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Vereniging Innovatieve Geneesmiddelen

Towards Better Cardiovascular Health in the Netherlands

Insights from a multi-stakeholder roundtable discussion

March 2026

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Foreword

Cardiovascular disease remains one of the leading causes of death across Europe, including in the Netherlands, and places a heavy burden on individuals, families and healthcare systems. Although significant progress has been made in recent decades, the challenge remains and is likely to intensify as populations age and key risk factors become more prevalent. The European Federation of Pharmaceutical Industries and Associations (EFPIA) and the Dutch Association of Innovative Medicines (VIG) have joined forces to facilitate this report, which reflects our shared commitment to advancing cardiovascular health. We would also like to express our gratitude to the experts who have contributed their valuable insights to this research, on which our recommendations are based.

This report comes at a critical time. The recent EU Safe Hearts Plan has set ambitious Europe-wide targets to reduce premature cardiovascular deaths by 25% and promote preventive health checks among adults. EFPIA has strongly endorsed this initiative, emphasising the need for rapid, coordinated action across EU member states. The Netherlands, thanks to its innovative healthcare approach, boasts a proactive, well-organised cardiovascular community that exemplifies how national efforts can advance broader European goals. The Dutch CardioVascular Alliance (DCVA), which encourages and coordinates collaboration among key stakeholders, is central to these initiatives.

The findings included in this report echo the priorities of the EU Safe Hearts Plan, which focuses on prevention, early detection, integrated care and reducing health inequality. The paper also highlights the urgent need to move beyond fragmented efforts towards a cohesive, patient-centred approach that maximises the benefits of public health systems, clinical care and digital innovation. Moreover, addressing disparities affecting vulnerable groups, including women as well as people from lower socioeconomic backgrounds, is essential to ensuring more equitable healthcare.

EFPIA and VIG remain dedicated to fostering partnerships that accelerate advances in integrated prevention, multidisciplinary care pathways and digital health solutions. Coordinated collaboration among governments, healthcare professionals, patients, industry and society will ensure that our shared ambitions are realised.

As the Netherlands continues to strengthen its national cardiovascular strategy, all stakeholders are encouraged to optimise European synergies, share best practices and invest in sustainable solutions. By aligning national efforts with the momentum of the EU Safe Hearts Plan, not only can we help to prevent cardiovascular-related events and improve health outcomes, but also foster a healthier future for all.

The EFPIA Cardiovascular Health Platform &
the Dutch Association of Innovative Medicines

02

Introduction

This report was compiled to support the improvement of cardiovascular health in the Netherlands and is part of a European-wide series led by the EFPIA and its partners. The series aims to consolidate expert views, support ongoing national initiatives and accelerate actionable progress in cardiovascular fields in European countries.

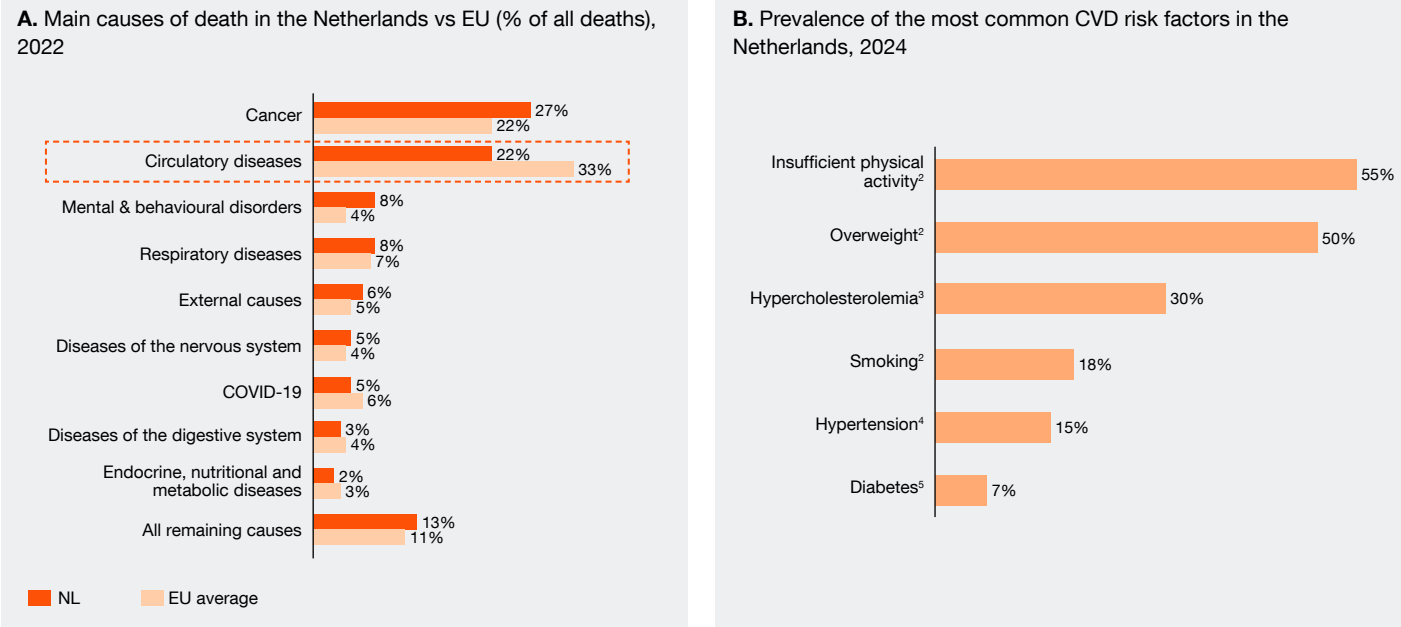
This publication reflects the shared views of leading Dutch cardiovascular experts, gathered in in-depth interviews and a multi-stakeholder roundtable discussion. It builds on established national frameworks and aligns with European priorities, including the European Society of Cardiology (ESC) guidelines and recent European Union (EU) Council Conclusions advocating for comprehensive national cardiovascular health plans.

It presents an integrated view of cardiovascular disease challenges in the Netherlands, drawing on diverse stakeholder perspectives and publicly available sources. It summarises recommendations that can help shape effective strategies to improve the outcomes of cardiovascular diseases (CVDs) over time.

2.1 The burden of cardiovascular disease in the Netherlands

CVDs continue to be one of the most pressing health challenges in the Netherlands, despite decades of medical progress. As of 2023, over 1.7 million people living in the Netherlands have chronic heart conditions, and approximately 38,000 people die each year as a result, accounting for 22–23% of all deaths and making CVDs the second leading cause of mortality after cancer (**Figure 1a**) (1). The burden is expected to rise sharply due to the rapidly aging population, which will increase demand for care at a time when the healthcare workforce is already under pressure. Persistent lifestyle-related risk factors, such as smoking, obesity and physical inactivity, further contribute to this trend, with projections indicating up to 2.6 million patients by 2030 if no additional measures are taken (2). This growth is not only socially unacceptable but would also place significant strain on healthcare capacity and costs, which already amounted to EUR 6.7 billion in 2019 (3).

Figure 1. Main causes of death and prevalence of CVD risk factors in the Netherlands



Bron: 1 EUROSTAT (2025); 2 VZINFO (2024), 3 NVHVV (2023), 4 VZINFO (2024), 5 VZINFO (2024)

Despite the scale of the problem, public and political awareness of CVDs remains insufficient, many people are unaware of their own cardiovascular risk factors and CVDs are often underestimated compared to other major diseases such as cancer. This lack of awareness hampers early detection, prevention and timely treatment, and contributes to persistent gaps in health literacy and engagement at both individual and societal level (1).

2.2 Key risk factors and vulnerable groups

The high prevalence of key risk factors continues to exacerbate the CVD burden (**Figure 1b**). More than one in five Dutch adults smoke, and 14% are classified as obese (BMI ≥30) (4). Hypertension and high cholesterol remain widespread, with an estimated 2.8 million people living with high blood pressure and nearly 1.6 million with fat metabolism disorder (1, 5).

Physical inactivity and unhealthy dietary patterns further contribute to the risk landscape, while socioeconomic disparities exacerbate the impact of these factors in vulnerable groups.

Women in the Netherlands represent a particularly vulnerable group, facing unique biological and gender-specific risks. Their cardiovascular conditions are systematically under-recognised and undertreated compared to men (6, 7).

2.3 National policy response

Recognising the urgency, Dutch policymakers have launched a series of national agreements and initiatives.

