Asia-Pacific
Economic Cooperation

Roadmap to Advance Sustainable Cardiovascular Health and Economic Resilience in APEC Economies 2026–2030



APEC Health Working Group
November 2026



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Abbreviations

APEC	Asia-Pacific Economic Cooperation
BPHS	Basic Public Health Service
COVID-19	Coronavirus disease 2019
CEV	Community emergency volunteers
CHD	Coronary heart disease
CR	Cardiac Rehabilitation
CVD Rehabilitation	Cardiovascular disease rehabilitation
CVD	Cardiovascular disease
DALYs	Disability-adjusted life years
ED	Emergency department
EMS	Emergency medical services
FONASA	Fondo Nacional de Salud
FUKKM	Formulari Ubat Kementerian Kesihatan Malaysia
GES	Régimen de Garantías Explícitas en Salud
IHD	Ischemic Heart Disease
INCOR	Instituto Nacional Cardiovascular
KOSPEN	Komuniti Sihat Pembina Negara
M&E	Monitoring and evaluation
MOH	Ministry of Health
MRFF	Medical Research Future Fund
NCD	Noncommunicable disease
NPHS	National population health survey
OECD	Organization for Economic Co-operation and Development
PSCV	Programa de Salud Cardiovascular
VHV	Village Health Volunteer

Executive Summary

Cardiovascular disease (CVD) is the leading cause of death across APEC economies, accounting for approximately 9.8 million deaths annually and nearly half of all Non-Communicable Disease-related mortality across the economies.

Since 1990, CVD prevalence has grown by more than 140%, driven by population ageing and rising rates of hypertension, obesity, and diabetes. The burden is distributed unevenly reflecting substantial variation in health system capacity, prevention infrastructure, and access to care across the economies. Progress across APEC economies has been uneven, and forecasts suggest that while mortality rates may continue to decline in some economies, total cardiovascular deaths are projected to rise sharply due to demographic and epidemiological pressures. Whether APEC economies will meet economy-wide NCD mortality reduction targets by 2030 remains uncertain, with rising rates of obesity, diabetes, and physical inactivity continuing to offset gains made through improved treatment and screening coverage.

The costs of CVD extend well beyond direct healthcare expenditure. Because a significant share of cardiovascular deaths occurs among working-age populations, CVD has direct consequences for labor supply, household incomes, and long-term economic growth. Global direct and indirect costs are projected to exceed USD 1 trillion by 2030, with indirect costs consistently exceeding direct costs by substantial margins. At the patient level, treatment costs for chronic ischemic heart disease frequently exceed per capita public health expenditure by several multiples, placing acute pressure on health financing systems. Unpaid family caregivers, predominantly women, absorb a further share of post-acute and long-term CVD care, compounding productivity losses in ways that economy level cost estimates rarely capture.



Most APEC economies have established the policy foundations for CVD prevention and care with NCD strategies, expanding health coverage, clinical guidelines, and prevention programs broadly in place. Progress has nonetheless been constrained by financing limitations, fragmented primary care systems, and access to care. Economic data on CVD remains underdeveloped, limiting governments' ability to frame cardiovascular health as a fiscal and workforce priority and sustain investment accordingly.

This roadmap provides a structured, evidence-informed framework to strengthen CVD policy and health system performance across APEC economies, with economic resilience as its overarching lens. It is designed to be adaptable across the economies health system contexts, from high-income economies focused on integration and quality improvement to middle-income settings where foundational primary care investment remains the priority. The roadmap also draws on case studies from member economies, reflecting the breadth of approaches already being implemented. A defining feature of the framework is its emphasis on the use of economic evidence in CVD decision-making, including the development of investment cases, application of health technology assessment to benefit design, and integration of productivity and workforce indicators into monitoring frameworks.

The roadmap identifies six priority areas spanning the continuum of care:



1 Policy Leadership and Governance

Strengthening CVD strategies with costed action plans, cross-sector coordination, sustainable financing, and equity-oriented accountability structures.



2 Prevention and Risk Reduction

Advancing tobacco and alcohol control through fiscal measures and governance safeguards, structural nutrition and physical activity policies, and institutionalized risk- factor surveillance.



3 Early Detection and Diagnostics

Improving risk-based screening frameworks, tiered diagnostic capacity, and primary care's central role in long-term CVD risk detection and management.



4 Emergency Response and Acute Care

Standardizing pre-hospital systems and emergency clinical pathways and developing regional referral networks to address geographic inequities in access to acute care.



5 Treatment, Rehabilitation and Secondary Prevention

Ensuring reliable access to essential medicines, institutionalizing cardiac rehabilitation within universal health coverage, and strengthening integrated chronic disease management pathways.



6 Health System Enablers

Building interoperable data systems, expanding workforce capacity through task-shifting and retention strategies, deploying context-appropriate digital health tools, and strengthening evidence-to-policy translation.

From Commitment to Implementation

Cardiovascular disease is a driver of workforce loss, fiscal pressure, and long-term economic underperformance, as well as a leading cause of death and disability across APEC economies. The investments required to change this trajectory are known, cost-effective, and in most economies already partially underway. Realizing them requires coordinated leadership across finance and health portfolios. Finance authorities have a central role in aligning fiscal policy with cardiovascular health, including through health-related taxation, sustainable financing for prevention, and the assessment of cardiovascular investment against workforce and economic returns. Health authorities lead in strengthening primary care, diagnostic capacity, and continuity of care. Joint accountability between these functions, supported by shared indicators that link health outcomes to economic and fiscal measures, positions cardiovascular health as a measurable contributor to economic resilience across APEC economies.



1

Introduction

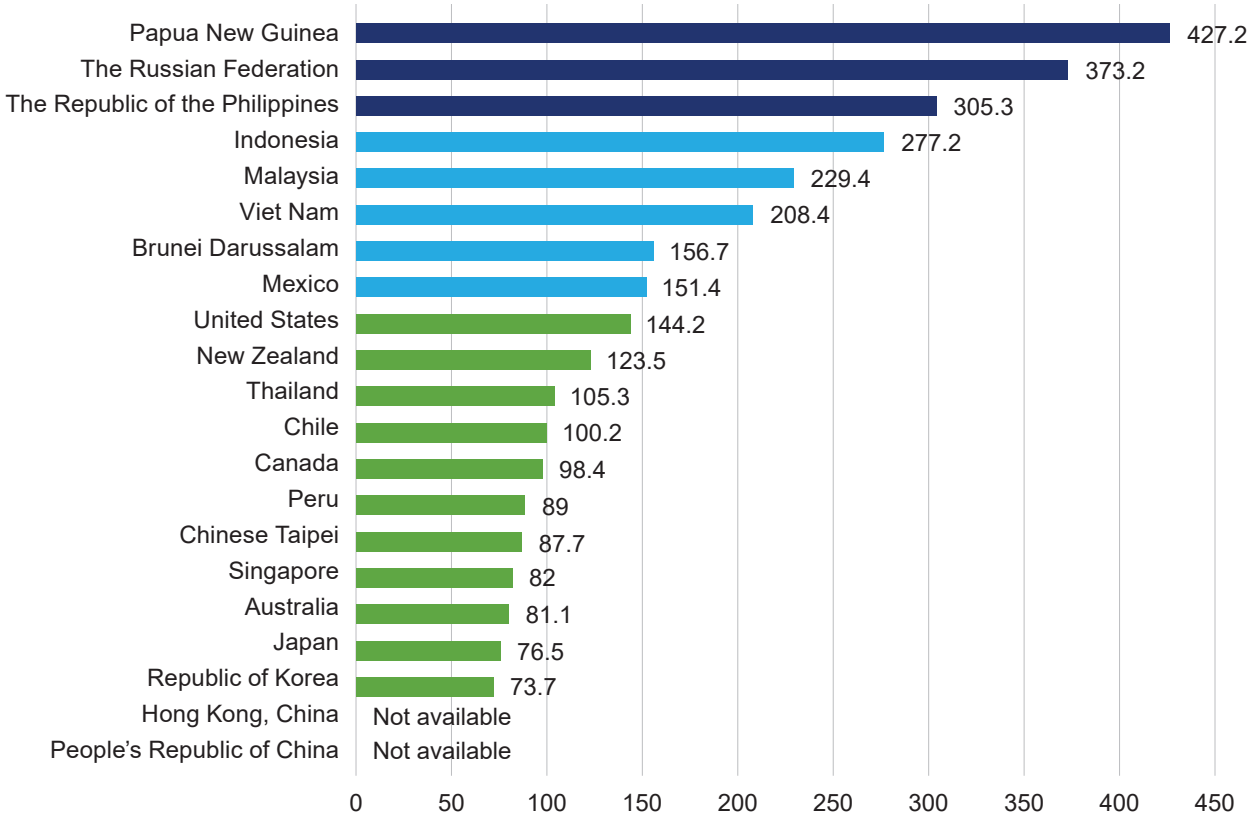
Cardiovascular Disease: an Urgent Public Health and Economic Challenge

CVD is the leading cause of death globally and represents a major public health and economic burden. In 2022 alone, an estimated 19.8 million people died from CVD. This accounted for approximately 32% of all global deaths, with 85% of these deaths resulting from heart attacks and strokes[1]. In addition to mortality, CVD contributes substantially to disability and reduced quality of life[2]. Ischemic heart disease (IHD) remains the single largest contributor to global disease burden, while stroke continues to be a leading cause of long-term disability globally[2].

Across APEC economies too, CVD remains one of the most significant and persistent health and economic challenges, accounting for a substantial and growing share of mortality, morbidity, and healthcare costs[3]. Estimates from 2022 suggest that CVD accounted for around 9.8 million deaths annually across different APEC economies, representing nearly half of all deaths related to noncommunicable disease (NCD)[4].

The prevalence of CVD is also increasing. Since 1990, the number of people affected has risen by more than 140%, driven by population growth, ageing, and increased exposure to risk factors such as hypertension, obesity, and diabetes[5]. These trends reflect both the scale of the problem and the epidemiological transition toward chronic diseases as populations age and lifestyles change.

