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NOTE

From:	General Secretariat of the Council
To:	Council
Subject:	COUNCIL RECOMMENDATION on cardiovascular health checks: an EU approach to early detection and screening *- Adoption*

1. On 28 September 2026, the European Commission submitted to the Council a proposal for a Council Recommendation on cardiovascular health checks: an EU approach to early detection and screening[1], based on Article 168(6) TFEU.

2. The proposal includes a series of recommendations for the preparation, implementation and evaluation of cardiovascular health checks by Member States.

3. The Working Party on Public Health examined the proposal at its meetings on 5, 14 and 30 October, and 9 November 2026.

4. Following an informal written consultation concluded on 17 November 2026, the Working Party on Public Health agreed on the Presidency compromise text for the Recommendation[2].

5. On 25 November 2026, the Permanent Representatives Committee (Part I) confirmed the agreement reached in the Working Party on Public Health and agreed to submit the corresponding text[3] to the EPSCO Council of 8 December 2026 for adoption.

[1] 13701/26 +ADD1
[2] 15270/1/26 REV 1
[3] 15504/26

6. The Council is invited:

   - to adopt, at its session on 8 December 2026, the Council Recommendation on cardiovascular health checks: an EU approach to early detection and screening, as set out in the Annex to this note, and

   - to enter into the minutes of the Council the statements in the addendum to this note.

7. After the Recommendation has been adopted, it will be published in the Official Journal of the European Union.

ANNEX

Proposal for a

COUNCIL RECOMMENDATION

on cardiovascular health checks: an EU approach to early detection and screening

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty on the Functioning of the European Union, and in particular Article 168(6) thereof,

Having regard to the proposal from the European Commission,

Whereas:

(1) Article 168 of the Treaty on the Functioning of the European Union, requires that a high level of human health protection be ensured in the definition and implementation of all Union policies and activities. It establishes the Union's role in complementing national policies, encouraging cooperation between Member States, and promoting the coordination of health-related initiatives, while respecting national responsibilities for the organisation and delivery of health services.

(2) Cardiovascular diseases are the leading cause of death and disability in the Union[1]. They claim 1.7 million lives every year and affect around 62 million people, and their economic costs exceed EUR 282 billion per year[2].

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1 OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en.

2 OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en.

(3) The 2024 Council Conclusions on cardiovascular health[3] invited the Member States to scale up secondary prevention through evidence-based cardiovascular health checks.

(4) On 16 December 2025, the Commission adopted a Communication on an EU cardiovascular health plan: the Safe Hearts Plan[4], which aims to support Member States in reducing the burden of cardiovascular diseases.

(5) Cardiovascular health checks support the early detection of cardiovascular risk factors, such as high blood pressure, high cholesterol, diabetes and obesity, which together with appropriate patient-centred follow-up care, including diagnosis and treatment, can reduce cardiovascular events, such as heart attacks and stroke.

(6) Primordial and primary prevention efforts such as reducing nutritional risk factors, implementing comprehensive interventions to combat and prevent alcohol-related harm, reducing the use of tobacco and nicotine-containing products, reducing exposure to second hand smoke and aerosols, promoting physical activity and good mental health and addressing environmental determinants, can mitigate major determinants of cardiovascular disease risk, thereby playing a key role in reducing the burden, morbidity and mortality of these diseases.

(7) This Recommendation aims to support Member States in their progress towards achieving target 3.4 of the Sustainable Development Goals, to reduce premature mortality from non-communicable diseases by one-third and promote mental health and well-being by 2030.

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3 Conclusions on the improvement of cardiovascular health in the European Union, General Secretariat of the Council, 14 November 2024. Available at: Consilium.

4 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on an EU cardiovascular health plan: the Safe Hearts Plan, COM(2025) 1024 final, 16.12.2025. Available on: EUR-Lex.