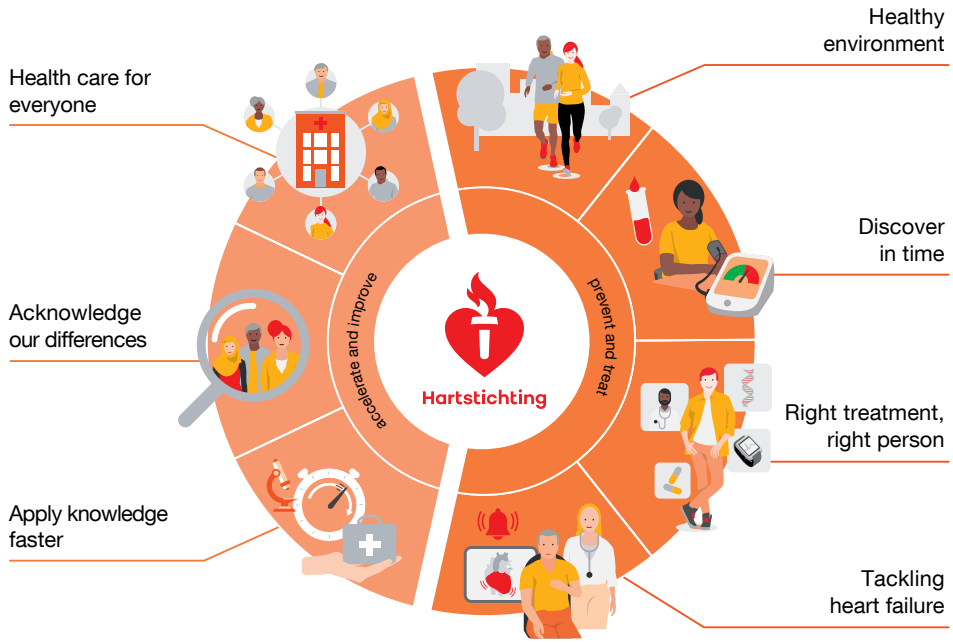
In 2018, a National Prevention Agreement (NPA) was introduced in which government, civil society and industry committed to improving public health by reducing smoking, alcohol abuse and obesity through lifestyle and environmental measures, rather than medical or secondary prevention interventions (8). While this represented an important step towards prevention by addressing behavioural risk factors, it also opened the door to further action towards broader and holistic cardiovascular prevention strategies for a more integrated approach. Building on this, the 2022 Integrated Care Agreement (IZA) and the 2023 Healthy and Active Life Agreement (GALA) expanded the focus towards prevention, primary care and local collaboration (9, 10). The 2025 Supplementary Care and Welfare Agreement (AZWA) further focused on reducing workforce shortages and promoting equitable access to care, emphasising digitisation, data exchange and regional cooperation (11).

These frameworks collectively underscore a policy shift from reactive treatment to proactive, integrated health management, with prevention and patient well-being at the centre. In addition, the Dutch government promotes the principle of appropriate care (passende zorg) to ensure that CVD interventions are evidence-based, efficient and tailored to patients' needs (12).

Alongside these national agreements, the Dutch approach to CVDs is anchored in two complementary frameworks. The Heart for Vessels report (Hart voor Vaten signalement), issued by Zorginstituut Nederland (ZIN), identifies key challenges in cardiovascular care and outlines actionable directions for making care more person-centred, sustainable and future-proof (4). Developed in extensive consultation with scientists, healthcare professionals and stakeholders, it presents a societal agenda that emphasises prevention, early detection and integrated care. Similarly, the Dutch Cardiovascular Agenda, coordinated by the Heart Foundation[1] (Hartstichting) in collaboration with the Harteraad and a broad guidance committee, was shaped through an inclusive process involving more than 11,000 participants, including patients, researchers, healthcare providers and policymakers (**Figure 2**) (1). This agenda distils the collective expertise and lived experience of the Dutch cardiovascular community into seven key themes, ranging from prevention and early detection to personalised treatment and the application of new knowledge. It can serve as the foundation for a national action plan against cardiovascular diseases.

1 Since September 1, 2025, the Heart Foundation has also become a patient organisation, underscoring its commitment not only to advocate for the patient perspective but to incorporate it actively into its initiatives.

Figure 2. The Dutch Cardiovascular Agenda



Adapted from Heart Foundation: Heart Foundation

The Dutch CardioVascular Alliance (DCVA) is a national platform consisting of 25 leading organisations, including patient representatives, researchers, healthcare providers, funders and industry, that are united in their shared mission to reduce the burden of CVDs in the Netherlands by 25% by 2030. DCVA acts as a catalyst for innovation, implementation and funding, connecting partners throughout the cardiovascular field to accelerate progress from research to real-world impact (13).

Together, these frameworks and alliances provide a widely supported, evidence-based foundation for addressing the growing CVD burden in the Netherlands.

2.4 Implementation challenges

Despite these promising frameworks, implementation remains inconsistent. Preventive policies, such as the multidisciplinary Cardiovascular Risk Management (CVRM) guidelines, are not uniformly translated into practice. Many adults at risk remain undiagnosed or untreated and lifestyle interventions often fail to achieve lasting behavioural change (14, 15). Moreover, persistent socioeconomic and ethnic health disparities mean that vulnerable groups benefit least from current programmes, highlighting the need for a tailored, community-based approach.

According to expert opinion, another challenge lies in the fragmentation of care and financing. Regional networks and multidisciplinary collaboration remain unevenly developed, while siloed funding streams hinder integrated solutions. Experts also highlight the fact that data exchange between care providers is still limited, impeding the continuity and quality of care. Additionally, patient involvement in policy and care pathway design, although improving, continues to be insufficient.

2.5 The way forward

The Dutch approach is characterised by incremental changes, broad stakeholder consultation and a commitment to harmonisation rather than abrupt transformation. Yet experts agree that the pace and consistency of transformation must increase to achieve meaningful results. The way forward requires not only robust policy frameworks but also decisive action, such as stronger enforcement of

preventive measures, clear national screening strategies, targeted interventions for high-risk groups, and structural integration of social and healthcare domains. Importantly, these efforts should be closely aligned with European policy directives, including the priorities set out in the recent Safe Hearts Plan (see Section 6.1 for further details). As the national platform bringing together key stakeholders, the DCVA is well positioned to translate these ambitions, and European priorities, into coordinated, evidence-based action.

CVDs remain the leading cause of death in the Netherlands, placing a significant burden on patients, healthcare systems and society. This report aims to provide actionable recommendations to address this challenge. Ultimately, reducing the CVD burden in the Netherlands will depend on turning ambition into coordinated, evidence-based action.

This requires a comprehensive national prevention strategy, integrated care and financing models, as well as a robust digital infrastructure to enable data sharing and empower patients. National cardiovascular registries, which would play a key role in evaluating treatment, quality benchmarking and enabling data-driven care during all stages of the patient journey, should be a critical component of this infrastructure. Promoting multidisciplinary teamwork and embedding patient-centred approaches throughout the care pathway is equally important. With sustained investment and shared commitment from government, healthcare professionals, patients and society, the Netherlands can prevent cardiovascular events and deaths, achieve better outcomes and foster a healthier population overall.

03

Key challenges in the Netherlands

Despite strong ambitions to reduce the burden of CVDs in the Netherlands, persistent challenges, especially in terms of screening, prevention and care coordination, are limiting progress. Expert interviews and a multi-stakeholder roundtable discussion (see Acknowledgements) highlighted two critical areas in which barriers remain significant.

- **Prevention and screening:** Existing primary and secondary prevention policies often lack sufficient enforcement and urgency. The target population for systematic or opportunistic cardiovascular screening is not consistently defined, with no alignment on the most cost-effective approach, leading to fragmented practices and missed opportunities for early detection. Notably, important disparities persist for certain groups, including women, who face unique challenges in cardiovascular prevention and screening. Prevention programmes also frequently fail to reach people with low socioeconomic status (SES) and migrant communities. As a result, many individuals in these groups lack access to early prevention and supportive social policies and only come into contact with the healthcare system once their disease has progressed and requires medical or surgical intervention. This pattern highlights the need for more a proactive, community-based approach that addresses social determinants of health before they lead to advanced disease and medicalisation.
- **Care coordination and multidisciplinary collaboration:** Regional networks are occasionally fragmented and underutilised. Siloed financing and budget structures among care providers hinder effective collaboration, while the quality of data and ICT infrastructure for information exchange remains poor. Furthermore, patients are insufficiently involved and their voices are often excluded from policy development and care pathway design.

This chapter examines these two critical challenges, which must be overcome to achieve effective and equitable cardiovascular health management in the Netherlands.

3.1 Prevention and screening

Current policies rely heavily on voluntary measures and education, with little enforcement or structural integration. Screening is fragmented, vulnerable groups are underserved and social determinants are often addressed only reactively within the medical system. Stronger regulation, clearer strategies and community-based interventions are needed to make prevention a lasting pillar of care.

