



EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
Health promotion, disease prevention, financial instruments

Healthier Together – EU NCD Initiative

The EU NCD Initiative addresses five strands: a) cardiovascular diseases, b) diabetes, c) chronic respiratory diseases, d) mental health and neurological disorders, e) health determinants.

Contribution from health stakeholders is essential to gather:

1. **priorities for action** in each of the above-mentioned strands;
2. **examples of effective policies, best practices, promising approaches**, innovative actions (to be put for consideration of Member States) to effectively address priorities;
3. the **field of work of stakeholders** and actions that stakeholders can do in collaboration with public health authorities and other parties.

Stakeholders may also wish to provide general comments (on the structure of the approach, information gaps, recommendations for better supporting stakeholders, etc.).

How to contribute

You can provide input –or revise and add to your previous input– at any time until the end of the drafting process of the EU NCD Initiative, expected by June 2022.

However, contributions will be particularly appreciated before the webinars, to feed the debate.

When you are ready to do so,

1. Download the document from the Health Policy Platform;
2. Introduce your input; please be concise;
3. Save and send the document to info@euhealthsupport.eu;
4. Revise and resend the document in case you wish to update your input. The previous version will then be replaced.

We may contact member of the Health Policy Platform NCD Stakeholder Group for clarifications. Unless you disagree, responses will be uploaded to the Health Policy Platform and thus readable by other network members. For that reason, please do not include personal information (e.g. names and contact details) in your document.

Stakeholder input

1. Please provide the **name of the organisation** you represent.
Individual names will not be disclosed; the list of responding organisations may be published.

EU Structural Heart Disease Coalition

2. On which strands of the EU NCD Initiative would you like to comment? Please select all that apply.
 - Health determinants
 - Cardiovascular diseases
 - Diabetes
 - Chronic respiratory diseases

- Mental health and neurological disorders

You can then fill in the relevant sections below. If you only fill in one section, please add any general comments you may have in the closing section.

Cardiovascular diseases

1. Please indicate your **priorities for EU-supported action** in this strand.

Please select up to five priorities and be as specific as possible.

You may provide a short clarification on why these priorities rank high and add relevant links (e.g. scientific literature, reports of reference institutions, policy documents).

	Priorities	Rationale	References
1	Addressing Structural Heart Disease: a degenerative disease that cannot be prevented.	<p>Structural heart disease (SHD) is a set of cardiovascular conditions that affect the structure of the valves, atria, ventricles and blood vessels in the heart. The majority of SHD is degenerative, affecting older people. Prevalence of the condition increases with age: 5% of 65–69-year-olds are estimated to have some form of SHD, and up to 30% of those aged over 85.</p> <p>It's estimated that 14 million people in Europe were living with SHD in 2020, and that by 2050, this will increase to 23 million.</p> <p>Unlike some other cardiovascular diseases (CVD), SHD can generally not be prevented by a healthy lifestyle. People with SHD are often unaware they have it, dismissing symptoms (such as fatigue, chest pain, shortness of breath, difficulty exercising) as due to aging. There also is a low awareness among health care professionals. SHD can shorten someone's life as well as leaving them with debilitating symptoms which impact on their quality of life and autonomy. In some cases, people are left bedbound.</p> <p>Severe aortic stenosis, one of the main types of the disease, has a worse prognosis than some metastatic cancers. If not treated properly, 1 out of 2 diagnosed patients will die after 2 years. After 3 years, this increases to 2 out of 3 patients.</p>	<ul style="list-style-type: none"> • Proposal for an EU Joint Action on SHD [LINK] • The 2019 European Heart Health Survey [LINK] • Report "The invisible epidemic – rethinking the detection and treatment of structural heart disease in Europe" (definition of structural heart disease and the economic case for tackling SHD) [LINK] • Figures on ageing population in Europe from Eurostat [LINK] • Political action and support for structural heart diseases [LINK]