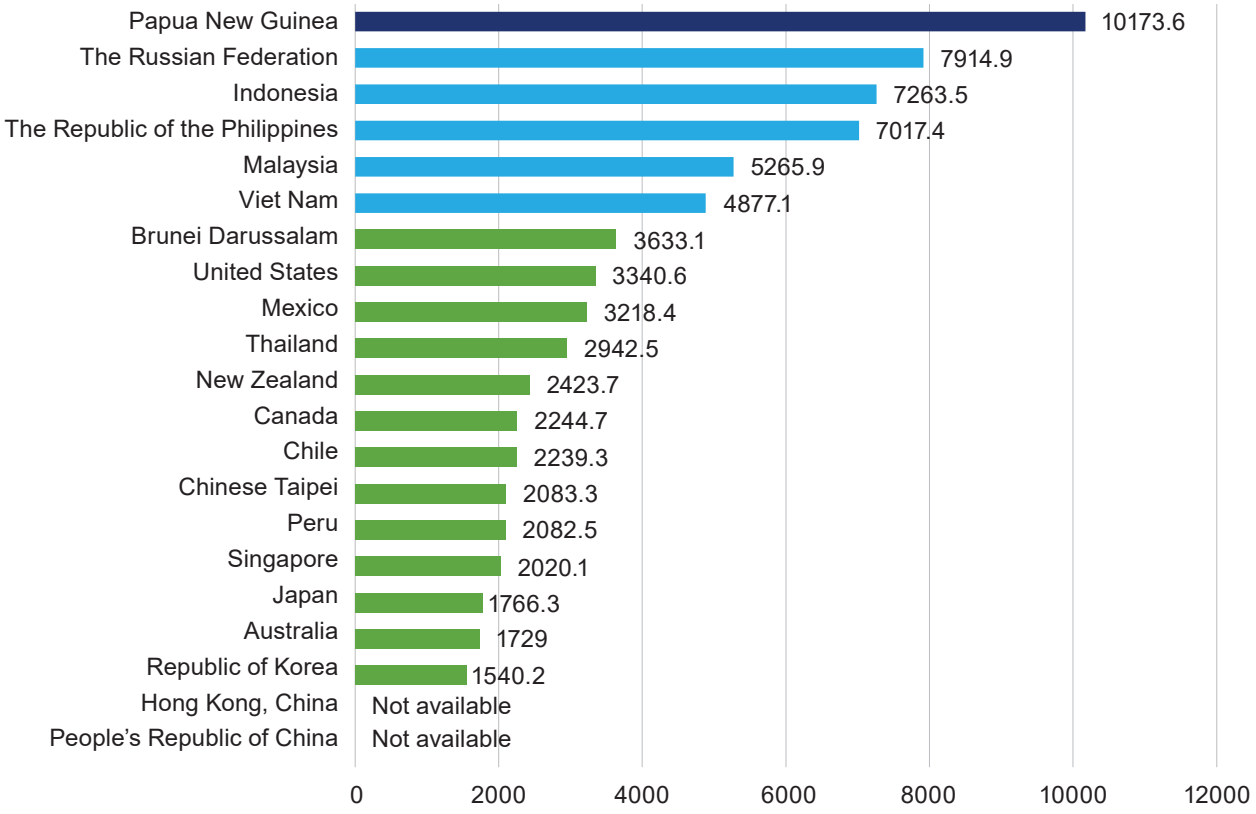
Figure 1. CVD age-standardized death rate across APEC economies (per 100,000 population)



Source: IHME Global Burden of Disease Study 2023 https://ghdx.healthdata.org/

There are substantial disparities in the burden of CVD across APEC economies. Higher-income economies tend to have lower mortality rates and better outcomes due to stronger health systems, while low- and middle-income economies face higher premature mortality and more limited access to care[6, 7]. Trends in age-standardized rates present a more nuanced picture. Many higher-income APEC economies have achieved declines in age-standardized mortality and disability-adjusted life years (DALYs) through improved prevention, early detection, and treatment[5, 7]. Forecasts nonetheless suggest that total cardiovascular deaths could rise sharply as gains in age-standardized rates are offset by population ageing[5].

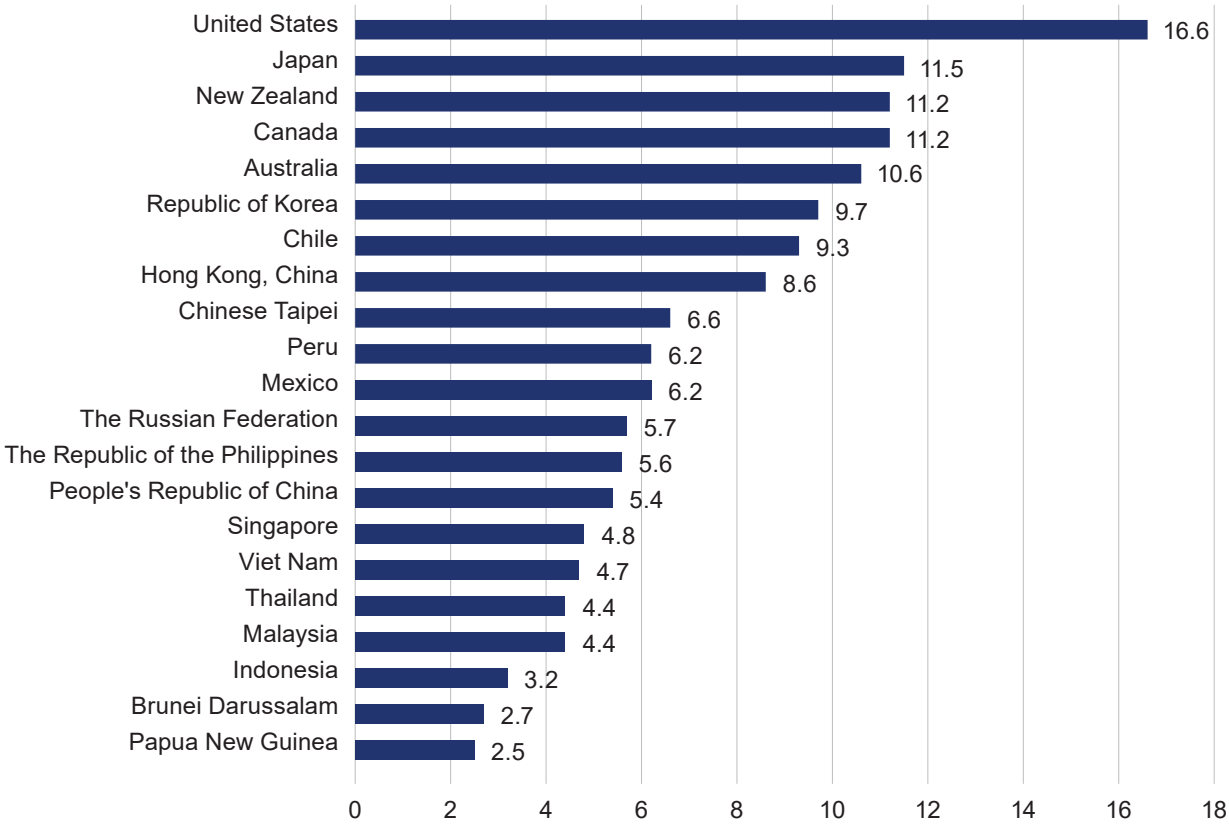
Figure 2. Age standardized Disability-Adjusted Life Years lost to cardiovascular diseases per 100,000 population (all ages)



Source: IHME Global Burden of Disease Study 2023 https://ghdx.healthdata.org/

Despite CVD being the leading cause of death and disability globally, the evidence base quantifying its economic costs remains incomplete. Across low- and middle-income economies, available estimates are largely drawn from small-scale, single-institution studies that may not be representative of economy level costs[8]. For ischemic heart disease (IHD) specifically, aggregate cost data exist for only 21 economies worldwide, with no estimates available from low- or middle-income economies[9].

Figure 3. Current health expenditure as a share of GDP across APEC economies



Global direct and indirect costs of CVD are projected to exceed USD 1 trillion by 2030[10]. At the patient level, treatment costs place disproportionate pressure on health financing systems, with annual per-patient treatment costs amounting to approximately 22% of GDP per capita globally. In most economies with available data, annual IHD treatment costs per patient exceed domestic health expenditure per capita by several multiples, reaching factors of nine in the United States and seventeen in Mexico[11]. This strain is particularly acute in middle-income economies. In Thailand, the cost of a single acute IHD episode has been estimated to exceed per capita public health expenditure by a factor of 38[9].

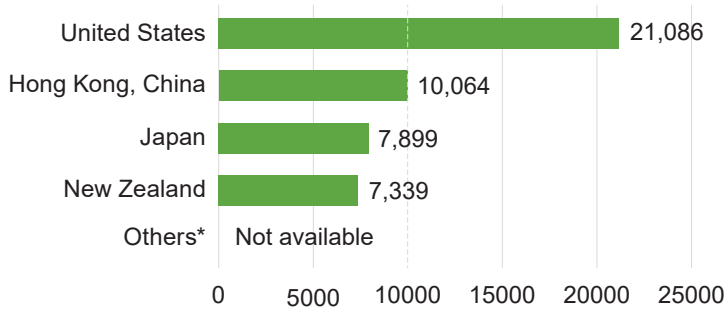
Figure 4. Direct Healthcare cost of ischemic heart disease across APEC economies

Total national cost of IHD (2019 PPP international dollars)



*Others: Brunei Darussalam; Chile; Hong Kong, China; Indonesia; Japan; Malaysia; Mexico; Papua New Guinea; Peru; The Republic of the Philippines; The Russian Federation; Singapore; Chinese Taipei; Thailand; Viet Nam

Direct cost per IHD patient-year patient-year (2019 PPP international dollars)



*Others: Australia; Brunei Darussalam; Canada; Chile; People's Republic of China; Indonesia; Republic of Korea; Malaysia; Mexico; Papua New Guinea; Peru; The Republic of the Philippines; The Russian Federation; Singapore; Chinese Taipei; Thailand; Viet Nam

Sources:

1. WHO Global Health Expenditure Database (GHED) for current health expenditure; Rittiphairoj et al., BMJ Global Health (2025) for national and per-patient IHD costs; Gheorghe et al., BMC Public Health (2018) for CVD cost-to-health-expenditure ratios in LMICs.

2. People's Republic of China: WHO GHED; Rittiphairoj et al. (2025); Gheorghe et al. (2018). LMIC pooled ratios are used as indicative benchmarks where economy-specific ratios are unavailable.

3. Hong Kong, China: Hong Kong Health Bureau Domestic Health Accounts and Rittiphairoj et al. (2025). CVD cost-to-CHE ratio not applicable to this high-income economy.

4. Chinese Taipei: Ministry of Health and Welfare domestic health accounts. No national IHD cost estimate identified; CVD cost-to-CHE ratio not applicable to this high-income economy.

5. CVD cost-to-CHE ratio: Based on Gheorghe et al. (2018) and intended for LMIC comparisons. Pooled median ratios: stroke 12.7×, coronary heart disease 10.0×, heart failure 9.4×, hypertension 0.7×, and overall CVD 1.0×.

The costs associated with CVD extend far beyond direct healthcare expenditure and include productivity losses from premature mortality, disability, absenteeism, and reduced workforce participation[1,10]. Because a large proportion of cardiovascular deaths occur among working-age populations, the condition has important implications for labor supply, household incomes, and long-term economic growth[1, 12]. This pattern is reflected in broader economy estimates of NCD economic burden, of which CVD is consistently the leading contributor.

Economy-level investment cases developed by APEC member economies illustrate that the economic burden of NCDs falls overwhelmingly on productivity rather than treatment. In Thailand, total NCD-related economic losses were estimated at 9.7% of GDP, with 91% attributable to lost productivity rather than treatment costs[13]; in Malaysia, the NCD burden reached 4.2% of GDP, with productivity losses more than four times direct healthcare expenditure[14]; and in the Republic of the Philippines, NCD costs were estimated at 4.8% of GDP, with indirect costs nine times higher than direct healthcare costs[13]. While these figures encompass all major NCDs, cardiovascular disease is the primary driver in each economy, underscoring that the economic case for CVD prevention is fundamentally a workforce and productivity argument.

