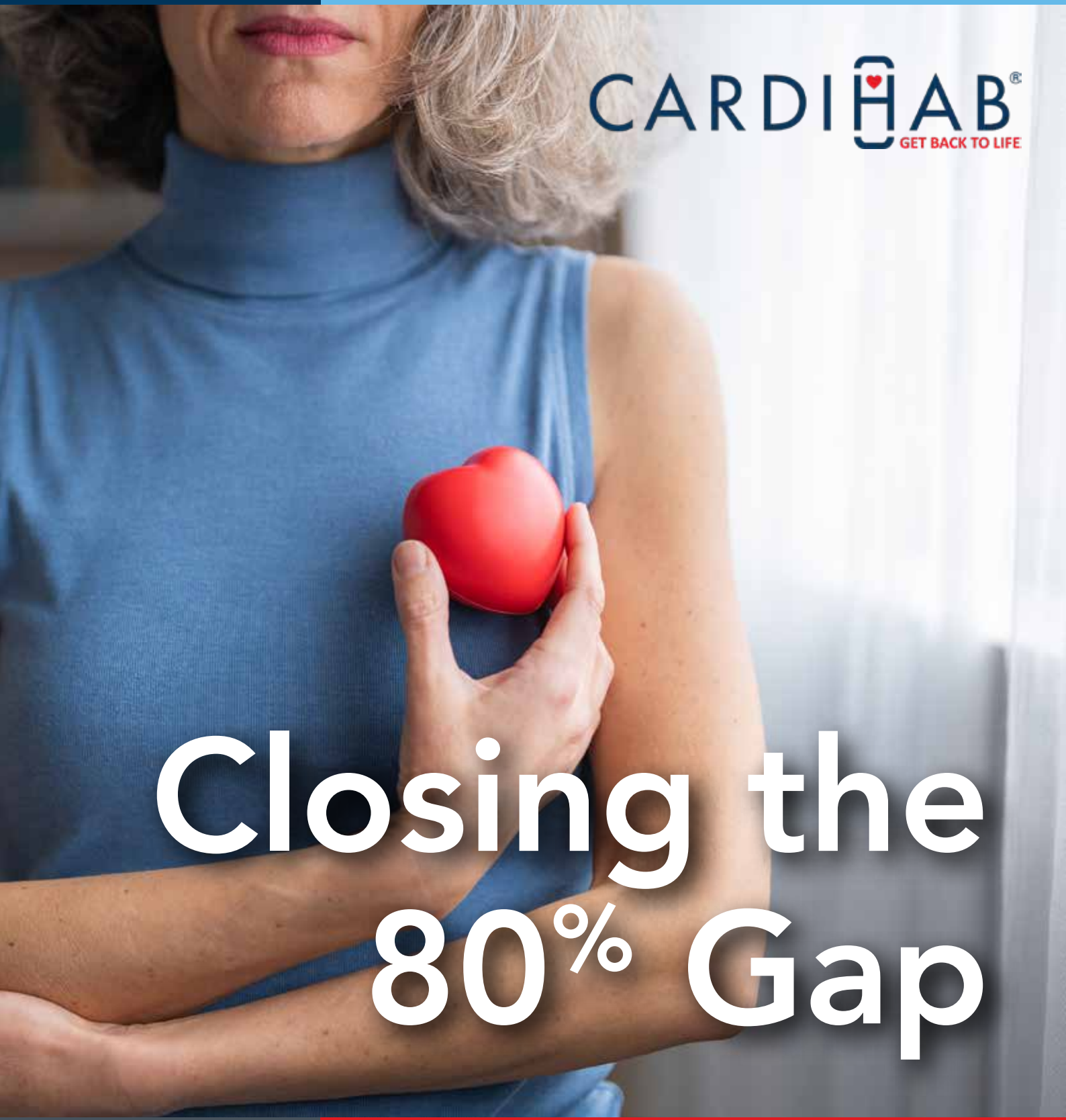
A WHITE PAPER

CARDIAC REHABILITATION ACCESS IN AUSTRALIA: THE SCALE OF THE GAP, THE CLEAREST EVIDENCE OF WHO IT FAILS HARDEST, AND WHAT CLOSES IT

CARDIHAB®
GET BACK TO LIFE



Closing the 80% Gap

Cardiac rehabilitation is proven, evidence backed and with digital therapeutics it's increasingly deliverable at scale. But still, most eligible Australians never receive it, and women are missing out even more.

September 2026

Executive Summary

Cardiac rehabilitation is one of the most evidence backed interventions in modern medicine. Across every Australian dataset detailed enough to measure it, roughly 80% of eligible patients never complete it, costing the healthcare system $2.4B p.a.