<p>2.</p>	<p>Addressing SHD through Early detection:</p> <p>Setting EU screening targets for SHD to improve early detection, reduce mortality and healthcare burden, coupled by implementing targeted screening programs at national level.</p>	<p>A degenerative disease that can generally not be prevented, SHD needs to be detected early to allow patients to benefit from treatments that will reduce mortality, improve quality of life, and reduce healthcare costs.</p> <p>SHD can be detected through simple heart checks by a General Practitioner (GP) using a stethoscope. When a heart murmur is identified during the consultation, the patient is referred to a cardiologist for confirmation of the diagnosis using echocardiography.</p> <p>Unfortunately, heart checks are not routine: a third of respondents to a 2019 European survey of people aged over 60 said their primary care physician checked their heart with a stethoscope “occasionally”; only 28% had their heart checked at every visit. Therefore, there is massive number of undiagnosed SHD cases, associated with a latent public health and economic burden.</p> <p>There are many contributing factors that hinder early detection of SHD in primary care:</p> <ul style="list-style-type: none"> - Most people are unaware of the symptoms of SHD and may dismiss them as the usual signs of aging. - There are no guidelines instructing primary healthcare professionals to check the heart for SHD in the elderly population, as well as no financial incentives. - Awareness of the condition among healthcare professionals is low, and General Practitioners lack time to perform a heart check during the consultation. In addition, access to the cardiologist can be difficult in some Member States due to capacity issues. - There are no specific screening programmes for SHD and even broader age-related CVD screening initiatives are lacking. 	<ul style="list-style-type: none"> • The 2019 European Heart Health Survey [LINK] • Report “The invisible epidemic – rethinking the detection and treatment of structural heart disease in Europe” (definition of structural heart disease and the economic case for tackling SHD) [LINK] • Proposal for an EU Joint Action on SHD [LINK] • EU SHD Coalition Recommendations on how to make SHD Detection happen in Europe [LINK]
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		<ul style="list-style-type: none"> • The EU must take steps to encourage the development of screening programs for CVD and SHD, set minimum screening targets, and invest sufficient funding towards improving early detection, notably through the forthcoming EU4Health Joint Action on CVD. • This will stimulate the exchange of best practices, data and knowledge across Member States, and enhance the development of guidelines and policy, ultimately improving health of elderly citizens in the EU. • Early detection of SHD could also be integrated into broader cardiovascular disease (CVD) screening in primary care, at certain age or events in older life. 	
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3. Please provide your selection of **effective policies, best practices, promising approaches** and innovative actions (to be put for consideration of Member States) to effectively address the priorities.

Please list up to ten suggestions and be as specific as possible.

You may provide a short clarification on why these suggestions rank high and add relevant links (e.g. scientific literature, reports of reference institutions, policy documents).

Please indicate if the action has been evaluated or piloted, whether there is information on (cost-)effectiveness, or why it should be tried as a novel option with high impact.

	Effective policies, best practices, promising approaches or innovative actions	Rationale	References
1	<p><u>Effective policies:</u></p> <p>To tackle SHD, there needs to be action at EU level, and within specific countries. No EU country has yet introduced a programme for early detection of SHD.</p> <p>At EU level, the EU should develop an EU wide target for early detection of CVD including SHD, similar to cancer screening targets.</p>	<ul style="list-style-type: none"> • The development of SHD screening programs can learn and benefit from the experience and organization already in place for other screening programs such as cancer, as these programs have shown to save lives and improve quality of life. For example, cancer detection programmes have delivered in some countries a reduction in mortality of 25-30% for breast cancer, 50-70% for cervical cancer and 21% for prostate cancer. • Screening programs are usually organised around a 4-step process: Identification of the target population, Invitation of 	<p>EU SHD Coalition Recommendations on how to make SHD detection happen [LINK]</p> <p>Schopper D, de Wolf C. How effective are breast cancer screening programmes by mammography? Review of the current evidence. Eur J Cancer. 2009 Jul;45(11):1916-23. doi: 10.1016/j.ejca.2009.03.022. Epub 2009 Apr 22. PMID: 19398327.</p> <p>Mayor, S. Screening reduced cervical cancer</p>