Investments in prevention, early detection, and effective primary care management therefore have the potential to increase health gains, but also broader economic and social benefits through improved productivity, reduced healthcare pressures, and healthier ageing populations[7]. Evidence supports the economic case for this approach. Across economies with available data, the costs associated with managing acute cardiovascular episodes substantially exceed those of ongoing chronic care, suggesting that preventing acute events through sustained primary care investment offers the greatest potential for reducing health system expenditure over time[9]. The scale, growth, and uneven distribution of this burden make CVD a central priority for coordinated action across APEC economies.



APEC economies' progress in addressing CVD

Policy and Governance

APEC economies have made notable progress in addressing CVD, with most establishing governance structures and NCD strategies that include cardiovascular health priorities, supported by domestic action plans and APEC wide cooperation mechanisms. Financing and health coverage for CVD prevention and management have expanded across several economies through health coverage packages, essential medicines lists, and the adoption of clinical treatment guidelines[15]. However, despite increasing policy attention, implementation remains uneven, with gaps between policy intent and effective delivery due to financing limitations, fragmented primary care systems, and access to care[16].

Prevention and Detection

Many economies have expanded screening programs, hypertension control initiatives, and tobacco reduction policies, while risk-factor surveillance systems have also been established. Population-level interventions targeting tobacco use, high salt intake, and trans fats have contributed to gradual improvements in cardiovascular risk profiles across some settings[17]. Improvements in healthcare access and risk-factor management have helped reduce mortality rates in several economies; however, progress has been limited by rising rates of obesity, diabetes, and physical inactivity associated with urbanization and population ageing[3]. Hypertension awareness, treatment, and control also remain inadequate in many settings, with substantial proportions of affected individuals remaining undiagnosed or untreated[18]. Lipid and cholesterol management follow a similar pattern, with screening and treatment coverage for dyslipidemia lagging behind other major risk factors in several economies despite strong evidence linking cholesterol control to reduced cardiovascular risk[19, 20].

Care and Treatment

Essential medicines, diagnostics, and technologies for CVD management are increasingly available across APEC economies and are progressively incorporated into publicly financed health systems. Various initiatives have supported the strengthening of primary healthcare and standardized approaches to hypertension and diabetes management[21]. Many economies have demonstrated that targeted interventions, such as improved hypertension management, expanded access to treatment, and tobacco control measures, can reduce CVD mortality. Nevertheless, these efforts have not yet reversed the overall increase in CVD incidence and prevalence, reflecting the continuing impact of population ageing, and growing metabolic risk factors across the APEC economies.

Figure 5. CVD Disease burden across APEC Economies

Economy	Ischemic heart disease (IHD) prevalence rate per 100,000 population	Ischemic heart disease (IHD) incidence rate per 100,000 population	Atrial fibrillation prevalence rate per 100,000 population	Atrial fibrillation incidence rate per 100,000 population	Stroke prevalence rate per 100,000 population	Stroke incidence rate per 100,000 population	Heart failure prevalence rate per 100,000 population
Australia	1558.4	98.5	994.5	82.4	752.3	66.6	793.5
Brunei Darussalam	3646.6	100.8	463.5	35.4	1105.3	116.6	448.8
Canada	2956.5	96.9	796.4	66.1	1108.6	81.4	900.4
Chile	2566.7	106.3	556.2	47.3	1016.5	90	633.6
People's Republic of China	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Hong Kong, China	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Indonesia	1820.8	135	661.5	57.5	1653.7	271.4	534
Japan	2150.3	78.7	400	32.2	1034	94.6	454.7
Republic of Korea	2514.7	52.1	641.2	45.9	986.3	88.5	533.3
Malaysia	1872.3	138.8	612.1	52.4	1450.2	171.7	551.5
Mexico	2703.3	126.6	779.4	64	942.9	81.2	587.8
New Zealand	2538.9	188.1	1016.1	87.5	825.4	70.8	624.4
Papua New Guinea	2192.3	59.3	525.2	45.4	1073	142.7	485.5
Peru	1417.8	63.7	708.6	57.8	992.3	81.2	630.8
The Republic of the Philippines	2064.9	173.4	611.1	53.8	1318.2	181.2	545.7
The Russian Federation	4865.5	328.5	746.2	58	1071.3	172.6	650.1
Singapore	3581.6	171.5	443.7	33.8	1189.6	99	523.1
Chinese Taipei	2938.4	38	553.7	47.7	896.7	91.5	644.5
Thailand	1042.4	69.4	563.6	48.7	1272.5	145	571
United States	3053.9	194.4	1199.1	99.8	1478.2	86.2	864.3
Viet Nam	1278.6	93.7	593.3	51.5	1447.4	236.3	539.3

Source: IHME Global Burden of Disease Study 2023

System Capacity and Enablers

Health system enablers, including data systems, workforce capacity, financing mechanisms, and digital health tools are increasingly recognized as critical foundations for effective CVD prevention and care. Many APEC economies have strengthened surveillance systems and expanded digital health initiatives to support screening, monitoring, and continuity of care. Despite these advances, progress is often constrained by persistent gaps in opportunity to access healthcare, uneven system capacity, and workforce shortages, particularly in rural and underserved communities[22]. Strengthening system capacity and framing cardiovascular health as both a public health and economic development priority will be critical to supporting more sustainable action across APEC economies.

Alignment with Global Health and Economic Initiatives and Goals

Beyond the economy-wide picture, the case for coordinated action on CVD is reinforced by its alignment with established global health and economic commitments. The priority areas in this roadmap align closely with key global health and development frameworks by positioning CVD as both a health priority and an economic consideration.

The roadmap aligns with UN frameworks, including the UN Political Declaration on the Prevention and Control of Non Communicable Diseases, which calls for whole-of-government action to reduce the global burden of NCDs[23], and the UN Decade of Action on Nutrition, which targets dietary risk factors that contribute significantly to cardiovascular disease[24].

The roadmap also speaks directly to APEC's own strategic priorities. It supports the goals of the Putrajaya Vision 2040 and the APEC Health Working Group Strategic Plan 2021–2025, and responds to commitments made at the 13th High-Level Meeting on Health and the Economy. In addition, its focus on risk-factor reduction, data sharing, and cross-sector policy coherence would complement global NCD action plans, ensuring that APEC economies are meeting international standards, but also adapting to domestic economic and demographic realities.

Taken together, these dimensions point to a consistent pattern across APEC economies. The policy frameworks and clinical interventions for addressing CVD are well established, while the capacity to implement them consistently, with adequate financing and clear accountability across the continuum of care, remains the principal constraint. It is this gap between policy intent and consistent delivery that the roadmap is designed to address.

2

Structure of Roadmap

Vision

By 2030, support APEC economies in reducing the burden of cardiovascular disease through resilient health systems, contributing to healthier populations, stronger economies, and sustainable growth.

Objectives

To achieve this vision, the Roadmap outlines three primary objectives to accelerate domestic and APEC wide progress in cardiovascular disease prevention, management, and care:

1. To guide APEC economies in strengthening policy, governance, and financing for sustainable CVD prevention and care, explicitly linking cardiovascular health to workforce productivity, economic resilience, and long-term fiscal sustainability.
2. To support APEC economies in building integrated health system capacity across the full continuum of CVD care, from prevention and early detection through treatment, rehabilitation, and secondary prevention.
3. To promote knowledge exchange and multi-sectoral collaboration among governments, health systems, academia, civil society, and the private sector, enabling economies to learn from each other and adapt proven approaches to their own contexts.

Relevance of Roadmap to APEC economies

The Roadmap is designed to support all APEC economies in strengthening their policy and programmatic response to cardiovascular disease. Population ageing, urbanization, rising metabolic risk factors, and the economic consequences of premature mortality and workforce loss are reshaping the CVD burden across the APEC economies, creating shared challenges that warrant coordinated action.

The roadmap's six priority areas and supporting actions are intended as a practical resource that economies can draw on selectively, guided by their own disease burdens, health system capacities, and fiscal contexts. Higher-income economies may find greatest relevance in actions related to data integration, CVD rehabilitation, and quality improvement; lower- and middle-income economies may prioritize foundational investments in primary care, screening, and emergency response capacity.

Sustained progress will require that implementation be intentional, adequately resourced, and adapted to local context. Coordinated action across the continuum of care, pursued through the structures and partnerships the roadmap supports, offers APEC economies a practical pathway to reduce the health and economic burden of cardiovascular disease.

Priorities and Actions

While awareness of the economic consequences of CVD is growing, the systematic integration of economic evidence into policy and planning remains limited across most economies. The roadmap outlines six priority areas for ensuring sustainable cardiovascular health and economic resilience, with key actions that would drive progress in these areas.

Figure 6. Roadmap priorities and actions

Policy Framework
6 Priorities | 27 Components

1 Policy Leadership and Governance

Action 1. Establish CVD policy with clear goals and costed action plans

Action 2. Strengthen cross-sector coordination with accountability cycles

Action 3. Optimize CVD financing and coverage guided by HTA guidance

Action 4. Build multi-stakeholder engagement with governance safeguards

Action 5. Integrate upstream drivers into CVD policy across sectors

Action 6. Address accessibility gap in policy with disaggregated data

2 Prevention and Risk Reduction

Action 7. Establish CVD risk-factor surveillance systems

Action 8. Strengthen tobacco and alcohol control measures

Action 9. Advance nutrition and physical activity policies

Action 10. Strengthen CVD awareness and health literacy campaigns

3 Early Detection and Diagnostics

Action 11. Design risk-based CVD screening frameworks

Action 12. Expand screening through community health workers

Action 13. Build tiered diagnostic capacity at all care levels

Action 14. Strengthen financial protection for diagnostics and care

Action 15. Strengthen primary care as cornerstone of CVD management

4 Emergency Response and Acute Care

Action 16. Standardize pre-hospital CVD protocols

Action 17. Ensure effective ED triage and clinical pathways

Action 18. Strengthen acute care through referral networks and hubs

5 Treatment, Rehabilitation and Secondary Prevention

Action 19. Ensure access to essential CVD medicines and technologies

Action 20. Strengthen integrated chronic CVD management pathways

Action 21. Expand coverage benefits to recognise CVD rehabilitation

Action 22. Strengthen secondary support

6 Health System Enablers

Action 23. Build interoperable CVD data systems and registries

Action 24. Establish CVD M&E with core indicator set

Action 25. Strengthen CVD workforce through task-shifting

Action 26. Advance context-appropriate digital health tools

Action 27. Strengthen CVD research and evidence-to-policy translation

3

Articulating the Roadmap: Priorities and Actions

The six priorities of the roadmap focus on strengthening CVD prevention, management, and care across the continuum, while reinforcing the key system enablers for long-term economic resilience. Across these priorities, the roadmap addresses major CVD conditions, including ischemic heart disease, stroke, and heart failure, alongside their shared risk factors and health system requirements. The actions that follow are intended to support APEC economies to reduce the growing burden of CVD, while developing context-specific strategies that reflect health system capacities, readiness and economic priorities.



