EU SHD coalition

EVENT REPORT

Delivering Impact

EU Safe Hearts Plan: Strengthening Care Through a Standardised Health Check Protocol

HOSTED BY MEP TOMISLAV SOKOL (EPP, CROATIA), WITH THE SUPPORT OF THE STRUCTURAL HEART DISEASE COALITION

25 FEBRUARY 2026
11:00 – 13:00 CET
EUROPEAN PARLIAMENT, SPINELLI 5E3

Summary

On 25 February 2026, Member of the European Parliament Tomislav Sokol (EPP, Croatia), supported by the EU SHD Coalition hosted the event "**Delivering Impact: EU Safe Hearts Plan on Strengthening Care Through a Standardised Health Check Protocol**".

The event brought together key European policy-makers, doctors, patient advocates and experts in the field of Cardiovascular Diseases (CVDs), who underlined:

Significant gender, socio-economic and geographic disparities, with women and rural populations facing higher rates of misdiagnosis, delayed referrals and poorer follow-up remain widely present in the EU. Across the EU, SHD often progresses silently, underscoring the need for systematic early detection. Evidence from experiences in Spain (including JACARDI and DETECT-SHD), the UK, Italy and San Marino showed that screening in primary care and community settings is feasible, cost-effective and improves outcomes.

Digital innovation, such as AI-supported auscultation and telemedicine, was recognised as essential for expanding screening capacity and supporting overstretched healthcare workforces across Member States. Speakers emphasised that AI can aid early detection, improve referral accuracy, and reduce the administrative burden on clinicians, allowing more time for patient care.

The panellists also highlighted that early detection must be paired with robust secondary prevention, as follow-up care and rehabilitation remain inconsistent across the EU. Fragmented referral pathways, workforce shortages and uneven access to cardiology services were identified as major barriers. A **standardised EU health check protocol** was widely supported by the panellists as the tool to reduce inequalities and streamline Structural Heart Disease patient pathways.

The programs carried out in Spain, Italy, and the UK demonstrated that screening models can be successfully implemented across diverse health systems independently from the level of centralisation. They also showed that early, community-based screening can **effectively support the wider adoption of Health Check Protocols**.

The event concluded with a clear **call for sustained political commitment and long-term investment within the upcoming Multiannual Financial Framework (2028-2032),** recognising that the EU now has both the evidence and the tools to advance cardiovascular and SHD detection. Sustained Funding mechanisms were highlighted as initiatives to achieve this goal. The task ahead lies in ensuring consistent implementation across Member States so that every citizen can benefit from timely, equitable cardiovascular care. were highlighted as initiatives to achieve this goal.

The EU Structural Heart Disease Coalition thanks all speakers and attendees for joining the event.

Report

On Wednesday, 25 February 2026, Member of European Parliament Tomislav Sokol (EPP, Croatia) hosted the event "Delivering Impact: Strengthening Care Through a Standardised Health Check Protocol", with the support of the EU Structural Heart Disease Coalition, which took place at the European Parliament in Brussels.

"Fragmented pathways and uneven access across the EU can no longer be accepted." **– MEP Tomislav Sokol (EPP, Croatia)**

MEP Sokol opened the discussion by underlining the persistent burden of cardiovascular diseases across Europe and the urgent need to shift from a predominantly lifestyle-focused prevention agenda toward systematic early detection and structured care pathways. Drawing on the lessons of the Beating Cancer Plan and the COVID-19 response, he highlighted the importance of coherent benchmarks, harmonised health checks, improved referral routes and equitable access to diagnostics. While clinical expertise exists, he stressed that fragmentation in patient pathways, variable access to care, and prolonged waiting times frequently lead to late diagnosis of SHD, poorer outcomes, and higher system costs. He reiterated Parliament's role in supporting Member States through guidance, best-practice exchange and by promoting the adoption of standardised health checks as a cost-effective approach for Europe's ageing population.

"Cardiovascular dieses are the leading cause of the death in Europe. Structural Heart diseases plays a big part in this grim statistics." – Commissioner for Health and Animal Welfare Olivér Várhelyi

In a dedicated video message, European Commissioner for Health and Animal Welfare Olivér Várhelyi underscored the Commission's emphasis on prevention, early detection, interdisciplinary care pathways, and clear, measurable targets within the EU Safe Hearts Plan published in December 2025. He framed these as essential to reducing the burden of cardiovascular disease across Europe with a specific mention to SHD. Additionally, he highlighted upcoming EU initiatives, including Council Recommendations and the launch of a €20 million incubator to accelerate the deployment of AI and data-driven tools in cardiovascular care will concretely advance on these objectives.

