European Heart Failure Mission

The Heart Failure Policy Network

Cardiovascular health checks
The opportunity in heart failure

The Heart Failure Policy Network 2026 manifesto

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The opportunity of the EU Cardiovascular Health Check

If cardiovascular health checks are to truly meet the needs of the European population and maximise benefits for our communities, health systems and economies, **they must deliver on the call of the European Union's (EU's) Safe Hearts Plan for 'early detection of heart failure risk… [to] be included in the scope of the screening'.**[1]

The EU's planned cardiovascular health check represents a major opportunity to reduce the toll of cardiovascular disease (CVD). CVD is estimated to cost the EU €282 billion annually and account for one in every three deaths.[2] This toll is largely driven by long-term exposure to known risks, poor management of those risks, and the often avoidable progression from early disease to severe illness[2 3] – all of which a well-designed health check could help to overcome.

If implemented effectively, these checks can shift health systems from late-stage crisis management towards more sustainable care. This would reverse a historical failure to 'predict, prevent and protect' that ultimately results in avoidable hospital admissions, reduced quality of life, disability and death.[2 3] Recent modelling indicates that reducing CVD hospital admissions could save the EU almost €45 billion each year – approximately 16% of its spend on CVD.[2] Health checks offer a unique tool to support this, but they will only deliver meaningful value to Member States if they are designed to improve outcomes rather than simply increase testing. While evidence on population screening is mixed, a pragmatic, multi-step health check – linked effectively into care pathways – has the potential to improve outcomes, even in the context of strained health system resources.

Why are health checks so relevant to heart failure?

Heart failure is a condition where the heart cannot pump enough blood around the body. Symptoms such as breathlessness and intense fatigue can substantially limit people's daily life – including participation in work and communities.[4]

It typically develops after years of exposure to chronic cardio-renal-metabolic risk factors, including diabetes, kidney disease, hypertension, high cholesterol, smoking and low physical activity.[5] Additionally, people are at increased risk of heart failure if they have previously received cancer treatment (due to the cardiotoxicity of certain therapies) or had a heart attack.[6] [7]

Heart failure affects millions of people across Europe, and its prevalence is projected to rise as populations age, more people live with chronic conditions, and advances in treatments improve survival.[8] According to the European Society of Cardiology, hospital admissions for heart failure could increase by as much as 50% over the next 25 years.[8] Importantly, while better management of cardiovascular risk factors is essential, this alone offers no guarantee that overall heart failure prevalence will fall, as demographic ageing and a growing burden of comorbidities continue to drive heart failure cases.[8] This makes early heart failure detection critical to support timely care and improve outcomes.

Yet heart failure still remains underdetected and diagnosed too late. Data show that approximately 80% of diagnoses are only made in emergency settings, after significant and often preventable deterioration has already occurred.[9] [10] A recent Portuguese screening study estimates over 16% of people aged 50+ in the general population are living with heart failure – yet 90% of them are unaware of their condition.[11] Women face distinct challenges in heart failure diagnosis and care; prevalence among women can be twice that of men, and there are persistent awareness gaps regarding female-specific symptoms and risk factors.[12] [13]

What does an effective health check look like in practice?

What is a cardiovascular health check?

A cardiovascular health check is a proactive and individualised risk assessment – typically delivered in primary care or community settings – that identifies CVD risk and early disease. It should help people understand their cardiovascular risk and how to manage their health, and be linked to evidence-based prevention or onward care.[2 14 15]

To achieve the goal of saving lives, costs and resources, countries must implement health checks in a careful and targeted way. It matters hugely who gets tested, which tests they receive, and how healthcare services respond to identified needs, such as a rapid progression to further diagnostics, evidence-based initiation and review of treatment, or referral to prevention or onward care services.

To be pragmatic, and to ensure they provide maximum benefit in the context of strained financial resources, cardiovascular health checks need to be responsive and multi-step. Evidence on the effectiveness of population-based screening is mixed, partly due to challenges such as overdiagnosis and overtreatment.[14 16] However, general health checks are linked to greater recognition and treatment of chronic diseases, improved control of risk factors, higher uptake of preventive services, healthier behaviours and better patient-reported outcomes.[14]

In practical terms, health check programmes must:

1. **Start with a basic check**

Cardiovascular screening should start with an accessible first-line check for a wide population, including simple questioning and risk factor examination.