Priority 1: Policy Leadership and Governance

Across participating economies, CVD is recognized as a priority within NCD frameworks, and most economies have established governance structures for CVD with expanding financing and coverage. However, there is significant variation in the maturity of these structures, and several governance dimensions, particularly the integration of economic evidence and cross-sectoral coordination remain underdeveloped relative to the scale of the burden.

Policy architecture: Strong policy architecture treats CVD prevention as an economic investment rather than a short-term health cost, supporting coordinated and cost-effective interventions such as risk-factor management, hypertension control, and secondary prevention.

Action 1

Establish and strengthen CVD policy architecture with clear goals, economic framing, costed action plans, and defined accountability.

1. Establish clear policy direction for CVD by developing a dedicated CVD strategy where appropriate or strengthening its prioritization within broader NCD frameworks with defined goals and implementation pathways for major CVD conditions, including heart failure, ischemic heart disease, and stroke.
2. Institutionalize CVD priorities within domestic development, economic, and health financing frameworks to ensure sustained investment and policy coherence.
3. Promote use of economic and investment framing in CVD policy planning by explicitly linking CVD policy targets to economic outcomes such as workforce productivity, healthy ageing, return on investment and long-term health system sustainability.
4. Ensure that CVD commitments within existing NCD strategies are backed by costed action plans and assigned accountability.
5. Integrate CVD targets into fiscal planning and ageing strategies, framing premature CVD mortality explicitly as a workforce productivity and long-term fiscal risk.

Institutional coordination: Strong coordination aligns sectors such as health, finance, food systems, transport, education, and labor to support risk reduction, care delivery, and financial protection, improving both health and economic outcomes. Effective multisector collaboration reduces duplication, strengthens policy enforcement, and increases the return on CVD investments.

Action 2

Establish and strengthen cross-sector coordination mechanisms for CVD with designated roles and regular accountability cycles to ensure commitments translate into action.

1. Map existing institutional actors, mandates, and coordination mechanisms relevant to CVD across health and non-health sectors to identify overlaps, gaps, and opportunities for stronger cross-sector alignment.
2. Designate roles for coordination mechanisms for CVD with participation that includes health, finance, alongside other relevant sectors.
3. Strengthen the decision-making authority of existing cross-sector CVD coordination mechanisms by clarifying who leads, supports, and is accountable for each cross-sector action.
4. Introduce regular accountability cycles such as shared cross-sector indicators linking health outcomes with economic and fiscal measures, and periodic progress reviews to track whether CVD commitments are being acted on.

Financing and coverage models: Effective financing and coverage design prioritizes cost-effective primary care and prevention, helping reduce avoidable hospitalizations, productivity losses, and catastrophic household spending while protecting public finances.

Action 3

Expand and optimize CVD financing and coverage across prevention, chronic and acute care, guided by health technology assessment and directed toward highest-value interventions.

1. Expand public financing and health coverage benefit packages according to local contexts and priorities to cover essential CVD prevention and chronic care, including medicines, diagnostics and long-term management.
2. Mobilize sustainable financing by reallocating resources toward primary and CVD care, leveraging health taxes where feasible and exploring innovative financing mechanisms.
3. Rebalance benefit package design to prioritize primary prevention, secondary prevention, and rehabilitation alongside acute care.
4. Use health technology assessment, including cost-effectiveness and broader value-based considerations to guide CVD benefit design and purchasing decisions.

Stakeholder engagement: Effective stakeholder engagement improves program uptake, sustainability, and health outcomes, while also supporting productivity gains and stronger returns on public investment.

Action 4

Build and strengthen structured multi-stakeholder engagement in CVD policy with clear governance guidelines, defined roles, and conflict-of-interest safeguards.

1. Establish structured multi-stakeholder platforms for CVD policy that engage civil society, patient groups and relevant sectors early in policy development.
2. Strengthen structured stakeholder engagement in CVD policy by clarifying who should be involved, at which stage of the policy cycle, and with what decision-making authority, including patients, clinicians, civil society, employers, and relevant private sector actors.
3. Establish conflict-of-interest safeguards for engagement with industries that drive CVD risks including disclosure requirements and governance arrangements.

Root causes of ill-health and upstream drivers: Factors such as income, education, employment, housing, urban design, food environments, and pollution exposure strongly affect CVD incidence, progression, and premature mortality by shaping everyday living and working conditions. Targeting upstream drivers helps reduce preventable disease before it reaches clinical care, strengthening economic resilience and population health.

Action 5

Integrate upstream and environmental determinants into CVD policy through cross-sector mechanisms and embedded monitoring indicators in routine governance and performance review.

1. Leverage available economic and health impact evidence, to guide upstream interventions and support coordinated cross-sector investment.
2. Introduce mechanisms such as joint policy planning, shared targets and health impact assessments to align transport, urban planning, education, labor and food policies with CVD prevention.
3. Institutionalize upstream determinants within formal CVD governance by embedding indicators into routine CVD performance monitoring and policy review cycles.

Accessibility gaps: Gaps in access to CVD and NCD prevention and care weaken economic resilience by reducing labor force participation, lowering incomes and increasing risks of catastrophic health spending, with impact concentrated among poorer, less educated and rural populations.

Action 6

Embed health accessibility throughout CVD policy and care delivery through priority population identification, differentiated delivery models, disaggregated data, and economic analysis.

1. Embed targeted objectives within CVD strategies by identifying and integrating priority populations into program design, coverage decisions and monitoring.
2. Adopt differentiated delivery models, such as community health workers, mobile clinics and telehealth, adapting effective global approaches to local health systems and geographic contexts.
3. Require disaggregated data by income, geography, sex, age, and population group to make CVD access measures and health outcomes visible.
4. Apply economic analysis to CVD policies to assess whether interventions are reaching disadvantaged groups and delivering value across all populations.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Priority 2:
Prevention and Risk Reduction

Prevention and risk reduction are well-established policy domains across most member economies, supported by risk factor surveillance systems and widespread tobacco and alcohol control frameworks. These foundations have contributed to meaningful progress, and created opportunities to further strengthen implementation, enhance measurement approaches, and improved population-level outcomes.

Risk factor surveillance: The systematic monitoring of CVD risk factors is crucial to identify population-level trends, high-risk groups, and emerging health challenges. It helps governments guide targeted prevention efforts and allocate resources more effectively, improving productivity while reducing health system and household costs.

Action 1

Establish and strengthen CVD risk-factor surveillance through regular surveys and integrated data systems that feed directly into multisector policy and investment decisions.

1. Institutionalize regular CVD risk-factor surveillance through periodic surveys and strengthened routine data systems.
2. Integrate and translate surveillance data across surveys, registries and administrative datasets to inform policy decisions, program design and investment priorities.
3. Standardize CVD risk-factor indicator sets across health, economic, and social data systems so that surveillance outputs are comparable across sectors and can feed directly into multisector policy and investment decisions.

Tobacco and alcohol control: Strengthening control measures, such as higher excise taxes, advertising bans, smoke-free policies, and restrictions on alcohol marketing can reduce consumption, prevent disease, lower healthcare expenditure, and create additional fiscal space for health investment.

Action 2

Strengthen tobacco and alcohol control through fiscal measures, tightened restrictions, coordinated enforcement, and protection from commercial interference.

1. Improve tobacco and alcohol control by raising excise taxes toward best-practice levels and tightening restrictions on marketing, availability and smoke-free environments.
2. Strengthen implementation through coordinated enforcement, monitoring and sanctions to ensure compliance with tobacco and alcohol regulations.
3. Establish transparent governance safeguards, including conflict-of-interest rules that limit industry influence on pricing, marketing, and regulation decisions.

4. Frame tobacco and alcohol control as economic resilience measures by quantifying their returns in terms of productivity gains, reduced healthcare costs, and household financial protection.

Nutrition and physical activity: Poor diet and physical inactivity are major risk factors for obesity, hypertension, diabetes, CVDs and other NCDs. Policies that promote healthier diets and physical activity can deliver long-term health and economic benefits but require coordinated action across sectors beyond just health.

Action 3

Advance structural nutrition and physical activity policies across sectors, using cost-effectiveness evidence to sustain progress against commercial and trade pressures.

1. Strengthen structural policies that shape healthier diets and physical activity, such as fiscal measures, food labelling, marketing restrictions and active urban design.
2. Support coordinated, life-course approaches across sectors, including schools, universities, workplaces and communities, to promote healthier behaviors.
3. Strengthen structural policy tools that support healthier food environments using cost-effectiveness evidence to build the economic case for measures such as sweetened beverage taxes, marketing restrictions, and reformulation, which can both reduce consumption and raise revenue for health investment.

Public awareness and health literacy: Low levels of health literacy are associated with poorer understanding of health conditions and treatments, lower adherence, higher rates of rehospitalization and mortality, and increased healthcare expenditure.

Action 4

Strengthen CVD public awareness and health literacy through sustained communication linked to accessible care, with tailored messaging and evaluation of behavior change.

1. Strengthen public awareness and health literacy on CVD risk factors and prevention through sustained higher level and community-based communication.
2. Ensure awareness initiatives are linked to accessible screening and prevention care and are adapted for different communities.
3. Counter misinformation and commercial health marketing in digital environments by ensuring CVD communication strategies explicitly address misleading health claims and build in evaluation of reach and behavior change.

Priority 3:
Early Detection and Diagnostics

Screening policies and clinical guidelines for CVD risk factor detection are increasingly well-defined, and screening programs have been expanding across economies. However, persistent gaps exist, particularly in the linkage between screening and confirmed diagnosis, the geographic concentration of diagnostic capacity, and the comprehensiveness of follow-up care.

Screening policy frameworks: Evidence consistently shows that early detection and risk-based management of common CVD risk factors, particularly through primary care, are cost-effective. Well-designed screening and prevention policies can reduce avoidable complications and hospitalizations while helping to maintain workforce productivity.

Action 1

Design and strengthen CVD screening frameworks using risk-based tools, with clear treatment pathways and economic evidence guiding prioritization and implementation.

1. Design/strengthen CVD screening policy frameworks that integrate risk-factor screening (e.g., blood pressure, atrial fibrillation, glucose and lipids) with clear pathways for confirmatory diagnosis, treatment and long-term management.
2. Encourage identification of inherited cardiovascular risk conditions, including familial hypercholesterolemia and elevated lipoprotein(a), through targeted and family-based screening approaches.
3. Promote the use of risk-based CVD assessment tools, including models calibrated to the populations and contexts of APEC economies and innovative technologies such as AI-assisted screening tools, to inform screening policies, treatment thresholds, and resource allocation.
4. Close the gap between guideline intent and practice by ensuring screening policies specify clear links to treatment pathways, follow-up arrangements, and responsible agencies.
5. Use economic and clinical evidence to guide the balance between targeted high-risk screening and broader population-based approaches, matching the strategy to the condition and the local resource context.

