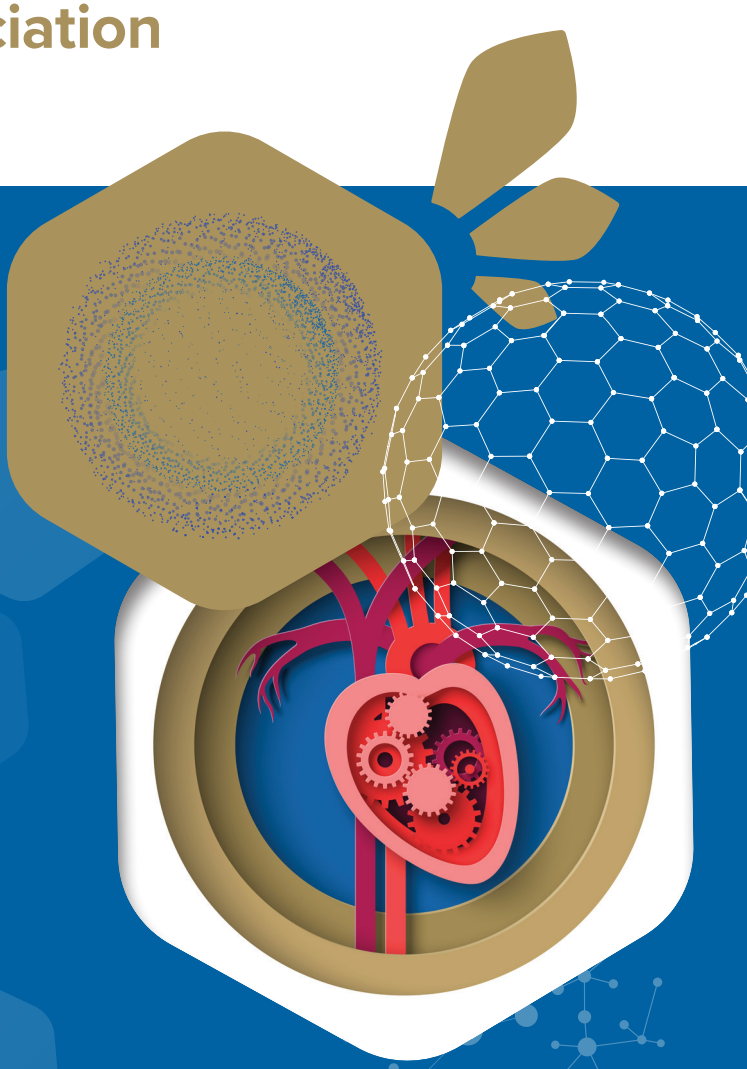
Irish Pharmaceutical Healthcare Association



An IPHA Policy Statement:

Prevent Earlier. Detect Sooner. Treat Better.

Establishing a national cardiovascular and cardiometabolic health-check programme

Prevent Earlier. Detect Sooner. Treat Better.

How Ireland should use the opportunity of its EU Council Presidency to establish a national cardiovascular and cardiometabolic health-check programme within a renewed National Cardiovascular Health Strategy: An IPHA Policy Statement[1].

Executive position. *IPHA supports a renewed Irish cardiovascular policy response that addresses all three EU Safe Hearts pillars: prevention, early detection and screening, and treatment and care. A renewed Irish National Cardiovascular Health Strategy should strengthen prevention, improve the identification and management of cardiovascular risk, support timely access to evidence-based care, and establish measurable national objectives for improving cardiovascular outcomes, including through prevention and management of intertwined diseases such as diabetes and obesity.*

Why Action is Needed Now

Cardiovascular disease (CVD) remains one of the leading causes of death, disability and long-term pressure on health systems in Ireland and across Europe. The policy case for renewed action is stronger now because major cardiovascular risk factors frequently remain undetected, while population ageing and the growing prevalence of interconnected chronic conditions are increasing the overall burden of disease.

- In Ireland approximately **10,000 people die** from cardiovascular conditions each year. This represents approximately 30% of all deaths in Ireland [2].
- Up to **600,000 people** in Ireland are living with a cardiovascular condition, demonstrating that CVD is not only a cause of death but also a major driver of chronic illness, disability and healthcare utilisation[3].
- **One in two families are impacted** by heart disease whether through premature death, disability or living with long-term chronic ill health[4].
- CVD continues to place a substantial burden on individuals, families, the health system and the wider economy - **40% of all hospital admissions** and **75% of hospital bed days** are due to chronic disease[5].

[1] This statement is aligned with the EU Safe Hearts Plan, Programme for Government 2025, Sláintecare, the EU Health-Check Agenda and the National Review of Adult Specialist Cardiac Services.

[2] Irish Heart Foundation Pre Budget Submission 2027 https://irishheart.ie/publications/ihf-pre-budget-submission-2027/

[3] Ibid.

[4] Croi_Manifesto_Future of Cardiovascular Health, 2024 https://croi.ie/croi-brings-civil-society-and-industry-together-to-highlight-urgent-need-for-national-heart-strategy/

[5] Ibid.



- Despite overall improvements in cardiovascular mortality over the past 20 years, **overweight/ obesity-related cardiovascular deaths have tripled**[6].

High blood pressure is one of the most important modifiable risk factors for cardiovascular disease, yet it remains substantially underdiagnosed and undertreated in Ireland. Ireland has one of the lowest rates of hypertension awareness, treatment and control.

High cholesterol is another major, modifiable risk factor for cardiovascular disease. Elevated LDL cholesterol can contribute to the development of atherosclerotic cardiovascular disease over many years without causing symptoms, meaning that risk may remain undetected until a serious cardiovascular event occurs. Earlier and more systematic lipid testing, followed by appropriate risk management and treatment, is therefore essential to preventing avoidable heart attacks and strokes.

The need for earlier identification is particularly important given that, for many people, a serious cardiovascular event may be the first indication of underlying disease. In 75% of people who experienced a heart attack, the heart attack was the first manifestation of cardiovascular disease[7].