(8) This Recommendation aims to contribute to the 2025 European Commission Communication on an EU cardiovascular health plan: the Safe Hearts Plan and takes note of the specific targets presented in the Commission Communication:

(a) to reduce premature cardiovascular mortality by 25%;

(b) at least 75% of people aged 25 to 64, and at least 90% of people aged 65 and older, have their blood pressure measured once a year by a health professional;

(c) at least 65% of people aged 25 to 64, and at least 80% of people aged 65 and older, have their cholesterol measured once a year by a health professional;

(d) at least 65% of people aged 25 to 64, and at least 80% of people aged 65 and older, have their blood sugar measured once a year by a health professional.

(9) It aims to support Member States in setting up cardiovascular health checks to improve the early detection and diagnosis of cardiovascular diseases through timely detection and management of risk factors, while allowing adaptation to national and regional needs and context, and respecting the diversity of healthcare systems, including their financing.

(10) Cardiovascular health checks are available in fewer than half of the Member States and vary significantly in their approach[5], in that some offer dedicated national programmes, whereas others integrate cardiovascular risk assessment across the life course through primary care and community-based services.

(11) Cardiovascular health inequalities persist between and within Member States[6], and enhancing access to cardiovascular health checks can contribute to reducing inequalities across the patient pathway.

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5 OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en.

6 OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en.

(12) Evidence shows the effectiveness of population-level interventions which focus on population groups at a higher risk, such as those with type 2 diabetes, in the early detection of cardiovascular diseases. Targeting individuals at a higher risk can improve the effectiveness and efficiency of cardiovascular health checks by increasing the likelihood of preventing avoidable cardiovascular events.

(13) In line with guidance from the World Health Organization (WHO)[7], Member States should target those individuals who may be at a higher risk due to age or a risk factor as entry points for cardiovascular risk assessment.

(14) Cardiovascular diseases develop gradually over the life course. A life-course approach should support prevention, early identification of risk factors and health promotion across different stages of life. As an individual's risk of cardiovascular disease increases with age, cardiovascular health checks should be adapted according to age to ensure their effectiveness in the timely detection of risk factors. The Expert Task Force of the European Society of Cardiology[8] recommends specific cardiometabolic health checks to detect risk early in adults under 35 years of age, in those aged 35 to 64 years and for older adults (over 65 years). Member States may consider offering personalised health checks for adults under 35 years of age in the case of existing risk factors.

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7 Jørgensen, T., Rotar, O., Juhl, C. B. and Linneberg, A., *What is the effectiveness of systematic population-level screening programmes for reducing the burden of cardiovascular diseases?* 2nd edition, WHO Health Evidence Network Synthesis Report No. 78, WHO Regional Office for Europe, Copenhagen, 2024, ISBN 978-92-890-6088-2, https://www.who.int/europe/publications/i/item/978-92-890-6088-2.

8 European Society of Cardiology, "Recommendations for EU-wide cardiometabolic health checks", ESC Newsroom, 15 January 2026, accessed 10 July 2026, https://www.escardio.org/news/news-room/recommendations-for-eu-wide-cardiometabolic-health-checks.

(15) The cost-effectiveness of cardiovascular health checks depends on several factors, such as the prevalence and incidence of cardiovascular diseases and their risk factors, the characteristics of the target population, healthcare system context and implementation approach for cardiovascular health checks. New evidence is emerging on the cost-effectiveness of cardiovascular health checks from the implementation of pilot projects in the Member States[9] and modelling estimates by the OECD[10]. Existing analyses[11],[12]indicate that targeted approaches focusing on individuals at a higher risk[13] present more favourable cost-effectiveness profiles than systematic population-level health checks.

(16) Cardiovascular health check approaches must be evidence based. The implementation of cardiovascular health checks should, therefore, be accompanied by continuous assessment of their quality, applicability and cost-effectiveness, where supported by available evidence and in line with national or regional priorities. Emerging scientific developments, including digitally enabled and artificial intelligence-based tools, where clinically validated and used under appropriate human oversight and-avoiding gender and other bias, may contribute to the development of new approaches for cardiovascular health checks.

