

Proposal
for a **Council Recommendation**
on Cardiovascular Health Checks
- an EU Approach to Early Detection and Screening

FHEF Community calls

Tuesday and Thursday, 6 /8 October 2026



Today: from understanding to action

What happened → What it means for us → What is still missing → What we can do now

1

Community pulse

Where are we today?

2

The proposal

What is a Council Recommendation and where are we in the process?

3

What it says

Main document + Annex, with the key wins and gaps for our community

4

National action

How we engage ministries, policymakers and the public constructively

First: a quick community pulse

1. Before our email, had you heard about the proposed Council Recommendation?

Yes / No

2. Have you looked at the proposal or Annex?

Yes / Partly / Not yet

3. Do you already have a Ministry of Health or national policy contact?

Yes / No / Not sure

4. Would your organisation be willing to take action by end of October?

Yes / Maybe, with support / Not currently

What is a Council Recommendation?

A common EU policy framework, with national responsibility for implementation

EU POLICY INSTRUMENT

A Council Recommendation sets common objectives and recommended actions for Member States.

It carries political weight and helps coordinate policy in areas such as health.

NOT LEGALLY BINDING

Unlike a Regulation or Directive, a Recommendation **does not impose legally enforceable obligations or penalties for non-compliance.**

WHY IT STILL MATTERS

Once adopted, it becomes an agreed European framework that can shape national policy, implementation priorities and future action.



For cardiovascular health checks, the key question becomes:
how will each Member State translate the European framework into practice?

What exactly are we talking about?

A **proposal** for a Council Recommendation, not yet the final Recommendation



Why this matters now

Because the proposal can still evolve, national governments are now a key advocacy audience.

And adoption is not the end. Because recommendations are non-binding, national implementation becomes the next advocacy phase.

Our approach:

support the Recommendation, protect the gains, and make a constructive case for stronger early detection across the life course.

Two documents, two jobs

Know where to look before you advocate

MAIN PROPOSAL

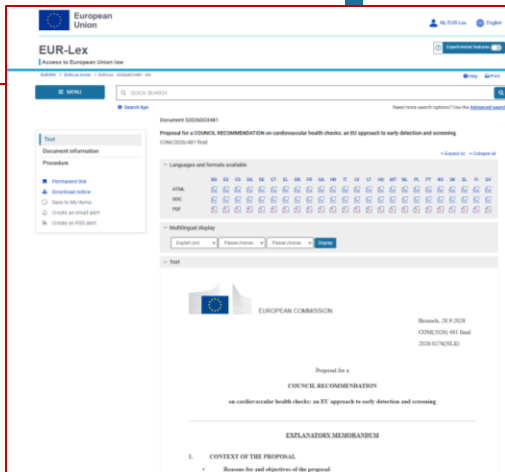
The political framework: objectives, principles, equity, governance, follow-up, personalised prevention and what Member States are encouraged to do.

ANNEX

The practical protocol: target populations, age groups, tests and assessments, frequency and further considerations.

For our community, the Annex is crucial:
it is where an ambition about prevention becomes an actual health check.

TIP: read both



What does the Annex recommend across the life course?

A simplified view of the proposed health-check structure

UNDER 35

At least one CV health check

Health behaviours, BP and other biological risk factors, glucose, kidney function, BMI; individualised evaluation with family history of premature CVD or sudden cardiac death.

35–64

Systematic checks at least every 5 years

Medical + family history; BP; full lipid profile including LDL, HDL and triglycerides; Lp(a) once in adulthood; glucose/HbA1c; kidney health; BMI/waist.

65+

Every 3–5 years

Health check as above, with additional age-relevant assessments such as ECG, NT-proBNP, pulse assessment for AF and others as needed.



Further considerations:

Member States **may consider** inherited or genetically influenced risk factors and conditions, including

elevated Lp(a), FH and type 1 diabetes, tailored to the national situation.

What do you notice?

