 diabetes affects around 1 in 200 individuals, yet 40 % of children with type 1 diabetes are diagnosed with diabetic keto-acidosis, a potentially life-threatening condition; whereas familial hypercholesterolemia affects around one in 250 individuals, yet less than 10 % of cases are detected and diagnosis is

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17 https://www.revespcardiol.org/en-psychiatric-behavioral-aspects-cardiovascular-disease-articulo-S1885585711004683.

18 https://pmc.ncbi.nlm.nih.gov/articles/PMC7068361/.

19 https://www.eea.europa.eu/en/analysis/publications/unequal-exposure-and-unequal-impacts
https://www.who.int/europe/publications/i/item/WHO-EURO-2019-3507-43266-60638.

often delayed until after a cardiovascular event has occurred;

R. whereas evidence from EU agencies and international bodies demonstrates that, in addition to lifestyle and environmental factors, work-related exposures contribute to the development and aggravation of CVDs; whereas EU-level risk assessments and occupational safety and health frameworks have traditionally focused on cancer, respiratory and acute toxic outcomes, while cardiovascular effects of occupational exposure remain under-recognised and insufficiently addressed;

S. whereas women are consistently underdiagnosed and undertreated for CVDs owing to biological risk factors including adverse pregnancy outcomes, and to gender bias in health policy, diagnosis, treatment and clinical research, including the persistent under-representation of women in clinical trials, leading to delayed care and poorer health outcomes;

T. whereas several reproductive health conditions, such as infertility attributed to ovulatory disorders and endometriosis, hypertensive disorders of pregnancy, hormonal contraceptives and the transition to menopause, are linked to increased cardiovascular risk[20]; whereas scientific evidence indicates that polycystic ovary syndrome is the most common endocrine disorder of women of reproductive age and is associated with an increased risk of hypertension, stroke and CVD, independently of body mass index[21]; whereas endometriosis has been found to be associated with an increased risk of ischaemic heart disease and cerebrovascular disease[22];

U. whereas research into CVDs and associated risk factors such as preeclampsia and gestational diabetes receives low funding in proportion to the health burden that they represent;

V. whereas CVDs are still perceived as a male problem; whereas women are five times less likely to consider heart disease as a major health issue[23] or leading cause of death; whereas women are less likely to undergo cardiovascular screening; whereas many commonly used cardiovascular medicines lack sufficient gender-disaggregated safety data, for example on use during pregnancy, which limits treatment options and exposes pregnant women to increased health risks;

W. whereas a coordinated and comprehensive EU cardiovascular health plan can support Member States in accelerating the implementation

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20 https://www.oecd.org/en/publications/the-state-of-cardiovascular-health-in-the-european-union_ea7a15f4-en/full-report/preventing-and-identifying-cvd-targeting-key-risk-factors_df4bf1f4.html#section-d1e26541-1bd943d292.

21 https://doi.org/10.1186/s12905-025-03927-5.

22 https://doi.org/10.1093/ejendo/lvad077.

23 https://pmc.ncbi.nlm.nih.gov/articles/PMC8835179/.

of integrated evidence-based prevention measures for CVDs and associated risk factors, including secondary prevention and systematic follow-up, strengthening healthcare systems, enhancing resilience, extending cross-border cooperation, raising awareness about symptoms and the actions to take in response to cardiovascular events, providing timely and affordable access to medicines, and reducing inequalities in cardiovascular outcomes and interconnected comorbidities across the EU;

X. whereas most deaths from CVD are preventable and 74 % of the CVD burden can be attributed to modifiable risk factors[24]; whereas many of these risk factors – including tobacco use, harmful alcohol consumption, particularly at levels exceeding scientifically established health recommendations, unhealthy diets, physical inactivity and environmental exposures – are shared with other NCDs, notably cancer;

Y. whereas some CVD deaths are also attributable to non-modifiable risk factors including genetically inherited conditions;

Z. whereas vaccination can constitute an effective health intervention to support the prevention and management of CVDs by providing for immunisation and therefore lowering the risk of infection-triggered cardiovascular events and related complications, and is an important measure to improve survival, decrease hospital admissions and enhance patients' quality of life; welcomes the forthcoming Council recommendation on vaccination against respiratory infections as part of CVD prevention strategies;

AA. whereas strong and adequately resourced primary care, effective prevention and risk-based early detection are essential for reducing avoidable deaths and disability and are the most cost-effective strategy to ensure the sustainability of universal healthcare;

AB. whereas most EU countries face a shortage of general practitioners and medical specialists and an uneven distribution of healthcare professionals across regions, driven by demographic pressures and challenging working conditions, including an ageing health workforce and difficulties in attracting and retaining professionals, which undermines timely patient access to medical advice and care, and the sustainability of healthcare systems; whereas according to current estimates, the future number of cardiologists will be insufficient to meet the growing demand for cardiovascular prevention and care, while psychosocial consequences of CVD are also inadequately covered;

AC. whereas out-of-hospital cardiac arrest remains a leading cause of

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24 https://www.oecd.org/en/publications/the-state-of-cardiovascular-health-in-the-european-union_ea7a15f4-en/full-report/preventing-and-identifying-cvd-targeting-key-risk-factors_df4bf1f4.html.

preventable mortality; whereas survival depends critically on the immediate recognition of cardiac arrest, early bystander cardiopulmonary resuscitation, rapid defibrillation and timely advanced life support; whereas improving community response and emergency medical services performance is essential to reduce avoidable cardiovascular deaths;

AD. whereas the speed of diagnosis and treatment plays a key role in mitigating the long-term effects of cardiovascular accidents; whereas many cardiovascular accidents are misdiagnosed, thus creating higher risks of recurrence and long-term health disorders for patients; whereas in acute coronary syndromes, and in particular ST-segment elevation myocardial infarction, outcomes depend strongly on the time to reperfusion; whereas delays in opening occluded coronary arteries increase myocardial damage, heart failure risk and mortality; whereas reducing system delays requires coordinated networks from first medical contact to definitive reperfusion;

AE. whereas reliable and timely access to essential cardiovascular medicines is a cornerstone of effective prevention and care[25] for CVD;

AF. whereas in certain circumstances, hospital and community pharmacists can be the most accessible healthcare professionals and contribute to CVD prevention, early detection, treatment adherence and long-term care;

AG. whereas social determinants of health refer to the non-medical factors and systems that shape everyday life conditions and are defined as the circumstances in which people are born, grow up, live, work and age[26,27];

AH. whereas social determinants of health, including marketing and unsubstantiated health claims, can undermine prevention policies and normalise harmful consumption; whereas addressing social determinants is essential to ensure coherence and effectiveness across the EU’s NCD strategies;

AI. whereas exposure to social determinants of health differs across socio-economic groups; whereas many unhealthy products are consumed by children and young people;

AJ. whereas effective population-level prevention requires structural

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25 https://www.escardio.org/news/press/press-releases/avoidable-inequalities-remain-in-cardiovascular-disease-burden-and-care/.

26 https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html.

27 https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

policy action beyond individual behaviour change[28];

AK. whereas according to the Safe Hearts Plan, taxation has played an important role in reducing risk factors linked to citizens' lifestyles and around 40 % of the decline in smoking in the EU in the past decade can be attributed to taxation;

AL. whereas nicotine is an addictive cardiovascular toxin, and its use poses serious health dangers; whereas tobacco use, including active smoking, second-hand smoke exposure and new nicotine products, remains a major risk factor for CVD in the EU and significantly increases the risk of ischaemic heart disease, stroke, aortic aneurysm and peripheral arterial disease; whereas in 2023, tobacco use was responsible for approximately 160 000 cardiovascular deaths and over 3,27 million disability-adjusted life years lost in the EU[29], with a disproportionate burden among men and socio-economically disadvantaged populations;

AM. whereas the economic cost of smoking in Europe, including healthcare expenditures, productivity loss and premature mortality, exceeds EUR 300 billion annually; whereas prevention is more effective than any cure, as well as the most cost-effective long-term cardiovascular control strategy;

AN. whereas tobacco use remains the leading preventable cause of NCDs in the EU, further exacerbating health inequalities; whereas strong tobacco control policies represent a cornerstone of cardiovascular and cancer prevention, these diseases being the two leading causes of death in the EU;

AO. whereas even low-intensity or occasional smoking substantially increases cardiovascular risk, and the use of novel tobacco and nicotine products is also associated with increased cardiovascular mortality;

AP. whereas scientific evidence indicates that e-cigarettes are not risk-free and pose significant cardiovascular risks, including through mechanisms that increase the risk of thrombosis and atherosclerosis, notably due to nicotine exposure and the inhalation of toxic substances;

AQ. whereas the WHO does not recommend e-cigarettes as a smoking cessation tool, and evidence indicates that e-cigarette use is associated with increased uptake of conventional tobacco products,

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28 European Commission: Group of Chief Scientific Advisors and Directorate-General for Research and Innovation, Towards sustainable food consumption – Promoting healthy, affordable and sustainable food consumption choices, Publications Office of the European Union, 2023.

29 IHME health data tool for 2023.

particularly among young people;

AR. whereas cardiovascular health is strongly influenced by environmental, social, commercial and economic factors beyond the health sector; whereas the systematic application of a Health in All Policies approach, together with a One Health perspective, is essential for effective CVD prevention;

AS. whereas obesity, diabetes, sedentary lifestyle and insufficient physical activity are major contributors to cardiovascular morbidity and mortality, and progress in reducing these risk factors has stalled or reversed in several Member States;

AT. whereas strong social connections and support from family, friends and communities have been shown to improve cardiovascular health outcomes, reducing the risk of cardiovascular events, supporting recovery and enhancing adherence to treatment, effects that cannot be replicated by artificial intelligence or digital interventions alone[30];

AU. whereas nearly 80 % of the cardiovascular burden is attributable to modifiable risk factors[31];

AV. whereas the exposome approach considers the totality of exposures, such as environmental, chemical, physical, biological, social and behavioural exposures across an individual's lifetime and provides a unified framework for targeted prevention; whereas studies have shown a strong correlation between the exposome and cardiovascular health[32], with various components of the exposome having been implicated in the development and progression of CVD;

AW. whereas evidence indicates that community noise exposure above Lden 70 dB and Lnight 60 dB may impair behavioural and cognitive development in children and is associated with increased cardiovascular risk across the life course[33];

AX. whereas reducing the CVD burden requires action at multiple levels, including population-level measures to reduce exposure to risk factors, strengthened health literacy and improved competencies

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30 Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. PMC link.

