Call to Action to Prioritize Combatting Cardiovascular Disease to Tackle NCDs and Achieve Healthy Aging

Building on the outcome of the Fourth UN High-Level Meeting on NCDs and Mental Health

Fewer than one in ten WHO Member States have a dedicated national cardiovascular health plan, and the lack of implementation poses a defining challenge to the global CVD response.[1] The Aging with Heart Alliance calls on UN Member States to move from a promise in a declaration to a delivery of these solutions, based on the commitments made at the Fourth UN High-Level Meeting on NCDs in September 2025, into funded, time-bound national action.

Cardiovascular disease (CVD) claims an estimated 20.5 million lives annually, nearly one-third of all global deaths, primarily caused by heart attacks and strokes.[2] In Europe, CVD costs an estimated €282 billion per year; in the United States, total CVD-related costs are projected to triple to $1.8 trillion by 2050.[3,4] Across ASEAN, the number of people living with cardiovascular disease increased by 148% between 1990 and 2021, with cardiovascular disease causing 1.66 million deaths in 2021.[5] Across the Middle East and North Africa, CVD-related deaths rose by 78% between 1990 and 2019.[6] Between 2025 and 2050, global CVD prevalence is projected to rise by 90% as the population ages and rates of hypertension, obesity, elevated cholesterol, and diabetes climb.[7,8,9] CVD affects roughly 40% of adults aged 40–59, 75% of those aged 60–79, and 86% of those aged 80 and older.[10]

Without accelerated action, these trends will overwhelm health systems, erode workforce productivity, and reverse decades of hard-won gains in life expectancy.

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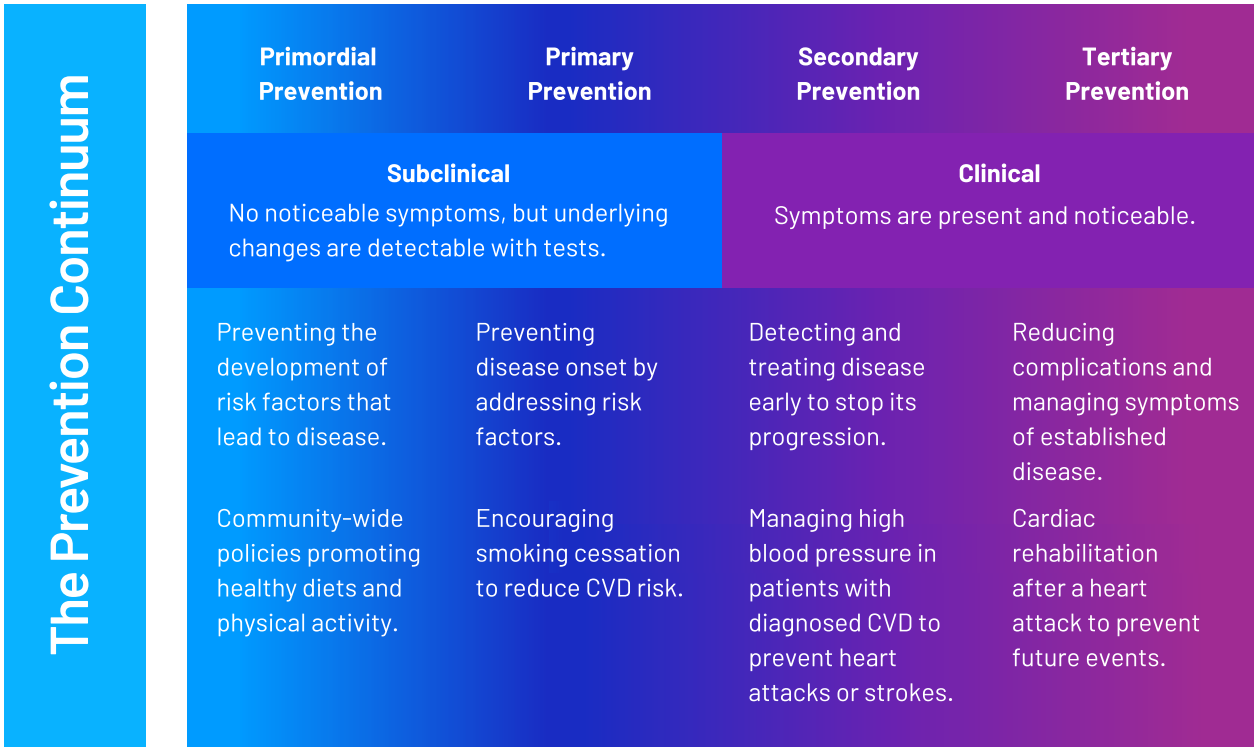
The HLM4 Political Declaration, formally adopted by the UN General Assembly on December 15, 2025, sets binding 2030 targets: 150 million more people with hypertension under control, 150 million fewer tobacco users, and 150 million more people with access to mental health care. In addition to the targets, the Declaration also includes strong language on preventing and treating CVD. The following month, the European Commission unveiled the Safe Hearts Plan, the first EU-wide approach to CVD, built around prevention, early detection, and treatment.[11]

Prevention at Every Age and Stage

Prevention is the most powerful lever in CVD response, with effects extending well beyond the heart. Reducing CVD risk also lowers rates of diabetes, cognitive decline, and other major NCDs.

