

## Submission to the European Commission Call for Evidence

### Council Recommendation on health checks for cardiovascular diseases: an EU approach to early detection and screening

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#### Submitter

**Sleep Health Europe** is a multi-stakeholder and science-based alliance and platform that brings together leading voices across sleep science, healthcare, advocacy and civil society. The coalition was launched in March 2026 with a mission to embed sleep health into European public health policy. Its current partners include the European Brain Council (EBC), the European Association for the Study of Diabetes (EASD), the British Sleep Society, the European Specialist Nurses Organisation (ESNO), WSCN (the Wellness, Sleep & Circadian Network), the European Psychiatric Association (EPA), the World Hypertension League, the Arrhythmia Alliance, and Resmed.

#### Executive summary

Sleep Health Europe welcomes the European Commission's proposal for a Council Recommendation on health checks for cardiovascular diseases. We welcome in particular the explicit recognition of obstructive sleep apnoea as a risk factor for cardiovascular diseases and the acknowledgement that it belongs within the screening scope of the EU Cardiovascular Health Plan. We submit five recommendations in support of giving this recognition operational substance, including that:

1. Screening for sleep disorders, using validated low-cost questionnaires and tools, should be embedded within the EU Protocol on Health Checks alongside blood pressure, cholesterol, blood glucose, and body mass index;
2. Validated low-cost screening tools are already in routine clinical use;
3. Sleep disorders are a cross-cutting risk factor across the cardiometabolic conditions the Plan prioritises;
4. Addressing sleep health is cost-effective and supports the Plan's prevention objectives;
5. and doing so is a concrete instrument to advance the equity goals already articulated in the Plan.

## Context

Sleep is a structural determinant of physical and metabolic health, alongside diet and physical activity. A 2026 study commissioned by the European Academy of Neurology and published in the European Journal of Neurology found that sleep disorders chronically affect 20 to 30 percent of the European population and impose an estimated annual societal burden of up to €423 billion across 47 countries in Europe<sup>1</sup>. These findings build on earlier RAND Europe analysis which estimated that insufficient sleep alone costs major European economies between 1.02 and 1.86 percent of GDP annually through lost productivity and mortality-related impacts<sup>2</sup>, and align with a 2024 editorial in The Lancet Diabetes & Endocrinology that characterised sleep as a neglected public health issue requiring systematic policy attention across modern industrialised societies<sup>3</sup>. Both obstructive sleep apnoea (OSA) and chronic insomnia with short sleep duration are independently associated with hypertension<sup>4</sup>, atrial fibrillation<sup>5</sup>, heart failure<sup>6</sup>, and stroke<sup>7,8</sup>, and approximately 40 to 60 percent of patients with cardiovascular disease are affected by OSA<sup>9</sup>. Yet the majority of sleep disorders remain undiagnosed, including in healthcare systems with adequate access to care<sup>10</sup>, and sleep is structurally absent from most national public health frameworks<sup>1</sup>.

The forthcoming Council Recommendation on health checks for cardiovascular diseases offers an opportunity to close this gap. The Communication on the EU Cardiovascular Health Plan already identifies obstructive sleep apnoea as warranting inclusion in the scope of cardiovascular screening<sup>11</sup>, and the 2024 European Society of Cardiology Guidelines on atrial fibrillation<sup>5</sup>, elevated blood pressure and hypertension<sup>12</sup>, and chronic coronary syndromes<sup>13</sup> recommend sleep screening as part of cardiovascular care. What is now needed is operational integration: clear guidance to Member States on what to screen, in which patient populations and how, embedded in the same primary-care pathways already being developed for blood pressure, cholesterol, blood glucose, and body mass index.

Sleep Health Europe therefore submits these 5 recommendations to support this integration:

### **1. Include screening for sleep disorders in the EU Protocol on Health Checks alongside the other modifiable risk factors.**

The Communication on the EU Cardiovascular Health Plan already identifies obstructive sleep apnoea as warranting inclusion in the scope of cardiovascular screening<sup>11</sup>. Sleep Health Europe welcomes this recognition. The Council Recommendation should now give it operational substance, embedding sleep within

the EU Protocol on Health Checks alongside blood pressure, cholesterol, blood glucose, and body mass index. We propose that the Recommendation include a validated sleep-screening section within the standard health-check questionnaire, with clear onward referral pathways for individuals at elevated cardiovascular risk.