Screening delivery models: Screening models determine whether screening policies translate into real-world impact. The value of any screening model depends on coverage, linkage to care, and adherence; programs that generate one-off tests without follow-up offer poor value and can increase costs without preventing disease.

Action 2

Expand screening reach through task-sharing and community-linked delivery, supported by training standards and routine evaluation of health accessibility and cost-effectiveness.

1. Design and deploy community- and facility-linked screening models that leverage non-physician health workers and team-based care, prioritizing reach into rural, low-income, and underserved populations.
2. Support the adoption of appropriate diagnostic and decision-support technologies, such as AI-assisted cardiac ultrasound, that enable general practitioners and trained non-specialist providers to conduct screening and risk assessment at the community and primary care level ahead of specialist referral.
3. Establish training standards, supervision structures, and patient-tracking mechanisms for task-sharing roles to ensure that nurses and community health workers can deliver screening and follow-up with sufficient quality assurance.
4. Shift from opportunistic to proactive and targeted screening actively reaching high-risk, rural, and disadvantaged populations.
5. Routinely evaluate the reach and cost-effectiveness of screening delivery models to identify gaps and guide improvement.

Diagnostic capacity: Early diagnosis prevents complications and reduces treatment costs that rise with disease progression, while also minimizing productivity losses. Essential diagnostic capacity provides the foundation, with proven, value-based innovations strengthening detection as systems mature.

Action 3

Build tiered diagnostic capacity aligned with global standards, with essential tests available at appropriate levels of care and investment guided by cost-benefit evidence.

1. Encourage economies to adapt global guidance into domestic standards that define diagnostic capacity across levels of care.
2. Establish mechanisms to assess and adopt proven, value-based diagnostic innovations as system capacity and evidence allow.
3. Incorporate evidence-based diagnostic criteria and markers, such as BNP or NT-proBNP for heart failure, into local diagnostic pathways to support early detection and inform treatment planning.
4. Improve tiered diagnostic systems for CVD by ensuring that tests and devices are available at appropriate levels of care, supported by clear referral pathways between primary care and diagnostic facilities.
5. Strengthen capacity at the primary care level and improve referral pathways to specialty care, using cost-benefit evidence to guide investment sequencing.

Financial access: Affordability barriers for CVD prevention, diagnosis and treatment translate into delayed care, treatment interruption, catastrophic spending and productivity loss, as well as undermining early detection benefits. Financial protection strengthens adherence and continuity of care, improving economic resilience.

Action 4

Strengthen financial protection for CVD care by expanding benefits coverage and aligning benefits design to remove barriers to diagnostics, medicines, and follow-up.

1. Increase financial protection for CVD prevention by lowering out-of-pocket expenses for essential medicines, diagnostics, and routine outpatient care.
2. Define a core high-value CVD primary-care package within health coverage schemes to cover screening, treatment, and follow-up.
3. Align insurance and benefit design with prevention goals, ensuring that coverage frameworks protect diagnostics, follow-up, and long-term medicines, with specific attention to marginalized groups who face barriers.

Primary care for detection and management: Strong primary care systems enable timely preventive treatment that can avert acute cardiovascular events, hospitalizations, disability, and premature mortality, making them highly cost-effective compared with late, event-driven care.

Action 5

Strengthen primary care as the foundation for CVD detection and long-term management through adequate resources, community linkages, and payment models that reward continuity.

1. Ensure primary-care facilities have essential diagnostics, medicines, and simple patient-tracking systems to support ongoing CVD management.
2. Link primary care with community and outreach screening to ensure that patients identified at risk are reliably referred, tracked, and followed up.
3. Reform payment and incentive models to reward continuity and preventive CVD risk management in primary care.
4. Strengthen integration between primary care, screening programs, and specialty care through clear referral protocols and feedback loops so patients move seamlessly across the care pathway.

Priority 4: Emergency Response and Acute Care

Across many APEC economies, Emergency Medical Services (EMS) and acute CVD care have been strengthened, with investments in pre-hospital systems, ED capacity, and specialist referral networks. Meaningful progress has been seen despite gaps in geographic coverage, coordination across the care pathway, and access to advanced interventions outside major urban centers.

Pre-hospital systems: Faster response and coordinated referral reduce premature mortality and long-term disability, preserving labor participation and avoiding high downstream costs, including long-term care needs.

Action 1

Establish and standardize pre-hospital systems for acute CVD through basic protocols, coordinated communication, and feedback loops between EMS providers and hospitals.

1. Establish basic pre-hospital protocols and referral pathways to ensure that suspected acute CVD cases can be rapidly identified, stabilized, and transported to appropriate care facilities.
2. Set up simple mechanisms for communication and data sharing between first-contact facilities, dispatch services, and receiving hospitals to track cases, reduce delays, and enable pre-notification.
3. Standardize pre-hospital protocols across facilities and jurisdictions particularly linkage to acute care to reduce variability in how acute CVD events are managed.
4. Establish feedback loops between EMS providers and receiving hospitals to track outcomes, identify response gaps, and drive continuous improvement.

ED capacity and clinical pathways: Structured ED pathways (standard triage, fast-track protocols for CVD, clear admission/discharge criteria) improve time-to-treatment and can substantially reduce hospital costs and adverse event.

Action 2

Ensure effective CVD triage and clinical pathways across all EDs, with consistent adherence, follow-up integration, and performance monitoring linked to accountability.

1. Ensure all EDs, including smaller hospitals, have basic triage protocols and referral pathways to stabilize acute CVD patients and direct them to higher-level care when needed.
2. Establish systems and pathways to connect ED care with follow-up care to support continuity of care and reduce avoidable readmissions.
3. Promote consistent adherence to evidence-based clinical pathways across all facilities and integration between EDs, catheterization labs, and stroke units.
4. Introduce routine monitoring of ED pathway performance, including key time-to-treatment indicators linked to accountability mechanisms.

Acute care availability: Gaps in access to definitive acute care result in avoidable deaths and long-term disability, with significant consequences for productivity and public spending.

Action 3

Develop and strengthen acute CVD care networks through referral hubs, economies wide coordination, minimum quality standards, and structured post-acute transition planning.

1. Identify and strengthen a network of hospitals with advanced acute CVD capabilities to serve as referral hubs, ensuring essential infrastructure, equipment, and trained staff are available.
2. Establish clear referral pathways and minimum quality standards between these centers and smaller or peripheral facilities to improve timeliness and continuity of acute CVD care.
3. Strengthen APEC economies wise referral coordination, including transport links and pre-notification systems to reduce geographic barriers to care.
4. Develop structured post-acute transition plans for high-risk patients covering early follow-up, medication review, and rehabilitation referral with condition-specific pathways, such as for heart failure, where they reduce avoidable readmissions.



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Priority 5: Treatment, Rehabilitation, and Secondary Prevention

Essential medicines and technologies for CVD treatment are broadly available and increasingly covered under public financing schemes across APEC economies. However, challenges remain in the comprehensiveness of coverage, the accessibility of CVD rehabilitation and the continuity of care required for effective secondary prevention.

Access to medicines and technologies: Investing in proven, cost-effective interventions for CVD and other NCDs delivers high economic and health returns, millions of lives saved, and significant gains in economic growth over the medium term. Reliable access to essential medicines is a foundational condition for cost-effective chronic disease control. Building on this foundation, the capacity to assess and adopt proven innovations that demonstrate value over time supports sustained improvement in outcomes.

Action 1

Ensure reliable access to essential CVD medicines and technologies through aligned procurement, better health coverage, and benefit design review that removes affordability barriers across all populations.

1. Establish a core set of essential CVD medicines and appropriate diagnostic tools for primary and secondary prevention to ensure minimum coverage across all geographic areas and population groups.
2. Ensure these medicines and technologies are consistently available and affordable at primary-care facilities through generic procurement, pricing policies, pooled purchasing and strengthening supply-chain arrangements.
3. Address co-payment and benefit design barriers by reviewing coverage limits for preventive, diagnostic, treatment, rehabilitation, and secondary prevention therapies, particularly for underserved populations.
4. Use strategic purchasing and regular benefit design review to ensure that co-payment structures and reimbursement frameworks continue to prioritize proven, value-based CVD medicines and therapies.
5. Establish clear, evidence-based pathways for assessing, financing, and adopting innovative CVD treatments, diagnostics, digital tools, and medical technologies where they improve outcomes and demonstrate long-term clinical and economic value beyond acquisition cost.

Chronic CVD management: Without continuous and effective management, episodes, admissions and complications increase sharply, driving higher direct costs and lost productivity, particularly for conditions such as heart failure that carry a high risk of recurrent hospitalization and long-term disability.

Action 2

Strengthen chronic CVD management through integrated care pathways, with adherence support and systematic outcome measurement.

1. Establish basic integrated care pathways that connect screening, acute care, and long-term management, including specific pathways for heart failure, with clear referral points, reassessment intervals, and handover processes between hospitals, clinics, and primary care.
2. Enable primary-care teams to deliver ongoing CVD care within these pathways, including monitoring, follow-up, and referral for complex cases.
3. Strengthen patient adherence and continuity of care through structured self-management education, systematic post-discharge planning, medication review, regular follow-up, and remote monitoring.
4. Introduce systematic measurement of chronic CVD management outcomes such as blood pressure control rates and follow-up completion and link findings to quality improvement and accountability cycles.
5. Establish or strengthen multidisciplinary clinics and coordinated care models for complex chronic CVD, including heart failure, to optimize treatment, support self-management, enable early post-discharge follow-up, and reduce avoidable readmissions.

CVD rehabilitation: Rehabilitation is a high-value but underused intervention for people recovering from major CVD events, including heart attack, heart failure, cardiac procedures, and stroke. It reduces mortality, readmissions, and recurrent events, supports functional recovery, independence, and return to work and lowers long term CVD-related disability.

Action 3

Establish and scale CVD rehabilitation as standard care through health coverage benefits recognition, automatic referral at discharge, and flexible delivery models to maximize reach.

1. Establish basic CVD rehabilitation (cardiac and post-stroke) care within health facilities and ensure they are recognized in insurance schemes.
2. Set up referral systems and basic databases to track patient referrals, enrolment and use to enable monitoring of demand and uptake.
3. Make referral to CVD rehabilitation automatic at hospital discharge following acute CVD events, including myocardial infarction, heart failure, cardiac procedures, and stroke, to close the gap between care availability and uptake.
4. Expand flexible delivery models (home-based, community-based, and digital rehabilitation) to improve access for rural, underserved and disadvantaged groups.
5. Support financing recognition, workforce development, and implementation guidance to increase adoption, while allowing delivery models to adapt to local capacity, and needs.

Secondary prevention: Secondary prevention (medication adherence, risk factor control, follow-up monitoring, lifestyle support) reduces recurrent events and long-term disability, improving productivity and reducing avoidable healthcare costs.

