



Submission to the Senate Select Committee on Women's Health inquiry into postpartum healthcare

13 October 2026

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About the Heart Foundation

For more than 65 years, the National Heart Foundation of Australia (Heart Foundation) has been the trusted, independent, not-for-profit organisation fighting cardiovascular disease and working to improve the heart health of people living in Australia. We work across the spectrum of cardiovascular disease research, prevention, detection, care and support, made possible through the generosity of our donors. Our work is delivered in partnership with health professionals, researchers, governments and the community.

A core part of the Heart Foundation's work has been to advance equity in heart health, including to improve cardiovascular health outcomes in women. In 2024 there were 6,122 women who lost their lives to coronary heart disease, the most common type of cardiovascular disease, which is equivalent to about one woman losing her life every 86 minutes.¹ There are at least half a million women who are living with cardiovascular disease, based on the most recent Australian data.² We continue our work to improve cardiovascular health for all women living in Australia as part of our 25-year vision for heart health, [*Health for Every Heart*](#).³

The Heart Foundation acknowledges the Traditional Owners and Custodians of Country throughout Australia and their continuing connection to land, waters and community. We pay our respect to them and their cultures, and Elders past, present and emerging.

Executive summary

The Heart Foundation welcomes the establishment of a Select Committee on Women's Health and the opportunity to contribute to the inquiry into postpartum healthcare. Our submission primarily addresses the inquiry's term of reference (c), *best practice pregnancy and postpartum care models to support long-term maternal physical and mental health*. We also provide contributions to terms of reference items (f), (h) and (p).

Pregnancy-associated complications including gestational diabetes, pre-eclampsia and preterm delivery significantly increase a woman's risk of long-term cardiovascular ill-health and mortality, including heart attack and stroke.^{4,5,6} While Australia's maternity care system is well-developed with high levels of engagement, postpartum care remains largely focused on the six weeks postpartum, with little capability to support management of life-long maternal care.^{7,8,9,10} Up to six weeks postpartum, care pathways are generally well established, connecting women and their babies with primary care and community-based maternal and child health services through a range of hospital, community and home-based care providers.^{9,11,12} After six weeks, ongoing care for mothers and children generally transitions to primary care, which is less coordinated and systematic.^{9,13} This model of care does not support long-term identification and management of cardiovascular risks due to pregnancy-associated complications, which are risks that remain well beyond the end of the pregnancy. Evidence has shown that cardiovascular risks caused by common pregnancy complications can last for at least ten years, and in some cases up to several decades.^{14,15,16,17,18}

The Heart Foundation is concerned that gaps in continuity and longevity of postpartum care, and the evidence that supports it, are putting tens of thousands of women who have experienced pregnancy complications at unnecessary long-term risk of cardiovascular disease. These gaps in care mean that pregnancy-associated cardiovascular disease risks are often under-recognised and under-managed, with serious implications for long-term maternal health.¹⁹ This also leaves many women with the false perception that increased risk of cardiovascular disease associated with pregnancy complications lasts only until the pregnancy ends, with limited awareness of their future risk of developing cardiovascular disease and how they can be managed.^{20,21} There are also gaps in care that could be missing rare but severe cardiovascular conditions associated with pregnancy and that occur in young women.^{22,23}

While commonly perceived as a disease predominantly affecting men, cardiovascular disease is a leading cause of ill-health and death in women in Australia and remains understudied, under-recognised, underdiagnosed and undertreated.²⁴ Lack of sufficient cardiovascular risk management for women postpartum is only one of several gaps in care for women in Australia. Worrying trends have been emerging, with some cardiovascular health outcomes that have improved more slowly or are poorer for women compared to men.^{25,26,27} Poorer cardiovascular outcomes for women have already been reported in other high-income countries including Canada and the USA, reversing a decades-long decline in cardiovascular mortality and illness.¹⁹

The Heart Foundation sees a significant opportunity to improve cardiovascular outcomes for women by ensuring best practice postpartum care includes cardiovascular risk management continuing throughout a woman's life. In this submission, we have provided the Committee with recommendations for the Australian Government that can help to address

gaps in identifying and managing pregnancy-associated cardiovascular risks and conditions. These recommendations build on the existing clinical systems and processes that transition clinical care between different providers, supporting more consistent communication of cardiovascular risk and follow-up across the life course. We also put forward recommendations that will continue to improve the standard of cardiovascular risk management in postpartum care by addressing gaps in clinical guidance that informs best practice care, the evidence base used to develop the clinical guidance, and women's awareness of risk factors that could impact their long-term health.