Despite sustained improvements in acute cardiovascular care, Ireland faces a changing and increasingly complex risk profile[8]. **Population ageing, demographic change, and the growing prevalence of chronic disease** mean that the overall burden of CVD is expected to increase unless prevention, early detection and long-term disease management are strengthened. Without a greater emphasis on upstream intervention, demand pressures on primary care, hospital services and community-based care will continue to intensify.

The growing prevalence of obesity and other interconnected cardiometabolic conditions is increasing cardiovascular risk and placing additional pressure on health systems. Obesity, diabetes, hypertension, elevated cholesterol and chronic kidney disease frequently coexist and can compound an individual's lifetime risk of cardiovascular disease. Ireland's response should therefore address these interconnected risks through an integrated cardiovascular and cardiometabolic approach, combining population-level prevention with earlier identification and effective management of modifiable risk factors.

CVD also disproportionately affects people living in areas of socioeconomic disadvantage, contributing to persistent health inequalities and avoidable premature mortality[9]. Furthermore, women in particular are more at risk of heart disease according to research undertaken in 2025 by the Irish Heart Foundation. Their survey of 1,000 women found that only 13 per cent of females correctly recognised

[6] Zahra Raisi-Estabragh et. al. (2023)
[7] Lynch, Priscilla (2023) https://www.medicalindependent.ie/clinical-news/advancing-a-prevention-agenda-for-cardiovascular-care-in-ireland/
[8] Ibid.
[9] OECD 2025 https://www.oecd.org/en/publications/the-state-of-cardiovascular-health-in-the-european-union_ea7a15f4-en/full-report/the-burden-of-cardiovascular-disease_e28210c3.html



heart disease and stroke, as their greatest health risk, despite these conditions killing six times as many women as breast cancer[10].

There is also a growing European policy focus on cardiovascular health and the prevention of interconnected non-communicable diseases. This is particularly evident in the European Commission's Safe Hearts Plan, published in December 2025, which calls for coordinated action across prevention, early detection and screening, and treatment and care. It recognises the interconnected roles of major modifiable risk factors and related conditions, including elevated cholesterol, hypertension, obesity, diabetes and chronic kidney disease. According to OECD's recent report on non-communicable diseases (NCDs), obesity offers the greatest opportunity to reduce the NCD burden, including CVD, across OECD countries. Around 90% of patients with diabetes also live with overweight or obesity. Type 2 diabetes (T2D) further amplifies cardiovascular risk, as people living with T2D are 2-4 times more likely to develop CVD than those without[11].

These factors all reinforce the need for an integrated approach to prevention, earlier risk identification and effective management across the life course.

Cardiovascular Prevention is Economically Smart

A renewed cardiovascular strategy is not only a health imperative but an economic necessity. CVD is estimated to cost the Irish State €1.7 billion annually, with 46% of this being direct healthcare costs.[12] The remainder arises from productivity losses, informal care requirements and wider societal impacts.

Research from University College Cork (UCC)[13] demonstrates that the incremental cost of healthcare service use in the population with CVD is an estimated €352.2 million, 93% of which is due to use of secondary care services. Furthermore, around 85,000 people are discharged from hospital each year following cardiovascular admissions[14]. This highlights that the greatest costs arise after disease progression rather than before with hospital admissions by far the greatest cost driver.

The economic impact on patients and families is also significant. Irish Heart Foundation research from 2024 found that employment among people living with heart failure falls from 62% pre-diagnosis to just 26% afterwards, while around 60% experience a substantial reduction in income[15].

[10] Irish Heart Foundation (2025) https://irishheart.ie/news/her-heart-matters-supporting-women-through-barriers/
[11] European Society of Cardiology (2023) https://www.escardio.org/guidelines/clinical-practice-guidelines/all-esc-practice-guidelines/cvd-and-diabetes/
[12] Dáil Debate 27th November 2025 https://www.oireachtas.ie/en/debates/question/2025-11-27/495/
[13] Stamenic D, et al. (2025) https://cora.ucc.ie/server/api/core/bitstreams/a40666cc-4e46-414d-8c94-3a25cc60210f/content
[14] Irish Heart Foundation Pre Budget Submission 2027 https://irishheart.ie/publications/ihf-pre-budget-submission-2027/
[15] Irish Heart Foundation, Pre-Budget Submission 2024 https://irishheart.ie/wp-content/uploads/2023/10/Irish-Heart-Foundation-Pre-Budget-Submission-2024.pdf

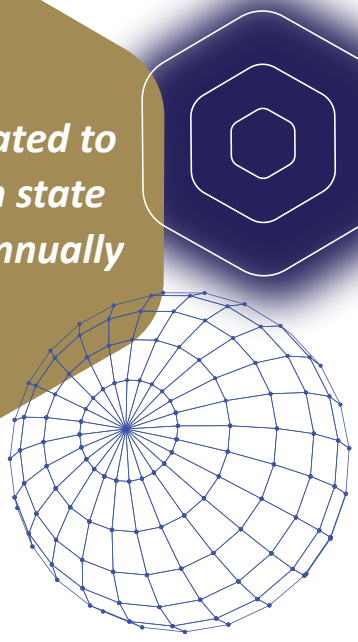
Investment in prevention, early detection and effective disease management pathways of CVD and interconnected diseases should be viewed as an opportunity to reduce avoidable downstream expenditure rather than as an additional healthcare cost. For example, two in three obesity-related deaths are linked to CVD[16] [17], and according to the OECD, obesity contributes to around 23% of CVD treatment costs[18]. Treating people with both T2D and CVD costs €3,000–€8,000 more per year than treating diabetes alone.