Action 4

Strengthen secondary prevention through quality measures, adherence support, structured hospital-to-primary-care handover, and routine performance monitoring.

1. Implement basic provider-level quality measures for secondary prevention, such as tracking blood pressure, LDL-cholesterol, and medication adherence for patients with established CVD.
2. Incorporate mechanisms to support patient adherence and follow-up, including reminders, counselling, and scheduled check-ins at primary care or outpatient clinics.
3. Strengthen the handover between hospital discharge and primary care, including a structured discharge plan, designated follow-up, and shared patient records.
4. Introduce routine performance monitoring of secondary prevention, quality tracking of medication adherence rates, follow-up completion, and risk factor control.



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Priority 6:
Health System Enablers

Data systems, workforce capacity, and digital health tools are recognized as critical foundations for effective CVD care. Progress has been made across all three dimensions, despite challenges that constrain system performance and limit the ability to monitor outcomes, plan services, and demonstrate the economic returns of CVD investment.

Data systems: Data systems and registries provide large-scale real-world data to inform decision-making, support quality improvement, audit and benchmarking, and assess care appropriateness and effectiveness against clinical guidelines.

Action 1

Build and connect CVD data systems from foundational registries to interoperable platforms, ensuring data actively drives quality improvement and investment accountability.

1. Establish or strengthen registries for priority CVD conditions, such as heart failure and acute coronary syndromes beginning as necessary with facility- or economies wide registries and expanding over time.
2. Link data from hospitals, primary care, and other relevant sources and share key information periodically with clinicians and policymakers to inform care and planning.
3. Improve interoperability across existing CVD data systems (clinical, public health, and administrative) to support data linkage across providers and sectors.
4. Shift the use of CVD registries from routine reporting to active quality improvement and policy feedback, ensuring data outputs inform investment decisions and accountability cycles.

Monitoring and evaluation (M&E): M&E allows for comparisons between actual situations and expected outcomes of policy/programs and allows for informed decision making.

Action 2

Action 2. Establish effective CVD monitoring and evaluation through a core indicator set, dedicated resources, and governance links ensuring findings drive policy and budget decisions.

1. Define a core set of CVD program indicators and establish routine data collection processes to track progress against internal cardiovascular targets.
2. Allocate dedicated resources for M&E activities and build the technical capacity within health teams to conduct and use program reviews to inform planning and budget decisions.

3. Simplify CVD M&E frameworks to a manageable core indicator set with clear governance links so findings drive policy adjustments and resource decisions.
4. Integrate economic and productivity indicators into CVD M&E such as workforce participation, productivity loss, and return on investment to track the broader value of CVD programs.

Workforce development: When skilled workers are insufficient in number, unevenly distributed, or overextended, service bottlenecks emerge, leading to delayed care, lower quality, and inefficient use of capital investments.

Action 3

Strengthen the CVD health workforce through capacity mapping, competency standards, task-shifting, expanded scopes of practice, and retention strategies.

1. Map current CVD-relevant workforce capacity, including numbers, distribution, and skill mix of physicians, nurses, pharmacists, and community health workers, to identify critical gaps and inform domestic workforce planning priorities.
2. Define core CVD competency standards across healthcare professionals, identify opportunities for task-shifting to expand care delivery within existing workforce constraints.
3. Expand scope-of-practice flexibility to enable nurses, pharmacists, and allied health workers to take on greater CVD management roles addressing workforce gaps in primary care and rehabilitation.
4. Address burnout and retention challenges particularly in primary care and rural settings through workload management, career development pathways, and supportive supervision.

Digital health enablement: Digital tools can strengthen surveillance, care coordination, patient follow-up and system efficiency, thereby improve adherence and reduce avoidable complications.

Action 4

Advance digital health for CVD by deploying context-appropriate tools, improving interoperability, and ensuring solutions are evaluated and aligned with care pathways.

1. Assess existing digital infrastructure, connectivity, and technical capacity to identify foundational gaps and establish a baseline for digital health readiness within the health system.
2. Identify and contextualize locally appropriate digital tools, from foundational solutions such as SMS reminders and telehealth to more advanced clinical decision-support and data platforms as system capacity allows.

3. Improve interoperability across existing digital health platforms prioritizing integration of current tools across primary care, hospitals, and public health systems.
4. Ensure digital CVD tools do not widen gaps in opportunity for health for older or disadvantaged populations.

Research and innovation: Clinical research and its application enhance the effectiveness and economic value of CVD strategies. Robust evidence helps prioritize high-value interventions, guide regulators through real-world data, and adapt global evidence to local systems.

Action 5

Strengthen CVD research and innovation through capacity building, evidence-to-policy translation pathways, and cross-economy knowledge exchange to accelerate implementation.

1. Assess current research infrastructure, funding mechanisms, and institutional capacity to identify gaps in the ability to generate and translate CVD-relevant evidence to inform economy level policy and investment decisions.
2. Build capacity to evaluate the value and effectiveness of CVD interventions, starting with foundational assessment functions.
3. Strengthen evidence-to-policy translation by building structured pathways that move research into guidelines, purchasing decisions, and program design.
4. Promote evaluation of care delivery innovations and support cross-economy knowledge exchange within APEC to share implementation learnings.

4

Approaches to Tackling CVD Across APEC Economies

The preceding section sets out the recommended actions across the six priorities. The Roadmap draws on APEC economies wide evidence and practical implementation experience from across APEC member economies to support action throughout the CVD continuum of care. In line with APEC's role as a platform for knowledge exchange, this section presents selected economy experiences across each of the six roadmap priorities, highlighting lessons learned, effective approaches, and innovations that member economies can adapt to their own health system contexts and economic circumstances.

Priority 1: Policy Leadership and Governance



Examples

Singapore's integration of CVD prevention and management within broader health system strategies

Through Healthier SG, the health system is shifting from episodic, acute CVD care towards preventive and longitudinal care, but anchored through primary care. Residents are encouraged to enroll with a family doctor for regular screening, lifestyle counselling, and management of major CVD risk factors such as hypertension, diabetes, hyperlipidemia, obesity, smoking, and physical inactivity. This approach is supported through financing mechanisms such as the Chronic Disease Management Programme, which enables use of MediSave for long-term management of chronic conditions, including hypertension, lipid disorders, diabetes, and stroke. In parallel, workplace health initiatives promote healthier behaviors, chronic disease prevention, and smoking cessation among working-age populations[25]. Together, these approaches link CVD prevention with healthy ageing, workforce health, reduced avoidable hospitalizations, and long-term health system sustainability.

Mexico's use of excise taxes to expand affordable CVD care

Mexico has leveraged excise taxes on unhealthy products, such as tobacco and sugary drinks, as health-promoting fiscal tools, and the Mexico Declaration advocates using such revenues to expand affordable CVD medicines and care. These excises are levied under Mexico's Special Tax on Production and Services (IEPS). In 2014, Mexico introduced an excise of one peso per liter on sugar-sweetened beverages and an 8% tax on non-essential energy-dense foods, in addition to its existing excise on tobacco products. Rates on sugar-sweetened beverages, non-caloric sweetened beverages and tobacco were further raised in 2026, with the Ministry of Finance projecting around MXN 41 billion (approximately USD 2.3 billion) in additional annual revenue. Evaluations of the 2014 sugar-sweetened beverage tax have found reductions in purchases of taxed beverages in the two years after implementation, with larger reductions seen among lower-income households[26]. Mexico's experience illustrates how health taxes can serve a dual function, reducing consumption of products that raise cardiovascular risk while generating revenue that can be directed toward expanding access to CVD care.

Australia's engagement with professional bodies, civil society, and patient-focused organizations to support CVD policy development

The Heart Foundation of Australia has played an important role in convening stakeholders across the cardiovascular ecosystem, including clinicians, researchers, professional associations, consumer groups, and advocacy organizations. A key example is the development of the 2023 Australian Guideline for assessing and managing CVD risk and the associated Aus CVD Risk Calculator[27], which brought together multidisciplinary clinical and consumer groups to inform updated recommendations for primary care CVD risk assessment and management[28]. The guideline was developed by the Heart Foundation on behalf of the Australian Chronic Disease Prevention Alliance, with participation from organizations such as the Stroke Foundation, Diabetes Australia, and Kidney Health Australia, and was endorsed by the Royal Australian College of General Practitioners. This illustrates how sustained engagement with professional bodies and civil society can improve policy legitimacy, support implementation, and strengthen uptake of evidence-based CVD prevention and care.

New Zealand's Wellbeing Budget integrates CVD prevention with broader economic resilience objectives

Through its Wellbeing Budget approach, New Zealand moved beyond traditional fiscal measures to consider how public spending affects broader outcomes such as health, child wellbeing, mental health, and environmental challenges[29]. New Zealand's wellbeing framework supports a more integrated policy approach by recognizing that improving health outcomes requires action across multiple sectors. The approach uses wellbeing priorities and evidence to guide budget decisions, encouraging ministries to consider long-term social and economic benefits rather than short-term sectoral outputs alone. For CVD prevention, this is pertinent because many cardiovascular risk factors are shaped by upstream determinants such as income, housing, education, employment, food environments, and access to care. Embedding health within a broader wellbeing framework can align cross-sector investment with the upstream determinants of cardiovascular risk.

People's Republic of China's integrated insurance schemes, alongside increased government spending, reduce out-of-pocket healthcare spend

People's Republic of China's merger of the New Rural Cooperative Medical Scheme with Urban Resident Basic Medical Insurance and expansion of government health spending have significantly improved financial protection, with out-of-pocket shares in total health expenditure decreasing and improved reimbursement for rural residents[30]. Notably, government health expenditure has continued to grow in parallel, rising by approximately 185% between 2012 and 2022. Out-of-pocket payments as a share of total health expenditure, which exceeded 60% in the early 2000s, declined to around 34% by 2022, against the 25% target set out in the Healthy China 2030 outline. Studies have observed improvements in health care utilization following the integration of the two schemes[31]. Consolidating fragmented insurance schemes, combined with sustained public investment, can improve financial protection and access to CVD care.

Priority 2:
Prevention and Risk Reduction

Examples

Singapore's integrated surveillance systems support CVD prevention and program planning

The National Population Health Survey (NPHS), jointly conducted by the Ministry of Health and Health Promotion Board in Singapore, regularly tracks population-level health behaviors, risk factors, and chronic disease prevalence among residents, including smoking, alcohol use, physical activity, obesity, hypertension, diabetes, and hyperlipidemia[32]. In addition to population surveys, Singapore has disease registries such as the Singapore Myocardial Infarction Registry and Singapore Stroke Registry, which support monitoring of CVD events and outcomes The linking of this surveillance data with policy and program planning enables targeted prevention, resource allocation, and population health strategies for long-term CVD risk reduction. These systems also allow policymakers to identify trends in risk factors, disease burden, screening uptake, and healthcare needs. NPHS findings are also used by MOH and HPB to inform prevention priorities, including efforts to address obesity, hypertension, diabetes, hyperlipidemia, smoking, and physical inactivity[33].