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9 Joint Action on Cardiovascular Diseases and Diabetes (JACARDI), EU4Health Joint Action (Grant Agreement No 101126953), 1 November 2023–31 October 2027, European Health and Digital Executive Agency (HaDEA). Available at: https://jacardi.eu/.

10 EU4Health 2025 work programme: CR/CV&NCD-CA-25-89 Investing in health promotion and disease prevention across the lifespan.

11 OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en.

12 Zanfina Ademi, Sheridan E. Rodda, Karl Vivoda, Susan Hennessy, Olive Fenton and James S. Ware on behalf of Global Heart Hub Manifesto, published in *PharmacoEconomics*, volume 43, issue 11, pages 1281–1292 (2025), https://link.springer.com/article/10.1007/s40273-025-01537-5.

13 Jørgensen, T., Rotar, O., Juhl, C. B. and Linneberg, A., *What is the effectiveness of systematic population-level screening programmes for reducing the burden of cardiovascular diseases?* 2nd edition, WHO Health Evidence Network Synthesis Report No. 78, WHO Regional Office for Europe, Copenhagen, 2024, ISBN 978-92-890-6088-2, https://www.who.int/europe/publications/i/item/978-92-890-6088-2.

(17) Cardiovascular health checks should involve the systematic application of tests and assessments within a defined target population, with the aim of detecting risk factors in the target population to facilitate their management, before symptoms appear or are detected.

(18) There are various approaches for identifying the target population to be invited for cardiovascular health checks. Eligible population groups may be identified using relevant epidemiological and healthcare data sources, including health examination surveys, disease registries and, where appropriate, healthcare records in compliance with applicable national and Union legislation, including data protection rules. Such a risk-based approach is consistent with the principles of the Joint Action on cardiovascular diseases and diabetes (JACARDI). JACARDI provides an overview of such approaches, which supports the identification of population groups at a higher risk for the prevention, early detection, and management of cardiovascular diseases, diabetes, and other cardiometabolic risk factors.[14]

(19) Ensuring that cardiovascular health checks are acceptable to the target population is important to enable their safe, affordable, efficient and effective implementation. Higher acceptability for individuals, including through integration of cardiovascular health checks into overall health checks, appropriate targeting and clear communication, supports the uptake of a cardiovascular health check and strengthens its overall effectiveness.

(20) Health literacy and awareness of their risk for cardiovascular diseases should be improved, in particular among vulnerable groups and those at a higher risk, with for example, community engagement, and culturally appropriate communication supported by training of healthcare professionals, because such literacy and awareness help to ensure participation and improve uptake of cardiovascular health checks.

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14 Leysen, W., Cardinale, A., Alexandra, C., Lampaert, A., Formenti, B., Armocida, B., et al., *Short Guide for Screening Individuals at Increased Risk of Developing Cardiovascular Diseases and Type 2 Diabetes*, Version 1.0.0, Zenodo, 2026, https://doi.org/10.5281/zenodo.18415472.

(21) To effectively reduce the burden of cardiovascular diseases, cardiovascular health checks should be linked to appropriate and personalised diagnostic testing and follow-up care including evidence based primary prevention and lifestyle intervention through an integrated, patient-centred care pathway.

(22) Access to existing electronic health data in the context of an individual's cardiovascular health check can help improve its quality and continuity. The European Health Data Space[15] (EHDS) establishes a framework for the secure access and exchange of priority categories of electronic health data, including data on medication, problems, procedures and medical test results, which may contain information relevant for cardiovascular risk assessment and follow-up care.

(23) Sex- and gender-specific risk differences should be considered in the design and implementation of cardiovascular health checks, as men generally develop cardiovascular diseases earlier in life, and women's risk is affected by life events, such as pregnancy related conditions and menopause.