"Many SHD conditions develop silently, with symptoms recognized only late. Early detection is critical yet inconsistent across Member States due to varying screening practices. While we have the tools, our challenge is integrating them in the routine practices." **- Dr Rafael González Manzanares,**

Cardiologist, Reina Sofia University Hospital, Córdoba

To provide a clinical perspective, Dr. Rafael González Manzanares, a cardiologist at Reina Sofia University Hospital in Cordoba, presented the SHD Coalition's proposal for an EU Health Check Protocol (attached in the Annex). He outlined the clinical burden of Structural Heart Disease (SHD), noting that more than 5,000 cardiovascular deaths occur each day in Europe. He also highlighted that forms of SHD, such as degenerative aortic stenosis and mitral regurgitation, often progress silently for years before symptoms appear. He stressed that cardiac auscultation remains a fundamental and efficient first-line detection tool, yet lacks standardisation across the EU.

Drawing on evidence from the JACARDI initiative in Valencia, regional programmes in Spain, protocols in the UK, the PREVASC study on asymptomatic valvular disease in older adults, and population-level screening in San Marino, it was showcased that scalable early-detection models are already functioning successfully regardless of the level of healthcare centralisation. He presented Spain's national SHD strategy and the DETECT-SHD pilot, which is assessing analogue auscultation, digital auscultation with AI support, and pocket echocardiography in adults aged 65+. The pilot aims to reduce mortality, emergency presentations and overall healthcare expenditure.

He concluded that the adoption of standardised protocols, comprising structured history-taking, systematic auscultation and defined minimum diagnostic testing, is both necessary and feasible at EU level.

"Europe has the resources and expertise, what it needed now is consistent political will" **MEP Brando Benifei (S&D, Italy)**

In a video address, MEP Brando Benifei (S&D, Italy) called for a unified European approach to cardiovascular health, emphasising the need for clear priorities, measurable indicators, universal access principles, and robust data infrastructure under the EU Safe Hearts Plan. As rapporteur for the Artificial Intelligence Act, he underscored the potential of AI-enabled diagnostic tools and digital stethoscopes in improving early detection and supporting clinicians in managing cardiovascular conditions more effectively. He emphasised that maintaining cardiovascular health is critical to both societal wellbeing and Europe's competitiveness, and that ambition must be matched with implementation.

Panel 1 - Advancing SHD Early Detection: From Vision to Action

"Innovation, AI, and strong research frameworks are essential to improving SHD detection." **– Grzegorz Owsianik, Team Leader in Unit D1, DG RTD, European Commission**

Commencing the first panel discussion, Grzegorz Owsianik, European Commission, outlined how Horizon Europe, EU4Health and several EU-level research partnerships are supporting Member States through

investments for cardiovascular health. He noted that these programmes provide substantial, multi-year EU funding designed to build research capacity, drive innovation and help Member States adopt digital and AI-enabled solutions within their health systems. He also underscored the commitment of DG RTD in facilitating investments for digitalisation, sex- and gender-specific research, and AI-driven diagnostic innovation. He emphasised the importance of multi-source data integration in improving SHD detection.

"The gap between detection and treatment is one of our biggest failures—delays lead to complications, emergencies and avoidable mortality. We must intervene sooner." **– Prof. Thomas Modine, Bordeaux University Hospital**

Prof. Thomas Modine from the Bordeaux University Hospital, identified the critical gap between diagnosis and treatment, explaining that delays often lead to deterioration and costly emergency admissions. He noted that systematic auscultation, clear referral criteria and defined minimum diagnostic steps could significantly narrow the dangerous gap between detection and treatment. A unified protocol would help ensure that suspicious findings trigger timely follow-up, reduce the number of patients deteriorating while waiting for specialist care, and prevent avoidable emergency admissions. Prof. Modine underscored that such standardisation is essential not only for improving clinical outcomes but also for addressing the fragmentation that currently undermines SHD management across Member States.

