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DRAFT REPORT

on an EU cardiovascular diseases strategy

(2025/2132(INI))

Committee on Public Health

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

On an EU cardiovascular diseases strategy

(2025/2132(INI))

The European Parliament,

– having regard Article 9 and 168 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 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 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),

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

– 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 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[6],

– having regard to Directive 2002/49/EC of the European Parliament and of the Council of 25 June 2002 relating to the assessment and management of environmental noise[7],

– having regard to the EU Zero Pollution Action Plan,

– having regard to the EU Strategy on Adaptation to Climate Change,

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

– having regard to the European Cancer Inequalities Registry,

– having regard to the World Health Organization (WHO) Global action plan for the prevention and control of noncommunicable diseases,

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

– having regard to the WHO HEARTS technical package,

– 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 (A[10-0000/2025]),

A. whereas cardiovascular diseases (CVDs) remain the leading cause of mortality in the EU, accounting for approximately 1.7 million deaths annually; whereas CVDs are associated with significant morbidity, reduced quality of life, losses in productivity and an estimated economic cost of EUR 282 billion annually;

B. whereas only a limited number of Member States met the global target of a 25 %

[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 152, 11.6.2008, p. 1, ELI: http://data.europa.eu/eli/dir/2008/50/oj.
[7] ELI: http://data.europa.eu/eli/dir/2002/49/2021-07-29.

reduction in the prevalence of high blood pressure by 2025, demonstrating insufficient progress in the prevention and management of one of the most significant cardiovascular risk factors;

C. whereas demographic ageing, combined with increasing exposure to cardiovascular risk factors, is projected to further increase the burden of cardiovascular diseases in the absence of strengthened prevention, early detection and health system responses;

D. 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, unemployed people and socio-economically disadvantaged populations;

E. whereas women are consistently underdiagnosed and undertreated for cardiovascular disease owing to gender bias in diagnosis, treatment and clinical research, including the persistent under-representation of women in clinical trials, leading to delayed care and poorer health outcomes;

F. whereas a coordinated EU cardiovascular health plan can support Member States in accelerating the implementation of evidence-based prevention measures, strengthening health systems, enhancing resilience and reducing inequalities in cardiovascular outcomes across the EU;

G. whereas most CVD deaths are preventable and largely attributable to modifiable risk factors;

H. whereas strong primary care, effective prevention and risk-based early detection are essential for reducing avoidable deaths and disability;

I. whereas commercial determinants of health, including marketing and misleading claims, can undermine prevention policies and normalise harmful consumption;

J. whereas in 2021 tobacco use was responsible for more than 152 000 cardiovascular deaths and over 3.4 million disability-adjusted life years lost in the EU, with a disproportionate burden among men and socio-economically disadvantaged populations;

K. 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 cardiovascular disease prevention;

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 mandatory health impact assessments for major EU legislative initiatives;

2. Stresses that Europe's response to cardiovascular diseases must move decisively from a predominantly acute care approach towards a prevention-oriented approach across the life course;

3. Stresses that high levels of health literacy are essential for reducing exposure to cardiovascular risk factors and for improving patient engagement, self-management and adherence to treatment;

4. Encourages the use of health promotion programmes, education, labelling and digital tools to improve consumer empowerment and protection, supported by advice delivered through primary healthcare;

5. Calls on the Council to adopt Council recommendations on comprehensive, evidence-based health education in schools, including cardiovascular health literacy, healthy lifestyles and 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;

6. Stresses that commercial determinants of health, including the aggressive marketing of tobacco, alcohol, ultra-processed foods and sugary drinks, play a decisive role in the development of heart diseases; underlines that corporate profit-driven practices often undermine public health objectives and disproportionately harm lower-income households;

7. Stresses that health policy must be free from undue corporate influence; calls for transparency in decision-making and lobbying related to cardiovascular health;

8. Stresses that false and misleading health claims, including claims suggesting cardiovascular or other health benefits of unhealthy products, constitute a major commercial determinant of cardiovascular disease risk; calls for strong EU action to prohibit such claims across all product categories, including tobacco and nicotine products, alcoholic beverages and ultra-processed foods, in order to protect consumers and prevent the normalisation of harmful consumption patterns; calls for strict EU action to prohibit or tightly regulate such claims, ensuring that any communication to consumers is based on independent scientific evidence, subject to prior authorisation by competent public authorities, and does not mislead consumers regarding cardiovascular and other health risks;