(24) To ensure the effectiveness of cardiovascular health checks and to reduce health inequalities, due account should be taken of the specific needs of vulnerable population groups, such as older people, socio-economically disadvantaged or marginalised groups and difficult-to-reach persons, as they are more likely to face barriers to participation and lower access to prevention and care.

(25) Primary care can be used for the delivery of cardiovascular health checks and to help individuals identified as being at higher risk to reduce their risk through personalised prevention and management of risk factors. Additionally, community-based cardiovascular health checks led by healthcare professionals, for example using mobile delivery models, can help to identify previously undetected cardiovascular risk in populations who may not otherwise have access to preventive services and follow-up care.

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15 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, OJ L, 2025/327, 5.3.2025, ELI: http://data.europa.eu/eli/reg/2025/327/oj.

(26) Broader campaigns, incorporating dedicated screening events, that bring cardiovascular health checks closer to people at higher risk could improve early detection rates, in particular in remote, rural or underserved areas.

(27) Personalised prevention should include preventive services and promotion of health behaviours including relevant vaccination, such as for influenza, which can contribute to reducing cardiovascular risks and complications.

(28) The effective implementation of cardiovascular health checks should ensure a sufficiently trained and adequately resourced health workforce, to carry out the health checks, provide information for informed consent, assess the risk profile of the individual and provide personalised support and care through a multidisciplinary and patient-centred approach.

(29) The effective implementation, monitoring and evaluation of cardiovascular health checks should be supported by appropriate and proportionate data arrangements and digital tools, including for the identification of eligible population groups, the recording of checks performed, and their outcomes. Where those arrangements involve electronic health data, Regulation (EU) 2025/327 on the EHDS provides the relevant Union framework for the secure and interoperable use and exchange of such data.

(30) The availability and use of data from relevant sources, including disease and mortality registries, data generated through cardiovascular health checks and, where appropriate, genomic and other relevant omics data, can contribute to more effective cardiovascular health checks. The secondary use of such data can support research, innovation and policy-making in cardiovascular care, in particular by improving the understanding of risk factors and higher-risk population groups, informing prevention priorities, and supporting the design and evaluation of prevention strategies. The EHDS facilitates such secondary use by establishing a common Union framework for the secure and trustworthy use of electronic health data for secondary purposes across the Union.

(31) Emerging data-driven and AI-supported risk assessment approaches may further improve the identification of individuals at a higher risk, provided that such approaches are clinically validated, deployed and are used under appropriate human oversight in accordance with applicable Union regulatory frameworks.

(32) Ethical, legal, social, medical, organisational, socio-economic, gender equality, and healthcare capacity and resource aspects should be considered before decisions can be made on the design and implementation of cardiovascular health checks.

(33) Effective design and implementation of cardiovascular health checks should entail appropriate governance by the relevant responsible authorities or healthcare providers, including multidisciplinary involvement, collaboration among relevant stakeholders at national and regional level, and the consideration of patient perspectives, to ensure quality and acceptability.

(34) A quality assurance framework should ensure the effective roll-out and monitoring of cardiovascular health checks.

(35) This Recommendation respects the responsibility of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.

HAS ADOPTED THIS RECOMMENDATION:

Objective

(1) This Recommendation aims to support Member States in reducing premature cardiovascular mortality and morbidity, thus contributing to the objectives of the Commission Communication on the Safe Hearts Plan.

HEREBY RECOMMENDS MEMBER STATES:

Design and implementation of cardiovascular health checks

Taking into account national and regional needs, contexts and existing health checks strategies while respecting the diversity of healthcare systems in the design and implementation of cardiovascular health checks,

(2) to design and implement accessible cardiovascular health checks for identified population groups at higher risk taking into consideration disease burden and the healthcare resources available, including the healthcare workforce and the basic principles of safety, ethics, public engagement and equity;

(3) to pay due consideration to inequalities in the determination of population groups at higher risks of cardiovascular diseases, based on individual biological and behavioural risk factors, as well as on socio-economic, occupational and environmental determinants of health;

(4) to base the cardiovascular health checks on the latest, robust scientific evidence, including demonstrated effectiveness and cost effectiveness, where available, while assessing and taking decisions at the national or regional level depending on the disease burden and the healthcare resources available, including the healthcare workforce.

