



Implementing a New National Cardiovascular Policy by 2027

2026



Cardiovascular disease is a leading cause of mortality, yet Ireland has been without a comprehensive national cardiovascular strategy since the previous one expired in 2019. Momentum is building towards accelerated policy development in this space, given the recent publication of the Nolan Report (Irish National Review of Adult Specialist Cardiac Services) as well as the launch of the EU's cardiovascular health initiative, the EU Safe Hearts Plan.

This is further emphasised by Ireland's holding of the EU Presidency and the alignment of Irish priorities with broader European goals.

In February 2026, a roundtable was held, attended by a wide group of stakeholders, including policymakers, consultant cardiologists and patients supported by Novartis. The goal of the meeting was to identify the necessary requirements to drive national action by establishing a comprehensive Cardiovascular Strategy for Ireland, fully aligned with the EU Cardiovascular Health Plan. The insights gathered from those present form the basis of this white paper.

Executive Summary

The consensus from the round table is that a lack of a national cardiovascular strategy is having a tangible, overwhelmingly negative impact on patient outcomes. With the publication of the Nolan Report and the recent EU Safe Hearts Plan, there exists both a strong foundation and framework for a national CVD strategy that incorporates adequate prevention, screening and management; one that would have strong backing from all stakeholders, including the medical community, policymakers and patient groups.

Immediate steps should be taken, including the introduction of annualised screening for at-risk populations and the adoption of the 23 recommendations of the Nolan Report. By 2027, this strategy should set clear, time-bound KPIs to deliver meaningful improvements in prevention, detection, and treatment, ensuring Ireland keeps pace with European best practice. The strategy should have a digitally-driven approach, built on accurate system-wide data (as enabled by the forthcoming electronic health record rollout). It will require broad multisectoral and cross-departmental cooperation and collaboration, and multiannual, ring-fenced funding.

Those championing the need for a national CVD strategy are keen to make their voices heard and aid in devising a strategy that is both actionable and achievable. Cardiologists say with the Nolan Report, much of the foundation has been laid for a national CVD strategy, and its recommendations offer an implementable framework that aligns closely with broader EU goals in this area and should be used as a jumping-off point. Patients are willing to offer their insights and input, to help develop a strategy that is patient-centric in its ethos. Policymakers are cognisant that Ireland's upcoming EU Presidency from July to December 2026 offers an opportunity to be a leader in Europe in this area, devising a National CVD Strategy that will endeavour to achieve ambitious EU targets and will deliver for its population.



Recommendations for Policymakers

- A structured, prevention-focused approach to CVD should inform the development of the strategy, with particular focus given to those with identifiable risk factors and/or a known family history.
- Introduce annualised screening of blood pressure and lipids, particularly among younger people and identifiable high risk populations, such as those with a family history. This would allow for timely and adequate lifestyle modifications and pharmacological treatment where needed.
 - » The strategy should include acknowledgement of Lp(a) as a risk factor, with national government funded testing for Lp(a) introduced in Ireland by the end of 2026
- Treatment of cardiac patients must come in line with current and future European Society of Cardiology (ESC) guidelines, with explicit commitments in the strategy that patients are treated to reach optimal targets in terms of blood pressure and lipids and access to approved medicines guaranteed.
- The Nolan Report forms a strong foundation for a national CVD strategy and its recommendations should be adopted as a matter of national urgency.
- A multistakeholder taskforce must be established to drive development and implementation of a national CVD strategy, one that is funded appropriately and is governed by clear timelines and targets.
- The strategy should be one that is patient-centric and digitally-driven, based on quality data so that the impact of the strategy can be accurately measured and assessed.



Introduction

The burden of cardiovascular disease (CVD) is significant: an estimated 600,000 people in Ireland are living with CVD and approximately 80,000 patients are discharged from hospital with CVD-related conditions annually. Extrapolating from UK figures, this means CVD is estimated to cost the state €1.7 billion annually,¹ with direct healthcare costs accounting for almost half of this total.² CVD is ultimately responsible for the deaths of approximately 10,000 people in Ireland each year, accounting for three in ten deaths in the state.³

But despite the stark statistics that clearly illustrate the heavy burden of cardiovascular disease in Ireland, a new comprehensive national cardiovascular strategy, to update the last strategy which expired in 2019, has not yet been drafted.