Assessing several risk factors during one consultation could reduce delays to diagnosis and treatment. The assessment should include blood pressure, weight, lipid and glucose profile, kidney function (via markers such as glomerular filtration rate and albuminuria (or urine albumin-creatinine ratio, uACR)), lifestyle (including smoking), family history, heart rate and rhythm (via stethoscope examination) and, crucially, red-flag symptoms of heart failure (i.e. breathlessness, fatigue and ankle swelling).

2. Progress to enhanced checks for people at risk, including NT-proBNP

Screening should be escalated to more frequent or enhanced checks (using biomarker testing and targeted diagnostic tools) for people at higher cardiovascular risk, including:

- people over 65[17]
- people living with type 2 diabetes or kidney disease (as recommended by European Society of Cardiology guidelines)[18 19]
- people with red-flag signs and symptoms of heart failure: breathlessness, swollen ankles and extreme fatigue[20]
- people living with comorbidities including obesity, atrial fibrillation, hypertension or high cholesterol[5]
- people who have had a heart attack[21]
- people who have received cardiotoxic chemotherapy[6 7]
- pregnant women who have a history of CVD[22]
- people with a history of smoking or harmful alcohol use.[5]

People at risk may also be identified via a review of electronic health records and individualised risk stratification, which could be supported by risk prediction algorithms (e.g. SCORE2-HF, SMART2-HF).[23 24]

Where risk of heart failure is identified, enhanced testing (e.g. NT-proBNP) should ideally be offered during the same appointment. Where this is not possible, follow-up testing should be arranged promptly to minimise diagnostic delay.

What is NT-proBNP, and why must it be included in cardiometabolic screening efforts?

Natriuretic peptide (NT-proBNP) is a hormone in the blood that indicates stress in heart muscle tissues and worsening heart function. Testing NT-proBNP is recognised as a mainstay of heart failure screening – including by European Society of Cardiology guidelines for CVD, diabetes and kidney disease – to help identify undetected heart failure, inform rule-in/-out, and direct onward assessment.[18-20 25 26]

NT-proBNP testing has been evidenced as a cost-effective tool for detecting heart failure among people at risk in several European countries (see Appendix).[27-29] NT-proBNP testing can expedite diagnosis, resulting in fewer medical visits and reduced hospitalisations, therefore generating cost savings for health systems.

See Appendix for examples of Member State screening programmes – including the EU's Joint Action on Diabetes and Cardiovascular Diseases (JACARDI) STOP-CVD pilot on NT-proBNP testing.

3. Be delivered in the right setting

Testing should be delivered in accessible locations, across primary care and community settings, where it can be implemented at scale.[2] This has been shown to accelerate early detection of heart failure, reduce hospitalisations and

improve outcomes.[11 30] It will also keep checks convenient, efficient, and best placed to reach the right people.

The Safe Hearts Plan champions expanding such approaches to reach a wider population and standardise access to timely cardiovascular assessment.[1] The location and structure of the health check will vary among countries, and community engagement should be sought to ensure the delivery format is appropriate.

4. Link to onward care

Detection alone is insufficient; health checks must inform initiation of active prevention strategies and disease management for those who need it.[1 10] Checks will otherwise not reduce levels of illness or death, or bring down costs. The effective management of cardiovascular risk has a strong influence on health outcomes, but it depends on prompt follow-up and ongoing monitoring.

Every person identified as being at risk of heart failure should benefit from rapid onward referral, informed by clear care pathways, to confirm diagnosis and receive evidence-based quality care. Screening may increase the volume of patients in the health system, which will require capacity-building via efficient care pathway and system design, and investment in the health workforce and infrastructure. This could be facilitated by digital tools, such as structured electronic referral pathways and AI-assisted echocardiography to support the identification of heart failure red flags.[31-33]

How can NT-proBNP inform onward referral?