3.1.1 Existing prevention policies are inadequately enforced and require acceleration

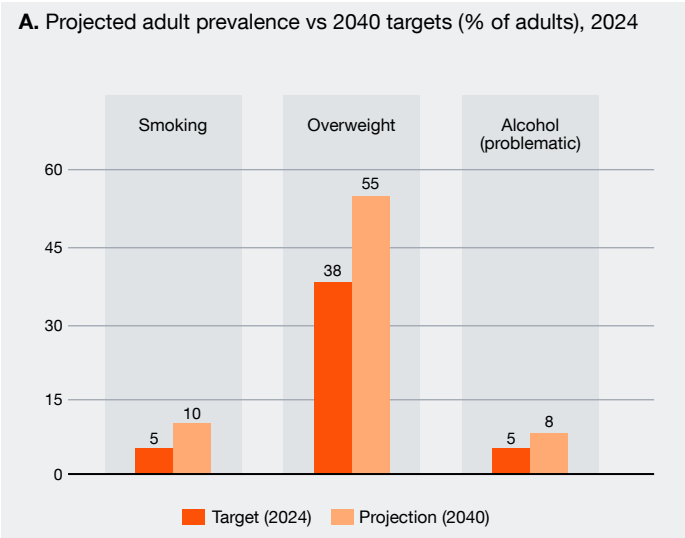
CVD prevention policies in the Netherlands are well-developed and supported by national plans such as the NPA (6). However, many measures are not enforced effectively or implemented in a timely manner. The limited impact of the agreement can be attributed largely to its voluntary nature and the absence of binding regulations, with most actions relying on public education and self-regulation rather than strong regulatory measures such as taxation or advertising restrictions. As a result, progress has been modest and key CVD risk factors such as smoking and obesity remain a concern.

The persistent underdiagnosis of women in cardiovascular screening and preventive care is also particularly challenging. Certain conditions are more common in women and often go unrecognised or misdiagnosed, resulting in delayed care and reduced quality of life.

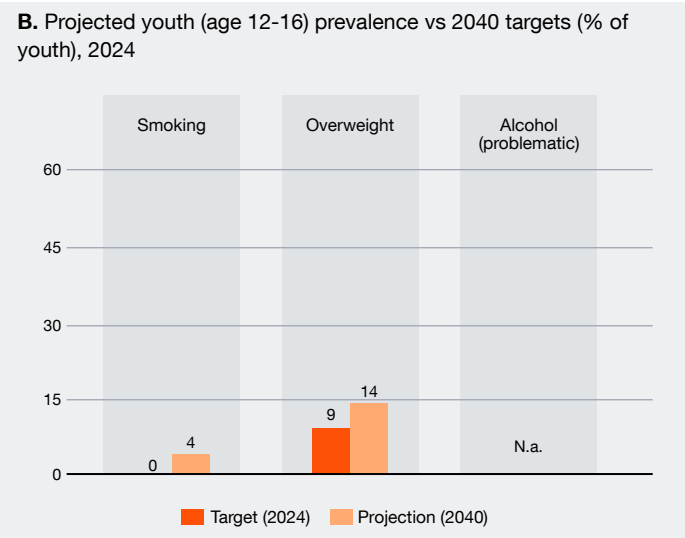
Experts agree with recent guidelines, which call for improved awareness, education and structured diagnostic strategies for women, including multidisciplinary clinics and targeted evaluation protocols to ensure timely identification and management, ultimately reducing inequalities and improving outcomes. (6, 16, 17).

Overall, experts highlight that stronger government regulation and faster, more decisive execution are essential to achieving the agreement's ambitious targets set for 2040 (6) (**Figure 3**). Without more decisive action, prevention and screening initiatives risk remaining a temporary rather than a structural pillar of the healthcare system, and the impact of current policies to reduce the CVD burden and its socioeconomic costs will remain limited.

Figure 3. National Prevention Agreement: targets vs projected outcomes (2040)



Source: 1 RIVM



Source: 1 RIVM

3.1.2 Target population for CVD screening is not consistently defined

In the Netherlands, there is no formal nationwide cardiovascular screening programme for adults. Instead, detection of cardiovascular risk factors primarily takes place within routine care, where general practitioners (GPs) use the NHG[2] CVRM guideline to identify and manage high-risk patients, such as those with hypertension, high cholesterol or diabetes (18). However, the implementation of these assessments varies widely across practices, and many adults at risk remain undiagnosed or untreated. Supplementary initiatives, such as the Hartstichting's Hartcheckpunt, offer free, voluntary checks for risk indicators such as blood pressure, cholesterol, and blood sugar at temporary locations across the country (19). While promising, these efforts are not yet structurally embedded or consistently available in all regions.

Other preventive health checks, such as the 'PreventieConsult' take a more proactive approach by advising GPs to invite adults aged 45 to 70 for a risk assessment (20). However, their implementation also varies significantly across practices (21). Differences arise from fragmented responsibilities between primary and specialist care and resource constraints in primary care, meaning that risk detection often depends on sporadic visits rather than systematic outreach. Furthermore, cardiovascular care guidelines are largely based on evidence drawn from predominantly male populations, leaving critical gaps in the recognition of female-specific risk factors. This imbalance perpetuates disparities in diagnosis and treatment for women (22).

Beyond primary care, there is an ongoing debate about the scope and cost-effectiveness of broader cardiovascular

2 Nederlands Huisartsen Genootschap (Dutch College of General Practitioners), the professional body for GPs in the Netherlands.

screening initiatives. Some experts warn that widespread screening could lead to overdiagnosis and unnecessary medicalisation, potentially burdening individuals and healthcare services, while others argue that the current approach leaves many high-risk individuals unidentified. The target population for screening is not consistently defined, and there is no consensus on the most effective approach. This lack of agreement creates a risk of inconsistent practices and missed detections, highlighting the need for a clear, evidence-based screening strategy that prioritises those most at risk.

3.1.3 Prevention programmes fail to reach people of low socioeconomic status and migrant communities

The Dutch prevention programmes often struggle effectively to engage individuals from low socioeconomic backgrounds and migrant communities. These groups usually experience significantly higher cardiovascular risk and poorer health outcomes (23). These disparities are caused by a combination of genetic predispositions and social determinants (24).

In particular, women from low socioeconomic and migrant backgrounds face higher CVD risks and are often overlooked in prevention programmes (25).

Traditional prevention efforts, such as media campaigns and lifestyle coaching, tend to have a lower uptake in migrant and low-SES populations due to language and cultural barriers and limited access to healthcare services and affordable healthy lifestyle choices. Moreover, current risk assessment in healthcare does not include socioeconomic or ethnic factors, focusing primarily on clinical indicators such as blood pressure, cholesterol and smoking. As a result, high-risk individuals in disadvantaged groups may not be identified for preventive treatment as early as needed. Researchers and experts advocate including socioeconomic and ethnic factors in Dutch cardiovascular guidelines to tailor prevention strategies more effectively, allocate resources and ultimately reduce persistent health inequalities (26, 27).

3.1.4 Social problems risk being medicalised

Many social determinants of cardiovascular risk, such as poverty, chronic stress and unhealthy living environments, are addressed in the Netherlands mainly within the medical system rather than through upstream social or community-based interventions that tackle the origins of these issues. Preventive care outside the clinical setting, including community-based support and public health initiatives, is fragmented and inconsistent[3]. These gaps in social and health responses intensify one another, resulting in heavy reliance on lifelong medication for millions in high-risk groups, while insufficient efforts are made to prevent the onset of disease (4).

In response to these challenges, Dutch health authorities are recognising the importance of prevention. The Zorginstituut Nederland's 'Heart for Vessels Report' (Hart voor Vaten signalement) emphasises that the greatest health gains lie in preventing the initial development of CVDs, particularly by addressing social determinants of cardiovascular risk. Current efforts remain excessively focused on medical management, resulting in approximately three million people in cardiovascular risk groups relying on lifelong medication such as blood thinners and cholesterol-lowering drugs. The report advocates for stronger coordination between healthcare, social services and public health sectors, and stresses the importance of early interventions, such as education on healthy lifestyles for families and children, to prevent the onset of disease rather than merely focusing on risk exposure (4).

Beyond structural and policy gaps, behavioural factors such as low public awareness further intensify these challenges. Evidence shows that awareness of risk factors and preventive behaviours significantly influences early detection and adherence to treatment, which are essential for reducing cardiovascular morbidity and mortality (28, 29). Studies indicate that populations with higher health literacy are more likely to participate in screening programmes, adopt healthier lifestyles and comply with prescribed therapies (30). Strengthening public awareness must therefore be a core component of any future prevention strategy.

In summary, the Netherlands is facing a 'prevention divide'. While advanced medical care is available for those who seek it, prevention and early detection remain fragmented and inconsistent, often leaving many vulnerable populations underserved. Existing policies lack full enforcement and there is a lack of systematic screening. Those at the highest risk, including people with low socioeconomic status and certain ethnic minorities, are benefiting least from current efforts. Building a more inclusive and effective cardiovascular prevention strategy requires shifting focus beyond early detection and treatment towards addressing social determinants of health and promoting healthy behaviours from childhood onwards. Without stronger integration of social support and a shift towards proactive, community-based prevention strategies, the healthcare system will continue to respond reactively to lifestyle-driven risks only after harm has occurred. Addressing these challenges is essential to building a more inclusive, coordinated and forward-looking cardiovascular prevention strategy.