The Irish National Review of Adult Specialist Cardiac Services, known colloquially as the Nolan Report, was published in 2025 (although completed some years earlier).⁴ The review encompassed a comprehensive and evidence-based assessment of adult cardiac services, covering both scheduled and unscheduled care. The central goal of the Nolan Report is to improve quality, safety, access and integration across the cardiac care pathway so that patients receive the right care, in the right place, at the right time.

The review identifies significant variation in access to acute and chronic cardiac services across regions and highlights fragmentation that disrupts continuity of care. It also notes broader national concerns that Ireland's cardiovascular prevention policies remain outdated despite clear evidence that most premature cardiovascular disease is preventable. The report concludes with 23 implementable recommendations that aim to support services delivering optimal patient outcomes.

Following publication, the Minister for Health instructed the HSE to deliver an implementation plan by June 2025 to translate the recommendations into operational change. To date, this has not been published.

Within the broader cardiovascular context, lipid management is a critical component of improved patient outcomes. LDL-C is identified in Irish clinical guidance as a primary causal and modifiable risk factor for atherosclerotic cardiovascular disease. Lowering LDL-C significantly reduces vascular events in individuals with and without established cardiovascular disease, yet population-level LDL-C control in Ireland remains suboptimal.

CVD is ultimately responsible for the deaths of c.10,000 people in Ireland each year, accounting for three in ten deaths in the state.

The goal of the Nolan Report is to improve quality, safety, access and integration across the cardiac care pathway so patients receive the right care





This reinforces the Nolan Review's emphasis on structured national pathways that ensure appropriate detection, monitoring and treatment. Lipoprotein(a), an apoB-containing lipoprotein and independent genetic risk factor for cardiovascular disease, further elevates risk even when LDL-C is well controlled. Strengthening national coordination and standardised pathways would support more consistent identification and follow-up of people with elevated Lp(a) and other inherited lipid disorders.

The Report offers stakeholders - including policymakers, clinicians, health system leaders and patient organisations - a clear and actionable roadmap for delivering more equitable, modern and prevention-focused cardiac care. It sets the foundation for an updated national cardiovascular strategy capable of addressing Ireland's high burden of disease, reducing regional disparities, improving lipid management, and building a system that is better aligned with both clinical evidence and population needs.

The publication of the Nolan Report aligns with broader EU goals in relation to CVD and its prevention, monitoring and management. The European Union has recently published its own comprehensive strategy aimed at promoting geographical equity in cardiovascular health across Member States, known as the EU Cardiovascular Health Plan: The Safe Hearts Plan.⁵ The EU Safe Hearts Plan is centred on three pillars; prevention, early detection and screening and treatment and care and has a named goal of a 25% decrease in cardiovascular mortality by 2035.

The Safe Hearts Plan encourages Member States to develop or implement standalone or integrated national cardiovascular health plans by 2027, and the European Commission has confirmed its intention to work closely with Member States to begin rolling out the Plan's key deliverables. Initial efforts are expected to focus on coordination, data collection and support for national cardiovascular health plans.

As Ireland prepares to take over the presidency of the Council of the European Union on July 1st, this presents an unprecedented opportunity to initiate action on the development of a comprehensive national CVD strategy that complements the Nolan Report and aligns with broader EU ambitions in this area. Minister for Health Jennifer Carroll McNeill has already repeatedly signaled her intent to prioritise CVD health during the presidency and to develop such a strategy.