<p>No EU citizen should be left behind because of lack of access to a heart check.</p> <p>The EU NCD Initiative and EU4Health should facilitate and invest in more systematic screening of CVDs and SHDs through:</p> <ul style="list-style-type: none"> ➤ Improving health literacy of older citizens aimed at increasing awareness on SHDs, symptoms, and the importance of early detection ➤ Development of guidelines on early detection, including a consensus on age range ➤ Training and education of healthcare professionals in primary care to ensure that checking for SHD is a priority ➤ Testing new innovative practices to facilitate early detection such as digital tools for heart checks and echocardiography, or blood markers. 	<p>defined population, Check of the disease, Referral if needed.</p> <ul style="list-style-type: none"> • Every step requires consensus by the relevant medical societies. A wide range of public stakeholders contribute to screening programmes: the national institutes of Health for the development of screening protocols and the programme evaluation, the regional or local health authorities for the programme coordination, the health insurances for the programme funding. • SHD screening could leverage the structures put in place for cancer screening, in particular the patient databases and the coordination structures in place. • SHD screening could as well benefit from the existing network of healthcare practitioners in primary care (GPs and cardiologists) who have the relevant skills and equipment (stethoscope, echocardiogram) for heart checks. • Applying the 4 steps of a screening program, an SHD program in a particular Member State could apply the following components: <ol style="list-style-type: none"> 1. Identification: SHD screening programme should be aged-based in order to ease implementation, as demonstrated in cancer screening. <ul style="list-style-type: none"> ⇒ Population target (age) and screening approach (i.e. frequency, methodology) should be defined by medical societies and Health Authorities 2. Invitation: Invitations for SHD screening can be sent through similar channels to cancer screening programs (e.g., by regional health authorities, insurers) <ul style="list-style-type: none"> ⇒ <i>The use of remote digital pre-screening tools (e.g., online validated questionnaire) could trigger more targeted invitations to heart auscultation when positive</i> ⇒ <i>Providing HCPs (e.g., GPs, pharmacists) and target patients with SHD knowledge and education materials would increase invitation conversion rates</i> 3. Check: Heart check is performed by GP or cardiologist in dedicated consultations <ul style="list-style-type: none"> ⇒ <i>Integration within broader CVD detection program (incl. Atrial Fibrillation and Cardiac Heart Failure) might ease</i> 	<p>deaths by more than two thirds, UK study finds. BMJ i5026 (2016) doi:10.1136/bmj.i5026</p> <p>Mählick, C. G., Jonsson, H. & Lenner, P. Pap smear screening and changes in cervical cancer mortality in Sweden. International Journal of Gynecology & Obstetrics 44, 267–272 (1994).</p> <p>Ilic, D. et al. Prostate cancer screening with prostate-specific antigen (PSA) test: a systematic review and meta-analysis. BMJ k3519 (2018) doi:10.1136/bmj.k3519.</p> <p>Cancer Plan stipulates that a new EU cancer screening scheme should ensure that 90% of the target population is offered breast, cervical and colorectal cancer screening by 2025. ec_rtd_sam-cancer-screening-opinion-executive-summary.pdf (europa.eu)</p>
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		<p><i>implementation of SHD screening</i></p> <ul style="list-style-type: none"> ⇒ Standardization of screening sequence (key questions to ask, best practices for auscultation, etc.) will increase sensitivity and specificity ⇒ Use of echocardiography as a first line screening tool would increase screening programme impact, especially in populations with the highest SHD prevalence ⇒ Innovative tools such as digital stethoscope and/or blood testing (e.g., NT-pro BNP) could increase screening performance <p>4. Referral: If the heart check performed by GP, the patients are referred to the cardiologist for SHD diagnosis confirmation with echocardiography</p> <ul style="list-style-type: none"> ⇒ Providing referral decision tool to GPs and development of standardized referral pathway might increase patient referral 	
2	<p><u>Best practice:</u></p> <p>To improve patient identification of SHD, tailored guidelines for General Practitioners should be ensured.</p> <p>Best practice in Canada shows the importance of involving local community, and the development of a ‘co-creation’ process to ensure strong patient identification, and adherence to the guidelines, as well as a process for regular review.</p> <p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<ul style="list-style-type: none"> • In Champlain (Canada), a well documented gap was identified between evidence and practice for clinical practice guidelines in cardiovascular disease (CVD) care. • Therefore, the Champlain Primary Care CVD Prevention and Management Guideline was developed by more than 45 local experts to summarize the latest evidence-based strategies for CVD prevention and management. • In order to develop the guideline, evidence-monitoring committees and a guideline coordinator were established for serious CVD risk factors and conditions. • Committee members reviewed Canadian guidelines and international guidelines, identifying gaps and proposing improvements • The initial guideline draft was then pilot-tested by a small group of family physicians and modified based on feedback received. • In order to make the guideline relevant to local physicians, a database of community resources pertinent to each vascular condition and risk factor was developed. • As an outcome, the guidelines (1,300 of them) were sent to each GP and CVD specialist in Champlain and made 	<p>Montoya, L. et al. Development of the Champlain primary care cardiovascular disease prevention and management guideline: tailoring evidence to community practice. Can Fam Physician 57, e202-207 (2011).</p>