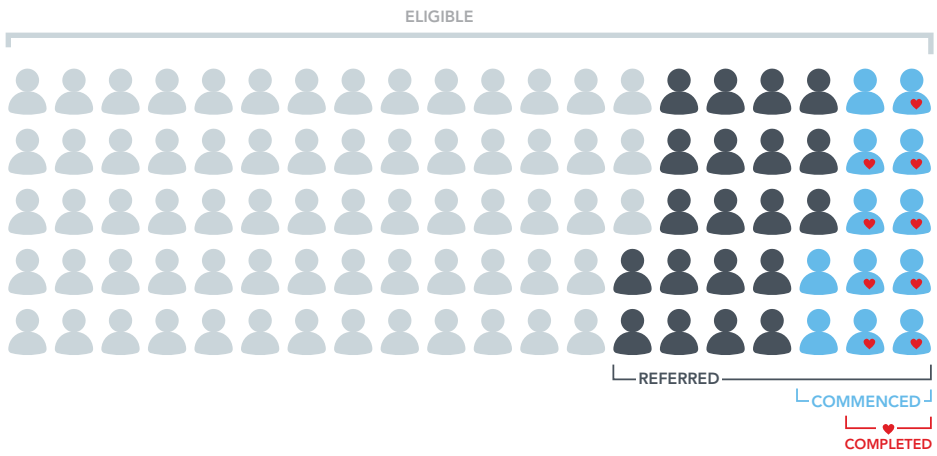
Cardiac rehabilitation (CR) is a Class 1, guideline recommended intervention. It is strongly recommended by the National Heart Foundation of Australia, the Cardiac Society of Australia and New Zealand and in August 2026, the European Society of Cardiology issued a standalone guideline for CR which is consistent with the US guidelines, from the American College of Cardiologists. Multiple randomised trials and, increasingly, large real world data linkage studies confirm it meaningfully reduces death, recurrent events and hospital readmission after a cardiac event. [1,2,3,4] It is not a nice to have. It is a proven part of standard care.

Cardihab's analysis of the AIHW hospitalisation data, uses cardiac diagnosis hospitalisations as the surrogate for the denominator of patients eligible for CR across every state paint a compelling picture. Nationally, an estimated 20% of the roughly 634,000 Australian hospitalisations with a cardiac principal diagnosis each year access cardiac rehabilitation, meaning around 80% do not. [5,6]

80%
of eligible Australians do not access cardiac rehabilitation

Yet the system does not deliver it to most of the people who qualify. In Australia as in many parts of the world, it is estimated that 80% of eligible patients miss out. In South Australia, the largest cardiac rehabilitation outcomes study conducted in Australia to date followed 84,064 eligible patients over 5 years: only 31.9% were ever referred, only 36.8% of those referred commenced, and only 77.8% of those who commenced completed [1]. Multiplied through the funnel, roughly 9 in every 100 eligible South Australians complete a program.

Only 9 in 100 eligible patients complete cardiac rehabilitation



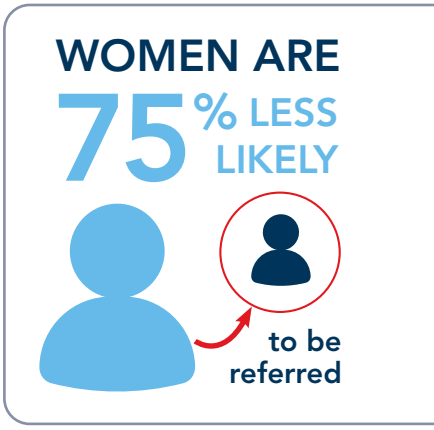
In Victoria, a newly published, 37,191 patient linked data study, found that even where referral has been improving, only 19.3% of PCI patients ever attended a single cardiac rehabilitation session. [2]

In Queensland, QCOR reports that 33,055 patients are referred, 63% then attend at least one session and 44.4% of attendees complete the full program. [7] Against the eligible population estimate 126,800 annual cardiac hospitalisations are reported by the AIHW), [5,6,7] only approximately 18% receive cardiac rehabilitation, a similar order of magnitude as South Australia and Victoria above, not the higher figure the referred-only numbers might suggest. National estimates, drawn from multiple Australian studies, cluster around 30% participation, with a documented range of 20% to 50% depending on definition and setting. [1,2,7]

This is not an Australian problem alone. In the United Kingdom, national cardiac rehabilitation uptake has plateaued at around 50% of eligible patients, well short of the NHS's own target of 85% by 2028, and varies by nation within the UK, 61% in Wales and 49% in Northern Ireland. [8] In the United States, participation runs at 20% to 30% of eligible patients nationally, and only around 1 in 4 Medicare patients participate. [9] The Million Hearts Cardiac Rehabilitation Collaborative, a national US initiative, has modelled that lifting participation from 20% to 70% would prevent an estimated 25,000 deaths and 180,000 hospitalisations a year [9], a scale of missed benefit consistent with the Australian data set out above.

The exact number depends on the state, the dataset and the definition used. The scale of the gap does not: on the most consistent evidence available, roughly 8 in 10 eligible Australians do not receive the full course of cardiac rehabilitation - a proven, life saving intervention.

Within that system wide failure, some groups are hit harder than others. This includes people that live in regional, rural and remote communities, Aboriginal and Torres Strait Islander peoples, and CALD communities; however, none is more clearly or consistently documented than women. Women are 75% more likely to never be referred at all (South Australia) [1], referred at lower rates internationally (39% versus 49%, per the American Heart Association's 2025 scientific statement on cardiac rehabilitation in women), and underrepresented even in Australia's own leading virtual cardiac rehabilitation evaluation, where the enrolled cohort was 70% male. [3,10,11] This paper treats women's heart health as one of the clearest and most urgent illustrations of the broader access failure, not as a separate problem.