Key Themes

Epidemiology of Cardiovascular Disease

The substantial CVD burden in Ireland manifests itself in high rates of morbidity and mortality.⁶ Experts at the round table agreed that a significant proportion of this is preventable with the appropriate screening, diagnosis, and management. The EU Safe Hearts Plan 2035 targets include ensuring a high percentage of people over age 25 annually have their blood pressure, cholesterol and blood sugar measured by health professionals. Achieving stricter control of these numbers can prevent future CV events.

Attendees spoke of the challenges involved in introducing more widespread screening programmes, particularly with regard to reaching younger populations and capacity challenges in primary care. Patients, physicians and policymakers were in agreement that there is a significant “opportunity loss” that exists when it comes to both high-risk screening and whole population schemes, to prevent downstream health impacts.

The need for screening for markers of heritable CVD was also discussed. It was noted that the National Genomic and Genetic Strategy has not yet been implemented. While the majority of cardiovascular events are related to polygenic factors, genetic markers for inherited cardiac diseases should also be considered, such as those with familial hypertension, inherited lipid disorders and certain cardiomyopathies. Mandatory Lp(a) testing for early identification of high-risk individuals is essential as Lp(a) is not detected in standard lipid panels.

Strengthening national coordination and standardised pathways would support more consistent identification and follow-up of people with elevated Lp(a) and other inherited lipid disorders.

While the EU Safe Hearts Plan suggests annualised screening of people over 25, one consultant cardiologist



Consultant
cardiologist

I truly believe no one should be dying from preventable heart disease and lipid screening is a huge part of that.



Consultant
cardiologist

The cost of treating somebody from their 20s to even get a small reduction of modifiable risk factors yields benefits.

stressed that this should be even younger, in order to identify the relatively high proportion of the population with heritable lipid risk factors.

The strategy should also incorporate a framework that allows for screening of family members if someone experiences a CV event. Another cardiologist emphasised the importance of integrated lipid testing (LDL-C), with blood pressure, cholesterol and Lp(a) being screened in a single patient encounter.

An opposition TD stressed the need for a “structured, prevention-focused approach to CVD”. A prevention strategy should be cross departmental in nature. It would largely align with the goals of Healthy Ireland and could complement this successful policy.

Attendees spoke of how issues such as inclusivity in terms of exercise participation, better facilities in schools etc., would also be key tenets of any prevention strategy, while the food industry was continually highlighted as having a key role to play in prevention.

Recommendation

Introduce annualised screening of blood pressure and lipids, particularly among younger people and identifiable high risk populations, such as those with a family history. This would allow for timely and adequate lifestyle modifications and pharmacological treatment where needed.