Before we tell you our interpretation, what stands out to you?

UNDER 35

35–64

65+



Where are children?

Where is systematic lipid screening earlier in life?

How should family history and inherited risk translate into action?

First: recognise how far we have come

There is a great deal in this proposal worth protecting

✓ Familial hypercholesterolaemia (FH)

✓ Elevated Lp(a)

✓ Triglycerides in the full lipid profile

✓ Family history

✓ Inherited / genetically influenced risk

✓ Follow-up and referral pathways

✓ Equity and vulnerable groups

✓ Patient representatives in governance

Our advocacy message is not “this proposal is wrong”. It is: protect these gains and make the life-course approach stronger.

The unfinished business

For inherited risk, prevention cannot begin only in adulthood

EARLIER

Strengthen explicit early identification of inherited cardiovascular risk in children and young people.

FH is inherited and LDL exposure begins from birth.

FAMILY-BASED

Translate family history into pathways for paediatric screening, cascade screening and reverse cascade screening.

Finding one person can help find a family.

LIFE-COURSE

Make the life-course principle meaningful for conditions present from birth.

The aim is earlier diagnosis, appropriate referral, treatment and lifelong follow-up.

TWEAKING: This is a strengthening agenda, not a rejection agenda.

Our coordinated advocacy frame

PROTECT

Keep FH, Lp(a), triglycerides/full lipid profile, family history, inherited/genetic risk, equity and follow-up.

STRENGTHEN

Make early identification of inherited cardiovascular risk in children and young people more explicit within the life-course approach.

IMPLEMENT

Build pathways from screening to diagnosis, referral, treatment and lifelong follow-up, including paediatric, cascade and reverse cascade approaches.

Constructive tone:

welcome the progress, use the proposal's own language, then show precisely where a small change could make prevention more effective.

Use the proposal's own language as your advocacy hooks

Connect our asks to concepts already in the text

LIFE-COURSE

If prevention is across the life course, what does that mean for a genetic condition present from birth?

FAMILY HISTORY

Connect family history to cascade and reverse cascade screening.

INHERITED / GENETIC RISK

Use this opening to explain FH, Lp(a) and the value of earlier identification.

EQUITY

Show why underserved communities need accessible, trusted and culturally appropriate screening pathways.

FOLLOW-UP

Screening is not an endpoint: diagnosis, referral, treatment and continuity of care must follow.

PATIENT PERSPECTIVES

Offer lived experience and patient organisations as implementation partners, not only consultees.

What are we asking every network organisation to do?

A practical national advocacy package

1

Identify*

Who in your country is responsible for this discussion?

2

Contact

Send the coordinated FHEF letter to your Ministry of Health / relevant authority.

3

Personalise and Use Evidence **

Add your national data, experience and lived-experience story. Use existing national and international evidence. (next slide)

4

Engage

Ask for a meeting or written response; offer your expertise.

5

Communicate

Use social media constructively: welcome, protect, strengthen.

6

Report back

Tell FHEF who you contacted, what you heard and what support you need.

Existing evidence and protocols, etc

1. **The time is now: Achieving FH paediatric screening across Europe – The Prague Declaration**
<https://pmc.ncbi.nlm.nih.gov/articles/PMC9583732/>
2. **The Brussels International Declaration on Lipoprotein(a) Testing and Management.** <https://pubmed.ncbi.nlm.nih.gov/40340180/>
3. **Lp(a) testing for the primary prevention of cardiovascular disease in high-income countries: a cost-effectiveness analysis**
<https://pubmed.ncbi.nlm.nih.gov/41101894/>
4. **Cost-Effectiveness of Screening Strategies for Familial Hypercholesterolaemia: An Updated Systematic Review**
<https://pubmed.ncbi.nlm.nih.gov/38265575/>
5. **International Atherosclerosis Society guidance for implementing best practice in the care of familial hypercholesterolaemia**
<https://pubmed.ncbi.nlm.nih.gov/37322181/>
6. **Familial hypercholesterolaemia in children and adolescents: a European Atherosclerosis Society consensus statement**
<https://pubmed.ncbi.nlm.nih.gov/42179051/>
7. **Lipid clinics worldwide: harmonization and guidance on how to optimally organize and fund. European Atherosclerosis Society consensus statement across 55 countries and more than 500 lipid clinics** <https://pubmed.ncbi.nlm.nih.gov/42178198/>