He also emphasised that early detection must be accompanied by strong and consistent secondary prevention if the EU is to meaningfully reduce the long-term burden of cardiovascular disease. He noted that half of patients who experience a major cardiovascular event are likely to suffer another, yet follow-up care and rehabilitation programmes remain insufficient or inconsistently implemented across Member States.

"Early detection means little without strong secondary prevention. Too many patients receive no structured follow-up, and that must change if we want to reduce repeat cardiovascular events." **- Emily Phillips, European Society of Cardiology**

Emily Phillips emphasised that while earlier detection is essential, it needs to be paired also with secondary prevention to meaningfully reduce the burden of cardiovascular and structural valve disease. She noted that half of all patients who experience a major cardiovascular event are likely to suffer another, yet follow-up care and rehabilitation programmes remain insufficient or absent in many Member States. These gaps, she explained, stem from the lack of a standardised protocol, fragmented implementation and variations between national systems.

Ms. Phillips highlighted a practical example of the European Society of Cardiology's work in the field of screening and early detection by noting that the organisation recently led an informal task force of experts spanning the diabetes, renal and obesity communities. The group's thorough discussions resulted in the

drafting of EU-wide recommendations to identify risk factors, define appropriate age-check frequencies and develop a simple, scalable protocol for health checks to be rolled out in the EU 27 Members States. As part of these recommendations developed by the experts, she emphasised the need for greater follow-up intensity, long-term adherence support and more coherent care pathways across Europe, noting that without these measures, effective prevention will remain out of reach.

"The biggest barrier is not clinical knowledge but system fragmentation. If early detection is to become routine rather than accidental, we need clearer pathways and real investment in capacity across the EU." **- MEP Aurelijus Veryga (ECR, Lithuania)**

MEP Dr. Aurelijus Veryga (ECR, Lithuania) reiterated that the principal barrier to timely SHD care is systemic fragmentation rather than clinical capability. Uneven access to diagnostics, unclear referral routes and workforce shortages contribute to late diagnosis and poorer patient outcomes. He emphasised that standardised protocols could make early detection routine, but only if accompanied by targeted investments in diagnostics, workforce capacity, AI tools and waiting-time monitoring systems. He further stressed that cardiovascular strategies must be long-term, as the demographic and financial pressures facing Member States require sustained and predictable investment.

Panel 2 - Zooming in on Addressing Inequalities: Diagnosis and Care

"We have the tools to treat SHD, but without early detection they are useless. Inequalities persist at every stage of the care pathway, and we must address them systematically." **- Arunima Himawan, Senior Health Policy and Research Manager at the International Longevity Centre.**

Arunima Himawan, Senior Health Policy and Research Manager at the International Longevity Centre, highlighted that while SHD affects all populations, women are among the most clearly disadvantaged. She emphasised that change is needed across the whole care pathway to significantly improve conditions and create economic benefits for disadvantaged groups. However, persistent barriers, notably the lack of comprehensive health data, continue to hinder progress. Ms. Himawan noted that emerging evidence on women's health outcomes demonstrates a concerning pattern: SHD is still widely perceived as a "disease for men,". Women are, in fact, 50% more likely to be misdiagnosed, and experience an average seven-month delay in receiving care. They are less likely to receive heart checks, tend to be diagnosed at a later age, face delays in referral and accelerated disease progression, and ultimately suffer worse health outcomes, including higher in-hospital mortality. Furthermore, women are less likely to receive combined treatments and benefit from less comprehensive follow-up monitoring.

According to Ms. Himawan, addressing regional and national disparities requires

strengthening care pathways and acknowledging systemic gaps. Implementing targeted interventions is also essential, particularly to ensure that individuals aged 65+ have consistent access to healthcare. Establishing a solid universal screening baseline would enable more effective outreach to the specific communities most at risk.

In this context, discussions also focused on what regular health checks should include and where they should be delivered. Himawan noted that reaching underserved communities demands accessible and trusted points of care, with heart health checks integrated into neighbourhood health hubs, "one-stop shop" community facilities, and community pharmacies. These settings, supported by trusted local staff who can also serve as educators, were identified as essential levers to improve uptake, promote prevention, and reduce entrenched inequalities in SHD outcomes.