Impact of Cardiovascular Disease on Ireland's Health System

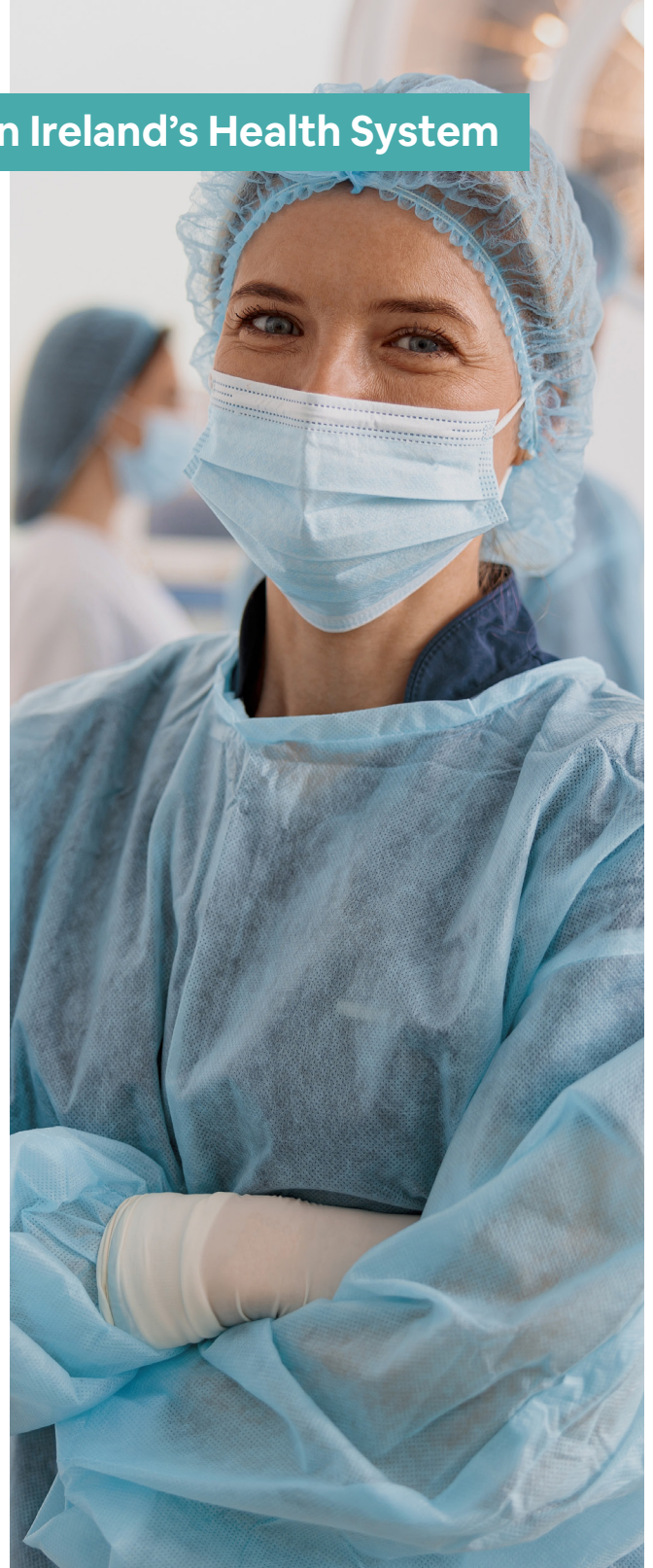
One TD noted that a “full reset” in terms of Ireland’s cardiovascular care is required, similar to the very successful National Cancer Strategy that has transformed cancer care and thus outcomes in Ireland over the past two decades. Although “huge strides” have been made in terms of the management of CVD, with tangible and significant improvements in survival, significant gaps remain.

Treatment in Ireland is not in line with clinically devised ESC Guidelines, which have not been fully or widely implemented. Consultant cardiologists spoke of the need to “treat to target”; yet the Da Vinci study (2023)⁷ showed that more than half of patients in Ireland failed to meet the strict 2019 ESC/EAS LDL-C goals.

The consensus was that any enhanced screening measures should come in tandem with appropriate and aggressive treatment where necessary, as well as education on lifestyle factors such as smoking cessation, weight management, and regular exercise.

In areas of cardiac care where there are data that gives “snapshots” of how the system is performing, there are some clear deficiencies, suggested one consultant cardiologist. This is particularly evident in acute care: for example, if someone has a particular type of heart attack and manages to get to a primary percutaneous coronary intervention (PCI) centre, their outcome is invariably good. However, if someone is instead brought to a Model 3 hospital, the objective is that they should be sent to a primary PCI centre within 30 minutes, yet this is happening in only 3% of cases.⁸

Access to innovative pharmacological treatments was another issue raised, and while this is improving somewhat, it was noted that this delay in accessing innovative treatments can impact Ireland’s ability to meet European treatment guidelines.



Recommendation

Treatment of cardiac patients must come in line with current and future European Society of Cardiology (ESC) guidelines, with patients treated to reach optimal targets in terms of blood pressure and lipids and access to approved medicines guaranteed.

Addressing Capacity & Access for Cardiovascular Disease Prevention

While enhanced screening would understandably result in capacity challenges, a number of workable solutions to circumvent these were suggested by attendees. Suggestions included screening in workplaces, third-level institutions, or mobile hubs. One consultant cardiologist suggested that screening could be incorporated into the Transition Year Programme, to get young people comfortable with the concept of their blood pressure and cholesterol levels, while also allowing for lifestyle interventions such as avoidance of smoking, diet changes and exercise, etc.

