Advancing Cardio-renal-metabolic health in Australia: Connected risks, coordinated solutions

ACCESS HEALTH INTERNATIONAL

About the report

This report presents key insights into cardio-renal-metabolic (CRM) health, with a focus on identifying gaps, measuring progress, and informing policy and practice. Drawing on the latest data, and evidence, it highlights trends in population health, the burden of disease, and the effectiveness of health systems in delivering equitable, high-quality care.

Our goal is to support decision-makers, clinicians, researchers, and advocates in understanding where we are—and where we must go— to improve outcomes for people living with cardio-renal-metabolic (CRM) diseases and to slow disease progression at the national level.

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Nomenclature and abbreviations

AUD	Australian dollars
BP	Blood pressure
CKD	Chronic kidney disease
CRM	Cardio-renal-metabolic
CVD	Cardiovascular disease
DALY	Disability-adjusted life years
eGFR	Estimated glomerular filtration rate
GP	General practitioner
HCC	Hepatocellular carcinoma
HF	Heart failure
KEEP	Kidney Early Evaluation Program
KEY	Kidney Evaluation for You
MASH	Metabolic dysfunction-associated steatohepatitis
MAFLD	Metabolic dysfunction-associated steatotic liver disease
MBS	Medical Benefits Schedule
NCD	Non-communicable disease
PBS	Pharmaceutical Benefits Scheme
SDG	Sustainable Development Goal
T2D	Type 2 diabetes
uACR	Urine albumin-to-creatinine ratio
WHO	World Health Organization

Executive summary

Australia faces a critical and escalating challenge from cardio-renal-metabolic (CRM) disease—a cluster of interconnected diseases including cardiovascular disease (CVD), chronic kidney disease (CKD), type 2 diabetes (T2D), hypertension, obesity, dyslipidemia, metabolic dysfunction-associated steatotic liver disease (MAFLD) and metabolic dysfunction-associated steatohepatitis (MASH). These conditions share common pathophysiological roots such as metabolic dysfunction and systemic inflammation and are driven by complex interactions between genetic, behavioral, and environmental factors.

Despite decades of progress in individual disease management, additional efforts are required for Australia to meet national and global targets for reducing the impact of chronic diseases, including those set out in the Sustainable Development Goals (SDG 3.4), see Table 1. The prevalence of multimorbidity—Australians living with two or more chronic conditions—has risen sharply, now affecting 38% of the population.[1] This clustering of CRM conditions results in disproportionately higher healthcare costs, increased complexity of care, and significant loss of productivity. Current policy approaches[2,3,4,5,6,7] remain largely siloed, with separate strategies for CVD, CKD, T2D, and obesity, and limited recognition of their interconnected nature. Implementation gaps, insufficient resource allocation, and lack of costed, accountable action plans further hinder progress. Vulnerable populations, including Aboriginal and Torres Strait Islander peoples, experience a cardio-renal-metabolic (CRM) burden up to three times higher than non-Indigenous Australians, amplifying health inequities.

Australia's annual spending on chronic conditions, including cardio-renal-metabolic (CRM) disease, reached $82 billion AUD from 2022-23 – nearly half of all disease-related expenditure.[8] Indirect costs, such as lost productivity and welfare payments, payments, are projected to rise steeply in coming years.

To reverse these trends and accelerate progress, Australia must adopt a more integrated, patient-centered approach to cardio-renal-metabolic (CRM) policy and care. This report outlines seven enablers for change—drawn from global best practice and tailored to the Australian context—including investment in interoperable data systems, payment model reform, multidisciplinary care, patient empowerment, research funding, cross-government collaboration, and robust accountability mechanisms. By prioritizing these actions, Australia can deliver better outcomes for patients, reduce health system pressures, and achieve its national and global health commitments.