(5) to designate a governance structure at the appropiate levels and by relevant responsible authorities or healthcare providers for decision-making on the design and implementation of cardiovascular health checks, including assessing and adapting the health checks based on outcomes, ensuring a multi-disciplinary approach and including relevant stakeholders such as patient representatives;

(6) to integrate sex- and gender-specific considerations in the design and implementation of cardiovascular health checks and also in risk assessment, personalised prevention and follow-up, taking into account that cardiovascular risk may manifest differently in women and men and that some combined risk factors affecting women may warrant earlier risk assessment and preventive interventions;

(7) to recognise the needs of vulnerable groups, such as migrants, socio-economically disadvantaged groups, those living in rural areas, and those living with disabilities or relevant co-morbidities in the design and implementation of cardiovascular health checks and cardiovascular health education, prevention and management;

(8) to advance equitable access to cardiovascular health checks, for instance through broader campaigns which support such checks in accessible primary care and community settings, and to consider mobile delivery models, in community or local settings, to bring them directly to people and improve early detection rates, in particular in rural or underserved areas;

(9) to ensure acceptability of cardiovascular health checks, prevention and follow up to the target population, including through clear and culturally-appropriate communication, health literacy and promotion, awareness-raising activities, community based interventions and adaptation of delivery models to their needs including sex-and gender-sensitive approaches;

(10) to consider the use of innovative technological solutions, including data-driven and AI-based tools, to support risk assessment and cardiovascular health checks, provided that such tools are evidence-based, clinically validated, safe and used under appropriate human oversight and implemented in accordance with applicable national and Union law;

(11) to ensure availability and accessibility of referral pathways for appropriate follow-up assessment, monitoring and care of individuals at a higher risk through an integrated, patient-centred preventive and care pathway;

(12) to promote where relevant a personalised prevention approach in managing individuals at higher risk through evidence-based lifestyle interventions, complemented by treatment and regular follow-up health checks to adjust interventions through a patient-centred approach;

(13) to consider recommendations for vaccination, where appropriate and deemed clinically relevant, within the personalised prevention approach;

(14) to consider the recommended elements of cardiovascular health checks provided in the Annex;

Registration and management of data from cardiovascular health checks

(15) to use appropriate arrangements and digital tools, in accordance with applicable Union and national law, including Regulation (EU) 2025/327 on the EHDS where relevant, to support the implementation and recording and exchange of data on cardiovascular health checks performed and the outcomes, including the identification of eligible population groups;

(16) to take appropriate and proportionate measures to ensure that persons eligible for cardiovascular health checks are informed about and invited to participate in the health checks;

(17) to ensure accessible and easy-to-read information about health checks for persons with disabilities while taking account of the different needs of such persons;

(18) to collect, manage and evaluate where appropriate, and in accordance with existing national systems, strategies and arrangements, relevant data relating to tests, assessments and diagnoses, where applicable, in the context of cardiovascular health checks;

(19) to take into account, where applicable and in accordance with Union law, including Regulation (EU) 2025/327 on the EHDS, the potential of relevant electronic health data generated through cardiovascular health checks and collected through existing data systems to support research, innovation and policy-making purposes, including the development and evaluation of prevention and early detection strategies;

Monitoring and evaluation

(20) to regularly monitor the process and outcome of cardiovascular health checks where feasible;

(21) to evaluate the effectiveness, cost-efficiency, resource utilisation, population engagement and participant outcomes of cardiovascular health checks; taking into account relevant governance structures for existing health checks or cardiovascular health strategies, including evaluation proccesses;