While there are significant capacity challenges in general practice/primary care, the Chronic Disease Management Programme (CDMP) has been extremely successful and a similar incentivisation model may also be an option.

Currently, access to healthcare can be patchy and often delayed - GP appointment times of more than two weeks were cited. The relatively large proportion of unclaimed GP visit cards and medical cards was highlighted, and efforts should be made to drive awareness of entitlement to these benefits. The high proportion of the population who pay for private health insurance points to a lack of satisfaction with, or trust in, the public system, commented one Government TD.

But even where there is entitlement to free care, people may choose not to access it or there may be poor awareness. A public awareness campaign should therefore be a core tenet of any new CVD strategy, reinforcing current messaging around prevention, and driving awareness of additional screening and testing options.

Attendees at the roundtable were unanimous on the importance of prevention. While cardiologists especially believe primary prevention of modifiable



People feel that they cannot depend on the public system if they get into trouble with heart disease or cancer and I think that's really, really regrettable



I think if we're talking about prevention, we also need pharmacological intervention, support and screening, and that needs to be rolled out - I think we miss a trick by not having an integrated approach

risks is of utmost import, all attendees felt any prevention strategy should be extremely broad in its approach, encompassing other social issues such as housing, education, and environment

Frustration was expressed by the consultant cardiologists present at the inertia in relation to implementation of the recommendations of the Nolan Report. They noted that not one of the 23 recommendations, nor the 34 sub recommendations, was highlighted in the Programme for Government, despite significant representations from the cardiology community.

The consensus was that the report provides a high-quality framework within which to improve cardiovascular care across Ireland.

Recommendation

The Nolan Report forms a strong foundation for a national CVD strategy and its recommendations should be adopted as a matter of national urgency.

Long-term Delivery of Cardiovascular Strategy

Any national CVD strategy will need to be appropriately funded and resourced. While the current economic burden of CVD care has been well-established, it was accepted that huge amounts of additional funding may not be made available, given the current constraints on the health budget.

One cardiologist spoke of the need to “expand their reach in a very cost-effective way”, by utilising the resources already afforded to cardiology, via the hubs/ integrated care model, for example. His point was that appropriate triage of patients by a nursing team, for example, or simple patient education, could allow two-thirds of patients to be dealt with before having to see a cardiologist. This would also allow for identification of higher risk people for prevention and screening - currently people with markedly different risk stratifications languish on the same waiting list, noted the cardiologist.

Such an approach could deal with the significant bottlenecks in the system and help avoid long waiting lists. It would also avoid the over reliance on the private system to deal with waiting lists when they become too long; “my concern is that we’re spending when there’s already built-in capacity.”

This would allow for greater and more appropriate access in a cost-effective way, as many agreed that spending more in certain areas isn’t always the answer. One TD noted the ongoing desire and need to treat people at the lowest level of complexity, with the majority of cardiac care carried out in primary care or in the integrated hubs.



Consultant
cardiologist

A nurse-led service is a much more cost-effective way of doing things than a purely tertiary cardiologist service

Ultimately, the need would be for ringfenced funding with multi annual budgets. Attendees agreed this is a long-term goal, not a quick fix nor a time-limited initiative. Central funding for the issue of prevention was specifically highlighted, with one consultant cardiologist noting that prevention will not be seen as a priority within a regional budget.

It was suggested that in tandem with the publication of any national CVD strategy should be the establishment of a multistakeholder implementation oversight group, with which accountability for delivery of the strategy would lie. This should include appropriate non- political, non-commercial stakeholders, as well as members of the Oireachtas.

The timeframe of any national CVD strategy would and should be longer than any one Minister’s tenure and therefore it will require unprecedented support and advocacy to ensure that its goals are achieved over its lifespan.

Recommendation

A multistakeholder taskforce must be established to drive development and implementation of a national CVD strategy, one that is funded appropriately and has clear timelines and targets.