Summary of recommendations

The Heart Foundation provides the Committee with the following recommendations for the Australian Government to support better long-term maternal health by addressing gaps in postpartum care.

- 1. Ensure that existing clinical systems and processes within the Australian health system are optimised to support best practice care for long-term management of pregnancy-associated cardiovascular disease risk factors and conditions by:**
 - a. standardising the inclusion of pregnancy-associated cardiovascular disease risk factors in hospital discharge communication, supporting better transition of care among providers (e.g. through nationally adopted digital templates and national hospital accreditation standards for safety and quality of care).
 - b. supporting general practices to ensure that patient recall and reminder systems include follow-up for management of cardiovascular disease risk that will better support risk management across a woman's life course.
- 2. Prioritise development of clinical guidance on identification and management of pregnancy-associated cardiovascular disease risks based on the best available evidence, to drive urgent and continuous improvements in long-term postpartum care for women.** *The Australian Pregnancy and Postnatal Care Guidelines and the Australian guideline for assessing and managing cardiovascular disease risk should be prioritised for updates with the new guidance.*
- 3. Address key gaps in understanding about long-term health impacts of pregnancy-associated risk factors for cardiovascular disease to improve identification and management of risk in clinical practice by:**
 - a. investing in research through national research funding programs (e.g. National Health and Medical Research Council and Medical Research Future Fund), focusing on the most urgent gaps in knowledge about the impact, assessment and management of pregnancy complications on cardiovascular disease risk.
 - b. supporting national linked clinical data systems, such as national databases and registries, to inform better identification, follow-up and monitoring of women who have experienced pregnancy complications and increased cardiovascular disease risk.
- 4. Ensure that all women in Australia can access evidence-based resources and education to increase their awareness and understanding of pregnancy-associated cardiovascular disease risk factors and how they can impact their long-term health.**

1. Existing clinical systems and processes for transition from maternity services to primary care do not consistently support follow-up for pregnancy-associated cardiovascular conditions or long-term risk

This section responds to terms of reference item (c).

1.1 Lack of consistency in hospital discharge communication for maternity patients

The model of postpartum care in Australia currently lacks a consistent approach for identification and long-term management of pregnancy-associated cardiovascular disease risks beyond the six-week postpartum check. It also lacks a consistent approach for identification and long-term management of pregnancy-associated cardiovascular conditions before, during and after maternity patients leave hospital. Both these gaps in care have implications for a mother's health in the short- and long-term.

Pregnancy complications that confer a significant increase in risk of cardiovascular disease developing later in life are common among women in Australia. Gestational diabetes, which is associated with 60-70% increased risk of cardiovascular disease, affected almost one in five women (18%) who gave birth in an Australian hospital in 2023–24.^{4,28} About 1 in 12 (8.4%) babies in Australia in 2023 were born preterm, which is associated with a 43% increased risk of maternal cardiovascular disease and a 2-fold increased risk of death from coronary heart disease, the most common cardiovascular disease condition.^{5,7} Pre-eclampsia, a hypertensive disorder of pregnancy, is associated with a 2-fold increased risk of cardiovascular disease and cardiovascular-related mortality.⁶ Pre-eclampsia and other hypertensive disorders of pregnancy affected about 1 in 17 women (6%) who gave birth in 2023.²⁹

A woman's risk of cardiovascular disease due to pregnancy complications may not become clinically apparent until well beyond the standard six-week postpartum appointment.^{14,15,16,17,18} For some pregnancy complications, such as preterm birth, excess risk can persist for several decades.¹⁸ While existing evidence suggests that most maternity healthcare providers are aware of the increased risk of cardiovascular disease linked to pregnancy complications, these factors are still often overlooked as part of longer term cardiovascular disease risk assessment.³⁰ Inconsistencies in identification and management of pregnancy-associated cardiovascular conditions could also be putting women at unnecessary risk during the immediate postpartum period. Conditions such as peripartum cardiomyopathy can develop during late pregnancy or the months after birth,²² while pregnancy-associated spontaneous coronary artery dissection (SCAD) occurs most commonly in the first month postpartum.²³ Both conditions are severe: peripartum cardiomyopathy causes a potentially life-threatening form of heart failure and pregnancy-associated SCAD causes heart attacks in young women.