31 B.A. Stark et al., 'Global, Regional, and National Burden of Cardiovascular Diseases and Risk Factors, 1990–2023', *Journal of the American College of Cardiology* 86, no. 22 (2025): 2167–2243, https://doi.org/10.1016/j.jacc.2025.08.015.

32 https://pubmed.ncbi.nlm.nih.gov/37290538/.

33 M. Raess, A. V. M. Brentani, B. Flückiger, B. Ledebur de Antas de Campos, G. Fink, M. Röösli, 'Association between community noise and children's cognitive and behavioral development: A prospective cohort study', *Environment International*, 158 (2022): 106961, https://doi.org/10.1016/j.envint.2021.106961. .

among health professionals and patients;

AY. whereas cardiovascular screening and follow-up screening are appropriate prevention solutions, to the extent that they are targeted on individuals presenting risk factors; whereas appropriate family screening should be provided where CVDs with genetic predisposition are detected;

AZ. whereas non-targeted or non-evidence-based cardiovascular screening and diagnostic practices may provide limited benefit while increasing overdiagnosis, overtreatment and inefficient use of healthcare resources, making the avoidance of low-value healthcare essential for patient safety and system sustainability;

BA. whereas regular physical activity is a key protective factor against CVDs and is particularly important for children and adolescents, as it lowers blood pressure, improves cholesterol levels, supports blood glucose regulation, helps maintain a healthy body weight and reduces systemic inflammation, establishing health behaviours that persist into adulthood[34];

BB. whereas diet and nutrition play a key role in preventing CVDs and poor diet and unhealthy habits are strongly associated with an elevated risk of CVDs morbidity and mortality; whereas cardiovascular health is influenced by the cumulative effects of dietary habits as they are shaped by food systems, social practices and patterns of availability, rather than by isolated dietary components; whereas approaches that abstract nutrition policy from this broader context risk oversimplifying the determinants of health and reducing the effectiveness of CVD prevention efforts;

BC. whereas a preventive health approach and the promotion of healthy habits play a fundamental role in addressing CVD and its risk factors;

BD. whereas food systems contribute to both human and planetary health;

BE. whereas ‘energy’ drinks may pose cardiovascular risks, especially to young people, due to high levels of caffeine and other stimulants, which can cause increased heart rate, elevated blood pressure and abnormal heart rhythms;

BF. whereas healthy diets have a positive impact on cardiovascular risk; whereas dietary patterns in many Member States are characterised by an excessive intake of salt, sugar and saturated fats; whereas balanced, healthy diets such as the traditional Mediterranean and

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34 World Health Organization (WHO), Guidelines on physical activity and sedentary behaviour, https://www.who.int/publications/i/item/9789240015128.

Nordic diets[35], as well as plant-based diets and certain diets based on organic food[36] are associated with significantly lower CVD risk;

BG. whereas only 12 % of Europeans eat five portions or more of fruit and vegetables daily; whereas this share is lower among lower-income groups (10,8 %) than among higher-income groups (14,8 %), indicating a social gradient in access to and affordability of healthy diets[37]; whereas independent scientific reviews have concluded that dietary patterns rich in vegetables, fruit, whole grains, berries, pulses, fish and a reasonable consumption of red and processed meats, added sugars, excess salt and processed foods are associated with lower risks of CVD, type 2 diabetes and premature mortality[38];

BH. whereas the EU is a world leader in research, including in health research; whereas structural barriers in the EU regulatory environment have led to this leadership not being adequately matched by its capacity to translate research into practical therapies; whereas cardiovascular therapies accounted for only 4 % of clinical trials started between 2017-2022; whereas the EU's scientific leadership should be harnessed to combat CVD; whereas the innovation capacity of the EU's life science sector needs to be supported and facilitated;

BI. whereas the effective and equitable use of digital health tools, AI and innovative medical technologies depends on adequate digital literacy among patients, health professionals and the wider population;

BJ. whereas rising temperatures and more frequent heatwaves are expected to have increasingly severe impacts on cardiovascular health, particularly among older people and people with chronic conditions, rare diseases and disabilities; whereas heat-related mortality represents the largest share of climate-related deaths in Europe, with cardiovascular causes accounting for a substantial proportion, and whereas the interaction between extreme heat, drought and air pollution further exacerbates cardiovascular risk;

BK. whereas occurrences such as climate change, extreme weather

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35 https://www.who.int/europe/news/item/07-05-2018-fostering-healthier-and-more-sustainable-diets-learning-from-the-mediterranean-and-new-nordic-experience.

36 https://www.thieme-connect.com/products/ejournals/abstract/10.1055/a-2747-5734?id=&lang=en.

37 https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Nutritional_habits_statistics.

38 SAPEA, Science Advice for Policy by European Academies. (2023). Towards sustainable food consumption. Berlin: SAPEA. doi:10.5281/zenodo.8031939 https://scientificadvice.eu/scientific-outputs/towards-sustainable-food-consumption-evidence-review-report/.

events, air pollution, environmental degradation, chemical exposure, security challenges and other stress factors significantly contribute to CVD risk by increasing rates of heart attacks, arrhythmias and other cardiac events and are expected to continue to influence future cardiovascular health outcomes;

Areas of action

I. Prevention

1. Reiterates the need to systematically apply a Health in All Policies approach at EU and national level; calls for health aspects to be included in impact assessments for major EU legislative initiatives which are relevant to public health; recalls that accessible, timely, affordable and good-quality healthcare is a fundamental right and part of the right to health; stresses that effective and sustainable healthcare systems should ensure equitable access to cardiovascular prevention, diagnosis, treatment and rehabilitation for everyone, irrespective of their circumstances, such as gender, income, employment status, residence status or place of living; stresses that this represents one of the most effective strategies to prevent, detect and treat CVDs; calls for the Commission and the Member States to urgently address inequalities;

2. Emphasises that effective prevention of CVDs starts in early childhood and continues throughout life and requires early and sustained action; underlines that tackling obesity at a young age is essential to lowering the risk of developing cardiovascular conditions later in life;

3. Stresses that Europe’s response to CVDs must move decisively from a predominantly acute-care approach towards a prevention-oriented and integrated approach across the life course, encompassing primary, as well as secondary and tertiary prevention; calls on the Commission to adopt a horizontal EU health prevention plan to address all risk factors for NCDs; underlines that prevention should include congenital heart disease transition pathways, pregnancy-related cardiovascular risk monitoring and age-adapted strategies for older adults; calls for a coordinated prevention approach to CVDs and their interconnected risk factors and comorbidities, including all major NCDs, given their overlapping clinical pathways; underlines the need to raise awareness about comorbidities and strengthen risk assessments;

4. Underlines that according to scientific advice, investing in effective prevention lowers healthcare costs in the long run, lessens the burden on the healthcare workforce and contributes to preventing workforce shortages;

5. Stresses that high levels of health literacy and understanding of various risk factors are essential for reducing exposure to cardiovascular risk factors across the whole population and for improving patient engagement, self-management and adherence to

treatment; calls on the Member States and the Commission to promote awareness campaigns in order to strengthen cardiovascular and health literacy across the life course, including early symptom recognition, basic life-saving skills and community-level response, recognising that empowered and informed populations are essential to reducing preventable cardiovascular deaths;

6. Encourages the Member States to put in place practical measures to support long-term adherence to treatment, including patient-centred treatment optimisation, coordinated follow-up by multidisciplinary teams and the use of validated digital tools (such as reminders and follow-up solutions);

7. Recognises that psychosocial factors and mental health conditions, including depression, chronic stress and anxiety, are increasingly relevant cardiovascular risk factors, particularly among adolescents and young adults; calls for rehabilitation policies to include psychosocial support across the life course;

8. Highlights the central role of primary care and community-based providers, including in advancing cardiovascular health literacy, with specific recognition of community pharmacists as often being among the most accessible healthcare professionals, especially in underserved regions, and hospital pharmacists in providing patient education, self-management support and adherence counselling through regular, low-threshold interactions with citizens;

9. Encourages the Member States to strengthen first aid education and rapid response capacity for medical emergencies through basic training, awareness-raising and the exchange of best practice at EU level;

10. Encourages the use of health promotion programmes, education, immunisation campaigns and labelling complemented by digital labelling and other digital tools to improve consumer information, empowerment and protection, supported by advice delivered through primary healthcare, including hospital and community pharmacies; considers that these measures should complement public health policies and a broader framework promoting healthier food environments, recognising that effective health prevention requires addressing wider socio-economic factors while empowering citizens to make informed choices;

11. Notes that viral infections, including respiratory infections, are associated with an increased cardiovascular risk; welcomes the announced Council recommendation on vaccination against respiratory infections as a preventive measure for CVDs and calls on the Commission to advance on it, in parallel with the development and implementation of national cardiovascular health plans and in consultation with national scientific experts and relevant stakeholders,

in order to ensure the timely coordination, coherence and complementarity of action at the EU and national levels; highlights that the prevention of infectious diseases can contribute to reducing the risk of CVDs; stresses the importance of targeted vaccination programmes for populations at increased cardiovascular risk;

12. Calls on the Council to adopt Council recommendations on comprehensive, evidence-based health education in schools, including cardiovascular health literacy and awareness of metabolic, behavioural, environmental and other risk factors for CVD, healthy lifestyles, including the effect of physical activity, reduction of sedentary behaviour and healthy diets, and the prevention of NCDs; calls on the Member States to implement these recommendations and make health education a core component of their national cardiovascular health plans;