9. Calls for the forthcoming revision of the Unfair Commercial Practices Directive 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;

Modifiable risk factors

Tobacco

10. Emphasises the importance of strong regulatory measures to reduce the affordability, appeal and harmfulness of tobacco and nicotine products, heated tobacco products, e-cigarettes and nicotine pouches, including through flavour bans, limits on nicotine

concentration and effective excise taxation;

11. Calls for all non-medicinal nicotine products, including nicotine pouches, smokeless tobacco and e-cigarettes, to be fully included within the scope of the Tobacco Products Directive, and to be subject to the same rules on age limits, flavourings, nicotine content, packaging and marketing as other tobacco products;

12. Welcomes the Commission's initiative to revise the legislative framework on tobacco control, first announced in Europe's Beating Cancer Plan; expresses concern about the continued delay in the revision of this legislation and calls on the Commission to present the revised framework without further delay;

Harmful use of alcohol

13. Calls on the Member States to strengthen alcohol excise taxation, including through regular inflation adjustment and minimum tax levels, in order to reduce affordability;

14. Calls for the introduction of mandatory, standardised and clearly visible health warning labels on alcoholic beverages, including warnings on cardiovascular risks associated with alcohol consumption, in order to improve consumer awareness and counter misleading perceptions of alcohol as a harmless or beneficial product;

Unhealthy diets and physical inactivity

15. Calls for binding EU measures to improve the food environment, including mandatory front-of-pack nutrition labelling, legally binding reformulation targets for salt, sugar and saturated fats, and restrictions on the marketing of unhealthy foods; stresses that voluntary industry commitments have proven insufficient and must be replaced by enforceable regulation;

16. Highlights that car-dependent urban planning, lack of green spaces and unsafe conditions for walking and cycling contribute directly to heart diseases; calls for public investment in healthy urban environments that promote physical activity and reduce cardiovascular risk;

Socio-economic determinants of health

17. Stresses that cardiovascular health is also a social and political issue and that the persistence of cardiovascular disease across the EU is closely linked to socio-economic determinants such as income inequality, insecure employment, housing conditions, education level and environmental exposure; recalls that these determinants disproportionately affect low-income households, workers in precarious employment, women, older persons and marginalised communities; calls for cardiovascular health policies to be firmly embedded within the EU's broader social, cohesion and inclusion policies;

18. Stresses the need to address the socio-economic determinants of cardiovascular health at both national and EU level; calls for the effective use of current EU frameworks, including the European Pillar of Social Rights Action Plan and the EU Anti-Poverty Strategy;

Environmental determinants of health

19. Stresses that environmental determinants, including air and noise pollution, chemical exposure and extreme temperatures, are major and preventable contributors to cardiovascular disease in the EU; 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;

20. 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 through urban planning, transport regulation and enforcement of current EU legislation;

II. Early detection and diagnosis

21. Welcomes the announced Council recommendation on cardiovascular health checks; stresses that any EU guidance must be evidence-based, respect Member State competence, reduce inequalities and avoid low-value practices;

22. Stresses that early detection should prioritise targeted, risk-based approaches in primary care, focusing on major conditions and CVD risk factors such as tobacco and alcohol use, obesity, hypertension, diabetes, kidney disease, dyslipidemia, coronary disease, atrial fibrillation, heart failure and structural abnormalities, while ensuring effective referral and long-term follow-up pathways;

23. Stresses that dyslipidemia such as familial hypercholesterolemia contributes substantially to cardiovascular risk; emphasises the importance of implementing lipid screening for all school children;

24. Recommends that individuals with at least one risk factor should undergo a cardiovascular-renal-metabolic health check at primary care level before the age of 35; recommends that individuals with elevated or abnormal findings should undergo systematic monitoring and follow-up;

III. Treatment, care and rehabilitation

25. Underlines that people living with cardiovascular disease must have timely access to high-quality, evidence-based and guideline-based care across the full care pathway; stresses that cardiac rehabilitation, occupational rehabilitation and social reintegration are integral components of effective cardiovascular care;

