ENHA's Input to the European Parliament Resolution on the Safe Hearts – EU Cardiovascular Health Plan

The European Nutrition for Health Alliance (ENHA), together with its alliance partners including the **European Society for Clinical Nutrition and Metabolism (ESPEN)**, the **European Federation of the Associations of Dietitians (EFAD)** and the **United European Gastroenterology (UEG)**, welcomes the publication of the European Commission's *Safe Hearts - EU Cardiovascular Health Plan* and acknowledges its ambition to address cardiovascular disease (CVD) across the life course.

From the perspective of people living with cardiovascular disease, however, the Plan does not yet sufficiently translate this ambition into a clear and operational framework, **nor does it fully reflect the realities of CVD as a chronic condition requiring long-term, integrated and adequately funded care**. In this context, the forthcoming European Parliament resolution represents a timely opportunity to strengthen the implementation of the Plan by addressing these gaps and ensuring that the needs of people living with CVD are effectively reflected.

Malnutrition is both a consequence and a driver of poor outcomes in cardiovascular disease (CVD), especially in heart failure, where it is associated with higher mortality, rehospitalisation, and reduced quality of life [3]. Despite this, systematic nutritional screening and support remain the exception rather than the rule in European healthcare. Nutritional screening should be systematically linked to timely dietetic assessment and individualized nutrition intervention, as screening alone without appropriate follow-up does not improve patient outcomes.

Evidence shows that **CVD is now predominantly a chronic-care burden.** The Global Burden of Disease Study estimates that around 68% of all disability-adjusted life years (DALYs) - a measure that combines years of life lost due to premature death with years lived with disability - arise from conditions requiring long-term care, including cardiovascular disease [1]. At the same time, mortality from acute heart attacks has declined, while deaths from chronic conditions such as heart failure, hypertensive heart disease and arrhythmias have risen [2]. **This shift underscores the need for a strategy focused not only on acute episodes but also on comprehensive, long-term, integrated care models**.

Malnutrition is common in chronic CVD and has clear prognostic value. **In many patients, this is further compounded by coexisting gastrointestinal, hepatic and metabolic disorders that impair**

nutrient intake, absorption and utilisation, reinforcing the need to integrate digestive health expertise within multidisciplinary cardiovascular care. The liver and digestive system are central regulating metabolism and inflammation, contributing to malnutrition and increased cardiovascular morbidity and mortality. Large systematic reviews show that simple, low-cost nutritional screening tools predict survival and rehospitalisation independently of other risk factors [3]. These tools can be used in routine clinical practice to identify patients at risk and to guide interventions. Early nutrition intervention has the potential to prevent or mitigate sarcopenia, functional decline, and poor clinical outcomes, highlighting the importance of integrating dietitians into routine cardiovascular care.

According to the Global Leadership Initiative on Malnutrition (GLIM) criteria, **up to 42% of older patients with heart failure are malnourished**, a condition that is independently associated with increased mortality [4]. In addition, sarcopenia, characterised by the progressive loss of muscle mass, strength and physical function affects between 10% and 69% of patients with heart failure and is associated with poorer survival outcomes [5]. Sarcopenia may also coexist with obesity, a condition referred to as sarcopenic obesity, further complicating clinical management.

In particular, Pillar 3 *Living with Cardiovascular Diseases* remains vague and does not sufficiently address the concrete, daily challenges faced by patients with established CVD. While prevention, mental health and person-centred care are rightly acknowledged, the Plan does not clearly distinguish between **primary, secondary and tertiary prevention**, nor does it define measurable actions or implementation pathways beyond a single flagship initiative. Crucially, **nutritional care services are not explicitly integrated**, **despite their essential role across all phases of CVD management.** Living with cardiovascular disease requires integrated, long-term care models that address not only cardiac function but also nutritional status, lifestyle habits, liver and digestive health and social determinants such as food insecurity. Ensuring continuity of nutritional care across hospital, rehabilitation, and community settings is essential to support long-term disease management and improve adherence and outcomes.