3.2 Care coordination and multidisciplinary collaboration

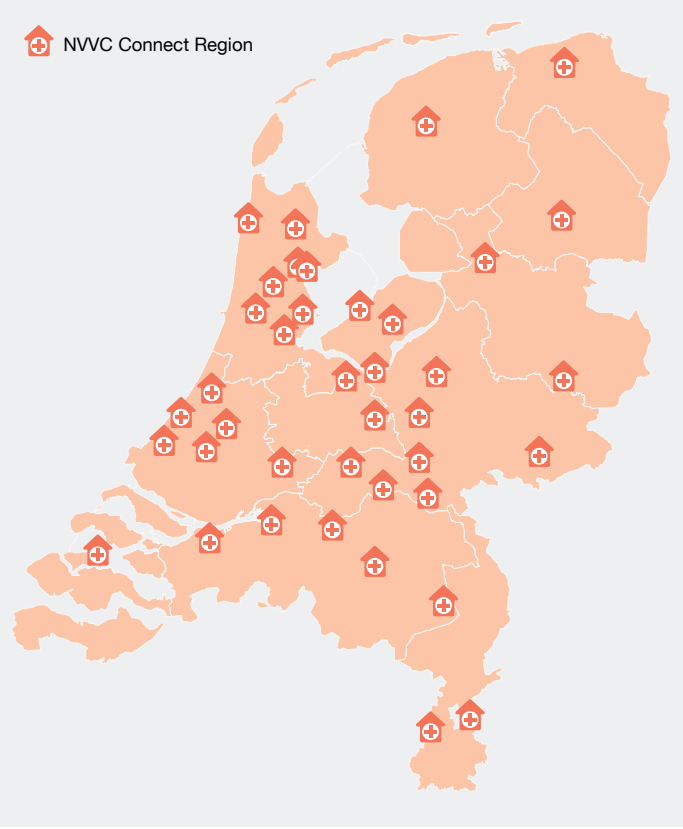
While the Dutch healthcare system is recognised for its high standards, patients with CVDs often encounter a fragmented care journey once they enter the system. Effective coordination among providers, specialisms and care settings remains a challenge, limiting both the quality and continuity of care for many individuals.

3 Based on expert opinion.

3.2.1 Existing regional networks are fragmented and underutilised

The Netherlands has established regional initiatives to improve integrated care and collaboration, most notably 'NVVC Connect regions' led by the Dutch Society of Cardiology (NVVC), and integrated care pathways for CVRM (31, 32) (**Figure 4**). NVVC Connect regions create formal partnerships between hospitals and GPs to implement transmural care agreements for conditions such as acute coronary syndrome, atrial fibrillation (AF) and heart failure. In addition, some regions have developed integrated CVRM pathways, such as the Zwolle programme, which brings together 26 general practices and secondary care providers to deliver structured cardiovascular risk management based on shared protocols and coordinated lifestyle and medication interventions (33).

Figure 4. Overview of NVVC Connect-regions in the Netherlands



Source: NVVC Connect

Despite these efforts, implementation remains inconsistent and coordinating care often depends on local agreements and personal communication between professionals rather than standardised regional protocols.

While some regions have established exemplary integrated programmes, such as Zwolle and the Netherlands Heart Network in the Zuidoost-Brabant region (see Case study 1), many others operate in silos, with each provider focusing on their own segment of care (32, 33, 34). This can result in gaps, redundant services and a lack of joint planning, forcing patients to navigate a complex healthcare system with limited support.

These persistent gaps are also evident in heart failure care. As highlighted in the Heart Failure Policy Network's 2025 country profile, people living with heart failure in the Netherlands frequently experience delays in diagnosis and inconsistent access to specialist care, reinforcing the need for more integrated and coordinated approaches across cardiovascular conditions (35). For example, individuals with atrial fibrillation or heart failure typically see multiple providers across different care settings, but seamless cooperation between these settings remains the exception rather than the norm. Factors such as separate financing streams for primary and hospital care and the absence of a government-endorsed national strategy continue to challenge the development of integrated care. In addition, limited interoperability of health data systems and uneven implementation of regional agreements further hinder the sustainability and effectiveness of coordinated approaches. As a result, existing regional collaborations often fall short of realising their full potential to improve patient outcomes and system efficiency.

Case study 1 – Netherlands Heart Network (Netherlands)

The Netherlands Heart Network (NHN) is a regional multidisciplinary collaboration in the Zuidoost-Brabant region, bringing together hospitals, general practitioners, rehabilitation centres and home care providers (36, 37). Serving approximately one million inhabitants, the network has developed unified care pathways and regional treatment protocols for conditions such as atrial fibrillation and heart failure. For example, a nurse-led AF clinic model was implemented across the region's hospitals and linked with GPs for consistent follow-up. Outcome data is collected and shared transparently among providers (36, 37).

Outcomes: The NHN has demonstrated improvements in care quality and efficiency, including better guideline adherence and fewer complications for AF patients. Patients benefit from smoother transitions, such as standardised handovers from cardiologists to GPs, reducing duplicate visits (38). Key success factors include strong physician leadership, multidisciplinary decision-making, and the use of real-world data. The NHN shows that with the right structure, individual hospitals and caregivers can collaborate as a 'virtual unified system' for patients. Funding has been a critical enabler: the network was initially supported by public grants and contributions from health insurers, which enabled the development of shared care pathways and infrastructure. Challenges included achieving effective coordination, collaboration and trust among diverse healthcare providers, for which NHN's central organisation and shared goals proved essential (39). The model is also included as an example for other regions on the NVVC Connect programme website.

3.2.2 Financing and budget silos hinder collaboration

A major barrier to effective collaboration in cardiovascular care is the division of healthcare financing into separate 'silos' by care settings. Hospitals, primary care, community care, and social services each operate with their own budgets and incentive structures, resulting in siloed negotiations and misaligned incentives that hinder the development of integrated, cross-sectoral care. This structural separation discourages collaboration and makes it difficult to share funding or redistribute savings across settings. Although alternative payment models such as shared savings and bundled payments have been piloted, these initiatives remain rare and limited in scope.

As a result, most provider contracts continue to be based on traditional, volume-driven payment systems, such as fee-for-service, that do not systematically reward or incentivise integrated care (40, 41).

While innovative financing models such as bundled payments[4] and outcome-based funding[5] are underway, many professionals still face bureaucratic obstacles when working across traditional boundaries (40). Consequently, providers tend to optimise their services within their own budgets rather than coordinating holistically throughout the patient's care journey, reinforcing a narrow focus and hindering integrated care.

4 Bundled payments are a financing model in which a single, fixed payment is made to cover all services related to a specific treatment or condition (such as cardiovascular care) over a defined period, encouraging providers to coordinate care and control costs across settings rather than billing separately for each service.

5 Outcome-based funding links provider payment to the achievement of specific patient outcomes or quality targets, rather than the volume of services delivered, aiming to reward improvements in health and patient experience.

3.2.3 Data and ICT infrastructure and information exchange are fragmented

Seamless coordination in cardiovascular care is further hampered by the fragmented availability and limited interoperability of cardiovascular data registries and electronic health records (EHRs). Although the Netherlands have several high-quality cardiovascular registries and most organisations use EHRs, these systems are often not interoperable, and data cannot be easily exchanged or integrated across institutions (41). This fragmentation also affects the integration of digital innovations. For instance, while home telemonitoring systems (hTMS) for heart failure have demonstrated positive effects on hospitalisations and mortality, a high degree of heterogeneity in the development and integration of hTMS in Dutch hospitals limits their large-scale use and the equitable delivery of high-quality remote care (42).

In practice, many care teams still rely on slow, outdated communication methods such as letters, faxes or information provided by patients themselves, often resulting in delays, errors and the duplication of tests. The challenges are not only technical, due to incompatible systems, but also organisational, with the absence of standardised data-sharing agreements complicating the secure exchange of patient information.

Experts agree that improvement of cardiovascular care and patient outcomes will require investment in robust data infrastructure and exchange, including digital platforms that facilitate real-time, shared communication and collaborative decision-making. Currently, the lack of a unified national data infrastructure undermines multidisciplinary collaboration, slows research and innovation, and leaves each provider with an incomplete picture of the patient's complex needs.

3.2.4 The involvement of patients in policy and care pathway design is limited

Traditionally, the design of healthcare policies or care pathways has been clinician- or system-driven, with patients playing a limited role. In cardiovascular care, this means that patients are not systematically involved in decision-making or policy-setting, although recent initiatives such as the Dutch Cardiovascular Agenda have begun to change this by formally incorporating patient perspectives (1).