26. Stresses the growing threat of health workforce shortages; calls for improved working conditions, training, retention and multidisciplinary team-based care, with strong primary care as the backbone;

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

28. Stresses that cardiovascular diseases cause substantial disability affecting patients' work and quality of life; calls on the Member States to devise care strategies addressing workplace reintegration measures and psychosocial support;

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

29. Highlights the crucial role of strong primary healthcare systems and community-based services in cardiovascular disease prevention, early detection and long-term risk reduction, particularly in underserved rural and deprived urban areas;

30. Calls on the Member States to adequately resource primary care infrastructure, multidisciplinary teams and preventive services, and stresses that early detection and preventive care should be financially accessible and, as far as possible, free;

V. Multimorbidity

31. Stresses that cardiovascular diseases frequently coexist with other chronic conditions, including diabetes, obesity, chronic kidney disease, rheumatic and musculoskeletal diseases and mental health conditions, which significantly increase cardiovascular risk, complicate treatment and worsen health outcomes; underlines that addressing cardiovascular disease in isolation is insufficient to reduce morbidity and mortality;

32. Underlines that people living with cardiovascular disease and coexisting chronic conditions often experience fragmented and poorly coordinated care, resulting in delayed diagnosis, inconsistent treatment and avoidable complications;

33. Stresses the need to strengthen the competencies of healthcare professionals to manage cardiovascular disease in the context of coexisting chronic conditions, including training in comprehensive risk assessment, medication management and shared decision-making;

VI. Reducing inequalities

34. Stresses that the burden of cardiovascular 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 and access to healthcare services;

Women's underdiagnosis and the gender gap

35. Stresses that cardiovascular diseases in women are frequently underdiagnosed and diagnosed too late on account of persistent gender bias, atypical symptom presentation and outdated diagnostic criteria; calls for systematic training of healthcare professionals to recognise gender-specific cardiovascular symptoms and to reduce diagnostic delays that increase morbidity and mortality;

36. Stresses the urgent need to address the under-representation of women in cardiovascular research and clinical trials; calls for adequate funding for gender-specific cardiovascular research, including research on female-specific risk factors related to pregnancy,

menopause and hormonal influences;

Social and regional inequalities

37. Stresses that action to reduce cardiovascular disease must explicitly address social and regional inequalities, such as disparities between urban and rural areas, including medical deserts, and among vulnerable and marginalised groups such as people living in poverty, migrants 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;

38. Calls for EU cohesion and structural funds to be used strategically to reduce cardiovascular health inequalities, including through investment in prevention programmes, healthcare infrastructure and health workforce capacity in disadvantaged regions;

VII. Digital health, data and artificial intelligence

39. Supports digital tools and telemedicine where they complement face-to-face care and strengthen continuity and empowerment; stresses the need to avoid digital exclusion;

40. Calls for strong public governance and safeguards for digital health and artificial intelligence, including transparency, accountability, clinical validation and measures to prevent bias and commercial exploitation;

41. Calls for interoperable registries and improved surveillance, leveraging the European Health Data Space for monitoring, quality improvement and research, with a view to ensuring common standards and equitable participation across all Member States;

VIII. Research and innovation

42. Notes that, despite EU investment under Horizon Europe and other programmes, cardiovascular diseases still face a persistent research and innovation gap; calls for strengthened independent, publicly funded cardiovascular research across the continuum from prevention and early detection to treatment optimisation and rehabilitation;

43. Calls for EU research and innovation funding to better support interdisciplinary and cross-sectoral approaches, including research on the links between cardiovascular disease, diabetes, obesity, kidney disease and other comorbidities, as well as on the role of nutrition, environmental exposures and social determinants of health;

IX. Governance, implementation and funding

44. Calls on all Member States to develop or update national cardiovascular health plans covering prevention, early detection, treatment, rehabilitation and long-term care, aligned with EU objectives and international commitments;

45. Stresses that effective cardiovascular disease prevention, preparedness, care and research require ring-fenced, stable and long-term EU public funding; underlines that

cardiovascular health is a public good and calls for dedicated EU health funding, including adequate support under the next multiannual financial framework, the Union Civil Protection Mechanism and cohesion instruments, in order to strengthen prevention, preparedness and equity across the EU;

46. Calls for clear targets, indicators and milestones, transparent monitoring and regular public reporting, including equity objectives and targeted measures for high-risk and underserved groups;

47. Calls for evaluation and accountability, including a Parliament implementation study and a Commission evaluation report within two years of adoption;

X. International dimension

48. Stresses that the EU's role in global action on CVDs and NCDs should be consistent with the EU Global Health Strategy;

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49. Instructs its President to forward this resolution to the Council and the Commission.