		available on a website. They are updated every two years.	
3	<p><u>Best practice:</u></p> <p>Combining aortic stenosis screening with influenza vaccination among patients of 65+ years of age in the UK.</p> <p>Aortic Stenosis, the most common form of SHD, is often diagnosed late when mortality risk is substantial.</p> <p>A pilot study in England (UK) tested providing heart auscultation and 2D echocardiography for people attending for influenza vaccinations.</p> <p>The study confirms feasibility of valvular heart disease screening in the elderly in a primary care setting.</p> <p>It indicates that a simple and inexpensive method of combining influenza campaign with AS screening could potentially identify 130,000 patients with moderate and severe Aortic Stenosis in England alone.</p> <p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<ul style="list-style-type: none"> The study determined the feasibility of AS screening during influenza vaccination at general practitioner (GP) surgeries in the UK via dedicate pilot program 167 patients were enrolled aged 65+ (with a mean age of 75 years) When patients went to the GP for influenza vaccination, they also underwent heart auscultation and 2D echocardiography (V-scan) Based on results, a patient management strategy was determined (referral to cardiologist, review within own practice or no follow-up measures) and status at 3 months was determined On auscultation, a heart murmur was detected in 30 of 167 (18%) patients and 16 of them had an abnormal V-scan finding that was largely related to the aortic valve 18 (10.8%) patients were referred onward with 5 of them diagnosed with mild AS and 3 of them with moderate AS 	<p>Steeds, R. P. et al. Community-based aortic stenosis detection: clinical and echocardiographic screening during influenza vaccination. Open Heart 8, e001640 (2021).</p>
4	<p><u>Best practice</u></p> <p>Combining aortic stenosis screening with influenza vaccination in 65+ population in Spain</p>	<ul style="list-style-type: none"> Background and objectives: Aortic stenosis (AS) is the most frequent valve disease in western countries as its leading aetiology is degenerative-calcified. As society grows older, AS represents more number of hospital admissions, diagnostic studies and interventional procedures. Delayed diagnosis, as well as high comorbidity or accompanying frailty status might worsen patient prognosis and affect therapeutic approach. Thus, addressing the current 	<p>Population-based screening for aortic stenosis: Prevalence and risk profile Jiménez et al. RECCardioClinics. 2021;56(2):77–84 https://www.sciencedirect.com/science/article/abs/pii/S2605153220300844?via%3Dihub</p>