The evidence also points clearly to what could close the gap, and what does not. Automatic, opt out referral is the single most effective lever for raising referral rates, proven across health systems from the United States to the Philippines. [12,13,14,15] But referral alone is not sufficient: Victoria's own data show referral rates improving while attendance stayed near 1 in 5. [2,16] Virtual, digitally enabled cardiac rehabilitation is what converts a referral into a completed program. The evidence also shows it disproportionately helps women, and regional and rural patients, reach it at all.

Cardihab's SmartCR platform, the only TGA registered Class IIa digital therapeutic for this purpose, already has an independently evaluated, cost effective proof point for this model at national scale: deployed within Medibank's Heart Health at Home program, delivered clinically via Amplar Health. [3,17,18,19] It achieved:

- **91% completion**, against a historical face-to-face dropout rate of 20% to 40% [3]
- **outcomes equivalent** to traditional face-to-face cardiac rehabilitation across every measure examined [3]
- **more cost effective** than usual care in 87% of modelled simulations, adding 1.4 quality-adjusted life years per patient versus usual care [17]

This paper sets out the evidence base for that conclusion, in full, and identifies the priority levers for health systems, insurers, government, member-based funds and investors.

1. A Standard of Care That Isn't Being Delivered

Cardiac rehabilitation should not be viewed as optional. It is a Class I recommended intervention in secondary prevention, with decades of trial evidence behind it. A well delivered program addresses physical recovery, risk factor modification, medication adherence, mental health, health literacy and behavioural change in a single, structured course of care.

Failure to complete it carries a real clinical cost: delayed return to work, a higher risk of recurrent cardiac events, avoidable hospital readmissions, and, as later sections of this paper set out with hard numbers, materially higher mortality.

Despite this, the system continues to treat cardiac rehabilitation as a referral based add on, a post discharge suggestion, and, too often, nobody's clear responsibility: hospitals, primary care, insurers and rehabilitation providers each assume another part of the system will close the loop. Traditional centre based programs sit at or beyond waitlist capacity in many regions, with no scalable alternative routinely offered, and broken referral pathways mean eligible patients are simply never identified, contacted or followed up. Once they leave hospital with or without a discharge summary they become invisible to the health system until they have a recurrent event.

If a patient does not receive cardiac rehabilitation, they have not received complete after care.

The consequences are not only clinical. Referral to cardiac rehabilitation is already part of the national Acute Coronary Syndromes Clinical Care Standard's recommended discharge plan, yet the practice persists at scale, as the next section sets out in detail. [5]

2. The Scale of the Gap

Who is eligible

Australian Institute of Health and Welfare data puts total hospitalisations with a cardiac principal diagnosis, the broadest and most defensible eligible population for cardiac rehabilitation, at approximately 634,000 a year nationally. Within that, coronary heart disease and heart failure are the two largest single categories, at roughly 160,000 and 80,000 a year respectively. [5,6] Cardiovascular disease overall is the leading cause of death for both men and women in Australia. [5,20]

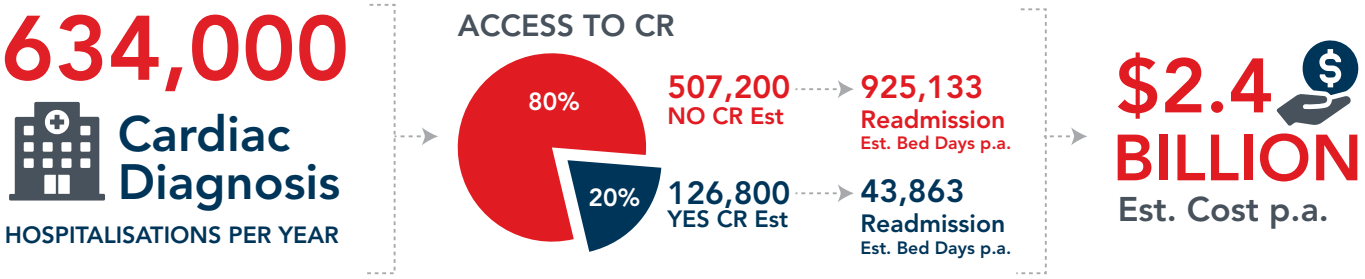
634,000

cardiac-diagnosis hospitalisations *each year*

Where the system loses people

Australia has no national cardiac rehabilitation registry, and every state records referral, uptake and completion differently, a limitation the researchers behind Victoria's own registry explicitly note. [2,16] That absence of consistent national data is itself part of the problem: it is difficult to fix what is measured four different ways in four different states. The table below sets out what the best available state level data shows.

Figure 1: 80% of eligible patients do not access Cardiac Rehabilitation costing the healthcare system $2.4B p.a.