"Improving SHD outcomes requires structured regional networks, clear referral timelines and guaranteed continuity of care, especially for the patients who need it most." **- Prof Martine Gilard, Brest Hospital University.**

Professor Martine Gilard, Brest Hospital University, outlined what specialised care for SHD should look like, stressing that minimum standards must be established to reduce misdiagnosis and delays and to guarantee equality of care. She structured intervention around four key pillars. First, the creation of regional SHD networks, linking outpatient clinics with specialist structural heart centres to ensure initial diagnosis, structured follow-up, and the systematic sharing of protocols across regions. Such networks should promote early referral, strengthen professional education, and enhance communication between care levels.

Second, national scientific societies must play a stronger role in improving early detection and reinforcing the importance of appropriate hospitalisation and imaging. Clear triggers for diagnostic imaging should be defined, with streamlined pathways to refer patients promptly to specialised outpatient centres.

Third, referral timelines must be clearly defined and monitored to ensure timeliness of care, recognising that different patient profiles require differentiated timeframes. Monitoring these benchmarks would allow health systems to identify where and why certain patients experience excessive delays.

Finally, continuity of care and structured long-term follow-up must be embedded in care pathways, particularly for disadvantaged patients, to ensure sustained monitoring and equitable outcomes.

Professor Gilard further addressed the organisation of centres of excellence, noting that access varies considerably between regions and Member States. To ensure patients are not excluded due to geography, outpatient specialised clinics must be expanded, both in number and distribution, so that services are available within reasonable distance. Given that SHD predominantly affects older populations and that patient numbers are expected to rise, sufficient financial and human resources must be allocated to meet growing demand. She underscored that investing in accessible specialised care is ultimately cost-effective, as inadequate

follow-up and delayed treatment significantly increase the risk of complications and associated healthcare costs.

***"Patients see where the system fails first. Standardised health checks can level the playing field, regardless of where you live, your gender or your ability to navigate the system."* – Jens Näumann, Patient Advocate**

Speaking both as a patient and as CEO of Initiative Herzklappe, Jens Näumann highlighted persistent gaps in the early detection and management of cardiovascular diseases, particularly SHD. He stressed that while improving early detection is essential across all cardiovascular diseases, it is especially urgent for SHD, where delays have serious consequences. He identified four main shortcomings. First, there is insufficient awareness of SHD symptoms in primary care, which undermines timely suspicion and diagnosis. Second, referral systems are marked by social inequalities: pathways often take too long, and patients who are better connected or more informed tend to navigate the system more successfully. Language barriers, mobility constraints, and socioeconomic status significantly influence how quickly a condition is recognised and addressed. Third, gender inequalities persist, with women being referred and diagnosed later than men, a disparity he emphasised is because of systemic failure. Fourth, rural–urban disparities remain pronounced, as access to timely detection often depends on place of residence. **A patient's postcode must not become a risk factor**; yet shortages of general practitioners and specialised practices in rural areas continue to delay diagnosis.

Mr. Näumann argued that the introduction of a standardised and carefully designed health check is an effective solution support earlier and more equitable detection. He underscored the critical role of patient organisations in shaping national health check protocols, noting that patients experience the healthcare pathway differently from providers and policymakers. As those who navigate the system firsthand, i.e. patient organisations, are often the first to identify structural gaps and inconsistencies in care delivery. Embedding their expertise into the development of standardised health protocols would strengthen responsiveness, improve equity, and ensure that reforms reflect the real-world challenges faced by individuals living with SHD.

Closing Remarks

Concluding the event, Professor Thomas Modine delivered a clear message of urgency, recalling that cardiovascular diseases remain the leading cause of death and require immediate and coordinated action. As Europe's population ages, he stressed that healthy ageing will only be achievable through strengthened early detection and robust crisis care systems. Too often, symptoms are misattributed to "normal ageing," contributing to delayed diagnosis and avoidable deterioration.

At the same time, structural gaps persist, including insufficient funding, shortages of trained imaging personnel, and inadequate access to essential equipment. While innovation in diagnostics and minimally invasive treatments already exists, the real challenge lies in their adoption and diffusion across health systems. Failure to

act not only worsens patient outcomes but also drives up the substantial costs associated with acute emergencies that could have been prevented through earlier intervention.

Professor Modine further emphasised the need to expand training in minimally invasive techniques, harmonise clinical registries to improve data comparability and monitoring, and prioritise high-risk populations in screening and prevention strategies. He pointed to existing European instruments, such as EU4Health and Horizon Europe, as practical tools that can support implementation and investment. Concluding his intervention, he underlined that this is not a call for additional layers of bureaucracy, but rather a call to make better use of existing frameworks and resources to deliver tangible improvements in cardiovascular care.