There is an opportunity to improve clinical care of these conditions and long-term risks by improving communication during transition of care between maternal health services (hospitals) and primary care. In Australia's current model of care, discharge summaries are provided by the hospital to several different care providers, including primary care (e.g. general practitioner; GP) and maternal and child health services. However, there is no consistent national standard or requirement for hospital discharge paperwork to include patient information relevant to pregnancy-associated cardiovascular disease risk factors and pregnancy-associated cardiovascular conditions.

Improving postpartum cardiovascular care and discharge communication in the transition of care requires that communication begins before hospital discharge and continues through the early weeks and months after birth. Women who experience hypertensive disorders of pregnancy, gestational diabetes, preterm birth or other pregnancy-associated cardiovascular conditions should have a documented clinical assessment, clear advice about warning symptoms, appropriate management of persistent hypertension or metabolic abnormalities, and a scheduled follow-up plan with a nominated healthcare provider. Clear written and verbal communication with women (patients) should accompany discharge documentation.

There are opportunities for the Australian Government to standardise discharge documentation through national bodies that support best practice healthcare. The Australian Digital Health Agency could include pregnancy-associated disease risk factors and conditions as a standard item on the templates it develops for implementation by hospitals nationwide.³¹ Standardising hospital discharge information in this way would help to ensure that essential information about a women's cardiovascular risk factors and conditions, in addition to other aspects of maternal care, are automatically captured in My Health Record and clinical management software used in general practice. This would mean that GPs are able to more easily recognise and manage cardiovascular risks in the long-term, including via recall systems and reminders for follow up in primary care settings (discussed in section 1.2).

Better discharge communication of cardiovascular risk and conditions could also be established through the National Safety and Quality Health Service Standards developed by the Australian Commission on Safety and Quality in Health Care. The Commission's National Standards set the quality of care that patients can expect when engaging with Australian hospitals, and cover different aspects of care, including medication safety, clinical concerns and safe discharge communication.³² Hospitals need to meet these standards to receive their accreditation as a healthcare provider. Including the expectation that standard discharge communication includes pregnancy complications and conditions, as well as other risk factors requiring long-term follow up, could drive a significant improvement in the transition from maternity services to primary care. The Commission's National Standards are complemented by the *National guidelines for presentation of electronic discharge summaries*,³³ which outline the expectation that discharge communication should include a current medicines list, a plan for referral and follow up, and requirements regarding ongoing care. The Commission could specify in the guidelines the expectation that postpartum considerations, including cardiovascular disease risk factors, should be included as a minimum in discharge communications following birth.

1.2 Recall and reminder follow-up systems in general practice could support better long-term continuity of postpartum care

There are no nationally coordinated systems or mechanisms in maternal care pathways to ensure women receive long-term and ongoing cardiovascular risk assessment throughout their lives. However, existing recall and reminder follow-up systems are in place across many general practices in Australia and could be expanded to ensure that women who have pregnancy-associated cardiovascular disease risk factors receive follow-up assessment and management of risks.

Recall and reminder systems could be used to improve long-term follow-up with women who have pregnancy-associated cardiovascular disease risk factors.³⁴ Recall systems that are

already in place in many general practices can generate automatic reminders, which could prompt patients who have experienced a pregnancy complication to return annually for cardiovascular risk assessment. Primary care recall and follow-up mechanisms have shown positive impacts on uptake of cardiovascular disease risk factor screening and monitoring at scale. A study led by the Heart Foundation demonstrated that “Text to Detect”, an SMS text message-driven program that used patient reminder messages to encourage cardiovascular disease risk factor screening, significantly improved uptake, including in regional and remote Australia.³⁵

For younger women, recall and reminder systems could facilitate periodic cardiovascular risk assessment until they become eligible for an annual Medicare-funded Heart Health Check) (Medicare Benefits Scheme items 699 and 177), supporting continuity of risk assessment and management throughout the life course.³⁶ Heart Health Checks are available for people from age 45 years, from age 35 years for people living with diabetes and from age 30 years for First Nations people.³⁷

Primary Health Networks are well-placed to support general practices (primary care) to include regular follow up of women with pregnancy-associated cardiovascular disease risk factors in their recall and reminder systems. Recall and reminder systems are implemented in general practices as part of accreditation requirements set by the Royal Australian College of General Practitioners (RACGP) Standards for General Practices.

