Brussels, February 2026

The Task Force on defining a cardiovascular-renal-metabolic health check (cardiovascular health check) - comprising the undersigned organisations representing the cardiovascular, renal, diabetes, and obesity community - invites the Commission to integrate the proposed structured approach for rolling out health checks across the 27 EU Member States and to reflect the following wording in the upcoming Council Recommendation as part of the European Cardiovascular Health Plan:

For **individuals under 35 years**, at least one cardiovascular-renal-metabolic health check (cardiovascular health check) is recommended, including assessment of health behaviours, measurement of biological risk factors (including blood pressure), fasting plasma glucose (FPG), estimated glomerular filtration rate (eGFR), albuminuria, body mass index (BMI), mental health assessment if needed and history of reproductive health factors such as pregnancy history and spontaneous abortion. The aim is early detection of risk factors and behaviours, promotion of self-awareness, education, behaviour change and initiation of treatment if indicated.
Opportunistic health checks should be considered when they come into contact with the healthcare system (e.g., primary care).

For all adults aged 35 to 65 years systematic health checks are recommended, focusing on early detection and timely management of key cardiovascular (renal-metabolic) risk factors. These should be repeated at minimum every 5 years, adapting the frequency according to individual or local risk profiles based on family history, ethnicity, and other dynamic cardiovascular-renal-metabolic risk factors.

The cardiovascular-renal-metabolic health check (cardiovascular health check) comprises all of the following elements: First, evaluation of **lifestyle and health behaviours**, including diet, physical activity, sedentary lifestyle, smoking, vaping and using smokeless nicotine products, alcohol and other toxins, **detailed family history**, age at menopauseand **assessment of mental health disorders** if needed, such as depression or anxiety, using abbreviated (2-items) questionnaires. Second, measurement of traditional cardiovascular risk factors, including **blood pressure, full lipid profile** (total cholesterol, LDL-C, HDL-C, triglycerides), and lipoprotein(a), the latter once in adulthood. For detection of **diabetes and pre-diabetes**, fasting plasma glucose (FPG), and glycated haemoglobin (HbA1c) should be used; for assessment of **kidney health**, estimated glomerular filtration rate (eGFR) from serum creatinine (using a validated equation) and albuminuria measurement (Urinary Albumin:Creatinine Ratio (uACR)), for assessment of **obesity**, body mass index (BMI) and waist circumference or waist-to-height ratio to assess overall and central adiposity.

Opportunistic health checks for individuals who missed the systematic assessment described above should be considered when they come into contact with the healthcare system (e.g., primary care), including Natriuretic Peptide Test (NT proBNP) to diagnose or exclude heart failure in the community.

For individuals over 65 years, a full cardiovascular-renal-metabolic health check (cardiovascular health check) as outlined above should be performed not less than every 3-5 years, including pulse (heart rate and rhythm), cardio-pulmonary auscultation, and evaluation of peripheral pulses for peripheral artery disease (PAD). The objectives are to monitor control of

known risk factors, identify new-onset factors, detect previously unrecognised organ damage, and facilitate the rule-out of subclinical cardiovascular disease. Health checks should be adapted to individual or local risk profiles, considering family history, ethnicity, and other dynamic cardiovascular (renal-metabolic) risk factors.
Opportunistic health checks should be considered when they come into contact with the healthcare system (e.g., primary care).

Decisions regarding the implementation and adaptation of these programmes should be guided by national and regional contexts, available healthcare resources, the balance of anticipated benefits and costs, and insights gained from relevant pilot initiatives and scientific studies. For individuals identified as having an elevated risk of cardiometabolic disease, Member States should consider the development of targeted programmes with expanded eligibility and increased intensity, reflecting current scientific evidence and local circumstances.

Integrated with health checks, Member States should also promote implementation of guideline-based management pathways at treating identified conditions and/or reducing cardiometabolic risk.

The undersigned and Members of the Task Force:

ESC European Society of Cardiology

European Diabetes Forum

ERA LEADING EUROPEAN NEPHROLOGY

ehn European Heart Network
Fighting heart disease and stroke

International Diabetes Federation Europe

EKHA EUROPEAN KIDNEY HEALTH ALLIANCE

EASO European Association for the Study of Obesity

GPcardio.org

JACARDI Joint action cardiovascular diseases and diabetes

ETHA European Thrombosis & Haemostasis Alliance


WORLD
HEART
FEDERATION


EUROPEAN INSTITUTE OF WOMEN'S HEALTH
EIWH