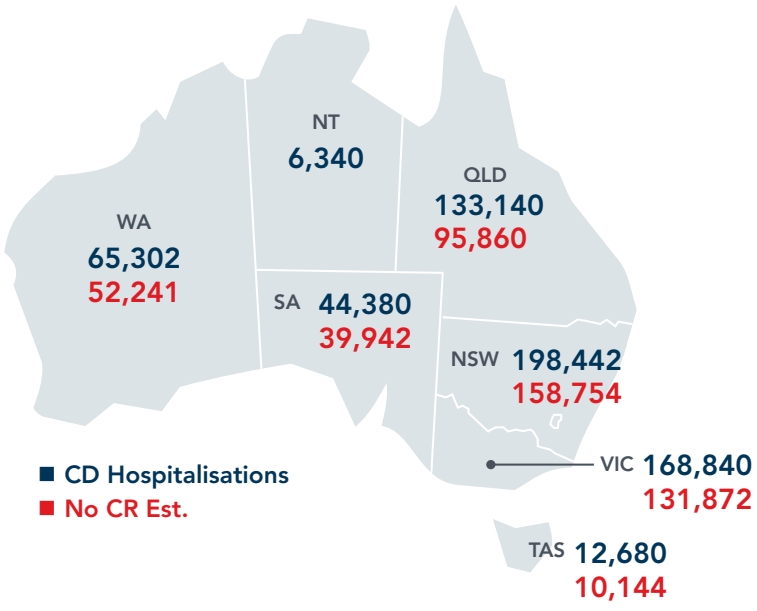
SOURCE: AIHW : Heart, stroke and vascular disease: Australian facts, Summary - Australian Institute of Health and Welfare

Effects of a digitally enabled cardiac rehabilitation intervention on risk factors, recurrent hospitalization and mortality | European Heart Journal - Digital Health | Oxford Academic

Cardihab's own analysis of this same AIHW hospitalisation data, using cardiac diagnosis hospitalisations as the denominator across every state, arrives at a consistent picture from a different angle entirely. [5,6] Nationally, an estimated 20% of the roughly 634,000 Australians hospitalised with a cardiac principal diagnosis each year access cardiac rehabilitation, meaning around 80% do not, the same order of magnitude as the state level linkage studies above despite using an entirely different data source and method. In Queensland specifically, where the Queensland Cardiac Outcomes Registry (QCOR) provides a more granular estimate, that figure is closer to 28% of the eligible population (an estimated 37,280 of 133,140 [5,6,7] annual cardiac hospitalisations), calculated against the AIHW hospitalisation denominator rather than a narrower, registry-defined one, still consistent with the broader national pattern of most eligible patients missing out.

Two things stand out. First, different jurisdictions fail at different points in the same funnel: South Australia's binding constraint is referral, Victoria's is what happens after a patient is referred. A single national fix, such as referral automation on its own, will not close the gap the same way everywhere.

Estimated Cardiac Rehabilitation Access Gap by State



This paper's argument does not rest on one company's reading of the data. In February 2026, four leading Australian cardiac rehabilitation researchers, writing in the Medical Journal of Australia's InSight+, reached the same conclusion in the clinical profession's own words: "Programs remain underutilised, underfunded, and access is unevenly distributed. Less than half of eligible patients are ever referred, and only a fraction attend. Each year, more than 375,000 Australians miss out on this vital stage of recovery." [21]

Less than half of eligible patients are ever referred, and only a fraction attend

The 375,000 figure comes from the InSight+ commentary rather than the formal position statement itself [21], but the two are closely linked. The same author group forms part of the 26 author panel behind the Australian Cardiovascular Health and Rehabilitation Association's June 2026 update to its Core Components of Cardiovascular Rehabilitation position statement, which reframes cardiac rehabilitation as part of lifelong cardiovascular health rather than a single, time limited program. Both independently corroborate, from inside the clinical establishment rather than from industry, the scale of the gap this paper documents from primary data. [21,22]

The strongest validation of all arrived days before this paper was finalised. In July 2026, the World Heart Federation published its global Roadmap on Cardiac Rehabilitation in Nature Reviews Cardiology, with a companion implementation paper in Global Heart, co-chaired by Professor Julie Redfern (Australia) and Professor Sidney C. Smith Jr (USA) and endorsed by the International Council of Cardiovascular Prevention and Rehabilitation. [23,24] The Roadmap puts global referral at around 30% of eligible patients, attendance at around 9%, and completion at under 5%. [23] The evidence base behind those figures is substantially Australian, a reminder that the data this paper draws on is not a parochial concern, but the same evidence the world's peak cardiology federation uses to define the scale of the problem globally. Professor Redfern also co-authored ACRA's June 2026 Core Components statement cited above: the global and Australian frameworks share leadership and were published within weeks of each other, reaching the same conclusion. [22,23]

This level of underuse would not be tolerated in most other areas of proven post-acute care. It is not a clinical value question. Cardiac rehabilitation works. It is a guideline implementation failure, at scale, and it is costing lives.

3. Why the System Fails

The gap is not the product of a single cause. Across clinical registries, systematic reviews and qualitative research, the same barriers recur.

- **Referral discretion.** Referral is too often a judgement call made by an individual clinician at the point of discharge rather than a default step, and research describes a pattern of "cherry picking": referring the patients seen as most likely to attend, which systematically disadvantages older patients, women and those with more complex presentations. [10,12,25]
- **Timing.** The national median wait between hospital discharge and program commencement is around 40 days, 12 days beyond the 28-day clinical recommendation in Australian cardiac rehabilitation guidelines. In South Australia, a wait beyond 28 days was independently associated with 15% higher odds of non-completion.
- **Program design.** Most programs remain centre based, group format and built around a single, inflexible weekly time slot, a model that does not accommodate shift work, caregiving responsibilities or rural and remote distances well, resulting in poor attendance rates.