A significant development in this regard is the merger of the Heart Foundation with Harteraad, which further strengthens the patient voice in cardiovascular health. Patient involvement has revealed important gaps in care, such as the need for empathetic communication, personalised support and better coordination, elements often undervalued by professionals who focus primarily on scientific or technical improvements (32).

In daily practice, shared decision-making is promoted but not always realised, especially for complex conditions such as CVD. At system level, patients rarely participate in the design of care pathways or regional programmes, which can result in services that are less accessible or responsive to their needs. Insufficient patient participation can also lead to distrust or low adherence, as policies and care models may feel imposed rather than co-created, undermining trust and health outcomes. Systematically including patient voices in multidisciplinary care teams, governance and quality improvement initiatives is essential to ensuring that cardiovascular care is truly patient-centred.

In summary, the continuum of cardiovascular care in the Netherlands is characterised by strong individual components but lacks integration across the patient journey. Fragmented regional networks, financial and organisational silos, poor data infrastructure and limited patient involvement are all contributing to suboptimal coordination and health outcomes. Addressing these challenges is critical to building a more integrated, patient-centred and effective cardiovascular care system.

04

Recommendations for improving cardiovascular health in the Netherlands

Achieving better cardiovascular outcomes in the Netherlands requires a fundamental shift from fragmented, project-based efforts to a truly integrated, patient-centred approach. Building on the challenges identified in prevention, screening and care coordination, several overarching solutions can help to strengthen the entire continuum of cardiovascular health management.

4.1 Develop an integrated prevention framework

To effectively manage and contain the burden of CVDs, the Netherlands should develop an all-encompassing national CVD prevention strategy that unites public health initiatives and clinical care efforts. International experience, such as the North Karelia Project in Finland (see Case study 2), demonstrates that sustained, population-wide prevention strategies supported by strong political commitment and community engagement can dramatically reduce CVD mortality and risk factors.

To make this integrated strategy effective and inclusive, equity must be a core design principle. Prevention and screening policies should systematically embed gender, socioeconomic and ethnic dimensions in risk assessment tools, ensuring that interventions are culturally and linguistically appropriate. Likewise, implementation policies related to screening interventions should be based on equity principles and cost-effectiveness considerations by risk population. Finally, municipal health services and community organisations should be proactively involved to co-create interventions with low-SES and migrant communities, while being gender-sensitive. Without such targeted measures, new programmes risk reinforcing existing inequalities instead of reducing them.

Case study 2 – North Karelia Project (Finland)

The North Karelia Project is a landmark community-based CVD prevention programme launched in 1972 in North Karelia, Finland, then a region with one of the world's highest heart attack rates (53). The intervention targeted the entire population's lifestyle, including anti-smoking campaigns, dietary changes (such as switching from butter to healthier oils and promoting vegetables), blood pressure screenings and public education on exercise. The project later expanded nationwide.

Outcomes: Over the following decades, North Karelia saw an 84% reduction in coronary heart disease mortality among middle-aged men. Smoking among men in North Karelia dropped from 51% to 36% during the first decade of the project. The key to success was broad community engagement, involving local media, schools, food producers and policymakers to make healthy choices accessible and socially supported. The project demonstrates that population-level prevention can produce substantial, cost-effective outcomes when sustained over time, and that long-term commitment and political support for clear policy goals can greatly improve a population's cardiovascular health (53).

A key benefit of an integrated strategy is improved public awareness and health literacy. Evidence-based campaigns such as 'Know Your Numbers' can be scaled to promote the monitoring of blood pressure, cholesterol and other key indicators, complemented by community-based education programmes and digital self-assessment tools (28, 29, 30, 43). To ensure inclusivity, participation should be monitored across socioeconomic and ethnic groups, supported by culturally tailored outreach (e.g. multilingual materials, partnerships with local organisations), and integrating social determinants into engagement strategies to prioritise high-risk populations. These measures will empower individuals to adopt healthier behaviours and strengthen adherence to preventive care. In addition, community-based initiatives such as 'lifestyle desks' (leefstijl loketten) and 'quit smoking' (stoppen met roken) offer accessible support for healthy living and smoking cessation, further reducing cardiovascular risk (44, 45).

Population-based interventions should be complemented by targeted family screenings for genetic CVDs, such as familial hypercholesterolemia and inherited cardiomyopathies (46, 90). The Netherlands has demonstrated that this strategy seems both effective and cost-efficient (47). National guidelines explicitly recommend systematically identifying and testing first-degree relatives of individuals diagnosed with familial hypercholesterolemia through cascade screening (47, 48).

This approach is supported by initiatives such as LEEFH within the DCVA, which coordinates cascade screening and improves early detection and prevention of CVDs (49).

Prevention and screening strategies must also be gender-sensitive. This includes integrating female-specific risk factors and presentations into guidelines, systematically gathering and reporting sex-disaggregated data, and drawing on Dutch expertise from existing initiatives and registries (50, 51, 52).

When it comes to stakeholder mobilisation, promising regional and national initiatives should be integrated and scaled under the coordination of the DCVA. Clear roles and accountability are essential to establishing a uniform, multidisciplinary approach to cardiovascular prevention across the Netherlands. Promising initiatives such as Check@Home (see Case study 3) and Hartcheckpunt (see Case study 4) should be scaled and integrated into a nationwide cardiovascular risk screening programme (54, 55, 56). Together, these models demonstrate how community-based engagement and digital solutions can complement each other to extend reach and impact.

Case study 3 – Check@Home (Netherlands)

Check@Home is a consortium-led initiative by the Dutch Heart Foundation, Kidney Foundation and Dutch Diabetes Research Foundation under the DCVA, piloting home-based screening for cardiovascular and metabolic risk. Since 2025, people aged between 50 and 75 in selected regions have been invited to test themselves at home for early signs of heart and vascular disease, kidney disease and type 2 diabetes. The kit includes a pulse check via app (for atrial fibrillation), a urine test and a short health questionnaire, supported by a digital platform for guidance. Participants with elevated risk are referred for confirmatory tests and follow-up at regional diagnostic centres (54, 57).

Outcomes: The pilot project, branded 'Ik test' in some regions, is enrolling participants and has shown a strong initial uptake. Early indications suggest that the approach is user-friendly and may detect previously unknown conditions such as atrial fibrillation and chronic kidney disease. By focusing follow-up only on those with positive home tests, the programme aims to balance its broad reach with the efficient use of resources. If results confirm its feasibility and impact, Check@Home could serve as a model for cost-effective, targeted CVD screening. The project also exemplifies collaboration between health NGOs, research institutions, care providers and private companies in a public-private partnership (PPS) (54, 57).

Case study 4 – Hartcheckpunt (Netherlands)

Hartcheckpunt is a nationwide initiative in the Netherlands launched by the Heart Foundation to improve cardiovascular health by providing accessible checks that raise awareness and offer insight into heart health, including the early identification of cardiovascular risk factors(55). The programme offers free checks at public locations such as community centres and gyms, making it easy for people to participate without an appointment (55, 56). It specifically targets adults between the ages of 40 and 70 who do not have known CVDs and are not on medication for blood pressure, cholesterol or blood sugar (56).

At each check point, participants can measure their blood pressure, cholesterol, blood sugar, BMI and waist circumference. Within 15 minutes, they receive their results along with personalised lifestyle advice to help lower unhealthy or maintain healthy values. In many cases, a local lifestyle coach is available to provide additional support on diet, exercise and giving up smoking (55).

Outcomes: The data shows that a substantial proportion of the measurements indicate elevated values, particularly for blood pressure, cholesterol, and blood sugar. The findings highlight the programme's role in uncovering hidden risks and encouraging preventive action.

By embedding prevention in everyday settings and connecting participants to local support and primary care, Hartcheckpunt seeks to form a bridge between community-based prevention and formal healthcare systems (55). Its ambition is to scale up to 400 pop-up locations nationwide within five years, making cardiovascular risk health checks a structural part of preventive care in the Netherlands (56).

A national programme should define clear age and gender benchmarks and coverage goals, supported by performance indicators such as coverage rates (for example, percentage of adults screened annually by age and gender), detection rates for hypertension and dyslipidemia, and follow-up compliance (for example, percentage of patients completing GP follow-up within three months). Screening strategies should combine periodic check-ups with patient-centred tools and strategies, such as home testing kits, digital self-assessment questionnaires and structured referral pathways through primary care.

Equity must remain central, with measures to monitor the uptake by gender – as well as socioeconomic and ethnic groups – of culturally tailored interventions (e.g. multilingual outreach, community partnerships), and the integration of social determinants into risk scoring to prioritise high-risk individuals. Dedicated resources and partnerships with local organisations and health workers will be essential. The National Prevention Agreement should be strengthened with interim targets and public reporting to ensure accountability and acceleration.