Strengthening cardiovascular prevention and risk-factor management aligns with broader national health reform objectives. We therefore have an opportunity to build on existing infrastructure:

- Programme for Government 2025 commits to develop "a new and more ambitious plan" building on the existing national cardiovascular policy, creating an immediate policy opening.
- Sláintecare, Ireland's universal healthcare strategy, is transforming cardiovascular health by shifting care from over-burdened hospitals to local communities. It focuses heavily on early intervention, integrated heart diagnostics, and post-event rehabilitation to decrease the overall burden of cardiovascular disease (CVD).
- The National Review of Adult Specialist Cardiac Services in Ireland, chaired by Professor Philip Nolan (known as the Nolan Review) reinforces the case for stronger preventive cardiology, systematic screening, patient empowerment, and better integration across primary, community and acute care.
- The HSE Chronic Disease Management Programme has the potential to be a valuable platform that could be expanded to support earlier prevention efforts and cardiovascular risk management in younger populations. With 50% of the Irish population set to be over 65 in five years, investing in a healthy, younger population is critical for the wider Ireland socio-economy. A primary care - cardiology - public health partnership could be facilitated via an expanded Chronic Disease Management framework, with cardiology leadership.

There is also a growing European policy focus on cardiovascular health and the prevention of interconnected non-communicable diseases (NCDs). This is particularly evident in the European Commission's Safe Hearts Plan, published in December 2025, which promotes an integrated cardiovascular and cardiometabolic approach, addressing major risk factors and related conditions including elevated cholesterol, hypertension, obesity and diabetes.

CVD is estimated to cost the Irish state €1.7 billion annually



[16] Martin-Timon I, Sevillano-Collantes C, Segura-Galindo A, et al. (2014)
[17] Collaborators GBDO, Afshin A, Forouzanfar MH, et al. (2019)
[18] OECD (2019). https://www.oecd.org/en/publications/the-heavy-burden-of-obesity_67450d67-en.html

EU Safe Hearts Plan: Summarised[19]

The Safe Hearts Plan is the European Commission's strategic response to cardiovascular diseases (CVD), which are the leading cause of death and disability in the EU, affecting 62 million people and costing over €282 billion annually. The plan aims to deliver tangible benefits for citizens, health systems, and society through ambitious, high-impact actions, focusing on prevention, early detection, and treatment/care, while addressing digital innovation, research, and inequalities.

Three Strategic Pillars

1. **Prevention**
2. **Early Detection and Screening**
3. **Treatment and Care**

The three Safe Hearts pillars and their relative merit for Ireland

PILLAR 1: Prevention	PILLAR 2: Early Detection and Screening	PILLAR 3: Treatment and Care
Prevention offers the largest long-term population-health return. It aligns strongly with current Government priorities on obesity, physical activity, tobacco and vaping, public health and health inequalities. **Relative merit:** Essential foundation and strongest long-range lever.	This is the most actionable EU Presidency-era opportunity. It provides a practical route to earlier identification of risk, especially through health checks covering blood pressure, cholesterol, glycaemic status, obesity-related risk, FH, Lp(a), smoking status, family history and community-facing "know your numbers" campaigns. **Relative merit:** Highest near-term advocacy value for Ireland, patients, the health system and the research-based medicines sector.	Detection only improves outcomes when it leads to action. Guideline-based treatment, timely referral, treatment intensification, rehabilitation and adherence support must therefore be built into any screening model from the start. **Relative merit:** Critical enabler of real-world impact and equity.

[19] Verify the summary against the original EU document and replace the AI attribution with an appropriate source reference

Now is the time for action. In 2010, the then Minister for Health, Mary Harney, launched a Cardiovascular Strategy which aimed to provide an integrated and quality-assured policy framework for the prevention, detection, and treatment of cardiovascular disease, including stroke and peripheral arterial disease. However, this expired in 2019 with several of the policy recommendations remaining unaddressed and the system operating within a vacuum. Yet, the National Institute for Prevention and Cardiovascular Health, Irish Heart Foundation and Croí have in recent years repeatedly highlighted that around 80% of premature cardiovascular disease is preventable.

Therefore, IPHA believes that the three pillars of the EU Safe Hearts Plan are mutually reinforcing and should not be considered in isolation. For Ireland, the greatest immediate opportunity lies in earlier identification of cardiovascular risk through systematic cardiometabolic health checks, supported by prevention initiatives and clear treatment pathways that improve outcomes following diagnosis[20].

Case Study 1: Greece's Landmark Cardiovascular and Metabolic Screening Programme[21]

The EU Safe Hearts Plan places particular emphasis on health checks, risk assessment and earlier identification of cardiovascular disease and associated risk factors such as diabetes and obesity.

Greece is at the forefront of EU cardiovascular screening initiatives. In 2025 Greece launched one of Europe's largest cardiovascular screening initiatives, aiming to screen 5.5 million people as part of its wider Prolamvano ("I Prevent") prevention programme. Cardiovascular disease is the leading cause of death in Greece, accounting for 31% of male deaths and 34% of female deaths, while costing the economy more than €4.3 billion annually. The Greek CVD and Metabolic screening programme is available to all citizens aged 30-70 years with no known history of CVD. Through a nationally digitally supported coordinated invitation process, eligible individuals receive free cardiovascular health checks including cholesterol, Body Mass Index (BMI), blood glucose and lipoprotein(a) testing. Those identified as being at increased cardiovascular risk are subsequently referred through structured clinical pathways for further assessment, specialist review and additional diagnostic testing where required, ensuring that screening is linked directly to diagnosis, prevention and ongoing treatment and care.

Already reaching 3 million people, the Greek initiative demonstrates how large-scale population screening can move beyond simple testing to create clear nationally coordinated pathways that link population health checks to risk assessment, specialist referral, diagnosis and ongoing management. It also aims to foster a stronger culture of prevention among the public and policymakers, with the goal of reducing future cardiovascular events, avoiding costly hospitalisations and improving long-term population health outcomes.

[20] IPHA supports a comprehensive approach to cardiovascular health that includes prevention, early detection and treatment. While recognising the critical role of measures addressing obesity, smoking, vaping, physical inactivity and poor diet, this paper focuses on detection and screening, where the innovative pharmaceutical industry can make a distinct contribution through advances in diagnostics, risk assessment and evidence-based interventions. IPHA recognises that sustained progress in CVD will require complementary action on obesity, smoking, vaping, physical inactivity and healthy ageing.