13. Underlines that social determinants of health, including the marketing of different products that contribute to the development of heart diseases and interconnected NCDs, can have a negative influence on consumer choices and therefore contribute to the development of CVDs; underlines that these practices can undermine public health objectives and have a disproportionate impact on lower-income households; reiterates the need for clear consumer information about the risk associated with the different categories of marketed products; emphasises that young people and children are particularly vulnerable and deserve specific and tailored protection from targeted advertising and marketing that are inappropriate for them; calls on the Member States to take appropriate measures to reduce children's and adolescents' exposure to the advertising of products which can contribute to the development of heart diseases and interconnected NCDs, including in the digital environment; calls on the Commission to address the regulatory gaps in the marketing of these products, including user content on social media platforms, websites, game platforms and apps, and to evaluate the Audiovisual Media Services Directive[39] in that respect;

14. Stresses that health policy must be evidence-based, aligned with the best available scientific data and be free from undue influence; recognises that successful health policy and cardiovascular prevention require a whole-of-society approach; calls for transparency in decision-making processes and lobbying activities related to cardiovascular health; recalls the EU's commitments under the relevant international treaties to safeguard public health policymaking from commercial and

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39 Directive 2010/13/EU of the European Parliament and of the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive) (OJ L 95, 15.4.2010, p. 1, ELI: http://data.europa.eu/eli/dir/2010/13/oj).

vested interests; recalls that the Commission and the Member States apply conflict of interest rules and calls on the Commission and the Member States to ensure the effective management of potential conflicts of interest in expert groups, advisory bodies and policymaking processes related to cardiovascular prevention and disease;

15. Stresses that false and misleading health claims presented without adequate context and unsupported by scientific evidence, on products such as foods, e-cigarettes and other novel and emerging nicotine and tobacco products, can influence consumer choices and the effectiveness of prevention policies; recalls that existing EU legislation regulates the use of health claims about food and drinks; calls on the Member States to consider further actions to protect consumers, particularly children; calls for an improved and evidence-based regulatory framework to ensure that any communication to consumers on products that could increase cardiovascular risk factors is based on independent scientific evidence, is subject to appropriate oversight by competent public authorities, and does not mislead consumers about cardiovascular and other health risks; notes the Commission's intention to establish nutrient profiles, as a measure to eliminate misleading nutrition and health claims; calls, furthermore, for the full enforcement of the prohibition on the free distribution of tobacco products;

16. Calls for the forthcoming revision of the Unfair Commercial Practices Directive[40] to move beyond the protection of consumers' economic interests alone and explicitly incorporate the protection of consumers' health, in order to effectively address commercial practices that undermine people's health;

17. Recognises that CVDs can be work-related and work-aggravated, and that occupational exposure constitutes a preventable risk factor for cardiovascular morbidity and mortality in the EU; calls on the Commission and the Member States to improve occupational risk assessment frameworks for cardiovascular risks;

18. Stresses that effective cardiovascular prevention requires healthier social, economic and physical environments; calls for comprehensive public policies addressing nutrition, working conditions, work-life balance, transport, physical activity, education and environmental

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40 Directive 2005/29/EC of the European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No 2006/2004 of the European Parliament and of the Council ('Unfair Commercial Practices Directive') (OJ L 149, 11.6.2005, p. 22, ELI: http://data.europa.eu/eli/dir/2005/29/oj).

protection;

MODIFIABLE RISK FACTORS

Tobacco and smoking

19. Emphasises the importance of strong, evidence-based and appropriate regulatory measures to reduce access to and the affordability, consumption and appeal of different smoking devices and nicotine and tobacco products, including novel and emerging nicotine and tobacco products; notes that such measures may include, where relevant, bans on flavours, which are particularly attractive to minors and non-smokers, and limits on nicotine content, as well as the appropriate and effective excise taxation of the various products; recalls that nicotine has been shown to increase cardiovascular risk;

20. Stresses the increase in uptake by non-smokers and women of novel and emerging nicotine products; highlights that minors remain particularly vulnerable to starting to use new nicotine products such as e-cigarettes, nicotine pouches and heated tobacco products, which often come in attractive flavours and packaging; stresses the need to strengthen preventive and educational measures and to prevent minors and adolescents from accessing tobacco and nicotine products, including through effective enforcement of the ban on sales to minors, and strengthened age checks at the point of sale, including uniform rules for digital sales; calls on the Member States, in this regard, to swiftly implement the EU digital identity wallet to prevent minors from purchasing age-restricted goods;

21. Stresses that smoking cessation strategies and policies must be strictly aligned with scientific evidence and shaped in line with the independent advice of the scientific community;

22. Stresses that nicotine consumption, in conventional, novel and emerging forms, can elevate blood pressure, increase the risk of arrhythmia and contribute to endothelial dysfunction and accelerated atherosclerosis; notes that nicotine content levels and delivery methods vary across products, and that different nicotine products may therefore have differentiated risk profiles, but that all such products still present health risks;

23. Calls for all non-medicinal nicotine products, including novel and emerging tobacco and nicotine products, to be included within the scope of the Tobacco Products Directive and to be subject to appropriate rules on age limits, flavourings, nicotine content, packaging and marketing, with the aim of ensuring legal certainty and strong safeguards, in particular for young people; stresses the need for clear, comprehensive and technology-neutral definitions; calls for better alignment with the principles of the WHO Framework Convention on Tobacco Control;

24. Calls for clear and effective regulation on the advertising, promotion and sponsorship of tobacco and nicotine products, including novel and emerging tobacco and nicotine products, across all media and communication channels, including online platforms and social media, and for the introduction of measures to eliminate indirect marketing practices and reduce product appeal, particularly towards minors, with due respect for national competencies; urges for social media advertising to be explicitly included and covered in the scope of the Tobacco Advertising and Sponsorship Directive[41];

25. Welcomes the Commission's initiative to revise the legislative framework on tobacco control, first announced in Europe's Beating Cancer Plan, which is, in synergy with the EU CVD strategy, critical to achieving agreed EU objectives on tobacco control policies; calls on the Commission to present a strong, science-based revised framework as soon as possible in order to reach the goal of a tobacco-free generation with less than 5 % of the population using tobacco by 2040, as set out in Europe's Beating Cancer Plan; notes with concern that current smoking rates in Europe risk undermining this objective; stresses the need for future proposals to be supported by proper impact assessments, in line with the Better Regulation guidelines; recalls the growing awareness around reconsidering the effectiveness of cigarette filters, since they may provide a false perception of reduced harm;

26. Calls for the introduction of pre-market health impact assessments for all new tobacco and nicotine products, including heated tobacco products, e-cigarettes, and nicotine pouches, where appropriate and in accordance with EU law;

27. Calls on the Member States to effectively enforce smoke-free legislation covering all indoor public places and workplaces and to further introduce smoke-free legislation covering outdoor areas frequented by children, such as school grounds, in order to protect the population from exposure to second-hand smoke;

28. Recalls that the Commission implements rules on lobbying transparency that also apply to the tobacco industry, and that certain directorates-general have applied additional arrangements when interacting with representatives of this industry; notes that the European Ombudsman, in her decision on case OI/6/2021/KR on the transparency of the Commission's interactions with representatives of the tobacco industry, made further recommendations to ensure transparency with regard to the WHO Framework Convention on

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41 Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products (OJ L 152, 20.6.2003, p. 16, ELI: http://data.europa.eu/eli/dir/2003/33/oj).

Tobacco Control;

Harmful alcohol consumption, particularly at levels exceeding scientifically established health recommendations

29. Stresses that harmful alcohol consumption, particularly at levels exceeding scientifically established health recommendations, increases the risk of CVDs, cancer and other NCDs; underlines that it can cause a sustained increase in blood pressure, which is a major risk factor for heart attacks, strokes and other cardiovascular conditions, and is associated with an increase in both ischaemic and haemorrhagic stroke;

30. Calls on the Commission and the Member States to build on the comprehensive alcohol policy measures set out in Europe's Beating Cancer Plan, including through a review of the Directive on the harmonization of the structures of excise duties on alcohol and alcoholic beverages[42]; recalls that taxation is primarily a matter of national competence; notes that Member States may use a variety of policy measures as part of their alcohol policy, including fiscal measures, and underlines that levies, taxes and duties can serve as incentives to influence consumer behaviour;

31. Calls for awareness among consumers to be improved by providing them with better, accurate nutritional and health information on alcohol; notes the Commission's proposal in Europe's Beating Cancer Plan to introduce the mandatory indication of the list of ingredients and the nutrition declaration on labels of all alcoholic beverages;

32. Underlines the need to take a clear alcohol prevention approach and calls on the Member States to implement education and communication campaigns on the cardiovascular and other health risks associated with harmful alcohol consumption, particularly at levels exceeding scientifically established health recommendations; encourages the exchange of best practice between Member States, including on awareness-raising campaigns and appropriate support services, to reduce underage drinking and protect people from alcohol-related harm;

33. Calls for the effective regulation of alcohol advertising and sponsorship in contexts where it could reach minors;

Drugs

34. Is concerned about the rise of drug consumption in the EU, with new types of drugs being increasingly available; highlights the lack of

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42 Council Directive 92/83/EEC of 19 October 1992 on the harmonization of the structures of excise duties on alcohol and alcoholic beverages (OJ L 316, 31.10.1992, p. 21, ELI: http://data.europa.eu/eli/dir/1992/83/oj).

awareness about the adverse effects that drug consumption and addiction have on the cardiovascular system; calls for the EU and the Member States to support and deploy awareness-raising campaigns on the dangerous effects of drugs and to better train health professionals on the complex patterns of polysubstance consumption; calls for the EU and the Member States to put in place ambitious cross-cutting policies to eliminate drug consumption in Europe;

35. Underlines the need to promote public awareness campaigns on the cumulative cardiovascular risk of the simultaneous use of harmful substances;

Unhealthy diets and physical inactivity

36. Stresses that unhealthy lifestyles and poor dietary habits contribute to the development of CVDs and other NCDs; highlights the importance of promoting balanced diets and physical activity;

37. Underlines that overweight and obesity are one of the major drivers of CVDs and are recognised risk factors for several cancers, and that dietary quality is a leading driver of cardiovascular health; highlights, therefore, the need for a comprehensive food system approach across all relevant EU policies, with a view to systematically reducing obesogenic food environments and promoting healthier dietary behaviours;