4.2 Implement integrated care and financing models

To overcome fragmentation, the Dutch system should adopt integrated care models where multidisciplinary teams jointly manage patients across settings. Cardiologists, GPs, specialised nurses, rehabilitation therapists, community nurses, social workers, and other relevant professionals (including internal medicine specialists, endocrinologists, vascular surgeons, neurologists, nephrologists, and others) should work together with clearly defined roles, supported by effective communication platforms. Under DCVA coordination, programmes like NVVC Connect[6] and the Netherlands Heart Network could offer blueprints for unified protocols and smoother transitions (31, 36).

Financial integration is equally important. Moving towards shared budgets or bundled payments for cardiovascular care can align financial incentives and encourage collaboration. For example, In the Netherlands, bundled payments for chronic care, including CVRM, are reimbursed through a single fee to regional care groups, which subcontract multiple providers such as general practitioners and allied health professionals. While this model aims to integrate care delivery, hospitals are generally not included in these bundles, and adoption is far from uniform. The share of CVRM patients treated under bundled payment contracts varies widely between practices and insurers, ranging from a very low uptake to more than half of eligible patients (58).

Internationally, the Gesundes Kinzigtal initiative in southwest Germany is an example of a shared savings model, where insurers and providers collaborate for a defined regional population. Savings from lower-than-expected health care costs are shared and used to support preventive and health-promotion programmes. This approach demonstrates how reorganising budget structures and aligning financial incentives can enable care teams to organise services around patient needs, moving beyond fragmented fee-for-service models (59).

4.3 Enhance data sharing and digital health

A modern cardiovascular health strategy must harness digital tools and data to improve the continuity and efficiency of care. Establishing a national cardiovascular data registry or hub, such as Heart4Data, can enable the aggregation of information from multiple sources such as hospitals, GPs or existing registries to track outcomes, identify gaps and develop evidence-informed services (60). To support gender equality, national cardiovascular registries and digital health platforms should systematically collect, analyse and report data by gender.

6 NVVC Connect is active in heart failure initiatives and has recently begun collecting information on regional networks for CVRM care. It has also published a CVRM toolkit on its website. The NHN case (Zuidoost-Brabant) primarily highlights heart failure agreements but also includes a transmural agreement for CVRM care. Additionally, regions such as Deventer and North-West Hospitals demonstrate well-developed nurse-led CVRM care and transmural working models.

Heart4Data is building a sustainable, FAIR (Findable, Accessible, Interoperable, Reusable) infrastructure for research, linking data across care settings to support studies and improve quality. While the Netherlands lacks a fully unified registry, initiatives such as Heart4Data and the Netherlands Heart Registration (NHR), the National Quality Registry for Cardiac Care and the National Registry of the Netherlands Heart Institute (NLHI), which includes resources such as the Dutch Cardiomyopathy Database, are important steps forward. NHR collects comprehensive data on interventions and syndromes, enabling benchmarking and research nationwide, while NLHI provides valuable disease-specific datasets that complement these efforts (61, 62).

International best practices, such as Sweden's SWEDEHEART registry (see Case study 5), demonstrate how unified, mandatory registries can achieve near-complete coverage, support benchmarking and improve outcomes. The Netherlands can learn from this by moving toward a standardised national registry linked to population data.

Case study 5 – SWEDEHEART (Sweden)

SWEDEHEART Registry is a nationwide Swedish initiative designed to monitor and improve cardiovascular care through comprehensive post-market clinical follow-up (63). Established in 2009, the registry integrates data from acute cardiac care, coronary interventions, secondary prevention and heart surgery. It enrols approximately 80,000 cases annually, including patients with acute coronary syndrome, those undergoing PCI and individuals in secondary prevention programmes. Data collection is continuous and prospective, supported by linkage to national health registries for mortality and long-term outcomes.

Outcomes: SWEDEHEART has achieved near-complete national coverage and high data accuracy (>97%) (63). It enables benchmarking across hospitals, informs guideline development and supports the evaluation of medical devices such as stents and drug-eluting balloons. Evidence from the registry has contributed to improved quality of care as well as reduced morbidity and mortality. Its model has been replicated in other countries, demonstrating its scalability and impact. By combining nationwide reach with rigorous follow-up, SWEDEHEART exemplifies how registries can drive evidence-based improvements in cardiovascular treatment and post-market surveillance.

To realise these benefits fully, digital health infrastructure must advance. Interoperable electronic health records should ensure that all providers – from specialists to primary care – can access relevant patient information. Policymakers should accelerate personal health environments and standardised data formats. Digital health services such as telemonitoring for chronic heart failure and hypertension should expand, as evidence shows their effectiveness in terms of hospitalisations and mortality reduction (42). For example, HartWacht[7] is expanding its telemonitoring services to include CVRM and lipid monitoring, with these programmes already being reimbursed by Dutch health insurers and enabling more comprehensive and continuous management of cardiovascular risk at home (64). Wearables, mobile apps and predictive analytics can additionally empower patients and enable personalised care.

7 An e-health telemonitoring service by Cardiologie Centra Nederland that enables patients to measure and share vital signs from home for remote monitoring by nurses and cardiologists.

These solutions should operate within a robust governance framework that ensures GDPR compliance, strong data protection and clear patient information, obtaining explicit consent where required for uses beyond direct care. By embedding privacy safeguards and transparency, digital health solutions can support continuous communication, early intervention and improved long-term cardiovascular outcomes.

4.4 Strengthen multidisciplinary teamwork and patient-centred care

A shift towards multidisciplinary, patient-centred care is as important as adopting new technical solutions. Healthcare providers should routinely operate in multidisciplinary teams, involving dietitians, physiotherapists, pharmacists, psychologists and social workers alongside doctors and nurses. Collaboration between cardiologists, endocrinologists, nephrologists and GPs is especially important, given the frequent overlap between cardiovascular, metabolic and renal conditions. In addition, closer cooperation among cardiologists, vascular surgeons, neurologists and vascular internists is crucial – also in secondary prevention, where shared expertise on vascular health can significantly improve outcomes. To make this collaboration effective, integrated clinics and heart team consultations should be extended to primary care settings, ensuring coordinated management for complex cases.

The clear division of tasks and effective communication protocols are essential not only to avoiding fragmented care, but also to ensuring that these complex cases receive the comprehensive management they need, working towards improved clinical outcomes. This approach is central to the DCVA Prevention Commission, which leads national efforts to optimise care pathways, clarify roles and strengthen communication protocols for comprehensive cardiovascular management (13, 65).

Importantly, multidisciplinary cardiovascular care teams and regional care pathways should also be trained to recognise female-specific presentations and risk factors. International and Dutch expert bodies and advocacy initiatives such as the DCVA and the ESC are increasingly emphasising the need for gender-sensitive care coordination, as women often present different symptoms and are at risk of misdiagnosis or undertreatment (66, 67). Embedding gender-sensitive protocols and training within regional networks is essential to ensuring equitable, high-quality care for all patients.

Alongside multidisciplinary coordination, empowering patients as active partners in care is equally critical. Patients should be engaged as active members of care teams through mechanisms such as shared decision-making (SDM) and self-management support tools. In Belgium, for example, the ‘SharedHeart’ digital SDM model was implemented in cardiac rehabilitation, enabling patients and caregivers to set exercise goals and create personalised plans jointly via a smartphone app. This approach led to improved quality of life and physical activity compared to standard care (68). In the Netherlands, the 2Decide programme is specifically studying the effectiveness of decision support for CVRM, further highlighting the relevance of SDM in cardiovascular care (69).

In addition, establishing patient coaches or navigators can help individuals better to understand the healthcare system and implement lifestyle changes. The Sanger Heart & Vascular Institute in the US, for instance, assigns nurse navigators to support patients after hospital discharge, resulting in reduced re-admissions and improved follow-up.

Moreover, including patient representatives meaningfully in designing and evaluating care processes, alongside systematically collecting patient-reported outcomes, will ensure that services are both clinically effective and meaningful to those receiving care (70). These measures collectively strengthen patient engagement and continuity of care across the entire pathway.

Beyond individual care interventions, patient involvement should also extend to policy level to ensure that system-wide priorities reflect patients' needs. The co-creation of the Dutch Cardiovascular Agenda ('Hart-en Vaat Agenda'), which was developed in a collaborative process involving patients, caregivers, clinicians, scientists and policymakers to identify priorities and ensure broad stakeholder alignment, is a recent example (see Case study 6).

Case study 6 – Co-creation of the National CVD Agenda (Netherlands)

In 2023–2024, the Dutch Heart Foundation and patients' organisation Harteraad led a co-creative process to develop the Dutch Cardiovascular Agenda. This involved 18 focus group sessions with about 180 participants, including patients, caregivers, clinicians, scientists and policymakers, to identify challenges and priorities. With over 10,000 respondents, the results of the survey helped to pinpoint the most important themes for national action (1).