	<p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<p>epidemiology of AS and patient risk profile in a steadily ageing society is crucial</p> <ul style="list-style-type: none"> • Methods: Patients aged ≥65 years referred for annual flu vaccination, without a history of AS or aortic valve replacement were invited to participate. • Results: A total of 522 individuals were included, with mean age 78.7 years and 61% of females. AS was present in 4.2% of the sample, with age-related dependency on its prevalence (12.8% of those aged ≥85 years). Most patients (72.7%; n= 16) presented comorbidity. However, frailty was not frequently described (13.6%; n= 3) and surgical risk was usually (54.5%, n= 12) low. • Conclusions: Burden of unknown AS in the elder general population is higher than previously reported. Although subjects with undiagnosed AS present most times with comorbidities, they are rarely frail and the majority shows low surgical risk. 	
5	<p><u>Best practice:</u> Increasing CVD detection activating pharmacy territorial network in the Hauts-de-France region (France)</p> <p>CVDs have a high burden in the Hauts-de-France population, esp. with a mortality rate higher than 35% and premature death rate (esp. before 65-year-old)</p> <p>Following a successful pilot in 2016, the region decided to launch the CVD pharmacy screening project in 2019, to last till 2023, with a budget for the total period of EUR 1,75M provided by the Regional Health Agency (Agence Régionale de Santé)</p> <p>This practice is applicable to Structural Heart Disease screening</p>	<ul style="list-style-type: none"> • Following a successful pilot, a pharmacy screening project has been launched to run from 2019 to 2023 in Hauts-de-France, France. • Pharmacists screen men over 40 and women over 50 with CVD risk factors. Pharmacists use a private space and screen for hypertension BMI, COPD, abdominal circumference, blood glucose and sedentary lifestyles. • 700 pharmacists from across the region are participating and the programme is expected to reach up to 40 000 people, including people some distance from health care centres. Patients are encouraged to see their GP for follow-up if required. • The project should the potential of collaboration with key stakeholders such as as pharmacists is in order to reach a large and geographically dispersed population. • Pharmacists could also be trained to carry out auscultations of targeted people. • Pharmacies can be levers used to share information about CVD, like, SHD and 	<p>ARS, CVD pharmacy screening project in Hauts de France, 2019, Titre de la réunion (sante.fr)</p>

		encourage people to visit GPs for follow up.	
6	<p>Best practice: Increasing Atrial Fibrillation detection by leveraging systematic screening with Electrocardiogram (Sweden)</p> <p>Atrial fibrillation is a leading cause of ischaemic stroke, and its early detection can enable anticoagulant therapy, thus reducing disease morbidity and mortality.</p> <p>The case focused on defining the prevalence of untreated atrial fibrillation in a systematic screening program using intermittent ECG recordings among 75- to 76-year-olds and assessing screening impact</p> <p>The case shows that screening of a targeted population can detect people with silent disease, and the opportunity to provide preventative treatment. Systematic screening with tools such as ECG can be effective ways to detect diseases.</p> <p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<ul style="list-style-type: none"> In 2 Swedish regions, half of the 75- to 76-year-old population was invited to AF screening. Individuals without a previous AF diagnosis underwent over 2 weeks intermittent Electrocardiogram (ECG) self-recordings via a handheld ECG recorder, sending data to the researchers. Specially trained research nurses manually assessed all ECG recordings, with abnormal ECGs referred to the investigating cardiologist All participants with newly-detected AF were offered individualized follow-up by a cardiologist to assure that adequate treatment with protective oral anticoagulant (OAC), as per EU guidelines, was carried out. During the 28-month study period 13,331 inhabitants were invited with 55% participation rate Mass screening for AF in a 75- to 76-year-old population identifies a significant proportion of participants with untreated AF, with ECG increasing new AF detection 4-fold The followed-up initiation of stroke prophylactic treatment was highly successful in individuals with newly diagnosed AF 	<p>Svennberg Emma, Friberg Leif et al. Population screening of 75- and 76-year-old men and women for silent atrial fibrillation (STROKESTOP), 2012, doi:10.1093/europace/eus217</p> <p>Svennberg Emma, Engdahl Johan et al. Mass Screening for Untreated Atrial Fibrillation: The STROKESTOP Study, 2015, DOI: 10.1161/CIRCULATIONAHA.114.014343</p> <p>Svennberg Emma, Friberg Leif et al. Clinical outcomes in systematic screening for atrial fibrillation (STROKESTOP): a multicentre, parallel group, unmasked, randomised controlled trial, 2021</p>
7	<p>Best practice: Reducing mortality of Abdominal Aortic Aneurysms (AAA) in men aged 65-74 years old by employing ultrasound screening (UK)</p> <p>The prevalence of AAA is age-dependent and among men 65+ it is between 4%-8% with a mortality rate in</p>	<ul style="list-style-type: none"> Four health centers in UK were engaged and screening was delivered in primary care settings with follow up and surgery offered in the main hospitals. A sample group of 67,800 men aged 65-74 years was enrolled, and each individual randomly allocated to either receive an invitation for an abdominal ultrasound scan or not. Men in whom abdominal aortic aneurysms were detected were followed- 	<p>Scott, R. The Multicentre Aneurysm Screening Study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial. The Lancet 360, 1531–1539 (2002).</p> <p>Multicentre Aneurysm Screening Study Group 2002</p>

