

EuroHealthNet – Response to the consultation on ‘Cardiovascular diseases – health checks’

May 2026

EuroHealthNet welcomes this initiative and strongly supports the goal of reducing cardiovascular premature mortality by 25% by 2035. The Call for Evidence rightly acknowledges that significant inequalities exist between countries, regions, and population groups, that socioeconomically disadvantaged groups face higher cardiovascular risk and poorer outcomes, and that women are at higher risk of misdiagnosis. EuroHealthNet's response focuses on ensuring these acknowledged inequalities are addressed through deliberate design choices across the full screening pathway. Without this, cardiovascular health checks risk primarily reaching people already connected to care, widening the very gaps the initiative aims to close.

EuroHealthNet calls for:

1. Embedding equity across the full screening pathway

Health equity must guide every stage of the screening pathway: outreach, screening, risk assessment, referral, follow-up, and long-term preventive care. The people who are most likely to benefit from early detection are often those least likely to be reached by standard approaches. This includes people in lower socioeconomic groups, migrants, people facing language barriers, those without a regular general practitioner, people living in medical deserts, people with disabilities, people with severe mental illness, and isolated older adults. Equity must therefore be built into the design of screening pathways from the outset, rather than addressed later as an add-on or in separate targeted sections of the Recommendation.

2. Making screening gender-responsive

Screening protocols and risk assessment tools must be validated for women, and data should be systematically disaggregated by sex and gender. Women remain under-screened, under-diagnosed, and under-treated for cardiovascular disease, partly because many risk prediction tools and diagnostic criteria have historically been developed predominantly on male populations. This gap should be explicitly addressed in the Recommendation.

3. Requiring active outreach to those with the highest unmet need

The Recommendation must go beyond applying risk algorithms to people who are already visible within health systems. It should require active outreach to those least likely to present for a standard health check. This includes mobile and community-based screening

in workplaces, pharmacies, and community settings, as well as partnerships with trusted community intermediaries who can help reach people facing barriers to access.

4. Treating digital inclusion as a structural challenge, not only as a literacy problem

Digital inclusion must be treated as a structural challenge, not simply as a matter of individual digital literacy. Non-digital alternatives should be available at every stage of the screening pathway, including human support when communicating risk results, accessible and multilingual information, and clear safeguards for data protection. Addressing inequalities in access to digital tools also requires action on infrastructure gaps, affordability barriers, accessibility challenges for older people and people with disabilities, and trust deficits among communities with negative experiences of health systems. Digital tools should complement human-centred care, not replace it, and they must never become a condition for accessing screening.

5. Using the European Health Data Space to monitor equity, not only coverage

The Recommendation should require cardiovascular screening data to be disaggregated by socioeconomic status, ethnicity, disability, migratory status, sex, gender, age, and geography. The European Health Data Space offers an important opportunity, but interoperability should serve equity monitoring, not only aggregate population-level analysis. The 25% premature mortality reduction target will only be credible if monitoring can demonstrate that improvements are reaching those with the highest burden, rather than merely improving averages while inequalities widen beneath the surface.

EuroHealthNet therefore stands ready to support the European Commission in placing health equity at the centre of the Council Recommendation on personalised treatment and monitoring of cardiovascular disease. This would help ensure that the Flagship Initiative of the Safe Hearts Plan on an “EU protocol on health checks for cardiovascular diseases” actively reduces cardiovascular inequalities, rather than inadvertently reinforcing them.



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