Outcomes: The initiative gained buy-in and consensus from all stakeholder groups by identifying and bridging differences in perspective between patients and professionals. Diversity and health equity became prominent themes, reflecting patient and public input. This co-creation was recognised as a model for engaging society in health planning, and the agenda was officially launched in October 2024 with endorsement from the Health Minister. In the early days of implementing the ten-year roadmap, the process already achieved broad stakeholder alignment and strengthened commitment to action. The case demonstrates the value of patient involvement at policy level, ensuring attention to issues such as communication, coordination and emotional support (1).

These general recommendations provide a direction for improving cardiovascular health across the Netherlands, from proactive prevention in the community to integrated, patient-centred clinical care. By aligning incentives, strengthening data infrastructure, fostering teamwork and embedding robust governance, the country can ensure that every patient receives the right care at the right time, and that prevention and management efforts reach those who need them most. Strengthening multidisciplinary teamwork and patient-centred care will be central to achieving these goals.

05

Guiding principles for continuous improvement of cardiovascular health

Improving cardiovascular health requires a collaborative and process of trial and error in which multiple stakeholders work, discuss and adapt together. This approach calls for making initiatives visible, inviting diverse perspectives and creating regular opportunities for dialogue and joint learning. The following guiding principles translate this mindset into specific actions and support building momentum through openness and mutual engagement.

5.1 Promote transparency and sharing of good practices and initiatives

Encouraging transparency and sharing good practices is essential for promoting excellence and innovation in the cardiovascular field. To achieve meaningful impact, initiatives must be actively showcased on a centralised national platform on which diverse stakeholders can provide feedback and contribute to ongoing improvement. Today, many promising projects and research findings remain confined to local networks or specialised expert groups, limiting their broader impact and opportunity to collective learning.

National health institutions, such as the Ministry of Health or other public health agencies, together with other organisations, such as the DCVA and the Heart Foundation, should establish and maintain a digital database to share initiatives, research outcomes and practical tools. By leveraging existing infrastructure and governance frameworks, this platform would not only collect and amplify effective initiatives from across the country but also invite active engagement and critical reflection from all parties involved.

Hospitals, research institutes and community programmes should be encouraged to share their innovations, research outcomes and practical tools openly, making valuable knowledge accessible beyond local boundaries and enabling a dynamic exchange. Patient organisations should play an important role in identifying and highlighting patient-centred innovations and ensuring that information remains accessible and understandable to all. Meanwhile, professional societies should support this process by curating and validating good practices, while acknowledging that it represents a continuous learning journey rather than a finite process.

By making good practices visible and accessible, all actors can actively contribute to accelerating learning and scaling effective solutions nationwide.

5.2 Foster a culture of knowledge exchange and collaboration

To have a collective impact on cardiovascular care, health stakeholders need a culture of knowledge exchange, collaboration, listening, and continuous learning paired with solid, nationally coordinated forums that enable regular dialogue and reflection. Structurally, this means creating regular opportunities for multi-perspective dialogue through conferences, webinars, and working groups that bring diverse voices together. These forums should include reflective dialogues in which different stakeholders discuss what worked, what did not, and which aspects can be improved going forward.

The DCVA and the Heart Foundation are well positioned to lead the coordination of regular national and regional cross-functional forums, such as conferences, webinars, and working groups, leveraging and expanding existing events. Healthcare providers, researchers and patients' organisations should be encouraged to participate in these forums, sharing experiences and adapting best practices to their local contexts. Insurers and regional care networks could support this process by facilitating participation and encouraging the spread of innovations across regions.

Through these established and new forums, stakeholders could foster peer learning, break down silos and make insights more actionable to promote continuous improvement throughout the sector.

5.3 Clarify and strengthen the responsibilities of all stakeholder groups

Every stakeholder in the cardiovascular health space – from government to healthcare providers to industry and from insurers, patients' organisations, policy makers to researchers – has a vital role to play in translating knowledge into meaningful action. Clarifying and strengthening each stakeholder group's responsibilities is necessary to maintaining progress.

For example, healthcare providers and professional societies should integrate new insights into clinical guidelines and daily practice and share outcomes to inform broader learning. The private sector (e.g. pharmaceutical companies or health technology firms) should contribute by developing innovative therapies and technologies while collaborating in research and knowledge dissemination, contributing data and insights to shared forums.

Policymakers and insurers should jointly develop feedback loops that track implementation and outcomes, ensuring that insights inform future policy. Patient organisations should ensure that patient perspectives are integrated at every stage and help translate lessons learned into accessible formats. Finally, researchers and academic institutions should publish timely, actionable findings and partner with clinicians to accelerate their translation into care.

By embracing these guiding principles and embedding a sustained cycle of action, reflection, and adaptation, the Netherlands can move from isolated pilots to a dynamic, learning-oriented system that delivers integrated, effective and equitable cardiovascular care for all.

06

Synergies with European initiatives

CVDs are a major health challenge across Europe as well as worldwide. The Netherlands can strengthen its national approach by aligning with EU health strategies and participating in cross-border projects. This creates opportunities to share expertise, access funding, and contribute to joint innovation efforts.

6.1 Alignment with EU health strategies

The EU has increased its focus on non-communicable diseases (NCDs), with CVDs as the leading cause of death in Europe, accounting for about one-third of all EU deaths (71). In 2022, the European Commission launched the 'Healthier Together' – EU NCD Initiative[8], which identified cardiovascular health as one of the public health priorities for member states to address (72). Building on this stepping stone and sustained advocacy efforts, the European Commission has recently published the long-awaited EU Safe Hearts Plan, a major milestone to respond to 'EU's leading health challenge', aiming to improve CV health for all people living in Europe. The Plan sets ambitious targets for the next decade, aiming to reduce premature cardiovascular deaths by 25% and ensure that at least two thirds of adults undergo annual checks for key risk factors. It is built on three pillars: prevention, early detection and screening, and treatment and care, with three key levers identified: digital innovation, research and knowledge, and tackling inequalities (73, 74).

The Dutch Cardiovascular Agenda's priorities (prevention, early detection, and integrated care) closely aligns with the focus areas highlighted at EU level, such as promoting healthy lifestyles, improving primary prevention, enhancing the management of cardiovascular risk factors, and addressing familial and genetic predispositions (1, 74). This alignment enables the Netherlands to share effective strategies and learn from other countries. While the Dutch Cardiovascular Agenda is comprehensive in promoting health and preventing risk factors, EU strategies add an explicit emphasis on secondary prevention, ensuring that patients with existing conditions such as diabetes, obesity, hypertension – but also people with kidney disease and congenital conditions – receive timely diagnosis, risk factor management and appropriate treatment to prevent progression and comorbidities. Strengthening this dimension within the Dutch approach would improve alignment with EU priorities and help reduce the burden of CVDs among high-risk populations (74, 75, 76, 77).

Organisations such as the ESC and the European Heart Network have long advocated for national CVD action plans, and the EU is now calling on member states to strengthen national policy efforts (73, 75, 76). To align fully with these developments, the Netherlands should develop a dedicated national cardiovascular health plan in collaboration with the policy makers, professional societies and patients' organisations. The plan should include measurable targets for prevention, early detection, treatment and equality. It should also set clear governance structures, such as a national steering group and regional implementation boards, and establish transparent reporting mechanisms aligned with ESC quality indicators and EU initiatives such as EuroHeart (see paragraph 6.2). Moving from project-based efforts to a long-term, system-level approach would ensure continuity, accountability and sustainable impact. Furthermore, the plan should incorporate EU priorities such as addressing gender disparities in prevention, diagnosis and treatment, and leverage EU-funded projects and cross-border collaboration to accelerate progress (78).

8 The 'Healthier Together – EU Non-Communicable Diseases Initiative' is a European Commission programme launched for the period 2022–2027 to support member states in reducing the burden of major NCDs, including cardiovascular diseases, through prevention, early detection and improved care.

6.2 Cross-border collaboration

The Netherlands already participates in various EU networks, particularly in terms of screening and early detection. Dutch experts participate in the Nordic Screening Network,[9] sharing insights on challenges such as defining target populations for screening and exploring tailored, risk-based approaches (79). Continued collaboration enables the Netherlands to learn from other countries' experiences, such as Denmark's approach to CVD screening or France's strategies for familial hypercholesterolemia detection (80, 81). Cross-border trials and pilot programmes, such as coordinated studies on AI for cardiovascular risk prediction, can provide valuable evidence and foster innovation. Initiatives such as EuroHeartPath exemplify a forward-thinking approach by leveraging artificial intelligence and health data to improve cardiovascular risk prediction and enable personalised care across Europe. The programme unites 35 experts' organisations from 10 countries, including leading hospitals, research institutions, public health associations, industry partners and the ESC (82).