40 DAYS
median discharge-to-program wait

VS

28 DAYS
RECOMMENDED

- **Psychosocial barriers.** A diagnosis of depression at initial assessment was independently associated with 17% higher odds of non-completion in the South Australian cohort, evidence that mental health support needs to be built into standard programs rather than offered as an optional extra.
- **Capacity and accountability.** Traditional programs sit at or beyond waitlist capacity in many areas, and responsibility for closing the loop, from hospital to primary care to insurer to rehabilitation provider, is fragmented enough that it frequently falls to no one.
- **Funding.** Prioritisation of funding towards treatment rather than prevention results in significantly under resourced services, that cannot scale to support the demand. [26]

"...mental health support needs to be built into standard programs..."

Within this system wide pattern, some groups are hit harder than others. None is more consistently or clearly documented than women, which is the subject of the next section.

4. The Clearest failure Point: Women

If the preceding sections describe a system that fails most people, this section describes the group it fails most consistently and is amplified across other parameters such as geography, complex medical history and CALD. The evidence here is unusually deep, drawn from Australian data linkage studies, an American Heart Association scientific statement dedicated to the topic, and international systematic reviews, and it converges on the same conclusion from multiple independent directions.

Referral and completion

In the South Australian data, being female was independently associated with a 75% higher likelihood of never being referred at all (odds ratio 1.75, 95% confidence interval 1.69 to 1.81), even after adjustment for age, comorbidities and the type of cardiac event. Women who did commence a program were also 12% more likely than men to not complete it (odds ratio 1.12, 95% confidence interval 1.01 to 1.24). [1]

75% HIGHER
likelihood of women never being referred

12% HIGHER
likelihood of non-completion among women who commenced

This mirrors the international evidence. The American Heart Association's 2025 scientific statement on cardiac rehabilitation in women, published in Circulation, confirms that women face persistently lower referral rates internationally, compounded by societal roles, medical comorbidities and financial constraints. [10,27] A widely cited meta-analysis found women are referred at markedly lower rates than men (39% versus 49%), and that once referred, women enrol less often (38.5% versus 45.0%) and adhere to fewer prescribed sessions (64.2% versus 68.6%) than men, per a first global assessment of cardiac rehabilitation barriers by the International Council of Cardiovascular Prevention and Rehabilitation. [11] For women from minority backgrounds, the gap compounds further: the American Heart Association statement cites referral rates of 48% for white women against 34% for Black women and 15% for Hispanic women in the settings studied. [10]

Even the evidence base underrepresents women

The problem extends to the research cardiac rehabilitation is built on. An analysis of 51 randomised cardiac surgery trials found women made up just 20.8% of participants. [28] A review of 740 cardiovascular trials from 2010 to 2017 found 38.2% female participation overall, and specifically 27.3% in coronary artery disease trials and 26.9% in acute coronary syndrome trials [29], the conditions most relevant to cardiac rehabilitation. The most recent available analysis, of 1,079 trials from 2017 to 2023, found participation had risen to 41% of participants overall, but coronary heart disease and acute coronary syndrome trials remained the most underrepresented categories. [30]

20%
OF PARTICIPANTS
in **51** randomised cardiac surgery trials
were *women*

The bias now extends into the digital tools increasingly used in cardiac care. Machine learning models for cardiac disease prediction, trained on datasets that underrepresent women, have been shown to systematically miss disease in female patients while overpredicting it in males, and standard fixes did not correct the disparity [31]. Large language models show the same pattern: GPT-4 and GPT-4o overrepresented men in simulated cases across 14 of 15 cardiovascular conditions, and diagnosed women less accurately for conditions including coronary artery disease and atrial fibrillation [32]. Without deliberate design, validation and monitoring, AI risks amplifying existing sex-based inequities in cardiovascular care rather than closing them [33].

This pattern shows up close to home. Medibank's own Heart Health at Home program, independently evaluated by the Baker Heart and Diabetes Institute and the strongest Australian evidence base for virtual cardiac rehabilitation available, enrolled a cohort that was 70% male and 30% female. [3,18] The study authors flagged this themselves as reflecting broader gender disparities in diagnosis, treatment and cardiac rehabilitation attendance, and called for future research to ensure greater representation of women in digital health studies specifically.

5. Why it matters: The Human, Clinical and Economic Cost

Before the clinical statistics, it is worth being plain about the human cost of missing out. Around one in five patients meet diagnostic criteria for depression while still in hospital for a cardiac event, and anxiety runs even higher, as high as 43% around the time of the event itself, easing to around 27% to 28% in early and late recovery. [34] Depression in the months after a cardiac event is not just a wellbeing concern: it is an independent predictor of not returning to work [35], and patients who remain anxious or depressed after their event face a higher risk of a subsequent one. Around ~75% of people experience the "cardiac blues", temporary sadness, worry, or tearfulness, after a cardiovascular disease (CVD) event like a heart attack. While these feelings are a normal part of emotional recovery and usually fade within months, about 20% of people go on to develop clinical depression. [34] Cardiac rehabilitation is one of the few interventions shown to address this directly, alongside the physical recovery, because psychosocial support and structured re-engagement with normal life are built into a properly delivered program, not left for the patient to manage alone.

~75% of people experience sadness after a cardiovascular disease event and 20% of people develop clinical depression.