Introduction

Non-communicable diseases (NCDs) are the dominant cause of death and disability across the Asia-Pacific region, and Australia is no exception. In 2021 alone, more than 43 million people globally died from NCDs, accounting for 75% of non-pandemic-related deaths.[9] Seven of the top 10 leading causes of death were linked to NCDs, and a staggering 86% of premature NCD deaths occurred in low- and middle-income countries.[10] Across the Asia-Pacific, NCDs now account for more than the global average of 74% of all deaths in 15 countries.[11]

Within this broader NCD crisis lies a particularly urgent and complex cluster: cardio-renal-metabolic (CRM) diseases. Cardio-renal-metabolic (CRM) diseases encompass cardiovascular disease (CVD), chronic kidney disease (CKD), type 2 diabetes (T2D), hypertension, obesity, dyslipidemia, and metabolic liver disease. These conditions share common biological, behavioral, and social risk factors, and often occur together converging into a cardio-renal-metabolic (CRM) multi-morbidity syndemic that is outpacing the capacity of most health systems to manage it effectively.[12]

Australia's cardio-renal-metabolic (CRM) disease burden reflects these global trends. The proportion of Australians living with multiple chronic conditions increased by 33% between 2007–08 and 2022, outpacing the growth in single-condition prevalence. In 2022, nearly four in ten Australians had two or more chronic diseases, with the highest rates seen in older adults, those in lower socio-economic groups, and Aboriginal and Torres Strait Islander communities.

The 2015 United Nations Sustainable Development Goal (SDG) 3.4 commits countries to reducing premature NCD mortality by one-third by 2030.[13] However, Australia's response remains fragmented. Disease-specific policies rarely address the interconnectedness of cardio-renal-metabolic (CRM) conditions, and key areas such as metabolic dysfunction-associated fatty liver disease (MAFLD) and obesity are insufficiently integrated into national frameworks. Implementation is further hampered by the absence of detailed, costed action plans, clear accountability, and adequate resource allocation—resulting in aspirational targets that are seldom achieved. The National Framework for Chronic Conditions contains disease-specific policies but does not highlight the interconnected

nature of these chronic conditions.[14] Obesity, despite being a major contributor to the national disease burden, is not managed in conjunction with other cardio-renal-metabolic (CRM) diseases. Similarly, metabolic dysfunction-associated steatohepatitis (MASH) is also not included in the national framework, contributing to missed opportunities in the management of common factors for interconnected cardio-renal-metabolic (CRM) diseases.

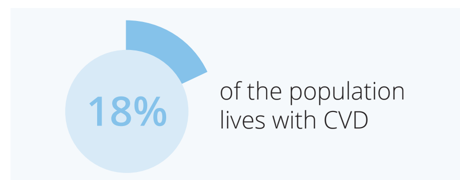
Equity gaps persist, with Aboriginal and Torres Strait Islander peoples, rural communities, and those with lower socio-economic status bearing a disproportionate burden of cardio-renal-metabolic (CRM) disease. This is in part due to the lack of implementation plans within policies such as the National Diabetes Strategy 2021-2030 which lacks operational detail for adequate implementation.[15] This thus limits outreach to Aboriginal and Torres Strait Islander peoples, rural communities, and those with lower socio-economic status which are key populations in the management of cardio-renal-metabolic (CRM) diseases. Culturally tailored interventions are urgently needed to address these disparities.

In May 2025, the 78th World Health Assembly recognized this with a landmark resolution promoting kidney health and the integration of CKD into national NCD strategies that considers a life-course approach.[16] This presents Australia with an opportunity to realign its approach – to move from fragmented responses towards a coordinated, person-centered system that addresses the full continuum of cardio-renal-metabolic (CRM) care, from prevention to treatment and long-term management.

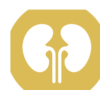
The state of cardio-renal-metabolic (CRM) diseases in Australia

Cardio-renal-metabolic disease (CRM) is a spectrum of interconnected chronic diseases encompassing cardiovascular disease (CVD), chronic kidney disease (CKD), type 2 diabetes (T2D), hypertension, obesity, dyslipidemia, and more recently, metabolic dysfunction-associated steatotic liver disease (MAFLD) and metabolic dysfunction-associated steatohepatitis (MASH). These conditions are driven by overlapping risk factors such as metabolic syndrome, insulin resistance, obesity, sedentary lifestyles, and unhealthy diets. Cardio-renal-metabolic (CRM) diseases pose a significant and growing threat to the Australian population, particularly among high-risk populations and vulnerable communities. The clustering of CVD, CKD and T2D results in increased morbidity, mortality and healthcare expenditure, with substantial disparities in health outcomes depending on socio-economic status and geographic location.