[21] European Society of Cardiology (2025) https://www.escardio.org/news/news-room/greek-screening-campaign-aims-to-reach-5.5-million-people

Early detection and screening represent one important area of alignment between emerging EU cardiovascular policy and Ireland's ambition to strengthen prevention and population health. IPHA members share a strong interest in earlier identification of cardiovascular risk, inherited risk, cardiometabolic health checks and integrated cardiometabolic prevention. Ireland's ongoing reforms across primary care, chronic disease management, pharmacy and community services provide a platform upon which a more systematic cardiovascular risk assessment framework could be developed.

Therefore, for Ireland, the Greek model provides a practical example of how a national cardiovascular strategy could combine broad population screening, targeted risk assessment and integrated follow-up care to deliver measurable health improvements and economic benefits. Applying a similar scale to Ireland would mean screening approximately 3 million people (of total 5.46 million – CSO, 2025) who are aged 35 years and over.



Early Detection for the general population: A Catalyst for Better Cardiovascular Outcomes

CVD risk factors, such as high cholesterol and uncontrolled hypertension, often do not cause symptoms and in some cases can only be detected through testing. In Ireland testing for these risk factors is currently recommended for individuals over 40 and those with risk factors, but uptake remains variable and dependent on healthcare utilisation patterns[22].

A more systematic approach to cholesterol testing, monitoring of blood pressure and assessment of BMI and waist circumference or waist-to-height ratio as part of mid-life health assessments would enable earlier identification of elevated LDL-C, uncontrolled hypertension and central adiposity, support timely holistic prevention, intervention and treatment pathway identification, and help to prevent avoidable cardiovascular events[23].

Ireland's new cardiac strategy should therefore enhance its current screening pathways, with targeted outreach to underserved populations to ensure equitable access and build on EU momentum through a national cardiovascular and cardiometabolic health-check framework centred on a:

Know Your Numbers by 35: A National Cardiovascular Health Check Framework

- Ireland's new cardiovascular strategy should build on EU momentum through a national cardiovascular and cardiometabolic health-check framework centred on a "Know Your Numbers by 35" campaign to be rolled out by 2028.

[22] Irish Heart Foundation (2023) https://irishheart.ie/wp-content/uploads/2023/11/IHF_CVD_PP_FINAL_SCREEN.pdf
[23] European Society of Cardiology (2021) https://eas-society.org/wp-content/uploads/2022/05/2021-Prevention-Guidelines.pdf

The strategy should involve a national 'Know Your Numbers, Own Your Numbers' campaign to empower people

This is aligned with recommendations by the European Society of Cardiology who earlier in 2026 called on the European Commission to include a structured approach for rolling out of health checks across all 27 EU Member States under the European Cardiovascular Health Plan with at least one cardiovascular-renal-metabolic health check for individuals under 35 years[24]. This also supports the EFPIA position on Cardiovascular Health Checks by 35 years[25] and the European Alliance for Cardiovascular Health (EACH) which supports the development of a coordinated, evidence-based European framework for cardiovascular health checks aligned with the objectives of the EU Cardiovascular Health Plan – Safe Hearts Plan[26].

The strategy should establish a clear maximum age of 35 for a first comprehensive cardiovascular risk assessment, with earlier assessment where clinically indicated for individuals at higher risk. The proposed age serves as a practical public-health anchor designed to support earlier identification of modifiable cardiovascular risk factors and encourage a life-course approach to cardiovascular prevention, rather than being regarded as a clinical threshold.

IPHA contends that every adult should receive a comprehensive cardiovascular risk assessment by age 35, including:

- Blood pressure
- Lipid profile, including LDL-Cholesterol and Lipoprotein(a) (Lp(a))
- Blood glucose and HbA1c, or equivalent measures
- Body composition measures and Body Mass Index (BMI)
- Chronic kidney disease (CKD)
- Smoking status
- Family history
- Validated cardiovascular risk assessment tools

Heart auscultation (stethoscope check) at key life stages would also support the early identification of heart valve disease and other structural cardiac conditions. Therefore, establishing an age-specific milestone creates a simple and memorable public-health objective that encourages individuals to engage with their cardiovascular health before significant disease develops.

The strategy should also establish national LDL-C screening and recording targets that ensure an annually defined proportion of adults should have a documented lipid profile, including LDL-C, by age 35, with repeat assessment intervals guided by risk and clinical need. This would turn the "Know Your Numbers by 35" concept into a measurable national implementation objective.

[24] European Society of Cardiology (2026) https://www.escardio.org/news/news-room/recommendations-for-eu-wide-cardiometabolic-health-checks/
[25] EFPIA (2026) https://www.efpia.eu/news-events/the-efpia-view/efpia-news/why-cardiovascular-health-checks-the-case-for-eu-action/
[26] EACH proposal for a European Cardiovascular Health Check Protocol (2026) https://www.cardiovascular-alliance.eu/each-response-to-the-public-consultation-on-cardiovascular-health-checks/

Know Your Numbers, Own Your Numbers

A national "Know Your Numbers, Own Your Numbers" public health awareness campaign would empower people to take an active role in managing their health by understanding key cardiovascular risk indicators such as blood pressure, cholesterol, blood glucose, body mass index (BMI), and heart rate. By increasing awareness of these important health markers, individuals can make informed decisions, engage more effectively with healthcare professionals, and take practical steps to reduce their risk of heart disease, stroke, and other chronic conditions.

This data could be captured, stored and monitored through the HSE App, providing people with easy access to and visibility of their health numbers through their mobile phone. Integrating these health metrics into the HSE App would provide a simple and accessible way for people to track their cardiovascular health over time. Individuals could securely view, store and monitor their key health numbers in one place, receive reminders for regular checks, and identify changes that may require medical attention. Importantly, the App would support, rather than replace, engagement with healthcare professionals by helping people better understand their health information and facilitating more informed conversations with their care team. By making health information more accessible and understandable, the initiative would empower people to take an active role in managing their cardiovascular health, promote preventive care, and enable earlier intervention where needed, while ensuring that clinical guidance and support remain central to decision-making.