38. Calls for EU measures to improve the food environment, including front-of-pack nutrition labelling in line with nutritional recommendations and the regulation of marketing practices for unhealthy foods; welcomes voluntary industry commitments but underlines that they should be complemented by more consistent and enforceable legislation; stresses that such measures should avoid having unintended impacts on foods designed to meet specific nutritional needs and takes note of the specific characteristics of products protected under EU quality labels such as the protected designation of origin (PDO) or the protected geographical indication (PGI);

39. Calls for EU measures to improve consumer awareness and access to information on the relationship between diet and health, including through educational campaigns in schools; emphasises that the promotion of a nutritionally adequate, diverse and balanced dietary pattern, encompassing a broad spectrum of nutrient categories in appropriate quantities and taking into account the cultural diversity across the EU, is a cornerstone of effective public health policy; underlines that prevention strategies should support informed consumer choices and dietary habits grounded in robust scientific evidence; further supports the launch of initiatives that encourage the consumption of natural, fresh, seasonal and local foods, enhancing short supply chains and strengthening the links between

agriculture and health; emphasises that farmers and their organisations should be involved in the delivery of such initiatives to foster connections between sustainable agriculture, nutrition and public health;

40. Calls on the Commission to ensure that the revision of the Public Procurement Directives enables public authorities to provide healthier meals, including foods produced locally and through sustainable practices; calls for the strategic use of public food procurement to improve equitable access to healthy meals in childcare facilities, schools, hospitals and other public institutions; welcomes the Joint Research Centre's technical guidance on promoting healthier options in public procurement and encourages its application by national, regional and local authorities;

41. Calls for stronger coherence between EU health objectives and EU agri-food policies to ensure that public funding supports the production and consumption of foods associated with reduced cardiovascular risk;

42. Stresses that effective prevention of CVDs, and other chronic diseases must begin early in life and follow a life-course approach; highlights the alarming rise in childhood obesity and unhealthy dietary patterns; calls for the continuation and sufficient financing of the EU school scheme for milk, fruit and vegetables; calls for healthy and accessible school meals and the introduction of minimum quality standards for school and public canteens; calls for the availability of fresh, natural and seasonal produce for these canteens to be ensured, while reducing their reliance on foods high in fat, sugar and salt; further calls for public authorities to promote and fund healthy dietary habits in all circumstances and from an early age, including sporting facilities and recreational areas;

43. Highlights that marketing practices for foods high in fat, sugar and salt may play a role in shaping children's dietary habits and therefore contribute to the onset of childhood obesity and other lifelong chronic diseases; stresses in particular the need to improve the regulation of the marketing and advertising of such products to children and adolescents across all channels, including online platforms, social media and influencer marketing and with respect to algorithmic targeting and emerging AI-enabled marketing practices; highlights the existing EU legislation in this area and welcomes ongoing initiatives, including the revision of the Audiovisual Media Services Directive, as announced in the Safe Hearts Plan, and the implementation of the Digital Services Act[43];

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43 Regulation (EU) 2022/2065 of the European Parliament and of the Council of 19 October 2022 on a Single Market For Digital Services and amending Directive 2000/31/EC (Digital Services Act) (OJ L 277, 27.10.2022, p. 1, ELI: http://data.europa.eu/eli/reg/2022/2065/oj).

44. Highlights that current diets in the EU are not in line with nutritional recommendations, with only 12 % of Europeans consuming five or more portions of fruit and vegetables daily; whereas balanced healthy diets such as traditional European dietary patterns, including the Mediterranean and Nordic[44] diets, as well as plant-based diets and certain diets based on organic food[45], are associated with significantly lower CVD risk; emphasises the importance of the daily consumption of fruits and vegetables and a reasonable consumption of red and processed meat in line with European public health recommendations; notes that fruit and vegetable consumption in forms that preserve fibre and nutritional value can support a healthy and balanced diet;

45. Underlines that there are a variety of barriers to healthy dietary choices; emphasises in particular that cross-sectoral action is necessary to create food environments where healthier foods are the easiest and most affordable choice for EU citizens, since healthier diets tend to be more expensive than less healthy ones and pricing disproportionately affects low- and middle-income segments of the population; emphasises the need to address obstacles in access to healthy and nutritious food; calls for adequate strategies that make healthier products more affordable; invites the Member States to improve the affordability and accessibility of fruits, vegetables, legumes and whole grains, including through targeted regulatory measures and by making full use of EU funding instruments;

46. Stresses that private operators should strive to enhance the nutritional quality of the products they offer for the health of consumers;

47. Welcomes the fact that the Safe Hearts Plan mentions an ongoing Commission study on the impact of the consumption of ‘ultra-processed foods’; calls on the Commission to develop and promote a clear, science-based and harmonised definition of ‘ultra-processed foods’ at EU level, with an exception for foods formulated to meet specific nutritional requirements arising from diagnosed medical conditions, allergies, severe intolerances or other pathologies, in order to support coherent nutrition policies, and strengthen evidence-based action to prevent cardiovascular and other NCDs;

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44 WHO, ‘Fostering healthier and more sustainable diets – learning from the Mediterranean and New Nordic experience’, 2018, https://www.who.int/europe/news/item/07-05-2018-fostering-healthier-and-more-sustainable-diets-learning-from-the-mediterranean-and-new-nordic-experience.

45 Dahm, J. B., ‘Geringere Inzidenz atherosklerotischer Herz-Kreislauf-Erkrankungen bei Ernährung mit Biolebensmitteln (dänische Kohortenstudie)’, 2026, https://www.thieme-connect.com/products/ejournals/abstract/10.1055/a-2747-5734?id=&lang=en.

48. Acknowledges that traditional processing techniques, such as fermentation, canning, drying and salting, have played an important role in ensuring food preservation, thereby enhancing health and safety standards and, in many cases, improving availability of agricultural products for healthier diets;

49. Calls on the Commission to assess the cardiovascular health impacts of ‘energy’ drinks and to subsequently support appropriate EU-level measures, where motivated by the assessment and scientific evidence, in particular to protect children and adolescents; calls on the Commission, where motivated by the assessment and scientific evidence, to also subsequently support and encourage Member States to consider measures regarding the availability of energy drinks in settings primarily used by minors, and supports the exchange of best practice at EU level;

50. Emphasises the importance of integrated urban and transport interventions aimed at reducing obesogenic environments, improving access to active mobility, and embedding health objectives across spatial planning, housing and infrastructure policies; highlights that urban planning, including through the provision of ample pedestrian and green spaces and safe conditions for walking and cycling, contributes directly to preventing heart diseases; calls for public investment in healthy urban environments that promote physical activity, improve air quality and reduce cardiovascular risk; calls for enhanced cross-sectoral cooperation to create supportive environments and aligned policies that encourage physical activity throughout the life course, contributing to both the prevention of CVD and effective rehabilitation;

51. Calls on the Member States to take targeted measures to promote healthier daily habits among children and young people by increasing opportunities for physical activity and reducing sedentary behaviour, as these actions help prevent key modifiable risk factors for CVDs such as physical inactivity, overweight and obesity; further stresses that education and access to reliable information on physical activity are crucial for people of all ages; calls on the Commission and the Member States to promote initiatives such as sports activities for seniors in local communities and accessible sports classes and to make sure that school curricula allow sufficient time for moving each day, in order to create an environment conducive to a healthy lifestyle;

52. Calls on the Commission and the Member States to engage the sports sector as a key setting for promoting physical activity and healthy behaviours, including through grassroots sports initiatives and by avoiding the marketing of foods high in fat, sugar and salt at sports events;

SOCIO-ECONOMIC DETERMINANTS OF HEALTH

53. Stresses that cardiovascular health is also a social issue of public concern and that the persistence of CVDs across the EU, including the contributing risk factors of diabetes and obesity, are closely linked to socio-economic determinants such as income inequality, insecure employment, housing conditions, education level, gender and environmental exposure; recalls that these determinants disproportionately affect low-income households, people with chronic, rare diseases and disabilities, workers in precarious employment, women, older persons, children and young people, and marginalised communities, generating cumulative, lifelong cardiovascular risks; calls for cardiovascular health policies to be firmly embedded within the EU's broader social, cohesion and inclusion policies and to ensure that those who are most at risk are sufficiently taken into account;

54. Stresses the need to address the socio-economic determinants of cardiovascular health at both national and EU level through the effective implementation of current EU frameworks;

55. Welcomes the Safe Hearts Plan and insists that any EU cardiovascular strategy must be integrated into the EU's social, environmental and economic policies; emphasises that poverty and job insecurity significantly increase exposure to cardiovascular risk factors, including chronic stress, unhealthy diets, physical inactivity, inadequate housing and limited access to preventive care;

56. Stresses that health policy should involve the perspectives of patients and informal carers to ensure that decision-making reflects their lived experiences and results in policies that meaningfully improve their daily lives and long-term well-being;

ENVIRONMENTAL DETERMINANTS OF HEALTH

57. Stresses that environmental determinants, including air pollution, noise pollution, pollution of soil and water, extreme temperatures and chemical exposure, in particular of populations who come in close contact with pesticides in their work or in their communities, are major preventable contributors to CVDs in the EU; highlights that these determinants are unevenly geographically distributed across and within Member States; highlights that heatwaves and other climate-related extreme events disproportionately affect older persons and people living in poorly insulated housing, thereby exacerbating cardiovascular risks and social inequalities; regrets that the Commission has not sufficiently recognised that reducing exposure to harmful environmental factors must be made a core pillar of any effective EU cardiovascular health plan and requires coordinated, cross-sectoral action beyond the health sector; emphasises that the prevention of CVD should be embedded in a One Health approach, recognising the interconnections between human, animal and environmental health;

58. Underlines that contrary to changes in lifestyle, people cannot protect their health against air or chemical pollution; calls on the Commission to put forward tangible action on these health determinants that falls within the EU's competences;