Training and capacity building

(22) to make use of existing and invest in further training programmes for healthcare professionals, as appropriate, to enhance skills in conducting cardiovascular health checks and engaging patients effectively including health promotion counselling and patient education;

Participation

(23) to enhance participation of populations at higher risk in cardiovascular health checks and follow-up care, based on fully informed consent, when cardiovascular health checks are offered;

(24) to consider appropriate measures to encourage participation of the populations at higher risk in cardiovascular health checks and follow up, for example, the possibility to take part in a personalised prevention programme or community based interventions;

Awareness: community engagement and collaboration

(25) to encourage collaboration and engagement among stakeholders, such as research institutions, patient organisations, civil society organisations, public health and professionals' organisations and clinical bodies, at national and international level to maximise resources and foster cross-border collaboration between relevant stakeholders with due consideration for the prevention and management of conflict of interest;

(26) to improve public awareness and citizen engagement in cardiovascular health checks, including through awareness campaigns and improved lifelong health literacy as appropriate.

Implementation report and follow-up

(27) to report to the Commission, where applicable in the context of already existing obligations, on the implementation of this Recommendation within three years of its adoption and, subsequently, every four years to help monitor the implementation of this Recommendation in the Union. The reporting should be done without imposing additional reporting burden on the Member States and their healthcare systems.

Done at Brussels,

For the Council
The President

ANNEX

Recommended elements of cardiovascular health checks

Member States are invited to design and implement cardiovascular health checks that include the systematic application of assessments including tests within a defined target population for the early detection of cardiovascular risk factors. The definition of the target population eligible for a cardiovascular health check, including the age group and risk profiles, depends on the national or regional context, including cardiovascular disease epidemiology, health inequalities, gender differences and existing national strategies and plans where appropriate.

The WHO recommends, in its assessment of the available evidence[16], targeting those individuals in primary care who may be at a higher risk for cardiovascular diseases, because of their age or the presence of a risk factor. The WHO HEARTS technical package[17] that includes risk prediction charts, takes a similar approach by using risk factors as entry points in primary health care settings for cardiovascular risk assessment.

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16 Jørgensen, T., Rotar, O., Juhl, C. B. and Linneberg, A., *What is the effectiveness of systematic population-level screening programmes for reducing the burden of cardiovascular diseases?* 2nd edition, WHO Health Evidence Network Synthesis Report No. 78, WHO Regional Office for Europe, Copenhagen, 2024, ISBN 978-92-890-6088-2, https://www.who.int/europe/publications/i/item/978-92-890-6088-2.

17 World Health Organization, *HEARTS: technical package for cardiovascular disease management in primary health care – Risk based CVD management*, World Health Organization, Geneva, 2020, ISBN 978-92-4-000136-7, https://www.who.int/publications/i/item/9789240001367.

The Joint Action JACARDI[18] provides practical recommendations for the design and implementation of a cardiovascular health check, including an overview of approaches to identify the target population to be invited for a health check, choice of cardiovascular risk assessment tool and frequency of follow-up of a health check[19].

Health data collected through existing data sources, such as the European Health Interview Survey (EHIS)[20], health examination surveys and other relevant sources, (in compliance with applicable national and Union legislation, including data protection rules) can guide the selection of the target population in which a cardiovascular health check can provide a significant impact. Cardiovascular risk assessment tools, such as the WHO cardiovascular risk prediction charts[21], SCORE2[22] and other nationally validated tools may be used during a cardiovascular health check, to estimate the probability of an individual suffering a cardiovascular event over a period of time. The choice of a cardiovascular risk assessment tool should be carefully considered based on the specificities of available tools, the latest evidence and the country or region's characteristics. It should also depend on the target group identified.