IPHA believes that by incorporating patient-reported outcomes will ensure that any strategy will empower individuals to actively participate in improving cardiovascular health.

LDL-C: A Causal and Modifiable Risk Factor

- Any national cardiovascular health-check framework should clearly recognise LDL cholesterol (LDL-C) as a causal and modifiable risk factor for atherosclerotic cardiovascular disease.

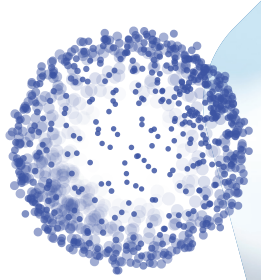
While blood pressure, diabetes, obesity and smoking remain critically important cardiovascular risk factors, LDL-C warrants particular focus because of its direct causal role in atherosclerotic cardiovascular disease and the emphasis placed on cholesterol management within the EU Safe Hearts Plan.

Unlike many cardiovascular risk markers, LDL-C is directly involved in the development of atherosclerotic plaque and can be effectively reduced through evidence-based medicines and lifestyle interventions such as dietary modification, physical activity promotion, smoking cessation, weight management and behavioural support.

Earlier identification of elevated LDL-C enables timely intervention that can substantially reduce the risk of heart attack, stroke and other cardiovascular events throughout a person's lifetime.

Lipid-lowering therapy (LLT) optimisation should be strengthened through improved adoption and implementation of guideline-concordant LDL-C management. This should include optimised LDL-C testing, screening and monitoring by 2028, alongside the introduction of LDL-C quality measures in Ireland by 2030.

Greater emphasis should also be placed on achieving LDL-C goals earlier, reducing cumulative lifetime exposure to elevated LDL-C and the associated cardiovascular risk.



Prioritising High-Risk Populations and Inherited Cardiovascular Conditions

- A renewed cardiovascular strategy should include targeted approaches for those at greatest risk.

Particular attention should be given to:

- Familial hypercholesterolaemia (FH)
- Elevated Lp(a)
- Diabetes
- Hypertension
- Obesity
- Chronic kidney disease
- Chronic inflammatory conditions
- Cardio-oncology patients
- Women with sex-specific cardiovascular risk factors
- Socio-economically disadvantaged populations
- Family history

This is consistent with the Nolan Review which specifically recommends systematic national screening for hyperlipidaemia and familial hypercholesterolaemia.

Ireland should support:

- Universal paediatric FH screening
- Wider access to genetic testing
- National cascade screening programmes
- Interoperable FH registries
- Once-in-a-lifetime Lp(a) testing
- Prenatal screening and neonatal detection (e.g. pulse oximetry) for congenital heart disease



These measures would allow Ireland to become a leader in inherited cardiovascular risk detection. But it is important to note that identifying risk factors alone will not improve outcomes unless accompanied by public health initiatives and associated action points such as structured management pathways, prevention programmes, behaviour-change interventions, and ongoing follow-up.

Innovation Must Be Part of the Solution

- A modern cardiovascular strategy should embrace innovation across the entire patient pathway from genetic testing, innovative medicines, electronic health records, advanced diagnostics, AI enabled risk stratification and real-world data collection and evaluation

As Ireland seeks to position itself as a European life sciences leader during its EU Presidency, cardiovascular health presents an important opportunity to demonstrate how innovation can improve both patient outcomes and health-system sustainability.

Innovation should be viewed as an enabler of better cardiovascular care rather than an end in itself. A renewed National Cardiovascular Health Strategy should create an environment in which validated innovations can be rapidly evaluated, adopted and scaled where they demonstrate improvements in outcomes, efficiency or equity. This should include genomic and biomarker-based risk assessment, AI-supported risk stratification and diagnostics, clinical decision-support systems, remote monitoring, interoperable health records and patient-facing digital tools. These technologies could help identify high-risk individuals earlier, support healthcare professionals to implement guideline-based care, enable patients to monitor and understand their own cardiovascular health, and generate real-world evidence on outcomes across the health system.



Ireland should establish structured mechanisms for piloting and evaluating cardiovascular innovation within the health service, with clear criteria for clinical effectiveness, cost-effectiveness, data governance, interoperability and equity. Successful innovations should have defined pathways for national adoption and scale-up, helping to close the gap between the availability of innovation and its implementation in routine care.

Detection Must Lead to Action

Screening alone does not improve outcomes. Earlier identification of cardiovascular risk must be linked to clear, evidence-based pathways that enable timely intervention, treatment and ongoing care. Every cardiovascular health check should therefore be supported by defined referral and management pathways, including:

- Risk-factor reduction interventions
- GP follow-up
- Specialist referral where appropriate
- Treatment initiation
- Treatment intensification
- Adherence support
- Secondary prevention interventions as appropriate e.g. cardiac rehabilitation
- Ongoing monitoring and reporting

Earlier detection only delivers population-health benefit when patients can access timely, guideline-concordant treatment. As cardiovascular screening expands, policymakers should ensure that reimbursement, access and treatment pathways support the rapid implementation of evidence-based interventions for those identified as being at high or very high cardiovascular risk. Delays between diagnosis and treatment can reduce the potential health gains associated with early detection programmes.

A renewed National Cardiovascular Health Strategy should support a treat-to-target approach for all modifiable risk factors, aligned with relevant European clinical guidelines, with national reporting on target attainment helping to monitor progress and outcomes over time. Such an approach would align with the growing emphasis across Europe on achieving measurable cardiovascular outcomes rather than simply identifying risk.

Preventive pathways should also incorporate broader cardiovascular risk-reduction measures, including appropriate vaccination, lifestyle modification and management of co-morbid conditions. A comprehensive approach to cardiovascular health requires both the identification of risk and action to reduce the likelihood of future cardiovascular events.