Annex: “Health Check Protocol”

3. Proven Feasibility in Europe

Several EU regions and health systems already apply routine auscultation:

Spain – Madrid Region3

- Systematic cardiac auscultation every 2 years for all citizens aged 65+.

Spain – Extremadura Region4

- Cardiovascular plan includes **routine auscultation** to improve early detection of valvular disease.

Spanish National Cardiovascular Strategy5

- Statesthat **up to 50%** ofmoderate-to-severe VHD can be detected through auscultation.
- Confirms auscultation is **simple, scalable, and cost-effective**.

NHS Health Check (UK)6

- Uses auscultation and **referral for ECG** as standard pathways for suspected heart disease.

Italy (PREVASC) – Prospective Registry of Epidemiology of Valve Disease Remote Area7

- Asymptomatic patients show prevalence of 30% mild/moderate valvular pathologies

San Marino [8]

- For all citizens aged between 50 and 70 with a 84% participation rate, involving Risk card analysis, cardiological examination, and advanced testing

JACARDI[9]

- JACARDI Work Package 8 (WP8) implements 19 pilot projects across 11 countries to develop and test standardised screening protocols and strategies aimed at the early identification and improved access for high-risk populations for cardiovascular disease and diabetes.

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3 Comunidad de Madrid, Consejería de Sanidad. (2025, September 30). Cartera de Servicios Estandarizados de Atención Primaria de Madrid. Actualización 2025, versión 8ª. Available here

4 Consejería de Salud y Servicios Sociales; Servicio Extremeño de Salud. (2024). Plan Integral de Enfermedades Cardiovasculares y Cerebrovasculares de Extremadura (PIECC) 2024-2027 (horizonte 2037). Available here

5 Ministerio de Sanidad. (2022). Estrategia en salud cardiovascular del Sistema Nacional de Salud (ESCAV). Available here

6 See here

7 Carrabba, N., et al. (2025). The PREVASC study: Prospective Registry of valve disease in asymptomatic Italian elderly subjects. Aging Clinical and Experimental Research, 37, Article 98. https://doi.org/10.1007/s40520-025-02937-5

8 See here

9 See here

4. Core Components of the Ideal EU Heart Health Check Protocol

To ensure consistent early detection and management, the protocol should include:

A. Standardised Health History

- Symptoms: breathlessness, chest discomfort, palpitations, dizziness, fainting, ankle swelling, reduced exercise tolerance.
- Risk factors: hypertension, diabetes, lipid disorders, smoking, alcohol use, family history, previous cardiac interventions.
- Lifestyle: diet, physical activity, sleep, stress.
- Tools: standardised set of tools for symptom and clinical history collection ensures consistency, data comparability and coherent implementation of the protocol across Member States

B. Physical Examination

- Vital signs: blood pressure (bilateral measurement on first visit), heart rate/rhythm, oxygen saturation, BMI/waist circumference.
- Peripheral signs: ankle oedema, jugular venous pressure (JVP), fluid retention.
- Cardiac auscultation: systematic, every 2 years for all citizens aged 65+ 10, standard valve areas, in multiple positions (sitting, supine, lateral), during normal and deep inspiration; detailed documentation of heart sounds and murmurs without requiring primary care diagnostic classification.

Basic standardised training in cardiac auscultation for primary care professionals, which encompasses these three key points, would ensure quality, consistency and confidence in the screening process at EU scale.

C. Minimum Diagnostic Tests

- Routine blood tests including cardiac biomarkers where indicated.
- ECG for patients with symptoms, murmurs, or irregular pulse.

5. Conclusion

The EU Safe Hearts Plan must explicitly include cardiac auscultation and ECG within its Health Check Protocol as standard components alongside blood testing. This will ensure early detection of structural heart disease, equitable access to diagnosis and treatment, and ultimately reduce morbidity and mortality across Europe.

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[10] Carrabba, N., et al. (2025). The PREVASC study: Prospective REgistry of valve disease in asymptomatic Italian elderly subjects. Aging Clinical and Experimental Research, 37, Article 98. https://doi.org/10.1007/s40520-025-02937-5