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18 Joint Action on Cardiovascular Diseases and Diabetes (JACARDI), EU4Health Joint Action (Grant Agreement No 101126953), 1 November 2023–31 October 2027, European Health and Digital Executive Agency (HaDEA), available at: https://jacardi.eu/.

19 Leysen, W., Cardinale, A., Alexandra, C., Lampaert, A., Formenti, B., Armocida, B., et al., *Short Guide for Screening Individuals at Increased Risk of Developing Cardiovascular Diseases and Type 2 Diabetes*, Version 1.0.0, Zenodo, 2026, https://doi.org/10.5281/zenodo.18415472.

20 Information on EHIS can be found in the dedicated section about health on Eurostat's website: Overview - Health - Eurostat.

21 World Health Organization, 'WHO updates Cardiovascular Risk Charts', WHO website, 2 September 2019, accessed 10 July 2026. https://www.who.int/news/item/02-09-2019-who-updates-cardiovascular-risk-charts.

22 SCORE2 working group and ESC Cardiovascular risk collaboration, 'SCORE2 risk prediction algorithms: new models to estimate 10-year risk of cardiovascular disease in Europe', *European Heart Journal*, Vol. 42, Issue 25, 2021, pp. 2439–2454, https://doi.org/10.1093/eurheartj/ehab309.

The frequency of follow-up for a cardiovascular health check should be based on individual cardiovascular risk and should be decided based on the local and national context and follow national guidelines and strategies, as relevant. Opportunistic health checks could also be offered through broader campaigns (e.g. screening days), and when individuals come into contact with the healthcare system (e.g. primary care).

Member States are invited to consider the following cardiovascular health checks in order to achieve the objectives of this Council Recommendation.

Adults under 35 years

Individuals under 35 years should be offered at least one cardiovascular health check based on individual needs and risk factors , including assessment of health behaviours (for example diet, physical activity, smoking, vaping and using smokeless nicotine products and consumption of alcohol), measurement of biological risk factors (including blood pressure), glucose, kidney function tests, body mass index, respiratory function[23] in the case of shortness of breath, mental health status and reproductive history, if needed. In individuals with a family history of premature cardiovascular disease or sudden cardiac death, risk assessment and further evaluation should be individualised according to clinical context.

[23] European Respiratory Society and European Lung Foundation, 'Safe hearts require safe lungs: ERS and ELF response to the European Commission's proposal for Council Recommendations on health checks for cardiovascular diseases', position paper submitted in response to the European Commission call for evidence, 2026. Available here: https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/17812-Cardiovascular-diseases-health-checks/F33401934_en

Adults aged 35 to 64 years

Systematic cardiovascular health checks are recommended for this age group, carried out at minimum every 5 years, adapting the frequency according to individual or local risk profiles based on family history and other risk factors.

The cardiovascular health check could include, based on healthcare professionals' assessment, the following elements:

Medical history, including family history of premature cardiovascular disease, reproductive health status and mental health, diet, physical activity, respiratory function, smoking, vaping and using smokeless nicotine products and consumption of alcohol;

Measurement of cardiovascular risk factors, including blood pressure, lipid profile (total cholesterol, LDL, HDL, triglycerides), and lipoprotein(a) (one measurement in adulthood), fasting plasma glucose and glycated haemoglobin (HbA1c);

Kidney health, including serum creatinine and albuminuria measurement;

Electrocardiogram (ECG), as needed;

Body mass index and waist circumference or waist-to-height ratio.

Adults 65 and older

A cardiovascular health check as outlined above is recommended every 3-5 years, pulse assessment to detect or exclude atrial fibrillation (heart rate and rhythm), cardio-pulmonary auscultation and evaluation of peripheral artery disease. Where clinically indicated, this may also include an ECG and natriuretic peptide testing (NT-proBNP).

Further considerations

Member States may consider relevant inherited or genetically influenced cardiovascular risk factors and conditions, including elevated Lp(a), Familial Hypercholesterolaemia and type 1 diabetes, tailored to the national situation.