Peru's laws aim to reduce exposure to tobacco products and smoke

Peru has longstanding smoke-free and warning-label provisions, and in 2024 approved Law No. 32159 (originally tabled as Bill No. 3437/2022), which imposes strict regulations on tobacco products and emerging nicotine products[34]. Under Peru's existing tobacco control framework, smoking is prohibited in all indoor workplaces, public places and means of public transport, as well as in the outdoor areas of educational and health facilities. Tobacco product packaging is required to carry combined text and graphic health warnings covering 70% of each main face, in line with standards set by the Ministry of Health.

Law No. 32159 broadens the scope of these measures by extending the same smoke-free and labelling requirements to electronic cigarettes, heated tobacco products and nicotine pouches, marking the first time that such products are regulated under Peruvian law. The law also introduces a comprehensive ban on tobacco advertising, promotion and sponsorship, including for emerging nicotine products, and applies smoke-free protections to additional settings such as enclosed public spaces and state entities. Extending established smoke-free and advertising restrictions to emerging nicotine products allows tobacco control frameworks to keep pace with a changing market and sustain progress on a major cardiovascular risk factor.

Viet Nam's multi-sector, integrated approach to tackling nutrition and physical activity through the National Nutrition Strategy

Viet Nam's National Nutrition Strategy 2011–2020 (with a vision to 2030) recognizes balanced nutrition as essential for physical and cognitive development, emphasizing strong government leadership, multi-sector action, and a focus on poor and disadvantaged areas. Community-based initiatives, such as the Viet Nam Physical Activity and Nutrition Programme, show that integrated approaches can improve physical activity and dietary behaviors. Building on this, Viet Nam approved an economy wide project on ensuring balanced nutrition and enhanced physical activity for children and students for the period 2018 to 2025, which links nutrition and physical activity interventions in schools to the prevention of cancer, cardiovascular disease, diabetes, chronic obstructive pulmonary disease and asthma. The economy has since moved into a follow-on National Nutrition Strategy for 2021–2030, which broadens the earlier focus to include linkages with safe water, the environment and air quality. A sustained, multi-sector economy level strategy can connect nutrition and physical activity interventions across schools, communities, and successive policy cycles to address cardiovascular risk from an early age.

Malaysia's workplace and community-based campaigns for prevention and early detection of NCDs

Malaysia has run heart-health and "Know Your Numbers" campaigns led by the Ministry of Health and partners, coupled with opportunistic screening and education in clinics and workplaces. These efforts sit alongside a broader set of community-based and workplace-based programs for the prevention and early detection of NCDs. Since 2013, the Ministry of Health has implemented Komuniti Sihat Pembina Negara (KOSPEN), a community-based intervention that trains volunteers as health agents of change to deliver NCD screening and health education in their communities on healthy eating, active lifestyles, body weight management, smoking and regular health checks. In 2016, this approach was extended to workplaces through KOSPEN Plus, which targets working-age adults and embeds NCD risk screening, lifestyle counselling and behavior-change support into the workplace setting.

Public information and community engagement work is reinforced by partnerships with non-government organizations such as Yayasan Jantung Malaysia (the Heart Foundation of Malaysia), which runs heart-health awareness, education and lifestyle campaigns aimed at reducing premature death and disability from cardiovascular disease. Community and workplace-based models can extend NCD screening and prevention into the settings where people live and work, broadening reach beyond clinical facilities.

Priority 3:
Early Detection and Diagnostics

Examples

Japan's screening system for primary prevention of obesity-related NCDs and CVD risk

Japan introduced the Specific Health Checkups and Specific Health Guidance program in 2008, targeting adults aged 40–74 years through health insurers[35]. The program focuses on metabolic syndrome and related risk factors, including obesity, blood pressure, blood glucose, lipid levels, smoking, and lifestyle behaviors[36]. This model illustrates how screening can be embedded into regular health system functions rather than delivered as a one-off campaign. By linking risk assessment with follow-up counselling and guidance, this approach connects screening policy with prevention and management pathways.

Thailand's village health volunteer model for early CVD detection

Thailand's village health volunteer (VHV) model shows how community-based early detection can improve CVD outcomes and support productivity cost-effectively. VHVs operate as the front line of Thailand's subdistrict health system. They work in close coordination with subdistrict health office personnel and primary care units, and their responsibilities span maternal and child health, immunization, infectious disease control and, increasingly, non-communicable disease management, including diabetes, hypertension, stroke, cardiovascular disease and chronic kidney disease. For CVD specifically, VHVs are equipped to measure blood pressure and blood glucose in the community, identify individuals at risk and refer them for clinical confirmation and treatment at the nearest primary care unit.

Indonesia's Puskesmas network of health centers are primary touchpoints for opportunistic NCD prevention, diagnosis and care

Puskesmas health centers are government primary-health centers serving defined catchment areas, intended to provide first-contact, comprehensive care, including NCD prevention, basic diagnostics and chronic-disease management. Puskesmas (Pusat Kesehatan Masyarakat) form the backbone of Indonesia's primary care system, with each facility responsible for a designated geographic catchment population and tasked with delivering preventive, promotive, curative and rehabilitative care. For NCDs, Puskesmas provide opportunistic screening for hypertension, diabetes and other CVD risk factors during routine consultations, as well as ongoing management of patients identified with chronic conditions.

Alongside the Puskesmas network, Indonesia operates Pos Pembinaan Terpadu Penyakit Tidak Menular (Posbindu PTM), or integrated health posts for non-communicable diseases, at the village and community level. Individuals found to

have raised blood pressure, elevated blood glucose or other risks at Posbindu are referred to the corresponding Puskesmas for clinical confirmation and treatment. A tiered network linking community-level posts to primary health centers can deliver opportunistic CVD screening at scale while maintaining clear referral pathways into clinical care.

Chile's FONASA public health insurance ensures CVD care

The Fondo Nacional de Salud (FONASA) is Chile's public health insurance fund and covers the majority of the population, including those who are unable to afford or do not opt for private insurance. FONASA is financed primarily through general taxation and employee contributions and provides free or subsidized care through the public health system. FONASA's coverage of cardiovascular conditions sits within Chile's Régimen de Garantías Explícitas en Salud (GES, also known as AUGE), introduced in 2005. GES is a legal entitlement framework that guarantees access, timeliness, quality and financial protection for a defined list of priority health conditions, which includes hypertension, acute myocardial infarction and ischemic stroke, along with Type 1 and Type 2 diabetes and chronic kidney disease.

At the primary care level, the Cardiovascular Health Program (Programa de Salud Cardiovascular, PSCV) operates within this public network and provides systematic risk assessment, treatment and follow-up for individuals with established cardiovascular conditions or elevated cardiovascular risk. A legal entitlement framework that guarantees coverage for defined priority conditions can connect screening, diagnosis, and ongoing follow-up within a single public system.

Canada's strong primary care foundation for CVD detection and long-term chronic disease management

Primary care in Canada plays a central role in prevention, early detection, risk assessment, and ongoing management of conditions such as hypertension, diabetes, dyslipidemia and coronary artery disease. Canadian cardiovascular guidelines also position CVD prevention, risk screening and risk stratification as core functions of primary care practice[37].

At the same time, Canada's decentralized health system means that primary care organization, team-based care models, and chronic disease integration vary across provinces and territories. Evidence shows that provinces are at different stages in implementing and evaluating team-based primary health care models, which can influence how effectively patients are linked to screening, follow-up, self-management support and specialist referral[38].

Priority 4:
Emergency Response and Acute Care



Examples

The inclusion of community-level responders in Thailand's Emergency Medical Services (EMS)

In rural areas of Thailand, Community Emergency Volunteers (CEVs, e.g., health volunteers, police, firefighters, teachers, and community leaders) are trained as first responders to improve emergency care access and link patients quickly to formal medical care, especially in resource-limited areas. The CEV program is led by the National Institute of Emergency Medicine, the lead agency for emergency care, and operates as part of Thailand's wider emergency medical care system under universal health coverage. Through this approach, CEVs serve as the first point of clinical contact in their communities, initiate time-sensitive care for conditions such as suspected stroke or myocardial infarction and reduce the delay between symptom onset and arrival at a hospital able to deliver definitive treatment. Community-based first responder networks in rural Thailand have effectively extended the reach of emergency care into areas where municipality-based EMS units alone would struggle to ensure a timely response[39].

Viet Nam's mode of investment in specialist stroke care

Bach Mai Hospital in Viet Nam has achieved World Stroke Organization certification as an Advanced Stroke Centre, becoming the first hospital in the economy to meet internationally recognized standards for advanced stroke care[40]. This demonstrates how investment in specialty care, clinical protocols and system readiness can raise the quality of acute stroke care and align economy level capacity with global best practice. Bach Mai Hospital's Stroke Centre receives approximately 12,000–13,000 stroke patients each year, the majority of whom are severe or complicated cases transferred in from satellite facilities. The establishment of certified Advanced Stroke Centre capacity is intended to support both improved outcomes for individual patients and the wider strengthening of the stroke care system, through clinical protocols, referral networks and training that can be extended to other facilities in the economy.

Priority 5: Treatment, Rehabilitation, and Secondary Prevention



Examples

Malaysia's public sector funding mechanism for CVD medication

Malaysia finances CVD medications in the public sector through the Formulari Ubat Kementerian Kesihatan Malaysia (FUKKM), also known as the Ministry of Health Medicines Formulary, and a listing process that emphasizes essential and cost-effective treatments. The listing process is managed by the Formulary Management Branch within the Pharmaceutical Services Division. Health technology assessment inputs are also provided by the Malaysian Health Technology Assessment Section, and final listing decisions are made by the MOH Medicines List Review Panel. For CVD, the formulary covers a full suite of first-line medicines used for the treatment and secondary prevention of hypertension, dyslipidemia, ischemic heart disease, heart failure and stroke, including statins, renin-angiotensin system blockers, calcium channel blockers, beta-blockers, antiplatelet agents and anticoagulants. The combination of the formulary and the listing process is intended to ensure that essential cardiovascular treatments are available to patients in the public sector while public drug expenditure remains aligned with available financial resources.

Integration across care settings for chronic disease management in Korea

Korea has introduced chronic disease management programs for hypertension and diabetes through primary care clinics, including financial incentives and reduced out-of-pocket costs to encourage patients to continue care with the same clinic. This supports continuity of care for major CVD risk factors such as hypertension and diabetes[41]. More recent primary care-based chronic disease management initiatives have also focused on care planning, patient education, monitoring, and self-management support for people with hypertension and diabetes. Evidence suggests these programs can improve medication adherence and strengthen patient follow-up[42]. This illustrates how economy level insurance coverage, primary care-based chronic disease programs, and quality assessment systems can support long-term CVD management, while highlighting the continued importance of improving continuity, referral linkages, and patient support across the care pathway.