	<p>case of a ruptured AAA of at least 80%</p> <p>More than 80% of AAA cases are clinically asymptomatic and are discovered by chance or during an ultrasound screening</p> <p>The Multicentre Aneurysm Screening Study in UK was conducted to assess screenings.</p> <p>The cost effectiveness analysis of data showed that cost-effective targeted SHD screening campaign for older people could be envisioned.</p> <p>This practice is applicable to Structural Heart Disease screening</p>	<p>up with repeat ultrasound scans (annually or every three months depending on aortic diameter severity) for a mean of 4.1 years.</p> <ul style="list-style-type: none"> • The cost effectiveness analysis of data from the randomized trial with follow up over four years showed 47 fewer deaths and additional costs of £2.2m in the group invited to screening. • The four-year analysis of the study shows a cost effectiveness ratio already at the margin of acceptability by NHS, with even better cost-effectiveness prospects over the longer term. 	<p>Eckstein, H.-H. et al. Ultrasonographic screening for the detection of abdominal aortic aneurysms. Dtsch Arztebl Int 106, 657–663 (2009).</p>
8	<p>Best Practice: HerzCheck - Mobile and telehealth screening to detect heart failure in remote areas (Germany)</p> <p>Heart failure is one of the most common causes of death in Germany and costs more than five billion euros a year. Heart failure is often initially asymptomatic and is best diagnosed with the aid of magnetic resonance imaging (MRI). In rural areas, however, there is often neither the equipment nor specialized physicians.</p> <p>The project will evaluate whether mobile cardiac MRI measurement of myocardial strain (GLS) can improve the prognosis of heart failure patients. The project HerzCheck is funded by the Innovation</p>	<ul style="list-style-type: none"> • The project HerzCheck enables modern heart failure diagnostics on site with the help of mobile MRI units and telemedical support by doctors with many years of experience. • The HerzCheck project for innovative heart failure diagnostics is aimed at physicians and AOK-insured persons (patients) in Brandenburg and Mecklenburg-Western Pomerania. • Targeted patients are identified through various routes: <ul style="list-style-type: none"> - Family physicians and specialists can identify suitable patients from their patient base and recommend that they participate in the project. - People can also proactively contact their doctor about possible suitability for participation. - Participating health insurance companies uses its own communication tools to address its insured target database. - After registering, the patient receives an appointment confirmation by e- 	<p>HerzCheck - Herzcheck</p>

	<p>Fund of the Joint Federal Committee (G-BA) under the medical direction of the German Heart Institute Berlin (DHZB) for a period of 3 years.</p> <p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<p>mail and arrives at the MRI trailer on the agreed date.</p> <ul style="list-style-type: none"> - On site, the patient receives project-specific information and consent forms as well as a telemedical explanation by an appropriately trained physician from the German Heart Center Berlin (DHZB). After consent has been given, an MTRA specially trained in cardio-MRI performs the MRI examination. After the examination, the patient receives further patient information in which the next steps are explained in detail. <ul style="list-style-type: none"> • The mobile MRI trailers for cardiac diagnostics are set up at regional clinics or outpatient facilities and accompanied by medical personnel who perform the MRI examination. The MRI examination takes only about 10 to 15 minutes, and specialist monitoring and care is provided by telemedicine. • The examination data are transmitted online to a specialist at the German Heart Institute Berlin (DHZB) in compliance with all data protection regulations. The findings are sent to the participants and their physicians. • Depending on the results of the examination, the patients are divided into groups. Together with the results, the treating physicians also receive recommendations for the further treatment of their patients. 	
9	<p><u>Best Practice:</u></p> <p>European heart health survey 2019</p> <p><i>This practice is applicable to Structural Heart Disease screening</i></p>	<ul style="list-style-type: none"> • Methods and Results: A survey was conducted, including a total of 12 832 people aged ≥ 60 years in 11 European countries. Of all the people surveyed, 5.6% could correctly describe aortic valve stenosis. Most participants (75.0%) claimed they regularly do activities like sports or social activities, 29.2% provide care for a family member, friend or acquaintance. The majority (69.2%) would be prevented from doing these activities by symptoms such as chest pain, fatigue or shortness of breath. Having chest pain (76.5%) and shortness of breath (57.8%) were reasons for most people to arrange 	<p>Gaede, L, Sitges, M, Neil, J, et al. European heart health survey 2019. Clin Cardiol. 2020; 43: 1539– 1546. https://doi.org/10.1002/clc.23478</p>