However, expanding cardiometabolic health checks will inevitably increase demand across primary care, diagnostic services and specialist cardiovascular care. Identifying more people at risk is only beneficial if the health system has the capacity to respond. Workforce planning must therefore be recognised as a critical enabler of any national cardiovascular strategy. Investment in screening should be accompanied by investment in resources for all HCPs involved in cardiovascular and multidisciplinary models of care, ensuring that patients can access timely assessment, follow-up and treatment.

Building workforce and service capacity from the outset will help avoid bottlenecks in care, prevent delays in treatment, and ensure that the benefits of earlier detection are fully realised. It will also support the delivery of more integrated care across primary, community and hospital settings, consistent with Sláintecare's objective of shifting care closer to home.



Ultimately, the success of a national cardiovascular strategy should not be measured by the number of tests performed, but by its ability to reduce cardiovascular events, premature mortality, hospitalisations, health inequalities and the long-term burden of cardiovascular disease on individuals, families and the health system.

Case Study 2: The United Kingdom Strategic Framework for Cardiovascular Improvement

Recent developments in the United Kingdom demonstrate how cardiovascular disease can be addressed through a structured national framework that combines prevention, risk-factor management, service reform, accountability and measurable outcomes. The UK's approach provides a useful example of how national policy ambition can be translated into a long-term implementation framework for cardiovascular health. The Cardiovascular Disease Modern Service Framework establishes a 10-year strategic vision for reducing the burden of cardiovascular disease and improving outcomes across the health system[27].

Measurable Outcomes and Mortality Reduction

A key characteristic of effective cardiovascular strategies is the establishment of clear national outcome measures. The UK framework includes an ambition to reduce premature deaths from heart disease and stroke by 25% over the next decade, providing a measurable benchmark against which implementation and progress can be assessed. This demonstrates the value of setting defined national objectives that can guide policy, resource allocation and service delivery over time.

Prevention and Cardiovascular Risk-Factor Management

The UK model places significant emphasis on prevention and the systematic management of modifiable cardiovascular risk factors. Cholesterol, blood pressure, smoking and diabetes are identified as key drivers of cardiovascular disease and are incorporated within a broader approach focused on earlier identification and management of risk. This preventive focus reflects a growing recognition that reducing the burden of cardiovascular disease requires action before the onset of major cardiovascular events.

Treatment Optimisation and Delivery Pathways

Effective screening only improves outcomes when it is linked to clear treatment pathways. A notable strength of the UK approach is the translation of policy ambition into practical delivery mechanisms. National priorities are supported through implementation frameworks, clinical pathways, service redesign and defined responsibilities across the health system, helping to ensure that policy objectives are translated into tangible improvements in prevention, diagnosis, treatment and patient care. NHS England's lipid optimisation pathways provide a practical example of this approach in action. These pathways support implementation of guideline-based care, treatment escalation where appropriate and more systematic lipid management, demonstrating how structured clinical pathways can help improve cardiovascular outcomes following identification of risk.

[27] NHS England (2026) Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach- the strategic vision and delivery model

Accountability and Governance

The UK framework is structured not simply as a policy statement, but as a long-term delivery model with defined priorities, implementation mechanisms and outcome measures. This approach strengthens accountability, provides clarity around delivery expectations and supports ongoing monitoring of progress. By linking strategic objectives to implementation frameworks and measurable outcomes, the model seeks to ensure that policy commitments translate into improvements in cardiovascular health.

Implications for Ireland

While Ireland's health system differs from that of the UK, the approach highlights several important principles that could inform a renewed National Cardiovascular Health Strategy:

- Publish a national cardiovascular strategy.
- Establish measurable cardiovascular outcome targets, including reductions in premature cardiovascular mortality through earlier screening and follow-up management of risk factors.
- Elevate LDL-C as a core cardiovascular risk factor within prevention, screening and treatment programmes.
- Support treat-to-target LDL-C management through guideline-based care pathways.
- Introduce measurable screening objectives, including population-level assessment of cardiometabolic risk factors.
- Strengthen accountability through governance structures, implementation milestones and public reporting.
- Develop annual cardiovascular outcomes reporting and a national dashboard to monitor progress.
- Ensure sufficient workforce, diagnostics, digital infrastructure and treatment capacity to support implementation.

A renewed Irish National Cardiovascular Health Strategy should therefore seek not only to expand prevention and screening initiatives, but also to establish a clear implementation framework with defined outcomes, accountability measures and regular public reporting on progress.

The patient voice should also be central to implementation, with initiatives and programmes co-designed in partnership with patient organisations

What the next Irish cardiovascular strategy needs to address:

A strong Irish policy response should be measurable, prevention-led and implementable. It should not simply restate ambition. It should define who is reached, who delivers, how patients move through the pathway, and how progress is reported publicly.

Cardiometabolic health checks should be practical, not abstract. The focus should be on delivery through primary care and community settings, supported by targeted outreach and, where appropriate, mobile or underserved-area approaches.

Inherited risk needs named policy attention. FH, cascade screening and once-in-a-lifetime Lp(a) testing are high-impact areas where Ireland can demonstrate leadership, within a broader cardiometabolic health-check framework.

Obesity and diabetes should be core to the health-check ask. Glycaemic status and obesity-related risk sit alongside blood pressure and lipid assessment within a single cardiovascular and cardiometabolic framework.

Health inequalities should be explicitly recognised. The Safe Hearts approach and the Irish evidence base support stronger recognition of differing risk profiles, unequal disease burden, and disparities in access to care.

The patient voice should also be central to implementation, with initiatives and programmes co-designed in partnership with patient organisations.

Workforce and Service Capacity: A Critical Enabler

A national cardiovascular health-check programme will only deliver value if there is a multidisciplinary approach and sufficient capacity across primary, community and specialist services, including lifestyle medicine and digital health, to support follow-up, treatment and ongoing management. Investment should therefore be accompanied by a workforce plan for all HCPs involved in cardiovascular care and preventive cardiology services, alongside expanded diagnostic and digital infrastructure. GPs in particular play a crucial role in terms of continuity of care and patient engagement through regular assessment of cardiovascular risk factors. Addressing these capacity challenges from the outset will help ensure that earlier detection leads to meaningful clinical action rather than longer waiting lists, ultimately strengthening both patient outcomes and health system sustainability.