The South Australian study's central finding is that completing cardiac rehabilitation is associated with a 38% relative reduction in the risk of death or cardiovascular readmission in the twelve months after discharge (hazard ratio 0.62, 95% confidence interval 0.58 to 0.66), sustained at a 33% reduction out to three years. [1] Even commencing without completing conferred meaningful benefit (hazard ratio 0.81) [1], though significantly less than full completion, evidence that partial engagement is not a substitute for the full program. Completion was also associated with a 65% relative reduction in cardiovascular specific mortality (subhazard ratio 0.35, 95% confidence interval 0.29 to 0.43). [1]

Victoria's newly published, 37,191 patient linked dataset tells a consistent story from a different angle, with an unusually clean dose-response finding. Twelve-month mortality was 2.9% among patients who attended no cardiac rehabilitation sessions, 1.5% among low-dose attendees (one to five sessions), and 0.6% among high-dose attendees (six or more sessions), a graded, statistically significant relationship (p less than 0.001). [2] In plain terms: even a handful of sessions roughly halves mortality risk against attending none at all, and a full course cuts it further still.

A 2023 systematic review and meta-analysis of 18 studies and 3,818 patients with coronary artery disease found mobile health enabled disease management programs reduced all-cause hospital readmissions by 32% (risk ratio 0.68), cardiac related readmissions by 45% (risk ratio 0.55) and emergency department visits by 63% (risk ratio 0.37) compared with standard programs without a digital component, adding a much larger, pooled evidence base behind virtual, technology enabled models of care.

Medibank's Heart Health at Home program adds a rigorously evaluated, Australian, insurer-scale health economic case. A Markov model built from 337 patients (88 receiving the digital program, 249 in usual care) found the digitally enabled program improved survival , adding +1.434 Quality Adjusted Life Years (QALY) vs usual care, for an incremental cost effectiveness ratio of $14,302 per quality adjusted life year gained, comfortably under the $50,000 threshold commonly applied in Australian health economic evaluation, and found cost effective in 87% of 10,000 modelled simulations. [17]

↓ 32%
all-cause hospital readmissions

↓ 45%
cardiac-related readmissions

↓ 63%
emergency dept. visits

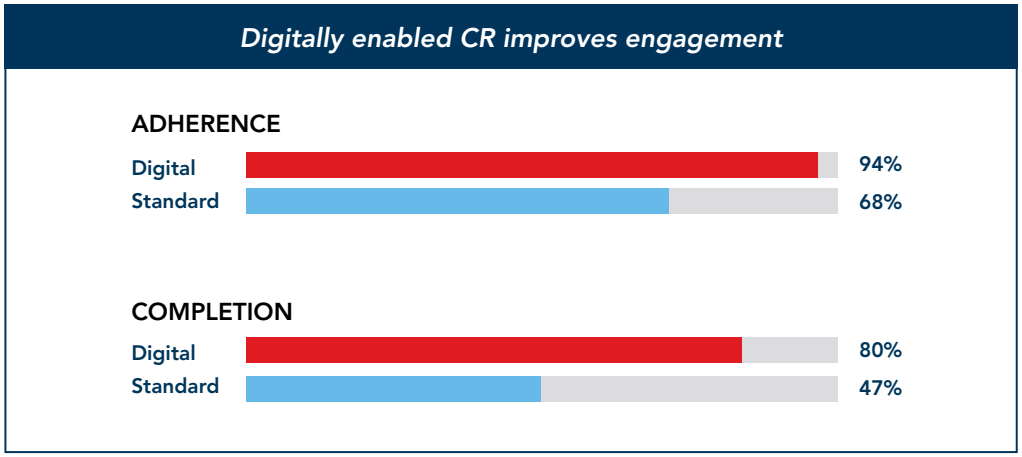
6. The Solution Already Exists

The barriers set out in this paper are well understood, and what has changed is that they are now solvable. Digitally enabled cardiac rehabilitation removes geographic constraints, increases capacity without requiring new clinic infrastructure, enables continuous and personalised monitoring, and, on the evidence, materially improves engagement and adherence. When routinely offered to patients as an option, participation rates increase. This is particularly relevant to people that have said no to conventional rehabilitation.

The founding evidence

The world-first randomised controlled trial behind Cardihab's SmartCR platform, led by Varnfield and colleagues and published in Heart in 2014, compared a smartphone-supported home based model against standard centre based cardiac rehabilitation. The smartphone-supported group achieved 94% adherence against 68% in the standard care group, a 38% relative improvement, and an 80% completion rate against 47% in standard care, a 70% relative improvement. [36] A subsequent Queensland study found offering the same digital option to patients

who had declined conventional cardiac rehabilitation lifted participation from 21% to 63%, and separately reported a five-fold increase in the odds of completion compared with other delivery modes. [37]



Proof at national scale: Digital therapeutic inside Medibank's Heart Health at Home

Cardihab's, TGA registered Class IIa digital therapeutic used for virtual CR including remote monitoring, medication adherence, symptom tracking and education, was deployed at national scale within Medibank's Heart Health at Home program: a 6 to 8 week model of virtual cardiac rehabilitation clinically delivered by Medibank's health services subsidiary, Amplar Health, combining weekly nurse telehealth consultations using the Cardihab platform. Medibank funded the evaluation. It did not conduct it: the clinical outcomes, cost effectiveness and patient and nurse experience of the program were independently evaluated by researchers at the Baker Heart and Diabetes Institute and published in three peer reviewed papers, [3,17,18] under standard academic peer review.