The prevention continuum runs from primordial (addressing root conditions before risk factors develop) through primary (reducing modifiable risk factors like hypertension, elevated cholesterol, obesity, and tobacco use), secondary (early detection and treatment), and tertiary (managing established disease to prevent complications). Most countries are underinvesting at every stage.[12]



Uncontrolled cholesterol and hypertension together account for a substantial share of CVD morbidity and mortality, with elevated cholesterol affecting an estimated 39% of adults globally — with rates considerably higher across Europe — and hypertension remaining the single largest modifiable risk factor for heart disease and stroke worldwide.[13,14] Both are preventable and treatable with existing tools. Chronic stress, depression, and social isolation also raise CVD risk.

The asks that follow address each stage of this continuum, from primordial prevention through to financing the system that makes it work.

What We Are Calling For

First Steps

National CVD plans. Every government should have a dedicated national cardiovascular health plan by 2027, aligned with the WHO HEARTS framework and the HLM4 targets. The EU Safe Hearts Plan commits to supporting all 27 Member States in developing or updating their plans by that deadline.[15] That standard should apply globally, with targeted technical assistance for countries that need it. Poland's National Program for Cardiovascular Diseases (2022–2032), covering education, screening, workforce investment, and innovation, is a replicable model.[16]

Risk Factor Management. The World Heart Federation estimates that scaling access to affordable antihypertensives to 500 million more people by 2030 could prevent at least 75 million deaths by 2050 and deliver net economic gains of $212 billion annually.[17] Across Southeast Asia and the Middle East and North Africa, high systolic blood pressure is the dominant attributable risk factor for CVD, yet detection and treatment rates lag far behind high-income regions.[18,19] Lipid management deserves equal attention: updated ESC and US guidelines, forthcoming WHO guidance on dyslipidemia, and the EU Safe Hearts screening targets all reflect growing recognition of elevated cholesterol as a major driver of CVD outcomes. Blood glucose control completes the core triad. Governments need national roadmaps to the HLM4 hypertension target and parallel commitments on cholesterol and blood sugar, grounded in primary care-based diagnosis and functioning follow-up systems.

Universal screening. Blood pressure, glucose, cholesterol, and weight screenings need to be accessible, recurring, and designed to reach the people who need them most: women, older adults, rural communities, and lower-income populations. The EU's forthcoming cardiovascular health checks protocol, a Council recommendation expected in 2026, offers a common approach that other regions should adapt.

Next Steps

Post-screening protocol. Treatment and management must follow detection. CVD care and first-line medicines should be part of essential health benefit packages, embedded in national UHC frameworks and benefit package reviews.

Fiscal and regulatory action. Tobacco taxes, levies on ultra-processed foods, trans fat elimination, front-of-pack labeling, and marketing restrictions are cost-effective, population-level CVD interventions endorsed by the HLM4 Declaration. Governments should implement them and direct the revenue toward prevention.

Digital health. Wearables, electronic records, telemedicine, and AI-assisted clinical decision-making are proven tools that governments can deploy now. The EU Safe Hearts Plan treats digital infrastructure as health infrastructure; other governments should follow. Governments should require interoperability standards and create procurement conditions that bring these tools to public health systems at scale.

Gender and CVD care. Women have been systematically under-enrolled in cardiovascular trials and under-diagnosed in clinical practice, resulting in lives lost. Governments and industry should fund sex-disaggregated CVD research, develop gender-specific screening protocols, and train clinicians on how CVD presents differently in women. The HLM4's call to mainstream a gender perspective needs to become a line item in national plans.

Mental health integration. National clinical guidelines, care models, and workforce training should reflect that mental health challenges like depression and isolation are cardiovascular risk factors. Civil society organizations and patient communities are essential accountability partners in supporting that integration.

Financing. CVD prevention is an investment in healthy aging and workforce productivity. Less than $1 per person per year in proven NCD interventions — the majority targeting CVD risk factors — could save 7 million lives and generate more than $230 billion in economic benefits in LMICs alone by 2030.[20] Governments should commit to domestic health financing for CVD prevention and report transparently on progress against the HLM4 targets. A concrete floor: at least 80% of primary health care facilities stocked with essential NCD medicines by 2030.

The Aging with Heart Alliance calls on all UN Member States to move without delay — developing or updating national cardiovascular health plans, meeting the HLM4 targets, and reporting transparently on progress.

About the Aging with Heart Alliance

The Aging with Heart Alliance was founded by the Global Coalition on Aging. It brings together experts from CVD, aging, and beyond to coordinate on messaging and drive policy change at the intersection of cardiovascular health and aging. For more information, contact Melissa Mitchell, Executive Director (mmitchell@globalcoalitiononaging.com) or Michiel Peters, Head of Advocacy Initiatives (mpeters@globalcoalitiononaging.com).

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