		<p>an appointment with their GP, whereas only 26.2% would visit a GP for fatigue. 67.6% of respondents claimed to be checked with a stethoscope by their GP occasionally, never, or only when they ask. The preferred treatment option for HVD is a keyhole procedure (45.8%), whereas open heart surgery would only be preferred by 7.0%.</p> <ul style="list-style-type: none"> • Conclusion: Knowledge about HVD is still low. Neither appointments with a GP driven by symptoms nor regular use of a stethoscope are a reliable guarantee for early diagnosis. With the over 60s in Europe playing an active role in social life, awareness campaigns and regular heart health checks may guarantee early diagnosis and treatment of HVD. 	
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4. What could be **role of stakeholders** for achieving the priorities, and the actions that the stakeholders can/should lead and can/should do in collaboration with public health authorities?

Please list up to five suggestions and be as specific as possible.

You may provide a short clarification on why these suggestions rank high and add relevant links (e.g. scientific literature, reports of reference institutions, policy documents).

	Roles	Rationale	References
1	Healthcare professionals in primary and secondary care, medical societies, pharmacist	<p>Healthcare professionals going from General Practitioners, nurses, cardiologists, geriatricians, will be key in providing the right inputs to develop guidelines and consensus on screening approach (age, frequency) as well as their implementation and the actual heart check.</p> <p>These stakeholders would also play a key role in gathering information and data through dedicated SHD patient registries.</p>	EU SHD Coalition Recommendations on how to make SHD detection happen [LINK]

2	Health authorities, payers	To implement more targeted screening and SHD, and to tackle the current gaps and barriers to improve access to early detection, both health authorities and payers in member states will be key: <ul style="list-style-type: none"> - Validation of target population to be included in the detection program - Setting up process and implementing the invitation process - Funding the screening visits - Define referral pathways to ease access to follow-up care 	EU SHD Coalition Recommendations on how to make SHD detection happen [LINK]
3	Patient groups, heart foundations, elderly associations, medical societies	These stakeholders will be key to support and implement awareness raising campaigns at the national levels	Global Heart Hub report on “Heart Valve Disease – Working together to create a better patient journey” [LINK]
4	Innovative medical technology Industry	To tackle the current gaps and barriers to access to early detection, there may be new innovative technologies such as digital stethoscopes, mobile heart checks, biomarkers, and tools to be implemented.	EU SHD Coalition Recommendations on how to make SHD detection happen [LINK]

Closing section

5. You may wish to add other comments (e.g. on the structure of the approach, information gaps, recommendations for better supporting stakeholders).

<p>Comments (maximum 500 words)</p>
<p>The EU Structural Heart Disease Coalition strongly welcomes the Healthier Together Initiative latest working document, which acknowledges the importance to reduce the burden of cardiovascular diseases.</p>

Structural heart disease (SHD) is a set of cardiovascular conditions that affect the structure of the valves, atria, ventricles and blood vessels in the heart, and affecting some 14 million people in Europe today.

A degenerative disease that can generally not be prevented, SHD needs to be detected early to allow patients to benefit from treatments that will reduce mortality, improve quality of life, and reduce healthcare costs.

SHD screening can learn from existing cancer screening programs, and the cancer screening targets at EU level.

The EU SHD Coalition therefore call upon the European Commission and Member States to continue to prioritize early detection of CVDs such as SHD.

The EU4Health Work Programme and forthcoming EU Joint Actions should support the development of **SHD detection guidelines, awareness campaigns, training and incentivization of HCPs and the evaluation of the use of new techniques that can improve SHD detection.**

Please check the boxes that apply:

- I agree that a PDF of this document is uploaded to the Health Policy Platform NCD Stakeholder Group
- I confirm that the document does not include personal information (e.g. names and contact details)

Thank you for your contribution