## **2. Validated, low-cost screening tools are already in routine clinical use across Europe.**

Three validated screening instruments are widely used: STOP-BANG<sup>14</sup>, Berlin<sup>15</sup>, and NoSAS<sup>16</sup>. All can be administered in under five minutes by a general practitioner or nurse, and the NoSAS score in particular was developed and validated in a European cohort<sup>16</sup>. The 2024 ESC Guidelines on the management of atrial fibrillation<sup>5</sup>, elevated blood pressure and hypertension<sup>12</sup>, and chronic coronary syndromes<sup>13</sup> explicitly recommend sleep screening in cardiovascular care. The 2024 ESC Clinical Consensus Statement on obesity and cardiovascular disease similarly recommends regular screening for non-restorative sleep in patients with obesity<sup>17</sup>. The 2025 European Society of Hypertension position paper on nocturnal blood pressure further underscores that sleep-related cardiovascular pathophysiology, including sleep-disordered breathing, requires systematic clinical attention in the management of hypertension<sup>18</sup>. What is missing is not the clinical tools or the clinical consensus, but the EU-level framework to support consistent implementation across Member States.

## **3. Sleep is a cross-cutting risk factor for cardiometabolic disease, with implications across the priorities the Plan already names.**

Sleep is bidirectionally linked with diabetes<sup>19</sup>, obesity<sup>20</sup>, and chronic kidney disease<sup>21</sup>, all of which the Safe Hearts Plan identifies as priority disease areas to address. Both obstructive sleep apnoea and chronic insomnia with short sleep duration are independently associated with insulin resistance, weight gain, and progression of metabolic disease<sup>5,19</sup>. Embedding sleep within the EU Protocol on Health Checks therefore reinforces the integrated cardiometabolic logic of the Plan, aligns with the priorities of the Healthier Together EU non-communicable diseases initiative<sup>22</sup>, and complements ongoing EU joint actions on cardiovascular and diabetes prevention<sup>23</sup>.

## **4. Including sleep is a cost-effective measure that addresses the Plan's prevention objectives directly.**

The Call for Evidence acknowledges that implementing health checks may entail short-term costs but expects these to be offset by reductions in long-term healthcare spending and productivity losses<sup>24</sup>. The economic case for including sleep is particularly strong. Sleep disorders impose an estimated annual societal burden of up

to €423 billion across countries in Europe<sup>1</sup>, and a 2025 meta-analysis of more than one million adults found that effective treatment of obstructive sleep apnoea was associated with substantial reductions in all-cause and cardiovascular mortality<sup>25</sup>. A 2023 RAND Europe study focused specifically on chronic insomnia, which affects approximately 8 percent of adults in high-income countries, estimated that affected individuals lose between 45 and 54 working days per year through reduced productivity, translating into national GDP losses of 0.64 to 1.31 percent annually<sup>26</sup>. Patients with untreated OSA also incur higher annual healthcare costs through increased hospitalisations and emergency care<sup>27</sup>. Including sleep in the Protocol therefore contributes both to the Plan's prevention objectives and to its long-term sustainability.

### **5. The undetected burden of sleep disorders deepens the inequalities the Call for Evidence itself identifies.**

The Call for Evidence highlights that women face higher rates of cardiovascular misdiagnosis and that socio-economically disadvantaged populations carry a disproportionate burden of cardiovascular disease<sup>24,28</sup>. Both groups also experience the highest rates of undiagnosed sleep disorders. Women, in particular, present with atypical OSA symptoms and are systematically under-referred relative to men with comparable risk profiles<sup>29</sup>. Including sleep in the EU Protocol on Health Checks is therefore not only a clinical measure but a concrete instrument to advance the equity objectives already articulated in the Safe Hearts Plan.

### **Conclusion**

The five recommendations above form a coherent case for embedding sleep into the EU Protocol on Health Checks. The clinical evidence base is mature, validated screening tools already exist and are in routine European clinical use, and including sleep reinforces rather than complicates the Plan's integrated cardiometabolic logic. The economic case aligns with the Commission's own expectations of long-term cost offsets, and including sleep would directly advance the equity goals the Plan has already articulated. This is therefore not an addition to the Plan's scope but a strengthening of its existing ambition. Sleep Health Europe stands ready to support the Commission and Member States with clinical evidence, primary-care implementation guidance, and multi-society coordination as the Recommendation moves from proposal to adoption.

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