EXPLANATORY STATEMENT

Cardiovascular diseases (CVDs) remain the leading cause of death in the European Union, responsible for approximately 1.7 million deaths each year and imposing an estimated economic burden of EUR 282 billion annually through healthcare costs, productivity losses and wider social consequences. Despite major advances in medical knowledge and treatment, progress in reducing mortality from cardiovascular diseases has been uneven and insufficient across the Union. The burden of CVDs is largely preventable, as most cardiovascular deaths are attributable to modifiable risk factors such as tobacco use, harmful alcohol consumption, unhealthy diets, physical inactivity and environmental exposures. Despite that, only a limited number of Member States are currently on track to meet agreed global targets. At the same time, demographic ageing, combined with continued exposure to these risk factors, is expected to further increase the burden of disease in the absence of sustained action across the life course. This resolution responds to the European Cardiovascular Health Plan[1] : the Safe Hearts Plan, published by the European Commission on 16 December 2025, and sets out the European Parliament's position on its priorities, implementation and governance.

Cardiovascular health is shaped by a broad range of factors extending well beyond healthcare systems. Social, economic, environmental and commercial determinants play a decisive role in influencing cardiovascular risk and health outcomes throughout the life course. Income inequality, insecure employment, education level, housing conditions, air and noise pollution and climate-related risks all contribute significantly to avoidable cardiovascular harm in the European Union. Recognising this complexity, the resolution situates cardiovascular disease prevention within a wider policy framework that encompasses multiple sectors and levels of governance.
Persistent inequalities in cardiovascular health remain a major challenge. Differences in morbidity and mortality between and within Member States reflect disparities in income, education, geographic location and access to healthcare services. Gender inequalities are particularly pronounced, with women continuing to experience delayed diagnosis and undertreatment of cardiovascular conditions, partly because of historical biases in research, diagnostic criteria and clinical practice. These structural factors continue to influence outcomes and underline the importance of equity as a cross-cutting dimension of cardiovascular health policy.

Early detection and strong primary care are essential to reducing avoidable complications and improving long-term prognosis. Risk-based approaches implemented in primary care settings, supported by effective referral and follow-up pathways, enable timely diagnosis while helping to avoid unnecessary or low-value interventions. At the same time, demographic ageing and the growing prevalence of multimorbidity place increasing pressure on health systems, highlighting the importance of integrated, patient-centred and multidisciplinary care models. Digital health technologies, data and research offer important opportunities to support surveillance, quality improvement and innovation in cardiovascular care. Their effective use depends on robust governance frameworks, interoperability and appropriate safeguards to ensure transparency, accountability and equitable access. In this regard, sustainable funding,

[1] https://health.ec.europa.eu/document/download/dfb60cde-21a5-426d-8616-e394a326abc2_en?filename=ncd_com-2025-1024_act_en.pdf

clear monitoring mechanisms and coherence with international commitments are essential for translating innovation into tangible public health benefits.
Taken together, the approach set out in this context seeks to contribute to a more coherent and equitable European response to cardiovascular disease. By supporting the implementation of the European Cardiovascular Health Plan, it underscores the importance of prevention, early intervention and cross-sectoral action in reducing avoidable cardiovascular burden and improving quality of life across the European Union.

ANNEX: DECLARATION OF INPUT

The rapporteur declares under her exclusive responsibility that she did not include in her report input from interest representatives falling within the scope of the Interinstitutional Agreement on a mandatory transparency register[1], or from representatives of public authorities of third countries, including their diplomatic missions and embassies, to be listed in this Annex pursuant to Article 8 of Annex I to the Rules of Procedure.

[1] Interinstitutional Agreement of 20 May 2021 between the European Parliament, the Council of the European Union and the European Commission on a mandatory transparency register (OJ L 207, 11.6.2021, p. 1, ELI: http://data.europa.eu/eli/agree_interinstit/2021/611/oj).