Australian Women's Health Alliance

Thought Leadership Series

Cardiovascular Health: The Silent Killer of Women

Key messages

- Cardiovascular disease (CVD) is one of the leading causes of illness and death among Australian women, responsible for approximately one in 4 female deaths in 2022, or around 20 women every day.
- Indigenous women carry a disproportionate share of Australia's cardiovascular burden. First Nations people are hospitalised for cardiovascular disease at 1.6 times the rate of non-Indigenous Australians nationally.

Purpose of this brief

Australian Women's Health Alliance works to articulate the policies and actions necessary to improve health outcomes for women and gender diverse people. The purpose of this brief is to put a gender lens on cardiovascular health and how current policies and practices potentially impact women's health equity.

Background

Cardiovascular disease (CVD) is one of the leading causes of illness and death among Australian women, responsible for approximately one in 4 female deaths in 2022, or around 20 women every day.[1]

Despite this burden, women's heart health has historically been under-recognised, under-researched and under-treated relative to men's. Women have made up only around 25% of participants in cardiovascular clinical trials, meaning that much of the diagnostic and treatment evidence base has been derived largely from male physiology. This has contributed to documented disparities in diagnosis, investigation and treatment, and to persistent gaps in community and clinical awareness of how heart disease presents in women.[2]

Encouragingly, national data show real progress: acute coronary event rates among Australian women fell by more than half between 2001 and 2016, and coronary heart disease (CHD) death rates fell by 46% over the decade to 2016. However, these gains have been uneven, younger women have seen smaller improvements than older women, and stroke incidence has actually risen among women aged under 55. The Australian Government's establishment of a Ministerial Expert Panel on

[1] Australian Government Department of Health, Disability and Ageing (2026) 'Heart health for women in spotlight', Ministerial media release.

[2] Ibid.

Women's Health, with cardiovascular disease as its first area of focus, signals recognition at the highest policy level that further action is required.[3][4]

This brief summarises the evidence on the scale and nature of the problem and sets out policy recommendations across awareness, clinical practice, research and monitoring.

The Problem: A Leading but Under-Recognised Threat

Scale of the burden

Cardiovascular disease caused more female deaths than any other disease group in 2016 (22,200 deaths, 29% of all female deaths) and remains a leading cause of death and illness for Australian women today, contributing to roughly one in 4 female deaths in 2022. An estimated 510,000 Australian women aged 18 and over live with a heart, stroke or vascular condition. CVD also accounted for 12% of the total disease burden among Australian females, with coronary heart disease alone causing a greater share of the female disease burden than any other single condition.[5]

Under-representation in research

Much of the clinical evidence base for diagnosing and treating heart disease was built on research conducted primarily in men. The Australian Government has noted that women have historically made up only around 25% of participants in cardiovascular research and clinical trials, meaning diagnostic tools and treatment guidelines have often been calibrated to male presentations and physiology rather than tested rigorously across both sexes.[6]

Differences in symptoms and diagnosis

Women presenting with heart attack are more likely than men to report symptoms such as shortness of breath, fatigue, weakness and indigestion rather than classic chest pain, which increases the risk that cardiovascular events are missed or misattributed. Physicians have also been shown to underestimate cardiovascular risk in women, and younger women under 55 with acute coronary syndrome are more likely than their male counterparts to be misdiagnosed and discharged from emergency departments.[7]

Consultations with Australian women who have lived experience of cardiovascular disease echo this evidence: women report being told their symptoms were "just anxiety" and experiencing longer delays before their symptoms were taken seriously in emergency settings.[8]

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[3] Ibid.

[4] Australian Institute of Health and Welfare (2019) Cardiovascular Disease in Women, Cat. no. CDK 15, Canberra: AIHW.

[5] Ibid.

[6] Australian Government Department of Health, Disability and Ageing (2026) 'Heart health for women in spotlight', Ministerial media release.

[7] Heart Foundation (2026) 'Women and heart health', heartfoundation.org.au.

[8] Australian Government Department of Health, Disability and Ageing (2026) 'Heart health for women in spotlight', Ministerial media release.