Central reimbursement for CR integrated within UHC in Japan

Cardiac rehabilitation care is covered under Japan's health insurance system and are integrated into hospital-based cardiovascular care, particularly following myocardial infarction, heart failure, cardiac surgery, and other major cardiovascular events. Economy wide reimbursement mechanisms and clinical guidelines have supported the establishment of structured inpatient and outpatient rehabilitation care across many hospitals[43].

Japan has also developed professional guidance and institutional support for CR through organizations such as the Japanese Association of Cardiac Rehabilitation. This illustrates how universal coverage according to local contexts and priorities and central reimbursement policies can support the institutionalization of CR care, together with the importance of strengthening referral systems, outpatient participation, and continuity of care to improve long-term uptake and outcomes.

Example: Health insurance supports continuity of care after cardiovascular events in Chinese Taipei

The National Health Insurance (NHI) of Chinese Taipei covers 99.9% of the population and includes medically necessary care and medicines[44], creating an enabling environment for long-term follow-up, medication access, and continued management after events such as myocardial infarction, stroke, or coronary revascularization. Evidence from an economy wide cohort study using health insurance data found that better adherence and persistence with statin therapy were associated with lower risk of secondary atherosclerotic cardiovascular disease rehospitalization and in-hospital death[45]. Chinese Taipei's example illustrates that comprehensive coverage according to local contexts and priorities can provide a strong foundation for secondary prevention, but should be complemented by structured post-discharge pathways, adherence support, and routine follow-up systems to reduce recurrent CVD events and improve long-term outcomes.

Priority 6:
Health System Enablers



Examples

Brunei Darussalam's e-health system supports integrated data collection and coordinated program planning

Brunei Darussalam has implemented Bru-HIMS, an e-health initiative under the Ministry of Health, which is intended to support a "one patient, one record" approach and improve access to patient information across the health care system. Brunei Darussalam's digital health ecosystem is also being further developed, with Bru-HIMS upgrades aiming to improve access to electronic medical records across government and private healthcare facilities. This illustrates how smaller and more centralized health systems may be well positioned to strengthen integrated data systems. However, the key opportunity is to improve interoperability, routine data use, and feedback loops so that clinical and program data can better inform prevention, chronic disease management, resource planning, and accountability.

Thailand's WHO HEARTS program for hypertension management

Thailand piloted the WHO HEARTS hypertension program in Lampang province in October 2020, using provincial electronic health records, dashboards and economy wide data systems to track coverage, control and costs of different hypertension management scenarios. The HEARTS technical package provides a standardized approach to hypertension management in primary care, built around healthy-lifestyle counselling, evidence-based treatment protocols, access to essential medicines and technology, risk-based management, team-based care, and routine systems for monitoring. The Lampang pilot, under the Ministry of Public Health, applied this package across primary care facilities in the province.

Implementation has been supported by an embedded monitoring system, with routine patient outcome data captured as electronic medical records and consolidated at the Lampang Provincial Health Office. Linked dashboards and provincial data systems are used to track coverage of screening and treatment, control of blood pressure among patients on the program, and the costs associated with different management scenarios. These data have been used in cost analyses comparing existing care with HEARTS-style standardized treatment, providing evidence to inform decisions on economy level scale-up[46]. The broader aim of the pilot is to establish a "learning health system" for hypertension and related non-communicable diseases, in which routine clinical and financial data feed back into the design and improvement of primary care.

Increased involvement of primary care providers in NCD management in People's Republic of China

The Basic Public Health Service (BPHS) program in People's Republic of China established a defined package of essential public health care delivered free of charge through community health centers and township health centers, covering hypertension and diabetes management, cancer awareness, mental health, cardiovascular disease and major NCD risk factors, alongside health care such as maternal and child health, vaccination and tuberculosis. Since the 2009 reforms and the launch of Healthy China 2030, community healthcare providers (including nurses) have taken on expanded roles in hypertension screening, regular check-ups, patient education and lifestyle promotion at community health centers.

Within this framework, community health centers serve as the main delivery platform for population-level hypertension control, with general practitioners, public health doctors and community nurses jointly responsible for population registries, regular blood pressure measurement, patient education on diet, salt intake and physical activity, and follow-up of patients on antihypertensive treatment. More recently, People's Republic of China has explored further expansion of community nursing roles, including the development of nurse-led care models and, in some pilots, prescribing authority for community nurses, with the aim of addressing general practitioner shortages and supporting the management of an ageing population with a rising burden of non-communicable disease. Expanding the roles of community nurses and primary care providers can strengthen population-level hypertension control where physician capacity is constrained.

Virtual CR in Peru

In Peru, a Cardiac Telerehabilitation program was implemented through a virtual platform during the COVID-19 pandemic. The program was delivered through the Instituto Nacional Cardiovascular (INCOR) and patients enrolled between August and December 2020 received structured CR remotely through a virtual platform, allowing exercise prescription, lifestyle counselling, monitoring of symptoms and patient education to be continued from home.

Evaluation of the program assessed effects on health-related quality of life, anxiety and depression, exercise safety and disease awareness among cardiac patients discharged from INCOR[47]. The results showed improvements in quality of life and reductions in stress and depressive symptoms over the course of the program, with no significant safety concerns associated with home-based exercise sessions. Through the INCOR experience, the use of digital tools and remote care delivery has been shown to support the continuity of cardiovascular care when access to in-person care is constrained, while preserving the core clinical components of exercise prescription, counselling, monitoring and education.

Embedding health care research and policy into CVD system strengthening in Australia

Through the Medical Research Future Fund (MRFF) Cardiovascular Health Mission, the Australian Government has committed funding to support research aimed at improving heart health and reducing stroke, including work on prevention, early detection, treatment, and implementation in healthcare settings[48]. The Mission is a AUD 220 million research fund focused on improving cardiovascular outcomes[49].

Australia's approach also links research priorities to economy level policy goals. The Strategic Action Plan for Heart Disease and Stroke includes research as one of its priority areas, alongside prevention, diagnosis and treatment, and support and care. This helps position research not only as scientific activity, but as a mechanism to improve care delivery and policy implementation, through identifying effective models of care, testing innovations, evaluating outcomes, and scaling evidence-based approaches into routine practice.

5

Conclusion

APEC economies have made meaningful progress in addressing cardiovascular disease, strengthening policy frameworks, expanding health coverage, and advancing prevention programs. Yet the health and economic burden of CVD remains high, and greater urgency is needed to translate these commitments into consistent delivery across the APEC economies.

This roadmap provides a practical, evidence-informed framework to do so, aligning health investment with economic outcomes across the full continuum of care. It offers a structured basis for sustained and coordinated action. By acting on its six priorities, economies can reduce premature cardiovascular mortality, protect workforce participation, lower long-term healthcare costs, and strengthen fiscal sustainability.

Realizing this requires sustained political commitment, governance that coordinates health and non-health sectors, financing aligned with prevention, and investment decisions that reflect both health and economic returns. APEC's role as a platform for APEC wide knowledge exchange and policy cooperation makes it a valuable forum for advancing this agenda, enabling economies at different stages of health system development to learn from one another and adapt proven approaches to their own contexts.

Acting on this roadmap offers APEC economies a shared framework to reduce the health and economic burden of cardiovascular disease, supporting healthier populations and more resilient APEC economies. With the necessary evidence, tools, and mechanisms for cooperation already established, sustained and coordinated implementation is the priority for the period ahead.


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Appendices

I. Acknowledgements

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Asia-Pacific Economic Cooperation

Executive Summary

Roadmap to Advance Sustainable Cardiovascular Health and Economic Resilience in APEC Economies 2026–2030

Six Priority Areas to Prevent Cardiovascular Diseases (CVD), Strengthen Care, and Build Resilient Health Systems

9.8 million
deaths annually

140%
growth in CVD prevalence since 1990

USD 1 trillion
economic burden by 2030

1 Policy Leadership and Governance

Strengthening CVD strategies with costed action plans, cross-sector coordination, sustainable financing, and accountability structures.

2 Prevention and Risk Reduction

Advancing tobacco and alcohol control through fiscal measures and governance safeguards, structural nutrition and physical activity policies, and institutionalized risk- factor surveillance.

3 Early Detection and Diagnostics

Improving risk-based screening frameworks, tiered diagnostic capacity, and primary care's central role in long-term CVD risk detection and management.

4 Emergency Response and Acute Care

Standardizing pre-hospital systems and emergency clinical pathways and developing domestic referral networks to address geographic gaps in access to acute care.

5 Treatment, Rehabilitation and Secondary Prevention

Ensuring reliable access to essential medicines, institutionalizing CVD rehabilitation within health coverage, benefits and strengthening integrated chronic disease management pathways.

6 Health System Enablers

Building interoperable data systems, expanding workforce capacity through task-shifting and retention strategies, deploying context-appropriate digital health tools, and strengthening evidence-to-policy translation.

From Commitment to Action Building Healthier, More Resilient APEC Economies

Cardiovascular health is a **strategic investment** in human capital, economic productivity, and long-term resilience across APEC economies.

Scaling **proven action and sustainable innovation** in prevention, early detection, treatment, and rehabilitation can reduce avoidable deaths, protect households, and ease future fiscal pressures.

Sustained political leadership and coordinated action across health, finance, and other sectors are essential to translate commitments into measurable results.

Strategic Actions to Build Healthier, More Resilient APEC Economies



1 Policy Leadership and Governance

Action 1. Establish CVD policy with clear goals and costed action plans

Action 2. Strengthen cross-sector coordination with accountability cycles

Action 3. Optimize CVD financing and coverage guided by HTA guidance

Action 4. Build multi-stakeholder engagement with governance safeguards

Action 5. Integrate upstream drivers into CVD policy across sectors

Action 6. Address accessibility gap in policy with disaggregated data



2 Prevention and Risk Reduction

Action 7. Establish CVD risk-factor surveillance systems

Action 8. Strengthen tobacco and alcohol control measures

Action 9. Advance nutrition and physical activity policies

Action 10. Strengthen CVD awareness and health literacy campaigns



3 Early Detection and Diagnostics

Action 11. Design risk-based CVD screening frameworks

Action 12. Expand screening through community health workers

Action 13. Build tiered diagnostic capacity at all care levels

Action 14. Strengthen financial protection for diagnostics and care

Action 15. Strengthen primary care as cornerstone of CVD management



4 Emergency Response and Acute Care

Action 16. Standardize pre-hospital CVD protocols

Action 17. Ensure effective ED triage and clinical pathways

Action 18. Strengthen acute care through referral networks and hubs



5 Treatment, Rehabilitation and Secondary Prevention

Action 19. Ensure access to essential CVD medicines and technologies

Action 20. Strengthen integrated chronic CVD management pathways

Action 21. Expand coverage benefits to recognise CVD rehabilitation

Action 22. Strengthen secondary support



6 Health System Enablers

Action 23. Build interoperable CVD data systems and registries

Action 24. Establish CVD M&E with core indicator set

Action 25. Strengthen CVD workforce through task-shifting

Action 26. Advance context-appropriate digital health tools

Action 27. Strengthen CVD research and evidence-to-policy translation



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