The Task Force on defining a **childhood health check for inherited lipid disorders and type 1 diabetes** invites the Commission to integrate the proposed structured approach for rolling out childhood health checks across the 27 EU Member States and to reflect the following wording in the upcoming Council Recommendation as part of the European Safe Hearts Plan:

Rationale:

Inherited lipid disorders such as familial hypercholesterolaemia (FH) and elevated lipoprotein(a) [Lp(a)], and type 1 diabetes are early-onset conditions with identifiable preclinical phases, validated biomarkers, and clear clinical benefits from early identification and intervention. Collectively, they affect an estimated 95 million people across 27 Member States.

Inherited lipid disorders can be detected in children by the measurement of a **full lipid profile** (total cholesterol, low-density lipoprotein (LDL) cholesterol, high-density lipoprotein (HDL) cholesterol, triglycerides and Lp(a)).

Type 1 diabetes can be detected in children in early stages, prior to the insulin-requiring clinical diagnosis, through screening for **islet autoantibodies against insulin, IA2, ZnT8 and GAD**.

Combining screening for inherited lipid disorders and type 1 diabetes in childhood would create efficiencies in delivery, improve uptake, and enhance prevention of both acute metabolic complications and long-term cardiovascular (CV) risk. A combined approach reflects the Safe Hearts Plan's emphasis on early detection, lifelong prevention, and coordinated care pathways. Existing evidence: scientific, medical, economic, behavioral, and related to quality of life and patient preferences, strongly supports the early screening approach to detect inherited lipid disorders and type 1 diabetes, and effectively prevent cardiovascular diseases across families and generations.

Screening:

Systematic lipid and type 1 diabetes screening for all children in the first decade of life is recommended to detect children with early-stage inherited lipid disorders and type 1 diabetes by measurement of a **full lipid profile and through screening for islet autoantibodies**.

For any screening, the age ranges indicated can be adapted to the screening opportunities provided within established public health activities.

Integrated with childhood health checks, Member States should also promote awareness and implementation of guideline-based management pathways for treating identified conditions and reducing CV risk.

Members of the Task Force:



Endorsed by:



This is also an intelligence network

We need information coming back from countries, not only messages going out

- What is your government's position on cardiovascular health checks?
- Who actually influences the national position?
- Is there support or resistance to childhood / family screening?
- What national programmes or priorities can we connect to?
- What language or evidence resonates with your policymakers?

BUILD A SIMPLE ADVOCACY DASHBOARD

Country | Organisation | Ministry/contact | Date
| Response | Meeting secured | Follow-up
needed

BUILD A BANK OF FAMILY STORIES

Do you know a family where a child's FH diagnosis led to finding a parent, sibling or grandparent? Could they share their story for advocacy?

Your turn: what can you commit to by end of October?

Please put your country + one action in the chat

EU

COUNTRY



ONE ACTION



BY WHEN?

Contact Ministry of Health

Follow up an existing policymaker

Request a meeting

Share national data / family story

Publish a constructive national post

At the end of this call we want to know:

Who is ready to act, where, and what support you need from FHEF.

FHEF will coordinate, support and track follow-up

Our advocacy journey

The center of gravity moves from Brussels to national capitals, and then back to implementation



BRUSSELS → NATIONAL CAPITALS → COUNCIL → NATIONAL IMPLEMENTATION

TODAY'S PURPOSE

Make sure our national decision-makers understand both what must be protected and what can still be strengthened. Use evidence that already exists! We have been working on it for years!