Disparities in treatment

National data show that women with coronary heart disease receive fewer medications and less aggressive, less invasive treatment than men. Following a heart attack, women are less likely to undergo timely angiography, percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG) than men, even after accounting for age and case complexity via comorbidities.[9]

Unique and sex-specific risk factors

Beyond the risk factors shared with men including smoking, physical inactivity, obesity, high blood pressure and abnormal blood lipids, women face several risk factors that are unique to them:[10]

- Diabetes raises heart attack risk more sharply for women (4.3 times) than for men (2.7 times), for reasons not yet fully understood.[11]
- Smoking confers a 25% greater relative increase in coronary heart disease risk for women than for men, and smoking combined with the contraceptive pill substantially raises the risk of heart disease, stroke and blood clots.[12]
- Pregnancy complications, including pre-eclampsia and gestational diabetes, are established risk factors for later cardiovascular disease.[13]
- Depression and anxiety show a stronger association with cardiovascular risk in women than in men.[14]
- Oestrogen appears protective before menopause, which may explain women's later average age of onset, but the relationship between menopause and cardiovascular risk requires further research.[15]
- Spontaneous coronary artery dissection (SCAD), a condition where a coronary artery wall spontaneously tears, occurs disproportionately in women, often with few conventional risk factors present.[16]

Widening gaps for younger women

Population-level trends mask a worsening picture for younger women. Between 2001 and 2015, stroke incidence rose by 16% among women aged 35–44 and by 12% among those aged 45–54, even as rates fell for women over 55. Similarly, hospitalisation rates for cardiovascular disease rose among women aged 25–44 between 2006–07 and 2015–16, while falling for older women. Younger women also experienced smaller falls in acute coronary event rates than older women or than men of the same age. This suggests prevention, awareness and early-intervention strategies are not reaching younger women as effectively as they are reaching older cohorts.[17]

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[9] Heart Foundation (2026) 'Women and heart health', heartfoundation.org.au.

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

[17] Australian Institute of Health and Welfare (2019) Cardiovascular Disease in Women, Cat. no. CDK 15, Canberra: AIHW.

Compounding disadvantage for Indigenous women

Indigenous women carry a disproportionate share of Australia's cardiovascular burden. First Nations people are hospitalised for cardiovascular disease at 1.6 times the rate of non-Indigenous Australians nationally, rising to 2.4 times in remote and very remote areas. Cardiovascular disease is the leading specific cause of the overall gap in death rates between First Nations and non-Indigenous Australians. Among First Nations people specifically, women account for 44% of cardiovascular deaths and are hospitalised for cardiovascular disease at a rate of 17 per 1,000 population, similar to the rate for First Nations men (18 per 1,000).

Onset for Indigenous women is also markedly earlier: cardiovascular disease typically develops 10 to 20 years earlier in First Nations people than in non-Indigenous Australians, and in a linked national study of heart failure admissions, First Nations women made up 17% of all female patients under 50, a far higher share than their proportion of the female population overall. Undiagnosed risk compounds this picture: 80% of First Nations adults with measured high blood pressure did not know they had it, and First Nations people hospitalised for coronary heart disease remain less likely than non-Indigenous Australians to receive angiography (53% versus 56%) or revascularisation (29% versus 32%). Culturally safe, community-controlled models of care such as Aboriginal Community Controlled Health Services have demonstrated measurable improvements in blood pressure, weight maintenance and cardiovascular risk, underscoring the value of investing in First Nations-led approaches to close this gap, with particular attention to First Nations women's distinct risk profile.[18]

Current Policy Response and Landscape

The Australian Government has begun to respond to this evidence gap. In 2026 it established a Ministerial Expert Panel on Women's Health, chairing its first focus area on women's cardiovascular health, bringing together clinicians, researchers, advocates and women with lived experience to identify practical ways to improve prevention, diagnosis, treatment and care. The Panel's establishment followed a broader nearly $800 million women's health package and has since convened clinical roundtables and lived-experience consultations to directly inform its recommendations. This builds on the National Women's Health Strategy 2020–2030, under which a national campaign to raise awareness of women-specific cardiovascular symptoms and risk factors was identified as a key action.[19]

These are welcome steps, but the evidence set out above indicates the underlying disparities in awareness, diagnosis and treatment remain substantial and, on current trends, will take decades to close without more deliberate intervention.