59. Recognises long-term exposure to environmental noise from road, rail and air traffic as a significant but under-addressed cardiovascular risk factor; calls for strengthened noise reduction policies in order to reduce harmful noise levels and protect health and well-being across the EU through urban planning, transport regulation and enforcement of current EU legislation; underlines that sufficient funding of nature-based solutions, which can have a positive impact on health, should be considered as part of the One Health perspective;

60. Calls on the Commission and the Member States to address the significant health risks arising from air, soil and water pollution; highlights that methane and ammonia are contributors to harmful air pollution, which is associated with reduced lung function, systemic inflammation and increased cardiovascular morbidity and mortality;

II. Early detection and diagnosis

61. Welcomes the announced Council recommendation on health checks for cardiovascular diseases; stresses that any EU guidance must be evidence-based, effective, focused on the needs of patients, healthcare professionals and carers and the problems they face, and accompanied by clear benchmarks and indicators, and must reduce inequalities and avoid low-value practices; notes that this guidance should be risk-stratified and include integrated referral pathways from primary care to follow-up secondary care for CVD and its comorbidities; highlights, furthermore, that such guidance must include recommendations on implementation, including active cross-border cooperation and quality assurance dispositions, to ensure effective coverage of at-risk populations; calls for the implementation in the Member States of the announced Council recommendation on health checks for cardiovascular diseases, while respecting their competences and emphasises the importance of promoting education and training for healthcare professionals on the early detection of CVD, with appropriate consideration of gender-specific differences;

62. Calls on the Commission to ensure adequate financial support for Member States for the implementation of the Council recommendation on health checks for cardiovascular diseases; stresses that this financial support should be appropriate for and proportional to the scale of the burden of CVDs;

63. Believes that early detection of CVDs should be pursued through an integrated, cross-disease approach that recognises interlinkages between cardiovascular and other NCDs and their shared risk

factors; points out that such broad prevention and early detection strategies addressing CVDs and other NCDs can empower patients to better understand and manage their health and can help to prevent premature mortality;

64. Is concerned about the number of misdiagnosed cardiovascular events and calls on the Member States to better train health professionals on possible symptoms, including in emergency services; underlines the importance of national healthcare systems introducing standardised protocols to better detect cardiovascular events; highlights the need for regional and local health infrastructures and hospitals to provide specialised services for cardiovascular events and to ensure that patients can get swift access to such services in order to prevent misdiagnosis and ensure adequate treatment;

65. Stresses that early prevention and detection should prioritise targeted, risk-based approaches supported by validated risk prediction models in primary care, including through screening where appropriate; emphasises the need to focus on risk factors such as tobacco consumption, harmful alcohol consumption, particularly at levels exceeding scientifically established health recommendations, obesity, insufficient physical activity, hypertension, menopause, family history and dyslipidaemia; underlines that individuals living with conditions such as chronic kidney disease, diabetes, obesity, chronic obstructive pulmonary disease, metabolic dysfunction-associated steatotic liver disease and chronic anaemia, as well as women with adverse pregnancy outcomes, should be systematically screened for CVD, while ensuring effective referral systems and long-term follow-up pathways; highlights that CVDs are often detected only after major events such as heart attack or stroke;

66. Underlines that early detection is often missed, especially in underserved and high-risk populations; calls on the Member States to ensure equitable access to diagnostics, paying particular attention to underserved areas and to women;

67. Underlines the essential role of secondary prevention for individuals who have experienced a cardiovascular event, including systematic risk-factor management, medication adherence, lifestyle and mental well-being support and regular clinical review to reduce the risk of recurrence;

68. Draws attention to the substantial underdiagnosis of inherited, genetic and congenital cardiovascular conditions in the EU, including cardiomyopathies, channelopathies, familial hypercholesterolaemia, type 1 diabetes, aortopathies, connective tissue disorders and congenital heart disease; stresses that dyslipidemias such as familial hypercholesterolemia, elevated

lipoprotein (a) and hyperglycaemia contribute substantially to cardiovascular risk; calls on the Member States to ensure equitable access to diagnostics and to support early detection of genetic conditions from the school age of children, where there is clear scientific evidence of clinical benefit, while fully respecting ethical principles, informed consent and data protection requirements; stresses that when CVDs with a genetic predisposition are detected, family/cascade screening should be provided;

69. Calls for the announced Council recommendation on health checks for CVDs to include clear guidance on comprehensive cardiovascular risk assessments and on providing health checks at an appropriate age to individuals with at least one risk factor, including those with a family history of premature CVD; also calls for clear guidance on systematic monitoring and follow-up of individuals with elevated or abnormal findings, including integrated pathways to care;

70. Stresses that persons with multiple modifiable cardiovascular risk factors should be offered comprehensive and accessible support to change their lifestyle behaviours with the assistance of appropriately trained lifestyle medicine specialists or equivalent healthcare professionals;

III. Treatment, care and rehabilitation

71. Underlines that people living with CVD must have timely and affordable access to high-quality, integrated, evidence-based and guideline-based care along the full disease care pathway, including to treatment control and adherence support, as well as appropriate diagnostics and therapies, irrespective of place of residence; recommends a possible cautious use of treat-to-target management frameworks, while avoiding low-value care and ensuring a person-centred, risk-based approach in line with WHO guidance; stresses that cardiac rehabilitation, occupational rehabilitation, integrated nutritional care, physical rehabilitation and social reintegration are integral components of effective cardiovascular care; notes that, in several Member States, access to rehabilitation services remains limited and emphasises the need to guarantee access to these services to all; stresses the need for dedicated age-appropriate rehabilitation centres;

72. Welcomes the announced Council recommendation on personalised treatment and monitoring of cardiovascular diseases, which will improve the quality and consistency of personalised and integrated care pathways;

73. Calls on the Member States to create comprehensive, standardised national cardiovascular care protocols for long-term care pathways, embedding multi-disease, multidisciplinary team models to enable proactive management of interconnected NCDs, ensure smooth care

transitions and deliver truly patient-centred care throughout the continuum of cardiovascular risk, diagnosis, treatment and rehabilitation; stresses that such pathways are essential to ensure continuity of care, reduce avoidable complications and hospital readmissions, and improve long-term outcomes for people living with CVD; stresses the need for more streamlined care pathways for reproductive and maternal health and CVD services; calls for the Member States and local and regional authorities to be supported in expanding access to multidisciplinary rehabilitation services;

74. Stresses the need for care and treatment to incorporate the latest scientific evidence; calls on the Member States to incorporate high-quality, innovative treatments into healthcare strategies and to make such treatments more accessible;

75. Calls on the Commission and the Member States to support wider deployment of and access to cardiopulmonary resuscitation (CPR) training and public awareness programmes, including for children and young people, as an essential component of strengthening CVD emergency preparedness and response; calls for strengthened EU support to improve survival following out-of-hospital cardiac arrest, including mandatory CPR and automated external defibrillator (AED) training in schools and workplaces; calls on the Member States to strengthen policies ensuring wide, visible and 24/7 accessible deployment of AEDs in public spaces and high-traffic settings and calls for the development of national AED mapping and maintenance systems and for the integration of AED location data into emergency dispatch systems;

76. Calls for the strengthening of the cross-border European transplant information system, especially for rare and congenital CVDs;

77. Calls for the creation of a European network of cardiovascular centres of excellence, including stroke and heart units, as specialised, multidisciplinary institutions, operating under the Cross-Border Healthcare Directive; stresses that these centres should act as national and regional hubs to improve access to high-quality, multidisciplinary care, reduce time to treatment and strengthen hospital capacity; emphasises their potential role in promoting common standards and best practices, facilitating access to clinical trials and optimising clinical development; highlights their potential contribution to implementing comprehensive, patient-centred care pathways and allowing for the translation of research into practice through multi-stakeholder collaboration, including public-private partnerships;

78. Emphasises the importance of integrating mental health support as a component of comprehensive physical and psychological rehabilitation for patients living with chronic cardiovascular conditions and for those recovering from serious cardiovascular

events;

79. Emphasises that uninterrupted access to safe, effective and affordable medicines and medical devices for CVDs is a prerequisite for continuity of care and favourable health outcomes; stresses that unequal access to essential cardiovascular medicines remains a major barrier to effective treatment and secondary prevention; calls for EU-level action, within the EU's existing competences, to support affordability, availability and security of supply and underlines the importance of the forthcoming Critical Medicines Act[46] in contributing to addressing those issues;

80. Stresses that delayed or absent treatment of structural heart disease significantly impairs quality of life and accelerates functional decline, frailty and loss of independence in older people; underlines that timely diagnosis and access to appropriate treatment are essential to preserve autonomy, reduce avoidable hospitalisations and support healthy and active ageing;

81. Stresses the growing threat of health workforce shortages in the Member States and underlines that the uneven distribution of general practitioners (GPs), especially in rural and disadvantaged areas, limits access to prevention and early detection of CVDs; calls for actions to improve the attractiveness of healthcare careers, which could include improved working conditions, adequate wages, training, retention measures and multidisciplinary team-based care, with strong primary care as the backbone; highlights the importance of technology and digital tools in enhancing efficiency, by reducing workload pressures and administrative burdens, and in increasing the attractiveness of healthcare careers; calls on the Commission and the Member States to enhance support mechanisms to improve retention and reverse mobility trends of cardiovascular medical personnel in areas affected by chronic shortages, including through targeted incentives and investments in working conditions, continuous training and attractive career pathways;

82. Underlines the importance of ensuring timely and equitable access to palliative care for people living with advanced CVD; calls for adequate training of healthcare professionals in the principles of palliative care in order to promote dignity, quality of life, and people-centred and gender-sensitive care throughout the life course;

83. Stresses that CVDs cause substantial disability affecting the work and quality of life of patients and their informal carers, as well as the

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46 Commission proposal of 11 March 2025 for a regulation of the European Parliament and of the Council laying a framework for strengthening the availability and security of supply of critical medicinal products as well as the availability of, and accessibility of, medicinal products of common interest, and amending Regulation (EU) 2024/795 (COM(2025)0102).

ability of patients to live independently; calls on the Member States to devise care strategies addressing workplace reintegration measures and psychosocial and peer support for patients and their families;