When combined with other health data (including age, sex and biomarker scores such as creatinine levels), NT-proBNP results enable vital care decisions to be made quickly. For example:

- **Normal NT-proBNP** enables swift rule-out of heart failure, if no other major risk factors are present,* helping redirect medical investigation to alternative causes.[20 25]
- **Elevated NT-proBNP** confirms the need for further investigation, especially for people at increased risk (e.g. those with diabetes or kidney disease).[20 26 34]
- **Very high NT-proBNP** should trigger rapid access to specialist heart failure imaging (i.e. echocardiogram) and confirmation of diagnosis.[25]

In some cases where elevated NT-proBNP is present alongside typical heart failure symptoms (e.g. breathlessness, fatigue, ankle swelling), immediate initiation of evidence-based therapies and multidisciplinary care can protect patients while further diagnostic assessments take place.[35]

** Factors such as obesity and kidney dysfunction can influence NT-proBNP levels. Results should therefore be interpreted alongside evaluation of CVD risk factors.*[20]

Conclusion

The forthcoming Council Recommendation on health checks represents a once-in-a-generation opportunity to strengthen cardiovascular prevention across Europe. By ensuring heart failure is included, the EU can deliver on the ambition set out for screening and prevention by the Safe Hearts Plan and create a tangible legacy for patients, health systems and economies.

In conclusion, we call for two clear inclusions of heart failure in the Council Recommendation:

1. Basic cardiovascular health checks should include **assessment of heart failure red-flag symptoms** (e.g. breathlessness, ankle swelling, extreme fatigue).

2. People identified as being at risk of heart failure should have **timely access to onward diagnostic assessment, including NT-proBNP** testing and echocardiography.

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Appendix: How Member States are already delivering effective heart failure detection

The EU Health Check Recommendation is an opportunity to implement and standardise cardiovascular screening in a way that improves lives and saves costs. There are resources already available to support shared learning and inform the design and delivery of targeted, evidence-based programmes.

Using NT-proBNP screening in primary care: Portugal
Research in Portugal highlighted the value of introducing NT-proBNP testing in primary care for health failure diagnosis to protect healthcare budgets. Analysis estimates that the use of NT-proBNP can generate cost savings of nearly €3m annually – 7.9% of the current heart failure care budget.[36]
STOP-HF heart failure screening: Ireland
The STOP-HF screening study helped determine the value of NT-proBNP testing for asymptomatic patients at high risk of heart failure. Among people with cardiovascular risk factors, NT-proBNP-based screening and collaborative care reduced the combined rates of progression to left ventricular systolic dysfunction, diastolic dysfunction and heart failure by ~50%. This model is now internationally recognised, with proven cost effectiveness, and is being established nationally in Ireland as part of the Chronic Disease Management Programme.[27]
STOP-CVD – a JACARDI screening pilot: Ireland
STOP-CVD is a pilot project in JACARDI's Work Package 08 'Screening high-risk populations and individuals'. It aims to define an effective care model for NT-proBNP screening and intervention for adults at risk of CVD to guide clinical practice and support informed care planning and resource allocation.[37]

Targeted screening of people with type 2 diabetes: Netherlands

A series of studies in the Netherlands evaluated the cost effectiveness of heart failure screening strategies for people with type 2 diabetes mellitus. People were identified using a combination of tools, including review of electronic health records, symptom assessment, natriuretic peptide testing and echocardiography. The studies showed that screening among people aged 60 or over with type 2 diabetes can help increase life expectancy in a cost-effective way.[38-40]

Identifying heart failure risk from electronic medical records: Belgium

A Belgian study assessed whether machine learning could improve the identification of heart failure in primary care. Analysis of over 18,000 patient electronic medical records (EMR) informed the development of an algorithm to support heart failure detection in primary care, including risk factors, symptoms, clinical signs and prescribed medications. The study revealed substantial misclassification in existing records; nearly half of patients with a recorded heart failure diagnosis did not have confirmed heart failure, while around 70% of confirmed cases were not formally registered. The findings suggest that EMR audits and machine learning tools could support earlier diagnosis and more accurate management of heart failure in primary care.[41]

Primary Care Chronic Disease Management Programme (CDM): Ireland

Ireland's CDM Programme, overseen by the Health Service Executive, provides structured care to adults living with long-term illnesses, including heart failure, diabetes, asthma and chronic obstructive pulmonary disease. As part of the programme, people receive twice-yearly check-ups from both a GP and a practice nurse. These enhanced health checks support early identification of risk factors and deteriorating conditions, the development of personalised care plans, and patient education to empower self-management – including for heart failure. Data collection performed as part of the programme facilitates the assessment of persistent care gaps and allows for continuous improvement.[42]

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