Of 524 patients assessed for eligibility, 294 were able to be screened, and 172 (59%) consented to participate. Of those, 156 (91%) completed the 6 to 8 week program with full follow-up data, a completion rate the study authors note is substantially better than the 20% to 40% dropout historically reported for face to face cardiac rehabilitation, in Australia and internationally. Compared with a propensity matched usual care group, the virtual cardiac rehabilitation group spent significantly fewer days in hospital: all-cause hospital bed-days were reduced by 71% at 30 days, 71% at 90 days and 51% at 12 months, and cardiac related bed-days by 88% at 30 days and 74% at 90 days. [3] Across every measure examined, outcomes were equivalent to a matched group of patients who received what is known as the gold-standard, traditional face-to-face cardiac rehabilitation.

91%
COMPLETED
156 of 172
PARTICIPANTS
completed the 6–8 wk program

71%
FEWER
HOSPITAL BED DAYS
at *30 & 90 days*

Built to scale with better reach and completion

Because delivery is digital, capacity is not bound by clinic floor space, geography or local clinician availability. The same evidence-based protocol can be delivered to a patient in metropolitan, regional or a remote community with the same fidelity, the same monitoring and the same clinician oversight. New cohorts can be onboarded without building new infrastructure.

Clinical and regulatory alignment

The clinical and regulatory settings have moved with the evidence. The Cardiac Society of Australia and New Zealand and the Australian Cardiovascular Health and Rehabilitation Association published a joint position statement on the quality use of telehealth in cardiovascular care in 2025, endorsed by CSANZ in August that year [38], confirming that telehealth-delivered secondary prevention can be safe and effective when built to standards, can improve access, and should be embedded as a permanent, complementary part of cardiovascular care rather than treated as a temporary pandemic-era substitute for in-person care.

The Australian Cardiovascular Health and Rehabilitation Association followed in June 2026 with an updated, 26 author consensus statement on the core components of cardiovascular rehabilitation [22], reframing the discipline around lifelong cardiovascular health rather than a single, time limited program, a shift that supports exactly the kind of default, ongoing, digitally enabled model of care this paper argues for. [22]

Most recently the European Society of Cardiology published its first-ever standalone Guidelines on Cardiac Rehabilitation (European Heart Journal, 28 August 2026). [39] Three things stand out:



Eligibility has expanded.

Beyond post-MI and heart failure, CR is now recommended for congenital heart disease, AF, post-valve intervention, and cancer patients on cardiotoxic therapies.



Digital CR now has a formal seat at the table.

Cardiac telerehabilitation and hybrid models earned Class IIa recommendations across multiple populations, backed by a network meta-analysis of 139 RCTs and 18,000+ heart failure patients. Telehealth consultation plus telemonitoring even reached Class I in heart failure, linked to reduced mortality and hospitalization. [39]



Access is still the real problem.

~40% of CR programmes in Europe lack reimbursement, and only 30–40% of eligible patients participate. [39] The guidelines frame digital delivery as core infrastructure for closing that gap - not a nice-to-have.

ONLY 30–40% of eligible patients participate

Funding policy

Funding policy is moving in the same direction but at a substantially slower pace than regulation.

Software based medical devices in Australia, defined as Software as a Medical Device (SaMD) were subject to a Therapeutic Goods Administration (TGA) reclassification, with a transition deadline of 1 November 2024 [40], under which many digital health solutions moved from Class I to a higher risk classification reflecting closer regulatory scrutiny. [40] Cardihab's platform has been included on the Australian Register of Therapeutic Goods (ARTG) since December 2020 initially as a Class I SaMD, and has since achieved Class IIa classification, ISO 27001 and ISO 13485:2016 [19] certifications. As of this paper's preparation, Cardihab is the only ARTG-registered digital therapeutic for cardiac rehabilitation in Australia. [19]

The Medical Technology Association of Australia's October 2025 analysis of digital therapeutics and remote patient monitoring illustrates the gap. It found that funding for these technologies in Australia is fragmented, inconsistent and not designed to support remote care or guided self-management. In some instances services are funded, but not the underlying software. In other cases it is the revers. In some instances – neither software or service is funded. Current funding is described in the report as workarounds rather than fit-for-purpose pathways, with access otherwise depending on isolated procurement decisions by the Commonwealth, states or individual health services, government grants or philanthropic gestures. [26]

Current funding is described as workarounds rather than fit-for-purpose pathways.

There are early signs of movement. In July 2026, the Department of Health, Disability and Ageing released the first consultation paper in its Private Health Sector Reform process, proposing that contemporary models of care be prioritised and encouraging insurers to reflect the proposed reforms in products developed for the 2027 Premium Round [41]. Technology-enabled models that support people to receive care in their own homes, such as virtual cardiac rehabilitation, are precisely the kind of contemporary care this direction is intended to support, but reform of private health settings alone will not resolve the structural funding gaps identified above.