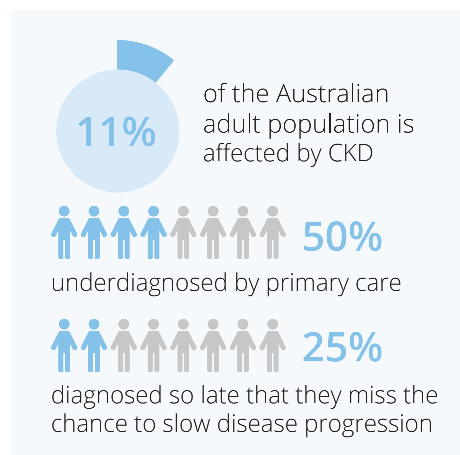
Cardiovascular Disease (CVD)



CVD, specifically coronary heart disease (CHD), is the leading cause of death in Australia. Approximately 18% of the population lives with CVD, and on average, one person dies from CVD every 12 minutes.[17]



Chronic Kidney Disease (CKD)



CKD is an urgent and costly public health challenge facing Australia today. It affects approximately 11% of the Australian adult population, with its prevalence increasing rapidly with age.[18,19] Despite its scale, under-diagnosis of CKD remains widespread - approximately 50% of Australians are undiagnosed by primary care physicians, and 25% diagnosed so late that they miss the opportunity to slow disease progression and prevent complications.[20]

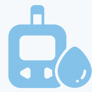
The burden of CKD is projected to escalate further, with its prevalence increasing to 42% by 2030.[21] This underscores the threat of CKD to Australia's health system, workforce and economy. If untreated, CKD substantially increases the risk of CVD, heart failure and premature mortality, further increasing the CRM burden.

The Aboriginal and First Nations communities face a particularly disproportionate burden of CKD - this disease is two times more common

in First Nations Australians.[22] Besides this, the incidence of treated end-stage renal disease (ESRD) was found to be around 3.2-10.3 times higher in indigenous Australians as compared to non-indigenous Australians, with the prevalence higher in remote areas.[23] These disparities are further compounded by their relatively limited access to early detection, screening, specialist care and culturally appropriate services in rural regions. Furthermore, difficulties with spoken and written English, lack of transportation options and financial limitations present barriers to timely and quality healthcare for these communities.[24]

Despite its scale, chronic kidney disease (CKD) remains relatively overlooked in national strategies. Early-stage interventions, such as estimated glomerular filtration rate (eGFR) testing, risk-based management, and blood pressure control, are inconsistently applied across both primary and specialist care. Closing these gaps through comprehensive, integrated cardio-renal-metabolic (CRM) care frameworks is crucial to preventing avoidable deaths from kidney disease. Greater focus is also needed on targeted detection in high-risk groups, including Indigenous and First Nations communities, where missed early intervention increases the risk of delayed diagnosis, poor outcomes, and rising long-term healthcare costs.[25]

Type 2 Diabetes (T2D)



3.6 million

people with diabetes are projected by 2050

2.5x from 2023

Diabetes[a] remains one of the ten leading causes of death in Australia, contributing to almost 22,000 deaths in 2022.[26] Where diabetes was identified as an underlying or associated cause of death, 60% were due to T2D.[27] The number of people living with diabetes[a] is projected to increase to 3.6 million by 2050, 2.5 times the current prevalence.[28]

Hypertension and Dyslipidemia

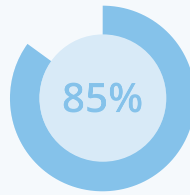
have hypertension

live with dyslipidaemia

1 in 4 adults have hypertension, and more than 2 in 5 adults live with dyslipidemia in Australia.[29] Hypertension and dyslipidemia are leading risk factors for CVD. In fact, 46% of CVD events can be attributed to hypertension.[30] However, Australia's hypertension control rate of 34% is significantly lower compared than that of Germany (58%), Canada (50%), and the USA (54%), indicating that more efforts are required to improve control.