IV. Role of primary care and community-based services in cardiovascular prevention and risk reduction

84. Highlights the crucial role of strong integrated primary healthcare systems and community-based services, including hospital and community pharmacies, in prevention, early detection and long-term risk reduction of CVD and its interconnected risk factors, particularly in underserved rural and deprived urban areas;

85. Calls on the Commission, in cooperation with the Member States, to support targeted pilot actions in high-burden and underserved areas, bringing together primary-care-led, risk-based checks, prevention offered by community services, telemedicine support, mobile diagnostic services and clear referral and follow-up pathways, with a view to evaluating impact and enabling effective models to be scaled up across the EU;

86. Calls for strengthened collaboration between primary care and cardiovascular specialist services to optimise interventions for the effective prevention and reduction of cardiovascular risk;

87. Calls on the Member States to adequately resource primary care infrastructure, multidisciplinary teams and preventive services, including access to essential diagnostic tools and digital infrastructure supporting screening, early detection and follow-up; encourages the Member States to reduce out-of-pocket payments, where appropriate, for essential cardiovascular prevention and care services, as high levels of direct payments by patients may constitute a major barrier to access to cardiovascular prevention and treatment, particularly for low-income households; stresses that early detection and preventive care should be affordable, including for low-income households; highlights the role of primary care in supporting adherence to cardiovascular treatments;

88. Stresses that early detection and prevention largely occur at the primary care level, where GPs are often the first point of contact for patients; highlights that GPs and primary care providers play a key role in assessing lifestyle-related risk factors and in providing evidence-based guidance on the type and frequency of physical activity individuals need to maintain or improve cardiovascular and overall health;

89. Emphasises that secondary prevention is essential for individuals who have experienced a cardiovascular event; highlights that secondary prevention encompasses structured risk-factor management, ensured medication adherence, targeted lifestyle

support and regular clinical monitoring to minimise the risk of recurrence;

90. Stresses the importance of strengthening the capacity of primary care providers to carry out brief interventions as part of routine clinical practice for cardiovascular risk reduction, including through the adoption of the Five As approach (ask, assess, advise, assist, arrange), to facilitate behaviour change related to major CVD risk factors;

91. Stresses the critical need for robust intensive care capacity within any EU cardiovascular strategy to manage acute cardiovascular events, such as cardiac arrest, cardiogenic shock and acute heart failure, through embedded regional intensive care unit (ICU) networks; expresses concern regarding the acute ICU staffing shortages, which are a barrier to high-acuity cardiovascular emergency response, and calls for targeted support, including mental health support, enhanced retention strategies and specialised multidisciplinary training, to sustain front-line capacity;

92. Calls on the Member States to strengthen community-based cardiovascular and emergency response capacity, including access to life-saving equipment, coordination with primary care and emergency services, and the development of local response networks, to reduce inequalities in survival and outcomes of acute cardiovascular events;

93. Calls on the Commission and the Member States to recognise the essential role of civil society health organisations and patient organisations in CVD prevention, awareness-raising, peer support, patient empowerment and policy development; stresses that the continuity, independence and effectiveness of their work rely on adequate, sustainable and transparent public funding;

94. Calls for the role of specially trained healthcare professionals in cardiovascular prevention, early detection and selected treatment tasks to be recognised and supported, as these healthcare professionals can partly compensate for the lack of cardiologists, including in rural areas; calls for the role of voluntary and community-based psychological support for cardiovascular patients to be formally recognised and appropriately supported; recognises the important role of psychological support in helping to address certain cardiovascular risk factors and aiding recovery; emphasises the role of community-led care in tackling social exclusion, low health literacy, stigma and access barriers, which worsen the impacts of CVD on vulnerable groups;

V. Multimorbidity

95. Stresses that CVDs frequently coexist with other chronic conditions, including diabetes, obesity, chronic kidney disease, rheumatic and

musculoskeletal diseases, pulmonary conditions including lung and respiratory diseases, metabolic dysfunction-associated steatotic liver disease , skin diseases, obstructive sleep apnoea, anaemia, chronic insomnia, and mental health and reproductive health conditions, as well as cancer and cancer survivorship, which significantly increase cardiovascular risk, complicate treatment and worsen health outcomes; underlines that addressing CVD in isolation is insufficient to reduce morbidity and mortality; stresses that prevention and control of these conditions could constitute a cost-effective way to contribute to the prevention of cardiovascular health problems; recognises the importance of ensuring equitable and timely access to treatment and therapeutic innovation in the area of CVD;

96. Stresses that diabetes significantly increases morbidity, mortality and healthcare costs; underlines that fragmented policy approaches addressing CVD and diabetes in isolation risk undermining prevention, early detection and long-term management outcomes; calls on the Member States to ensure that national cardiovascular health plans include a comprehensive diabetes component, or are clearly aligned with existing national diabetes strategies; stresses that special attention must be paid to children and adolescents diagnosed with type 1 diabetes and, increasingly, type 2, who face a lifelong disease burden and an elevated risk of early cardiovascular complications and mortality; stresses that diabetes and obesity are major drivers of CVD and share common risk factors and biological mechanisms; underlines that effective prevention and management of diabetes and obesity are essential components of CVD prevention and care, including through early detection, long-term management and lifestyle support; stresses that effective obesity and CVD management can be hindered by the lack of awareness of obesity as a chronic disease or a fragmented policy approach to obesity care pathways;

97. Highlights the strong and bidirectional relationship between chronic kidney disease and CVD; stresses that kidney disease is frequently underdiagnosed in people with cardiovascular risk factors and is associated with increased cardiovascular morbidity and mortality; calls for better integration of kidney health into cardiovascular risk assessment and care pathways;

98. Stresses that chronic obstructive pulmonary disease (COPD) is a frequent and serious comorbidity in people living with CVD; stresses that COPD and CVD share major risk factors, such as tobacco use, air pollution and socio-economic disadvantage; underlines that COPD significantly increases cardiovascular morbidity, mortality and hospitalisations;

99. Highlights that aortic diseases, including aortic aneurysms and aortic dissections, are severe and often underdiagnosed cardiovascular conditions closely linked to hypertension, smoking,

genetic disorders and ageing; stresses that delayed detection of aortic disease is associated with high mortality and avoidable emergency interventions; calls for improved awareness, timely diagnosis and appropriate referral pathways for aortic disease within cardiovascular prevention, early detection and long-term care strategies;

100. Draws attention to metabolic dysfunction-associated steatotic liver disease as a highly prevalent yet under-recognised comorbidity in people living with CVD, diabetes and obesity; underlines that metabolic dysfunction-associated steatotic liver disease, particularly in the presence of liver fibrosis, is an independent predictor of myocardial infarction, stroke and heart failure, and that in people with type 2 diabetes it can increase cardiovascular risk up to fourfold;

101. Calls on the Commission to ensure that the upcoming Council recommendation on personalised treatment and monitoring of CVDs provides clear guidance to Member States on the development of integrated prevention and disease management programmes that incorporate diabetes and obesity care, including weight management, within cardiovascular prevention protocols;

102. Stresses that chronic inflammatory skin diseases, including psoriasis, atopic eczema and acne, are associated with an increased risk of cardiovascular and cerebrovascular diseases due to shared systemic inflammatory mechanisms; underlines the importance of integrating cardiovascular risk assessment into dermatology care pathways;

103. Stresses that cardiomyopathies, as a heterogeneous group of often inherited heart muscle diseases, can affect people of all ages and are a significant cause of heart failure, arrhythmias, stroke and sudden cardiac death; stresses that cardiomyopathies remain underdiagnosed and are frequently identified only after serious or life-threatening events;

104. Stresses that rare CVDs affecting children represent a major cause of morbidity; stresses that delayed diagnosis and fragmented care during childhood can lead to preventable complications, disability and premature mortality across the life course; calls on the Commission and the Member States to strengthen early detection, specialised paediatric referral pathways and seamless transition from paediatric to adult care, including through European Reference Networks;

105. Highlights the growing burden of heart failure and other chronic heart diseases linked to population ageing; stresses that early diagnosis, continuity of care and access to multidisciplinary healthcare teams are essential to improve quality of life, reduce avoidable hospitalisations and strengthen long-term disease

management;

106. Underlines that people living with CVD and coexisting chronic conditions often experience fragmented and poorly coordinated care, including immunisation services, resulting in delayed diagnosis, inconsistent treatment and avoidable complications;

107 Stresses that, to effectively tackle CVDs and related comorbidities, healthcare systems must move away from siloed approaches towards integrated prevention and care, in order to improve outcomes, optimise resource use and strengthen clinical management through EU funding, cross-country collaboration, training and the exchange of best practice;

108. Stresses the need to strengthen the competencies of healthcare professionals to help them manage CVD in the context of coexisting chronic conditions; calls on the Member States to ensure training in comprehensive risk assessment, medication management and shared decision-making for primary care providers;

109. Calls for the development of integrated, person-centred care pathways for people living with CVD and coexisting chronic conditions, ensuring coordination between primary care, specialised care and community services, and supporting continuity of care over time at Member State and EU level;

VI. Reducing inequalities

110. Stresses that the burden of cardiovascular and other major non-communicable diseases is unevenly distributed among and within Member States, resulting in persistent inequalities in morbidity, mortality and quality of life; underlines that these disparities are closely linked to socio-economic status, geography, gender, age, access to healthcare services, affordable healthy food, safe and accessible spaces for physical activity, and availability of health promotion and prevention education;

111. Calls on the Commission and the Member States, within their respective competences, to make the reduction of cardiovascular health inequalities a measurable objective of EU health policy and therefore welcomes the Commission’s flagship initiative to develop an EU cardiovascular health inequalities dashboard, modelled on the European Cancer Inequalities Registry; stresses that such a dashboard must be based on up-to-date, comparable and disaggregated data provided by Member States, and should go beyond headline health outcomes by systematically monitoring the implementation of measures addressing social and environmental determinants of health, in order to ensure accountability, evidence-based policymaking and transparent tracking of progress in reducing cardiovascular health inequalities across the EU; stresses that the data collected should also be reflected in the State of Health in the