Recommendation 1. Ensure that existing clinical systems and processes within the Australian health system are optimised to support best practice care for long-term management of pregnancy-associated cardiovascular disease risk factors and conditions by:

- a. standardising the inclusion of pregnancy-associated cardiovascular disease risk factors in hospital discharge communication, supporting better transition of care among providers (e.g. through nationally adopted digital templates and national hospital accreditation standards for safety and quality of care).
- b. supporting general practices to ensure that patient recall and reminder systems include follow-up for management of cardiovascular disease risk that will better support risk management across a woman’s life course.

2. Existing clinical guidelines lack advice on recognition and management of long-term cardiovascular disease risks related to pregnancy complications

This section responds to terms of reference item (c).

Existing clinical guidelines and risk assessment tools do not sufficiently incorporate pregnancy-associated cardiovascular disease risk factors in advice for clinical care, particularly related to long-term care. There is an opportunity to improve long-term maternal health outcomes by ensuring that clinical guidance is developed for long-term assessment and monitoring of pregnancy-associated cardiovascular risk factors in all relevant guidelines for best practice care through a woman’s life course.

Long-term cardiovascular risk assessment and management in postpartum care is not sufficiently covered in the Australian Pregnancy and Postnatal Care Guidelines, which focuses primarily on assessment and management of early postpartum complications such as perineal health, mental health and infant feeding.⁹ This gap in clinical guidance contributes to pregnancy complications being overlooked during routine clinical assessment of cardiovascular disease risk.³⁸

Clinical guidelines for cardiovascular care also contain limited advice on pregnancy-associated cardiovascular risk factors, likely resulting in further missed opportunities to support women who are at risk. The *2023 Australian guideline for assessing and managing cardiovascular disease risk* provides general clinical advice about some pregnancy complications but does not provide specific recommendations that would better ensure routine risk assessment for postpartum women as best practice cardiovascular care.³⁹ This in part reflects the evidence available at the time the guideline was developed, which lacked sufficient detail to inform practical clinical advice. Evidence that has been emerging since then can better inform development of clinical guidance for health professionals providing maternity care and primary care in clinical practice.

Cardiovascular conditions associated with the immediate postpartum period such as peripartum cardiomyopathy and pregnancy-associated spontaneous coronary artery dissection are also not consistently addressed in national guidelines. Detailed clinical guidance for these and other relevant cardiovascular conditions could prompt more rapid assessment of postpartum women presenting with warning symptoms such as chest pain, unexplained breathlessness, orthopnoea, oedema or persistent tachycardia, reducing diagnostic and treatment delays and improving outcomes.

Recommendation 2. Prioritise development of clinical guidance on identification and management of pregnancy-associated cardiovascular disease risks based on the best available evidence to drive urgent and continuous improvements in long-term postpartum care for women.

The *Australian Pregnancy and Postnatal Care Guidelines* and the *Australian guideline for assessing and managing cardiovascular disease risk* should be prioritised for updates with the new guidance.

3. Improving management and monitoring of pregnancy-associated cardiovascular risk in best practice care is limited by gaps in evidence and linked national clinical data sets

3.1 Underrepresentation of pregnant and breastfeeding women has led to gaps in evidence that inform best practice care

This section responds to terms of reference item (f).