Measurable outcomes and accountability

The renewed strategy should include a set of national outcome and implementation targets from inception. These should include:

- reduction in premature cardiovascular mortality,
- reduction in avoidable cardiovascular events and hospitalisations,
- narrowing of inequalities,
- population screening uptake,
- LDL-C screening, and target attainment among high-risk populations.
- FH detection and cascade screening,
- Lp(a) testing,
- Overall and central adiposity assessment through measuring body mass index (BMI) and waist circumference or waist-to-height ratio.
- Blood pressure monitoring and recording.

The strategy should establish an annual public implementation report and a national cardiovascular outcomes dashboard, allowing Government, the HSE, clinicians, patients and other stakeholders to assess progress against agreed milestones.

Vaccination should also be monitored as part of broader cardiovascular prevention for at-risk populations.

Funding

The renewed National Cardiovascular Health Strategy should be published with a clear Government implementation commitment from inception, including multi-annual funding, workforce planning, delivery milestones and public reporting arrangements. Without funding and delivery infrastructure from the outset, the strategy risks restating ambition without enabling implementation.

IPHA's Asks:

1

Publish a new national cardiovascular health strategy and build delivery capacity

Ensure coherence with Department of Health strategies for cardiovascular disease, obesity, diabetes and related co-morbidities which is aligned with the Safe Hearts Plan.

Set measurable national targets, governance, delivery milestones and dedicated funding. Measurable outputs should include tracking:

- percentage of population screened
- proportion of population achieving blood pressure and HbA1c targets
- cardiac rehabilitation participation
- reduction in waitlists for key diagnostics

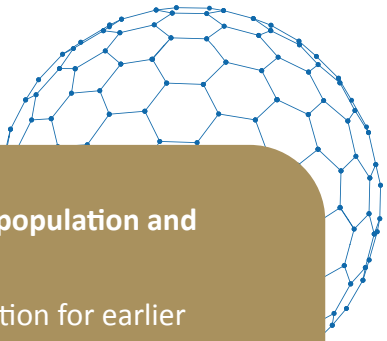
Publish and commence implementation of the Irish strategy in 2027 with an accompanying multi-annual implementation budget, workforce plan and delivery roadmap from inception, so that commitments are funded, sequenced and accountable from the point of launch.

The strategy to include supports for GPs, community diagnostics, pharmacies, preventive cardiology services, referral pathways and interoperable digital systems so that risk assessment is consistent, accessible and scalable nationwide.

Use the Irish Presidency period to position Ireland as an implementation leader within the EU Presidency Trio.



IPHA's Asks:



2

Introduce a national cardiovascular health-check framework for the general population and prioritise high-risk populations

Develop a national cardiovascular health-check strategy to provide the foundation for earlier detection, risk stratification and structured follow-up across the population.

This should include a practical "Know Your Numbers by 35" framework covering blood pressure, lipid profile (including LDL-C), lipoprotein(a), blood glucose and HbA1c, BMI and waist circumference, smoking status and family history, supported by validated risk assessment tools and clearly defined follow-up pathways.

LDL-C management should be embedded as a core priority, including improved LDL-C screening and monitoring by 2028, LDL-C quality measures by 2030, and explicit national targets for LDL-C screening, recording and follow-up.

Priority needs to be given to inherited and cardiometabolic high-risk populations. This requires strengthening of detection and management pathways for familial hypercholesterolaemia, elevated Lp(a), diabetes, chronic kidney disease, hypertension, obesity, chronic inflammatory disease, cardio-oncology patients, women with sex-specific risk factors, and socioeconomically disadvantaged groups.

Digital enablement should support people to "Own Their Numbers" through the HSE App, providing secure access to their personal cardiovascular health information in one place. Engagement in this specific measure of the new strategy can be tracked through the App usage.

3

Guarantee action after the check

Ensure that earlier detection leads to timely intervention, treatment optimisation, rehabilitation and ongoing support. A screening model without action will not deliver equity, event reduction or value for money.

Promote integrated cardiovascular prevention measures, including risk-factor management, health literacy initiatives and appropriate uptake of recommended vaccination programmes among at-risk populations.

Ensure national health-check programmes are supported by pathways that provide timely access to evidence-based care for eligible patients.

Establish a national cardiovascular outcomes dashboard and annual implementation report to be operational by 2028 covering mortality, cardiovascular events, hospitalisations, screening uptake, FH detection, Lp(a) testing, LDL-C target attainment, equity measures and service capacity.

Conclusion

Ireland now has a credible opportunity to move from a policy gap to a policy leadership position in cardiovascular health and in doing so design recommendations that reflect Irish clinical practice, healthcare structure and guideline implementation realities. The combination of the Safe Hearts Plan, Programme for Government 2025, Sláintecare reform, the Nolan review and the EU health check agenda creates a rare alignment between European direction, national policy intent and service reform need.

IPHA advocates for the establishment of a national cardiovascular and cardiometabolic health-check framework within a renewed National Cardiovascular Health Strategy. This prevention-led, action-oriented health-check framework would allow Ireland to show how Safe Hearts can be translated into practical national policy with measurable benefit for patients, health systems and society.

A renewed National Cardiovascular Health Strategy should be built around a simple principle:

Prevent earlier. Detect sooner. Treat better.

By linking prevention, early detection and timely treatment, Ireland can reduce avoidable deaths, improve patient outcomes, address health inequalities and deliver a more sustainable health system for future generations. The strategy should be explicitly outcomes-led, with a national ambition to reduce premature cardiovascular mortality and measurable targets for screening, treatment optimisation, health inequalities and implementation progress.