The EU also supports initiatives such as the Global Alliance for Chronic Diseases (GACD), which coordinates international research into chronic diseases, including CVDs (83). Dutch researchers can participate in these programmes, contributing to global strategies for prevention and treatment. In the realm of data and research, the EU's push for a European Health Data Space and interoperable health records aligns with Dutch goals for improved data sharing. By contributing to and adopting European data standards, the Netherlands can facilitate cross-border research and enable citizens to access digital health services throughout the region.

Examining policy measures implemented by other EU countries can also inform Dutch strategy. For example, Portugal introduced mandatory salt targets for bread as part of its salt-reduction law to reduce salt intake and prevent hypertension and CVDs (84). Similarly, the UK has implemented population-level screening programmes through the NHS Health Check, which offers free cardiovascular risk assessments for adults aged 40 to 74 to detect heart disease, diabetes and stroke risk factors (85). To monitor outcomes and improve care quality, Denmark operates a comprehensive heart registry that collects nationwide data on coronary interventions and surgeries for benchmarking and research (86). These efforts are complemented by pan-European initiatives such as the ESC's EuroHeart, which harmonises data collection across countries to enable benchmarking and improve cardiovascular care (87). The Netherlands can consider adopting similar measures to complete its set of CVD policy actions and learn from European peers.

9 The Nordic Screening Network is a collaborative forum of screening experts from Denmark, Finland, Iceland, Norway, Sweden and partner countries such as the Netherlands. It focuses on sharing best practices and tackling challenges in population screening, including accessibility, defining target groups, risk-based approaches and innovations such as AI.

6.3 EU funding and joint projects

The EU supports health through programmes like Horizon Europe, which funds research and innovation, and EU4Health, a multi-billion-euro initiative designed to strengthen health systems and tackle major diseases. In the future, new tools will become available, such as the recently established European Competitiveness Fund, which recognizes health as one of the core strategic sectors essential for Europe's competitiveness and resilience (88). The Netherlands should continue to tap into these opportunities for its cardiovascular initiatives. Horizon Europe enables Dutch universities and companies to lead or join consortia focused on prevention and personalised medicine (89). While EU4Health previously backed actions on cardiovascular health, it will be phased out after 2027 as part of a broader reform under the new Multiannual Financial Framework. Health funding will be integrated into the European Competitiveness Fund, bringing the opportunity of positioning cardiovascular health as a strategic investment priority alongside cancer and mental health. This marks a move away from isolated grant programmes towards long-term, integrated investment in health resilience and innovation, including improved use of data and early detection (89).

By tapping into these funding streams, the Netherlands could scale up programmes like Check@Home with European partners or develop a secure national CVD registry aligned with the European Health Data Space (EHDS), ensuring interoperability within a broader European network. Active engagement in European policy dialogues is equally important. By contributing to the local implementation of the Safe Hearts Plan, Dutch stakeholders can help keep cardiovascular health high on the agenda. A stronger EU commitment can translate into increased structural funds for member states to implement prevention and care improvements, benefiting the Netherlands both directly and indirectly.

European synergies offer a two-way benefit: the Netherlands can share its expertise in cardiovascular health while also learning from innovations abroad. Access to EU funding, data and partnerships can accelerate the implementation of the national cardiovascular strategy. By working as part of a collective European effort, the Netherlands can strengthen its own approach and contribute to a healthier Europe. Cardiovascular health is now a clear priority in European health policy, and by aligning national efforts with this momentum, the Netherlands can help to avert future CVD crises through better prevention and management.

07

Conclusion

This report highlights the complex and pressing challenges of managing CVDs in the Netherlands, highlighting both unique national issues and similarities with European trends. Despite significant medical progress, CVDs remain a leading cause of death, with prevalence expected to grow due to ageing population and lifestyle-related risks. Risk factors such as smoking, obesity, hypertension and high cholesterol continue to impact the Dutch population heavily, with socioeconomic and ethnic disparities causing worse outcomes among vulnerable groups.

Dutch policymakers have made significant progress through ambitious agreements and integrated care strategies, including the National Prevention Agreement, IZA, GALA and AZWA, signalling a promising shift towards prevention and local collaboration. However, critical gaps remain between policy intent and real-world implementation. Prevention and screening programmes are inconsistently applied, care coordination is fragmented, and digital health solutions are underutilised. Although patient involvement is improving, it has yet to become systematic.

Addressing these gaps requires urgent, decisive action from policymakers. In partnership with the DCVA, the Heart Foundation, and other stakeholders, the Ministry of Health must strengthen enforcement mechanisms, invest in targeted interventions and promote integration between social and healthcare domains to ensure effective, sustainable improvements.

The DCVA stands at the forefront of bridging the gap between policy and practice. As a national coalition uniting 25 organisations, the DCVA is actively promoting a shift from scattered pilot initiatives to a coordinated, national cardiovascular care framework. Complementing these efforts, the Dutch Cardiovascular Agenda, developed by the Heart Foundation and a broad coalition of stakeholders, provides a widely supported national framework to address key challenges, including prevention, early detection, personalised care and knowledge sharing. These strategic themes offer a clear pathway for collective action and align closely with this report's analysis and recommendations.

This report outlines four recommended priorities that require immediate policy focus:

Recommendations

1. Develop an integrated prevention framework: Create a national CVD prevention strategy combining public health and clinical care, expand cost-effective screening programs and ensure equity by targeting high-risk, genetically predisposed and underserved groups.

2. Implement integrated care and financing models: Scale multidisciplinary care pathways nationwide, guided by the DCVA Prevention Commission's national efforts to optimize care pathways, clarify roles, and strengthen communication protocols for comprehensive cardiovascular management. Align incentives through bundled payments or shared savings models to reduce fragmentation.

3. Enhance data sharing and digital health: Establish a unified cardiovascular data registry, accelerate interoperable electronic health records, and expand digital health tools such as telemonitoring, wearables, and predictive analytics for personalized care.

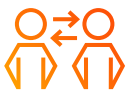
4. Strengthen multidisciplinary teamwork and patient-centered care: Foster cultural change toward collaborative care, embed shared decision-making and self-management tools, and involve patients meaningfully in care design and evaluation

To accelerate progress, guiding principles are needed to turn ambition into coordinated stakeholder driven action:

Guiding principles

1. Promote transparency and share good practices and initiatives through a centralised, accessible knowledge hub that not only highlights successful initiatives but invites feedback and reflection to encourage continuous learning and improvement.

2. Foster a culture of knowledge exchange and collaboration by enabling stakeholders to engage in multi-perspective forums, working groups and online communities that encourage dialogue, humility and adaptation while breaking down silos.



3. Clarify and strengthen the responsibility of all stakeholder groups by ensuring that all stakeholders contribute actively to action, reflection and knowledge exchange, embedding feedback loops that turn insights into meaningful progress.

By adopting these recommendations, the Netherlands can move towards a cardiovascular health system that is more integrated, equitable and effective, fully integrating gender-sensitive approaches across policy, prevention, care delivery and data collection. Leveraging European synergies and aligning with international best practices will amplify impact and ensure that all individuals, regardless of gender, background or location benefit equally from advances in cardiovascular health.

Tailored solutions are needed to address local disparities and systemic weaknesses. By leveraging the Dutch Cardiovascular Agenda as a shared foundation and turning policy ambition into coordinated, evidence-based action, the Netherlands can not only improve national cardiovascular health outcomes but also set a leading example for integrated care across Europe. Ensuring dedicated resources, strengthening governance and mandating transparent accountability will be key to transforming this vision into reality.

08

About this research

This report documents the outcomes of an expert roundtable discussion held in Amsterdam on 3 October 2025. This initiative was made possible through the support of EFPIA Cardiovascular Health Platform, in collaboration with VIG.

The roundtable convened a diverse group of stakeholders, including representatives from patients' organisations, academia, professional societies and the pharmaceutical industry (see Acknowledgements). Prior to the roundtable, two priority themes – 1) prevention and screening and 2) care coordination and collaboration – were identified as priorities through secondary research and extensive expert interviews conducted by PwC.

Following the roundtable discussion, the PwC team consolidated the insights and formulated a set of critical areas and initial recommendations. These recommendations were collaboratively validated by PwC, EFPIA, VIG and the roundtable experts. Relevant scientific and grey literature was also consulted to strengthen the evidence base.

The final version of this report was prepared by PwC in January 2026, incorporating feedback from all roundtable participants, EFPIA, VIG and local industry representatives.

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Many thanks to all experts consulted for this work, with particular acknowledgment of those who participated in the roundtable discussion, contributed through interviews, and provided review and input to the final text.

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Sincere thanks to PwC Strategy& Netherlands for the collaboration and kind hospitality.

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