While pregnancy complications are consistently associated with risk of cardiovascular disease, the underlying mechanisms and how risk develops over a women's life are not well understood. These areas are understudied, in part due to historical biases in how research studies, particularly clinical trials, are designed and conducted. To date, women, particularly

women who are pregnant or breastfeeding, have been underrepresented in cardiovascular clinical trials with a recent analysis reporting that only 0.7% of 586 trials allowed pregnant women to participate.⁴⁰ Research into pregnancy-associated cardiovascular risk factors has also been constrained by limited collection of detailed pregnancy histories in cardiovascular cohorts and clinical trials.^{41,42}

Investment in clinical trials that can address key evidence gaps could significantly improve the quality of care for women postpartum.⁴¹ Better understanding of the biological mechanisms underlying the association between these pregnancy complications and long-term risk of cardiovascular disease could inform more targeted approaches to risk management. Understanding how risk is modified by factors such as maternal age, maternal parity and the accumulation of multiple pregnancy complications could help to better identify an individual women's risk of cardiovascular disease through her life course. Understanding the extent to which effective management of pregnancy complications alters long-term cardiovascular risk could greatly improve long-term maternal health outcomes. Determining how these risk factors can be effectively incorporated into clinical guidance and tools will better support clinical decision-making and better clinical care.¹⁹

3.2 Lack of linked clinical data is limiting improvements in postpartum care

This section responds to terms of reference item (h).

A significant opportunity to address the most urgent evidence gaps is ensuring that researchers and health professionals have access to a national data set linking pregnancy complications to cardiovascular disease outcomes. While national data sets such as the National Perinatal Data Collection⁴³ and National Hospital Morbidity Database⁴⁴ capture the incidence of gestational diabetes, hypertensive disorders of pregnancy and preterm birth, there is no nationally coordinated mechanism for determining whether women with pregnancy complications develop cardiovascular-related conditions and how they could be contributing to cardiovascular disease burden.

Registries offer a potential mechanism for long-term monitoring and follow up for women with pregnancy-associated risk factors, including cardiovascular disease risk. Existing registries that support long-term care could be explored and evaluated to inform development of a national registry that would support a more comprehensive approach to long-term monitoring and screening for women through their life course. For example, the National Gestational Diabetes Register supports long-term, ongoing follow-up and screening for women who have experienced gestational diabetes.⁴⁵

Recommendation 3. Address key gaps in understanding about long-term health impacts of pregnancy-associated risk factors for cardiovascular disease to improve identification and management of risk in clinical practice by:

- a. Investing in research through national research funding programs (e.g. National Health and Medical Research Council and Medical Research Future Fund), focusing on the most urgent gaps in knowledge about the impact, assessment and management of pregnancy complications on cardiovascular disease risk.
- b. Supporting national linked clinical data systems, such as national databases and registries, to inform better identification, follow-up and monitoring of women who have experienced pregnancy complications and increased cardiovascular disease risk.

4. Lack of awareness about the implications of pregnancy complications may be putting women at unnecessary risk

This section responds to terms of reference item (p).

Evidence has shown that women with pregnancy-associated cardiovascular disease risk factors are often unaware or underestimate their risk of developing cardiovascular disease later in life. An observational study found that nearly 70% of women attending a postpartum cardiovascular presentation clinic were not aware of the association between their pregnancy complication and future cardiovascular disease risk.²⁰ Similarly, a 2025 systematic review found that women had low to moderate knowledge of cardiovascular disease risk from pregnancy complications; a contributing factor to this was limited counselling from health professionals.²¹

Existing tools and resources for women who have experienced a pregnancy complication could inform a national approach to improve awareness of future cardiovascular disease risk. Greater awareness and understanding of this risk may encourage women to engage in ongoing cardiovascular screening, risk assessment and preventive care. Evidence has shown that this engagement is more likely when the advice provided is personalised and addresses barriers such as parenting responsibilities.⁴⁶

Resources and education should be informed by women's preferences for risk communication, including the provision of personalised, repeated and actionable information about future cardiovascular risk and opportunities for prevention.^{21,47} These resources should also address distinct and intersecting barriers to receiving best practice cardiovascular risk assessment and management experienced by women in priority populations. These populations include First Nations women, women from culturally and linguistically diverse communities, and women living in rural and remote areas.^{48,49,50} Women from these communities should receive tailored, co-designed and culturally relevant advice on how to identify pregnancy-associated cardiovascular risk factors and manage their risk across the life course.

Recommendation 4. Ensure that all women in Australia can access evidence-based resources and education to increase their awareness and understanding of pregnancy-associated cardiovascular disease risk factors and how they can impact their long-term health.

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