7. What Closes the Gap: Referral Alone Isn't Enough

Across every health system studied, one intervention consistently ranks above all others for closing the referral gap specifically: making cardiac rehabilitation referral the automatic, default outcome of an eligible diagnosis or procedure, rather than a discretionary decision left to an individual clinician at the point of discharge. This removes unconscious or conscious biases that lead to the tendency to refer patients perceived as more likely to attend, which systematically disadvantages older patients, women and those with more comorbidities. [12,13,25]

This is not theoretical. A United States tertiary hospital system that replaced an opt-in referral pathway with a default opt-out pathway built into the electronic medical record lifted referral from 31.6% at usual-care sites to 85.7% at the intervention site, a 47-percentage point increase. [12] The American Heart Association's Get With The Guidelines quality program, embedding automatic referral prompts, lifted participating hospitals to a 56% referral rate, above the national average. [13] A standardised discharge education protocol at a University of Pennsylvania hospital lifted referral from 4.2% to 24.8%. [14] In a lower resource Southeast Asian setting, automatic referral following coronary artery bypass grafting more than doubled enrolment. [15]

Why referral automation is necessary but not sufficient on its own

Victoria's own data is the clearest caution available against treating referral automation as a complete fix on its own. Among Victorian PCI patients, referral climbed to 85% by the end of one multi-site study period [16], about as close to universal as referral gets in any Australian dataset in this paper, yet in a later cohort from the same registry, attendance still remained near 1 in 5 PCI patients. [2] Even near-universal referral did not, by itself, get people through the door. South Australia's own rural CATCH and CHAP programs tell the same story from the inside: a 2026 evaluation across 15 rural and remote cardiac rehabilitation

Even near-universal referral did not, by itself, get people through the door.

services found that a centralised, flexible referral pathway left attendance essentially unchanged (24.2% versus 23.8% under usual care), even though completion among those who did attend rose sharply, from 57.5% to 77.1%. [42] A safety-net hospital initiative in the United States that embedded an automatic referral order in the electronic record found a persistent gender gap afterwards regardless: men averaged 45.5% referral against 26.0% for women, with some months recording zero female referrals. [25] Three separate health systems, three different mechanisms, the same finding: automatic referral raises the floor for everyone. It does not by itself guarantee equity, and it does not by itself convert into attendance.

Referral raises the floor, but it does not always convert into attendance. Closing the gap requires both an automatic referral pathway and a low-friction model of care that people can actually complete once they are referred.

8. Recommendations, By Stakeholder

How you can help

Health systems & hospitals

- Make referral automatic and opt-out by default
- Track referral, uptake and completion separately, by sex
- Treat uptake as its own problem: liaison and fast scheduling drive attendance

Insurers & health funds

- Make virtual cardiac rehab first-line, not a fallback
- Automate eligibility ID, don't rely on referral alone
- Track and act on gender-disaggregated outcomes as standard practice

Super funds & member organisations

- High-return member investment: +1.4 QALYs vs usual care, well under the $50k/QALY threshold
- Target activation for members least likely to attend: women and rural members

Government & policymakers

- Fund digital CR access now for patients who have none - in particular for regional rural and remote patients
- Fix the two structural funding gaps that prohibit access:
  - MBS item descriptors and
  - the absence of an assessment pathway for digital therapeutics that prevent digital models being funded as standard care.

9. Towards a Coordinated Response

This white paper sets out the evidence base for one of the most addressable failures in Australian healthcare, in one of its highest-cost disease areas: cardiovascular disease is the second largest category of disease expenditure in the country, at $16.9 billion a year, three-quarters of which is spent on hospital care alone. [43] It is also the clearest illustration of who the system fails hardest. Closing this gap will take more than one document, and more than one organisation.

This is an open invitation, not a single-organisation initiative. Every insurer, super fund, hospital network, state health system and government body named in Section 8 is sitting on the same evidence base, with the same opportunity, and arguably the same obligation, to act on it. Cardihab is already working with partners to translate this evidence into concrete, costed and measurable interventions, and welcomes the chance to do the same with any organisation ready to close this gap for its own population, with women as a priority focus given the depth and consistency of the evidence in Section 4.

This also places Australia's response inside a global framework, not ahead of one. The World Heart Federation's July 2026 Roadmap sets five global priorities for closing this same gap: prioritising lifelong cardiovascular health, strengthening patient and clinician engagement, expanding flexible models of care, building workforce capacity, and advancing advocacy and supportive policy. [23] The recommendations in Section 8, and the model of care set out in Sections 6 and 7, map directly onto each of these, evidence that closing Australia's cardiac rehabilitation gap is an implementation of where the global evidence has already landed, not a local initiative running ahead of it.

Conclusion

Cardiac rehabilitation is one of the few interventions in modern cardiovascular medicine where the evidence, the mechanism and the return on investment are all closely aligned. The technology and evidence needed to close the access gap already exist inside Australia's own health system, independently evaluated, cost effective and regulator approved. The barrier is no longer clinical, and it is no longer technological.

Roughly 8 in 10 eligible Australians still miss out on a proven, life-saving intervention, and women miss out even more consistently than the average. It is time to stop treating cardiac rehabilitation as optional, and to stop treating the model that already closes the gap as a pilot rather than the default.

ROUGHLY

8 *in* 10

eligible Australians

STILL MISS OUT

Cardiac rehabilitation is a clinical obligation. The failure to deliver it, to most patients, and to women most consistently of all, is a system failure. The evidence for what fixes it already exists.

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