EU reports and Country Health Profiles and be considered in the formulation of the European Semester recommendations for Member States; underlines that transparent and standardised reporting will facilitate comparison across Member States and support the EU's objective of reducing the burden of CVD;

WOMEN'S UNDERDIAGNOSIS AND THE GENDER GAP

112. Stresses that CVDs in women are frequently underdiagnosed and diagnosed too late or misdiagnosed on account of gender-specific risk factors, persistent gender bias, atypical symptom presentation and outdated diagnostic criteria, with women living with type 1 diabetes facing up to a tenfold higher risk of premature CVD at a younger age; calls for systematic training of healthcare professionals to improve understanding and recognition of gender-specific cardiovascular symptoms and to reduce diagnostic delays that increase morbidity and mortality; underlines the importance of improving the detection and management of congenital heart diseases in women and of strengthening cardiovascular screening and monitoring during pregnancy and the perinatal period in order to identify risks at an early stage;

113. Highlights that women living with diabetes and other metabolic diseases are, on average, diagnosed up to 4,5 years later than men; emphasises that this delay in diagnosis increases women's risk of cardiovascular mortality by approximately 30 %[47]; stresses that delayed diagnosis results in delayed access to timely and appropriate care, further increasing the risk of cardiovascular complications and exacerbating existing cardiovascular health inequalities among women;

114. Calls on the Commission and the Member States to integrate a gender-responsive approach into cardiovascular health policies across prevention, early detection, diagnosis, treatment and rehabilitation, including through targeted awareness campaigns on gender differences in CVDs, on the atypical symptoms that women face in cardiovascular health, and on access to cardiovascular risk assessment for women across the life course; further calls on the Commission and the Member States to institutionalise gender-specific diagnostic protocols; call for the implementation of clinical training for healthcare professionals on gender-specific differences in pathophysiology and treatment response;

115. Calls on the Commission and the Member States to integrate female-specific conditions into cardiovascular risk assessment and

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47 Ballotari, P., Ranieri, S.C., Luberto, F., Caroli, S., Greci, M. et al., 'Sex differences in cardiovascular mortality in diabetics and nondiabetic subjects: a population-based study (Italy)', *International Journal of Endocrinology*, 2015, https://doi.org/10.1155/2015/914057.

management as part of standard care for affected women; calls for the monitoring of cardiovascular risk factors exclusive to women, such as early menopause, whether natural or induced, the use of oral contraceptives, prolonged exposure to endogenous oestrogens, polycystic ovary syndrome, endometriosis, gestational diabetes, and hypertensive disorders of pregnancy, all of which should be addressed specifically; underlines that preterm births are also a risk factor for developing CVDs, as they reflect placental insufficiency and indicate endothelial dysfunction; highlights the increased cardiovascular risk in transgender women who have undergone hormone therapy; calls for the systematic integration of reproductive history and life-course factors, including age at menarche, infertility, adverse pregnancy outcomes, breastfeeding history, and the menopause transition, into cardiovascular risk assessment and management as part of standard care for women;

116. Calls on the Commission to publish gender-sensitive clinical guidelines and to introduce strengthened requirements for the inclusion of women in publicly funded cardiovascular research; calls on the Commission to include gender-disaggregated data collection, analysis and reporting mandatory in all EU-funded cardiovascular research, programmes and digital health initiatives, with a view to systematically identifying diagnostic gaps and eliminating gender bias in cardiovascular care;

117. Stresses that reproductive and maternal health are intrinsically connected to cardiovascular health and calls for a reversal in the chronic underinvestment in research on female-specific conditions, including reproductive, gynaecological and maternal health issues;

118. Stresses the urgent need to address the under-representation of women in cardiovascular research and clinical trials through the inclusion of clear strategies to improve gender parity in study design, recruitment and analysis, including gender-disaggregated reporting and adequate representation of women across all age groups and life stages; further demands that all medical device authorisations for interventional cardiology and electrophysiology be based on gender-disaggregated data; calls for adequate funding for gender-specific cardiovascular research, including research on female-specific risk factors related to pregnancy, menopause and hormonal influences; emphasises the need to expand research and prevention strategies on women’s cardiovascular symptomatology, disease progression and treatment responses, including for congenital and pregnancy-related heart conditions, in order to ensure evidence-based, gender-responsive care and to inform the development of novel health technologies;

119. Calls on the Member States to ensure the inclusion, within sexual and reproductive healthcare services, of routine screening for infectious diseases causing cardiac disorders for all women of

reproductive age, including pregnant women; stresses that such measures contribute to preventing the development of severe cardiac disease and to interrupting the vertical transmission of infections;

SOCIAL AND REGIONAL INEQUALITIES

120. Stresses that action to reduce cardiovascular and other related NCDs must explicitly address social and regional inequalities, such as disparities between urban and rural areas, including medical deserts, and disparities among vulnerable and marginalised groups, such as people living in poverty, people who have lived in areas where infectious diseases that lead to cardiovascular pathologies are endemic and people in precarious employment; calls for targeted, community-based and primary-care-led interventions, to ensure equitable access to prevention, early detection and care, including through measures that improve access to affordable healthy food, safe and accessible environments for physical activity, and targeted health and prevention education; highlights that limited health insurance coverage may prevent vulnerable groups from accessing cardiovascular prevention and treatment;

121. Stresses that solidarity between Member States is essential to addressing CVD, particularly in the context of cross-border healthcare and health workforce mobility; calls on the Member States to strengthen the effective implementation of the EU framework on cross-border healthcare, in order to enable patients to access treatments and surgical interventions in other Member States when such care cannot be provided in a timely manner in the Member State in which they live;

122. Calls for cooperation with candidate and potential candidate countries to support the development of interoperable cardiovascular and cardiac arrest surveillance systems, registries and training standards, in line with EU data protection rules and recognised European and international scientific frameworks, with a view to improving preparedness, comparability and long-term integration into EU health initiatives;

123. Calls for EU funding to be used strategically to reduce cardiovascular health inequalities, including through investment in prevention programmes, such as immunisation and healthcare screening infrastructure and health workforce capacity in disadvantaged areas, and to strengthen primary care and rehabilitation capacity, particularly in communities such as those in rural or deprived regions; stresses that reducing cardiovascular inequalities also depends on Member States' administrative capacity to design and deliver investments; calls for strengthened technical assistance, best practice exchange and better access to EU funding for areas with persistent health and infrastructure gaps;

124. Calls for the Commission to establish an EU mission on CVD prevention and inequalities, which should bring together a dedicated EU-level task force of public authorities, scientific experts, civil society and relevant industry actors, coordinated with relevant EU bodies, in order to support Member States with data, foster structured dialogue, share evidence and provide evidence-based recommendations in order to promote the development and implementation of effective and accountable measures to improve cardiovascular health and close inequality gaps;

VII. Digital health, data and AI

125. Supports the responsible use of digital tools, telemedicine, wearable devices and data-driven solutions in cardiovascular prevention, early detection, diagnosis, care and rehabilitation, where they complement face-to-face care; stresses that digitalisation should strengthen continuity of care, clinical decision-making and patient empowerment, while fully respecting patients' rights, including informed consent, privacy, data protection and equitable access to care, and must not increase fragmentation of services or shift responsibility away from healthcare systems; recognises the potential of digital tools and AI in enhancing access to care in rural or remote areas; highlights the role of accessible, affordable and user-friendly medical devices and remote monitoring tools in secondary prevention; stresses the need to enhance digital and health literacy among the population and to avoid digital exclusion, ensuring that no patient is disadvantaged by their age, socio-economic status or digital skills; highlights the potential of integrated digital health solutions, including patient-centred tools and applications, to complement prevention, monitoring and long-term management of CVDs, while safeguarding patient autonomy and choice; notes that experiences from EU-supported digital cancer care and survivorship projects can help to demonstrate synergies, scalability and patient empowerment across disease areas;

126. Calls for the Member States to consider how digital tools and AI can appropriately and safely enhance the quality of national healthcare systems; calls for EU funding measures to be leveraged, where appropriate, to support the use of such tools; stresses that the main challenge in digital and AI-based cardiovascular innovation lies not in the lack of technologies, but in the persistent gap between pilot projects and real-world implementation, as well as in ensuring their ethical use; calls on the Commission and the Member States to prioritise the careful, evidence-based integration of proven and validated digital solutions into routine care pathways, workforce training and healthcare system workflows; calls, in particular, on the Commission and the Member States to support the facilitation and uptake of portable and remote monitoring devices and AI-enabled tools in CVD prevention, early detection and management where they demonstrate clear clinical benefit and respect for patient safety

and rights; highlights that digital and innovative technologies, including AI, can enhance personalised care, improve early diagnosis, reduce health inequalities and strengthen patient-centred cardiovascular healthcare;

127. Recognises the potential contribution of modern precision medicine to combating CVD through individually tailored prevention, diagnosis and treatment, based on the unique genetic circumstances of each individual;

128. Calls on the Commission and the Member States to strengthen the digital competencies of healthcare professionals by integrating dedicated training in digital cardiology, including AI-assisted diagnostics, simulation-based learning and digital literacy programmes, into both initial medical education and continuous professional development; highlights that equipping the cardiovascular workforce with these skills is essential to ensure the safe, effective and ethical deployment of emerging digital and AI-driven tools in clinical practice;

129. Stresses that, when appropriately governed, digital tools can also support healthcare systems by enabling continuous evidence generation, quality improvement and adaptive care pathways across populations;

130. Calls for strong public governance and safeguards, as well as guidance and standards, for digital health and AI, including as regards privacy, ethical standards, human oversight, transparency, accountability, clinical evidence requirements based on real-world and representative data, clinical validation and post-market surveillance, and measures to prevent bias and undue data use;

131. Calls for accessible, secure and interoperable digital health records to support continuity of care, prevention strategies, health preparedness and surveillance; calls for the integration of these digital health records within the European Health Data Space, which should be leveraged for monitoring, quality improvement, research and innovation, with a view to ensuring common standards and equitable participation across all Member States and to enabling cross-border access, improving uptake of preventive measures and supporting evidence-based policymaking, while strictly respecting personal data protection, the meaningful informed consent of patients and transparency over data use, with effective safeguards against misuse; stresses the importance of including data on quality of care and patient-relevant outcomes and disaggregated data by age and gender in these digital health records, with specific requirements for pregnancy-related health data, to capture differences in experiences, needs and outcomes across populations;