References

Crio Manifesto Future of Cardiovascular Health (2024) https://croi.ie/croi-brings-civil-society-and-industry-together-to-highlight-urgent-need-for-national-heart-strategy/

Dáil Debate 27th November 2025 https://www.oireachtas.ie/en/debates/question/2025-11-27/495/

EACH proposal for a European Cardiovascular Health Check Protocol, (2026) https://www.cardiovascular-alliance.eu/each-response-to-the-public-consultation-on-cardiovascular-health-checks/

EFPIA, Why cardiovascular health checks: The case for EU action (2026)

https://www.efpia.eu/news-events/the-efpia-view/efpia-news/why-cardiovascular-health-checks-the-case-for-eu-action/

European Society of Cardiology, ESC Guidelines for the management of cardiovascular disease in patients with diabetes, (2023) https://www.escardio.org/guidelines/clinical-practice-guidelines/all-esc-practice-guidelines/cvd-and-diabetes/

European Society of Cardiology, Greek screening campaign aims to reach 5.5 million people, (2025) https://www.escardio.org/news/news-room/greek-screening-campaign-aims-to-reach-5.5-million-people

European Society of Cardiology, (ESC) Prevention Guidelines (2021) https://eas-society.org/wp-content/uploads/2022/05/2021-Prevention-Guidelines.pdf

European Society for Cardiology, Recommendations for EU-wide cardiometabolic health checks (2025) https://www.escardio.org/news/news-room/recommendations-for-eu-wide-cardiometabolic-health-checks/

Irish Heart Foundation Pre Budget Submission 2027 https://irishheart.ie/publications/ihf-pre-budget-submission-2027/

Irish Heart Foundation, Pre-Budget Submission 2024 https://irishheart.ie/wp-content/uploads/2023/10/Irish-Heart-Foundation-Pre-Budget-Submission-2024.pdf

Irish Heart Foundation, Her Heart Matters – supporting women through barriers (2025) https://irishheart.ie/news/her-heart-matters-supporting-women-through-barriers/

Irish Heart Foundation – Primary Prevention of CVD (2023) https://irishheart.ie/wp-content/uploads/2023/11/IHF_CVD_PP_FINAL_SCREEN.pdf

Lynch, Priscilla, Advancing a prevention agenda for cardiovascular care in Ireland, Medical Independent summary of NIPC/National CVD Prevention Council report (2023)

https://www.medicalindependent.ie/clinical-news/advancing-a-prevention-agenda-for-cardiovascular-care-in-ireland/

Martin-Timon I, Sevillano-Collantes C, Segura-Galindo A, et al. Type 2 diabetes and cardiovascular disease: Have all risk factors the same strength? World J Diabetes. 2014; 5:444-470;

NHS England, Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach (2026) Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach - the strategic vision and delivery model

OECD, The State of Cardiovascular Health in the European Union (2025) https://pubmed.ncbi.nlm.nih.gov/25126392/

OECD, The State of Cardiovascular Health in the European Union (2025)

https://www.oecd.org/en/publications/the-state-of-cardiovascular-health-in-the-european-union_ea7a15f4-en/full-report/the-burden-of-cardiovascular-disease_e28210c3.html

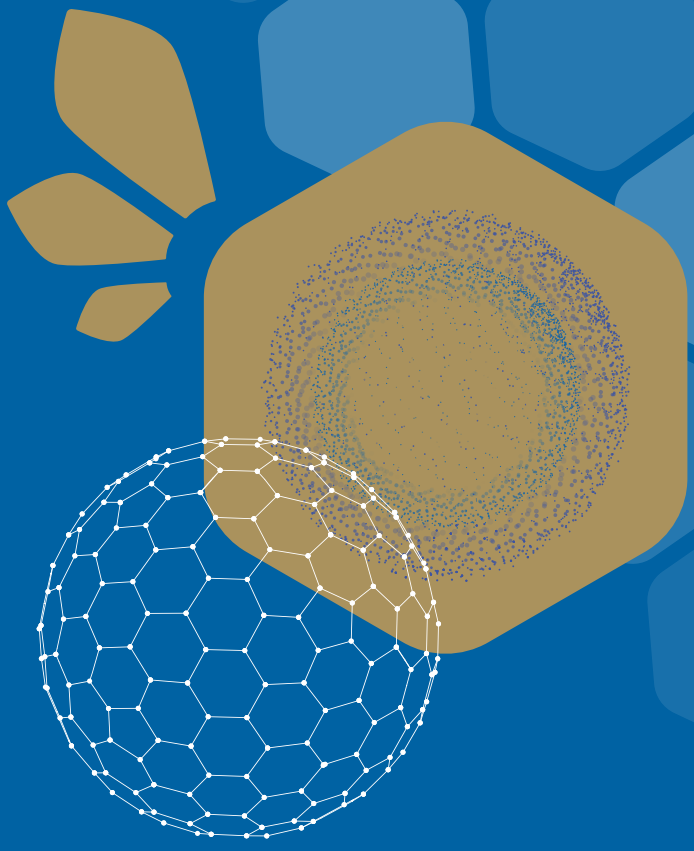
OECD, The heavy burden of obesity (2019) https://www.oecd.org/en/publications/the-heavy-burden-of-obesity_67450d67-en.html

Collaborators GBDO, Afshin A, Forouzanfar MH, et al. Health Effects of Overweight and Obesity in 195 Countries over 25 Years. N Engl J Med. 2017;377:13-27 https://pmc.ncbi.nlm.nih.gov/articles/PMC5477817/

Stamenic D, et al. Health care utilisation and the associated costs attributable to cardiovascular disease in Ireland: a cross-sectional study. European Heart Journal-Quality of Care and Clinical Outcomes 2025;11(1):37-46. https://cora.ucc.ie/server/api/core/bitstreams/a40666cc-4e46-414d-8c94-3a25cc60210f/content

Zahra Raisi-Estabragh et. al. Racial Disparities in Obesity-Related Cardiovascular Mortality in the United States: Temporal Trends From 1999 to 2020 (2023). https://pubmed.ncbi.nlm.nih.gov/37671611/

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