[18]Australian Institute of Health and Welfare & National Indigenous Australians Agency (2026) Measure 1.05 Cardiovascular Disease, Aboriginal and Torres Strait Islander Health Performance Framework.

[19]Australian Government Department of Health, Disability and Ageing (2026) 'Heart health for women in spotlight', Ministerial media release.

Policy Recommendations

1. Build public and clinical awareness of sex-specific presentation

- Fund and deliver a sustained national public awareness campaign as committed to under the National Women's Health Strategy 2020–2030 that teaches women and health professionals to recognise non-chest-pain symptoms.
- Embed sex- and gender-specific presentation, risk assessment and management into medical, nursing and paramedic curricula and continuing professional development, so that under-recognition in emergency and primary care settings is addressed at its source.
- Target awareness efforts specifically at women under 55, who face higher rates of misdiagnosis and discharge from emergency departments, and at Indigenous women, who face earlier and more severe onset of disease.[2021]

2. Close treatment and investigation gaps

- Support the Ministerial Expert Panel's clinical roundtables to translate findings on treatment disparities into updated clinical guidelines and referral pathways.
- Introduce routine sex-disaggregated audit and public reporting of cardiac investigation and treatment rates in public and private hospitals, to allow disparities to be tracked and addressed at the service level.
- Expand support for Aboriginal Community Controlled Health Services and culturally safe cardiac care pathways.[22]

3. Strengthen the research and evidence base

- Mandate or strongly incentivise sex-balanced recruitment in publicly funded cardiovascular clinical trials, moving beyond the historical benchmark of around 25% female participation.
- Fund dedicated research into conditions and mechanisms disproportionately affecting women.
- Support longitudinal research specifically tracking the drivers of rising stroke and hospitalisation rates among women under 55, to inform targeted prevention strategies for this cohort.

4. Improve prevention and risk-factor management

- Extend and promote free Heart Health Checks, with particular outreach to women aged 45 and over (30 and over for Aboriginal and Torres Strait Islander women), aligning with Heart Foundation guidance.[23]
- Address rising overweight and obesity among women (60% in 2017–18, up from 49% in 1995) through integrated preventive health policy, while sustaining the gains already made in reducing female smoking rates.[24]

[20]Heart Foundation (2026) 'Women and heart health', heartfoundation.org.au.

[21]Australian Institute of Health and Welfare & National Indigenous Australians Agency (2026) Measure 1.05 Cardiovascular Disease, Aboriginal and Torres Strait Islander Health Performance Framework.

[22]Australian Institute of Health and Welfare & National Indigenous Australians Agency (2026) Measure 1.05 Cardiovascular Disease, Aboriginal and Torres Strait Islander Health Performance Framework.

[23]Heart Foundation (2026) 'Women and heart health', heartfoundation.org.au.

[24]Australian Institute of Health and Welfare (2019) Cardiovascular Disease in Women, Cat. no. CDK 15, Canberra: AIHW.

- Incorporate cardiovascular risk counselling into maternity and post-partum care, given the established link between pregnancy complications such as pre-eclampsia and later cardiovascular disease.

5. Sustain monitoring and accountability

- Task the Australian Institute of Health and Welfare with regular, updated national reporting on cardiovascular disease in women to track progress against these recommendations over time.
- Set measurable targets for narrowing the sex gap in cardiovascular mortality and treatment rates, with public reporting to maintain accountability beyond the life of the current Expert Panel.

What does this mean for health equity?

Cardiovascular disease remains one of the most significant, and most addressable, threats to Australian women's health. The evidence is clear on the scale of the problem and the specific points: awareness, diagnosis, treatment and research, where intervention can make a measurable difference. The Ministerial Expert Panel on Women's Health, with its initial focus on cardiovascular disease, offers a timely platform to convert this evidence into sustained action. Without deliberate acceleration, current trends suggest the gender gap in heart disease outcomes will take decades to close. Coordinated action can shorten that timeline and save Australian women's lives.

About us

Australian Women's Health Alliance provides a national voice on women's health. We highlight how gender shapes experiences of health and health care, recognising that women's health is determined by social, cultural, environmental, and political factors.

Contact us

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We acknowledge the Traditional Custodians of the lands and waters on which we live and work. We pay our respect to Elders past and present. Sovereignty has never been ceded.