132. Calls for improved EU-level collection and comparability of data on

CVDs and heart conditions, including data disaggregated by gender, age, socio-economic status, education, geography and other relevant characteristics; stresses that high-quality, complete and representative data are essential for effective prevention policies, equitable early detection and the development of reliable and bias-free digital and AI systems;

133. Calls for the integration of CVD surveillance and registries into national health information systems, ensuring interoperability, follow-up and linkage with relevant data on risk factors, care pathways and outcomes; stresses that registries should support not only clinical care and research, but also the monitoring of inequalities in access, quality of care and health outcomes;

134. Calls on the Commission to support the Member States, including through the European Health Data Space, EU4Health, Digital Europe and technical assistance instruments, in building the digital, governance and workforce capacities necessary for the safe, effective and equitable deployment of digital and AI-based solutions in cardiovascular health, while actively addressing digital exclusion and population-specific needs;

135. Recognises that several Member States already have well-functioning and developed registries; calls for the establishment of an EU cardiovascular health knowledge hub to accelerate the integration of existing cardiovascular registries, share best practices and support data harmonisation and accessibility;

VIII. Research and innovation

136. Notes that, despite EU investment under Horizon Europe and other programmes, CVDs and other interconnected conditions still face a persistent research and innovation gap and structural barriers that require coordinated EU-level solutions; underlines that despite the scale of CVD, EU research funding on CVD accounts for less than 5 % of total health research within Horizon Europe; calls for actions to strengthen independent cardiovascular research across the continuum, from prevention and early detection to treatment optimisation and rehabilitation; calls for research in access to long-term care, community participation and quality-of-life support for people living with the long-standing consequences of CVD; further calls for dedicated research on congenital, inherited and rare cardiovascular conditions in children, adolescents and young adults; recalls the need for digitalisation of EU health data to facilitate AI research;

137. Stresses that innovation in the area of cardiovascular therapy should be translated into clinical practice to support the EU’s goals related to prevention and care; calls for stronger support for medical technology innovation, including in mechanisms to accelerate

translation into practice, such as pilot programmes, implementation research and investment in cardiovascular research infrastructure;

138. Calls for EU research and innovation funding to better support interdisciplinary and cross-sectoral approaches, including through public-private partnerships; stresses that this research and funding should support research on the links between CVD, diabetes, obesity, metabolic dysfunction-associated steatotic liver disease, kidney disease and other comorbidities, as well as on the role of nutrition, environmental exposures, social determinants of health and gender-specific risk factors;

139. Insists that publicly funded research must deliver clear public benefit, including open access to results, affordable resulting innovations and equitable access for patients across all Member States;

140. Recognises the contributions of the life science sector to strengthening the EU’s research capacity on CVDs and its importance for European competitiveness; calls for the Member States and the Commission to work together with the EU life science sector to promote research and innovation, mobilising public and private capital to support research and development targeting CVD; emphasises that research and innovation must translate into clinical use, supporting the transition from research to commercialisation for the innovative EU life science sector and providing more effective treatments to patients;

141. Calls on the Commission and the Member States to support research, innovation, production and marketing of nutritious foods, in order to improve dietary quality and reduce the burden of CVD;

142. Calls on the Commission and the Member States to make the One Health approach (research, health data, prevention) central to CVD policy, including by strengthening cross-sectoral collaboration and monitoring across human, animal and environmental health to better prevent and reduce CVD risks linked to cumulative exposures; calls for an ambitious exposome research and innovation agenda, including through Horizon Europe, to improve evidence on cumulative exposures and their links to CVDs, and stresses that the results should be translated into prevention-oriented policymaking, aligned with zero-pollution goals, the implementation and enforcement of environmental and health standards, and the precautionary principle, as appropriate;

143. Welcomes the Commission's proposal for a European Biotech Act[48]; notes that providing for increased regulatory flexibility, simpler bureaucracy and strong intellectual property rights is essential in order to spur further research and innovation in the EU, including in the field of CVD;

144. Calls for cooperation between the Member States to be strengthened on the clinical assessment of new health technologies through the EU regulation of health technology assessment[49], especially for high-risk medical devices and implantable devices designed for treatment of CVDs;

145. Underlines that increased investment in cost-effective public health and prevention research has significant potential to reduce the incidence of CVDs, delay disease onset and prevent complications; stresses that prevention-oriented research remains structurally under-prioritised compared to therapeutic innovation, despite its high societal, economic and healthcare returns;

146. Calls on the Commission, in cooperation with Member States and relevant stakeholders, to develop a coherent EU cardiovascular research and innovation roadmap that aligns funding instruments, reduces fragmentation, targets unmet needs across the full disease continuum, and accelerates the translation of research into prevention, diagnosis, care and rehabilitation, while complementing existing initiatives such as the Innovative Health Initiative and Horizon Europe partnerships;

IX. Governance, implementation and funding

147. Calls on all Member States to develop or update national cardiovascular health plans, which should cover prevention, early detection, treatment, rehabilitation and long-term care, as well as all major risk factors, and should be aligned with the Safe Hearts Plan, EU objectives and international commitments, including the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being, and the EU Global Health Strategy; stresses that such plans should encourage structured

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48 Commission proposal of 16 December 2025 for a regulation of the European Parliament and of the Council on establishing a framework of measures for strengthening Union's biotechnology and biomanufacturing sectors particularly in the area of health and amending Regulations (EC) No 178/2002, (EC) No 1394/2007, (EU) No 536/2014, (EU) 2019/6, (EU) 2024/795 and (EU) 2024/1938 (European Biotech Act) (COM(2025)1022).

49 Regulation (EU) 2021/2282 of the European Parliament and of the Council of 15 December 2021 on health technology assessment and amending Directive 2011/24/EU (OJ L 458, 22.12.2021, p. 1, ELI: http://data.europa.eu/eli/reg/2021/2282/oj).

coordination between public authorities, healthcare providers, patient organisations and responsible private-sector partners, with clear governance, transparency and accountability mechanisms;

148. Calls on the Commission to develop guidelines, including on the identification and exchange of best practice, to support Member States in the design and implementation of effective, evidence-based measures aimed at promoting participation in preventive health services and screening programmes;

149. Calls on the Commission to support Member States in the development and implementation of national cardiovascular health plans through EU-level guidance, appropriate funding, exchange of best practice and technical assistance, and to facilitate coordination between national strategies in order to help reduce disparities in cardiovascular outcomes across the EU;

150. Calls for the Commission to develop a Safe Hearts Plan implementation roadmap, based on clear and strong political commitment, supporting innovation and flagship initiatives throughout the Member States and at EU level;

151. Stresses that effective CVD prevention, preparedness, care and research require adequate, dedicated, stable and long-term EU public funding from all relevant EU programmes; underlines that cardiovascular health is a public good and that adequate funding should allow prevention, preparedness and equity to be strengthened across the EU, including support to reduce access barriers to diagnosis, affordable medicines, medical interventions and treatment; calls for EU funding, data collection and research to include a gender dimension, including targeted support for innovation addressing women’s specific cardiovascular risks and care pathways;

152. Calls on the Commission to set clear and comprehensive targets, indicators and milestones for cardiovascular risk reduction and control, including for the effective management of major risk factors and comorbidities; calls for transparent monitoring and regular public reporting, including on equity objectives and targeted measures for high-risk and underserved groups, and calls for clear targets for reducing mortality from CVDs;

153. Emphasises that national cardiovascular health plans should explicitly address health inequalities by incorporating equity objectives and targeted actions for populations at higher risk;

154. Calls on the Commission to include data on cardiovascular health, its determinants and public attitudes in Eurobarometer surveys and statistics;

155. Calls for evaluation and accountability; in that respect, commits to

undertaking an implementation study assessing the progress, coherence and effectiveness of the Safe Hearts Plan across the Member States, paying particular attention to prevention, equal access, early detection and action on the social and environmental determinants of health; calls on the Commission, in parallel, to present an evaluation report on the implementation of the EU cardiovascular health plan no later than four years after its adoption, assessing progress against stated objectives, identifying gaps and barriers to implementation and proposing solutions where necessary, in order to ensure accountability, transparency and continuous improvement; calls on the Commission to continuously monitor the situation and present regular evaluation reports after the first report;

X. International dimension

156. Stresses that the EU's role in global action on CVDs and NCDs should be consistent with the EU Global Health Strategy and the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being; underlines that this should support the strengthening of CVD prevention, preparedness and care systems, with a view to enhancing resilience;

157. Stresses that the EU's role in global action should also include strengthened cooperation with candidate and potential candidate countries, to support the strengthening of CVD prevention, preparedness and care systems, with a view to enhancing resilience and facilitating gradual alignment with EU objectives and standards; highlights that such cooperation could include participation in EU health programmes, cross-border projects and technical assistance aimed at strengthening healthcare systems and reducing cardiovascular mortality;

158. Stresses that CVD mortality is a key driver of premature mortality from NCDs globally and that reducing cardiovascular mortality is essential to achieving SDG 3.4 by 2030; underlines the EU's commitment, in line with its external action objectives, to contribute actively to global efforts to reduce the burden of CVDs through prevention, early detection and healthcare system strengthening; calls, therefore, for internal and external policy alignment, including the consideration of populations in low- and middle-income countries in research activities to tackle CVD and related risk factors such as adverse pregnancy outcomes, given the high burden of maternal morbidity;

159. Calls for the alignment of EU action on cardiovascular health with international frameworks and commitments, including strategies and action plans developed by the WHO, in order to promote policy

coherence, comparability of data, mutual learning and the exchange of best practice between the EU, neighbouring countries and global partners; further encourages the Commission and the Member States to strengthen cooperation with relevant international organisations and partners to support CVD prevention, surveillance, research collaboration and healthcare system resilience globally;

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160. Instructs its President to forward this resolution to the Council, the Commission and the governments and parliaments of the Member States.