Metrics & Accountability for the

Implementation of Cardiovascular Strategy

Ireland significantly lags other EU member states when it comes to digital adoption within the health services. Although general practice and primary care has been largely digitalised, this was self-funded by GPs. Lack of digital integration between health settings has a negative impact on care, and ensures Ireland does not collect accurate data on its CVD patients, a number of the attendees noted.

A fragmented health service populated by legacy infrastructure has stymied digital adoption, although momentum in this area is gathering with the Government having gone out to tender on Ireland's first electronic health record (EHR).

The lack of progress in digitalisation across the health service was highlighted by a number of attendees, who cited it as a major barrier to implementing a broad-ranging CVD strategy, and noted that progress in digitalisation must happen in tandem to allow for the successful rollout of any such strategy.,

It was highlighted by patient attendees that the paucity of digital communication within the health service can lead to duplication of information and even treatment, with the patient experience negatively impacted as a result. There is energy and appetite to expedite the digitisation of the health service but there is a consensus that Ireland has a significant way to go in terms of catching up.

Denmark was cited as one European country of similar size to Ireland that has exemplary management of patient data via patient registries and ongoing strategies that have been well implemented; these can easily show "return on investment". Without proper digitalisation of the health service, and therefore accurate and detailed patient data, the success of any proposed CVD strategy would not be known.

It was noted that enhanced digitalisation and automation would also free up time in terms of administrative burden and allow for greater capacity within the system. This could mean automation of appointments to the use of artificial intelligence (AI) in screening and



Consultant
cardiologist

You have to know your starting point. If you want to change anything, you need to know where you are to show progress

diagnosis. The rollout of an EHR would also allow for accurate up to date patient registries to be quickly and easily established, which would allow for systemwide analysis of the true burden of CVD in Ireland. The belief was expressed that a national strategy could help in terms of streamlining information for patients and avoiding duplication of information and care. One attendee had a stroke in the US and continued her care in Ireland but when it came to moving from Galway to Dublin, "it was like starting all over again".

Ongoing monitoring and sharing of information would provide greater efficiencies within health services but also enable a much-improved patient experience. A patient portal with access to their own data would help make the system more efficient but also empower the patient in terms of shared decision-making and helping to manage their own care.

The exposure offered by the EU Presidency will mean there is a spotlight shone on Ireland's pace at developing a national CVD strategy as outlined by the Safe Hearts Plan, which will be a priority of Ireland's EU Presidency. It was noted that this scrutiny at European level may finally drive efforts in this area. Previous EU presidencies have allowed accelerated progress in certain areas of Europe-wide importance.

Members of the Oireachtas health committee and other TDs who acknowledge this as a critical issue should also continue to highlight and make the case for concrete action.

The cardiology community is used to advocating for their patients and the broader umbrella of issues pertaining to CVD prevention, screening and management.

Recommendation

The strategy should be one that is patient-centric and digitally-driven, based on quality data so that the impact of the strategy can be accurately measured and assessed.



Conclusion

A palpable sense of urgency was evident from the gathered stakeholders when it came to the pressing need for a national CVD strategy. There was consensus that people are being under diagnosed and undertreated with a huge lost opportunity in terms of screening and prevention. These elements, when combined with the 23 recommendations of the Nolan Report, could form the basis for a national CVD strategy with the same fundamentally transformational effect as the national cancer strategy. Prevention and screening, as core tenets of any national strategy, could be effectively integrated into the recommendations of the Nolan Report and an overall broader alignment with the EU Safe Hearts Plan.

Explicit targets and timelines will be essential components of any national CVD strategy - attendees noted that most policies fail because they have no deadline for their implementation. All agreed this will require accountability at the highest level and advocacy by all stakeholders - Government, professional representative bodies, patient organisations and industry. A multistakeholder implementation taskforce with the agency to devise a national strategy and a concomitant plan for its implementation could be established to ensure this stays on the political agenda and is executed sooner rather than later.

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