This represents a missed opportunity. Nutritional challenges differ substantially across the CVD continuum: while obesity is a key concern in primary prevention, **undernutrition and sarcopenia are highly prevalent and clinically relevant in secondary and tertiary prevention**, **particularly among patients with heart failure,** where they are associated with increased mortality, rehospitalisation and reduced quality of life. **Despite strong evidence and the availability of simple, low-cost screening tools, nutritional screening and personalised nutrition support remain largely absent from routine cardiovascular care.** Integrating nutrition, liver and digestive health is essential to improve outcomes, and to **reduce inequalities and deliver a person-centred cardiovascular care in Europe**. Nutritional care should also be culturally adapted and personalised to reflect individual patient needs, preferences, and social context, which are key

determinants of adherence and effectiveness. Malnutrition in cardiovascular disease encompasses both quantitative undernutrition and qualitative malnutrition, characterised by excess caloric intake but poor nutritional quality. In addition, food insecurity is increasingly recognised as a major determinant of cardiovascular risk, malnutrition, digestive and liver disease, contributing to unhealthy dietary patterns, metabolic dysfunction and inequities in cardiovascular outcomes.

Multimodal rehabilitation programs including tailored exercise and nutritional intervention can improve exercise capacity, decrease sarcopenia, improve quality of life, reduce hospitalisations, and can influence mortality. **However, these programs are scarcely implemented; only in 20% of centers in Europe (6).**

ENHA and its alliance partners are apprehensive that, unlike Europe's Beating Cancer Plan, the *Safe Hearts Plan* does not clearly outline dedicated **financial mechanisms** or indicative budgets to support the implementation of its flagship initiatives. Without explicit funding pathways, there is a risk that well-intentioned objectives will remain aspirational rather than **transformative**.

ENHA and its partners are also concerned that nutrition risks are being even more overlooked in the Safe Hearts Plan than in Europe's Beating Cancer Plan, where the importance of nutritional care is more readily recognised. Addressing cardiovascular disease as a chronic condition requires moving beyond narrative ambition **towards concrete, evidence-based and funded actions that improve quality of life for the millions of Europeans living with CVD**. A comprehensive European cardiovascular strategy must address liver health, digestive function, malnutrition, lifestyle habits modification and food insecurity to ensure person-centred care.

Recommendations

In order to strengthen the implementation of the *Safe Hearts – EU Cardiovascular Health Plan*, we recommend that the European Parliament call on the European Commission and Member States to:

1. **Explicitly include nutritional care services across primary, secondary and tertiary prevention**, recognising the role of nutrition in prevention, disease progression and long-term management of cardiovascular conditions and digestive diseases;
2. **Require opportunistic, regular nutritional screening** including liver and digestive diseases as key determinants of nutritional status and cardiovascular risk **for all people living with CVD**, in both hospital and outpatient settings, as a standard component of cardiovascular care;

3. Ensure access to a cardiovascular-trained dietitian, gastroenterologist and hepatologist as part of the multidisciplinary care team (MDT);
4. Establish EU-level standards for nutritional assessment and personalised nutrition interventions, ensuring continuity of care across hospital, rehabilitation and community settings;
5. Develop minimum EU criteria for continuous education and training on nutritional care for the multidisciplinary cardiovascular workforce, including cardiologists, nurses, general practitioners, rehabilitation specialists and allied health professionals, with dietitians actively involved in the development and delivery of training curricula;
6. Define clearer and measurable implementation measures under Pillar 3 – Living with Cardiovascular Diseases, moving beyond narrative objectives towards operational actions addressing the needs of people already living with CVD;
7. Fund patient empowerment and food and nutrition literacy initiatives, to support adherence, self-management and shared decision-making for people with chronic cardiovascular conditions;
8. Incorporate nutrition-related quality indicators (such as screening rates, prevalence of malnutrition, sarcopenia and CVD-related readmission rates) into national cardiovascular plans and monitoring frameworks;
9. Ensure adequate and transparent funding mechanisms to support the delivery of these measures at national and local level, including through existing EU health funding instruments.
10. Adopt bold, evidence-based roadmaps, policies and implementation measures to reduce Europeans' exposure to unhealthy food environments, namely ultra-processed foods and sugared beverages, with particular attention to children, young people and vulnerable groups.
11. These measures should explicitly acknowledge the shared risk factor profile and high multimorbidity between cardiovascular disease, digestive and liver diseases and malnutrition, and address their combined impact through integrated prevention pathways, coordinated clinical management, and aligned health system planning.
12. Promote early, family-inclusive, and culturally adapted lifestyle and nutrition interventions across the life course, including evidence-based dietary patterns such as the Mediterranean diet, to prevent disease progression and support long-term cardiovascular health. Such interventions should empower patients and their families to adopt sustainable dietary and lifestyle changes as part of routine cardiovascular care (7,8).

References

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