[a] Refers to diabetes inclusive of type 1 diabetes, type 2 diabetes and gestational diabetes

Metabolic dysfunction-associated fatty liver disease (MAFLD) and metabolic dysfunction-associated steatohepatitis (MASH)



Expected rise of advanced liver desease and liver deaths related with MASH by 2030

MAFLD is the accumulation of fat in the liver as a result of metabolic dysfunction. Its progressive form, MASH, is marked by liver inflammation and cell damage that can lead to fibrosis, cirrhosis and liver cancer.[31] The prevalence of MASH is projected to increase from 5.3% in 2020 to 6.2% by 2030, with advanced liver disease expected to rise by up to 85% over the same period.[32] Additionally, MASH-related liver deaths are also estimated to increase by 85%, from 1,900 in 2019 to 3,200 by 2030.[33] These alarming trends underscore the need for greater attention, early detection, and intervention to curb the growing burden of liver disease.

People with MAFLD and MASH often tend to have other metabolic conditions that include CVD, hypertension, and T2D - increasing their risk of cardiovascular and renal complications.[34] Despite their growing clinical and public health impact, these conditions are still overlooked as key contributors to Australia's cardio-renal-metabolic (CRM) disease burden.[35] Metabolic dysfunction remains largely absent from current screening frameworks and chronic disease strategies, including routine screening for patients with obesity, T2D, and metabolic syndrome. To address this gap, national strategies must begin to integrate metabolic risk assessment into routine care to enable earlier detection and intervention.[36]

Increasing prevalence of multi-morbidity

Australia needs to strengthen efforts to achieve the targets set out in most national policies, including but not limited to those set for chronic kidney disease (CKD), type 2 diabetes (T2D), heart disease, stroke, and obesity (see Table 1). In fact, the prevalence of chronic disease has increased, which has led to increased multi-morbidity. Data from 2022 illustrates that the proportion of the population living with multi-morbidity has increased at a greater rate compared to the proportion of the population living with only one chronic condition – a 33% increase for multiple conditions from 2007-08 vs. an 18% increase for only a single condition.[37] In 2022, 38% of Australians had 2 or more chronic conditions.[38]

Multi-morbidity presents a growing challenge for Australia and its healthcare system and has various social and economic implications due to its impact on resource utilization, economic productivity, and quality of life. For example, patients living with multi- morbidity require more frequent medical appointments and more medication. Apart from the increased complexity of care required, such patients will inevitably have greater absenteeism from work due to ill health, affecting workplace productivity and economic output.[39]

How has Australia fared so far?

Australia has made considerable progress in tackling the growing burden of NCDs through various national strategies, action plans and frameworks, including an overarching preventive health strategy as well as disease-specific policies. However, national targets across most policies are largely not on track (refer to Table 1). This can be partly attributed to gaps in policy implementation due to the absence of implementation plans for policies that seek to improve the care continuum, and insufficient resource allocation to support population needs and priorities. Moreover, geographical and socio-economic disparities continue to subject certain populations to higher risks of chronic disease, exacerbating the threat of NCDs on the Australian population.

Table 1: Progress on policy targets

Progress	Policy/Strategy	Timeline	Target Progress
Target(s) attained	Australia's Primary Health Care 10 Year Plan[40]	2022 – 2032	Increased primary care service usage, including a 25% increase in telehealth usage from 2016-17 to 2020.[41]
Progressing towards target(s)	National Preventive Health Strategy[42]	2021 - 2030	Obesity among adults increased by 0.4% from 2017-2018 to 2022. Smoking prevalence among adults decreased by 3.2% from 2017-2018 to 2022.[43]
Target(s) not attained	National Strategic Framework for Chronic Conditions[44]	2017 – 2025	50% of Australians had one or more chronic conditions in 2022, an increase from 47% in 2017-18 and 42% in 2007-08.[45]
Target(s) not attained	National Strategic Action Plan for Kidney Disease[46]	2020 – 2030	Kidney disease prevalence increased by 0.2% from 2011-12 to 2022, and underdiagnosis is significant.[47]
Target(s) not attained	Australian National Diabetes Strategy[a][48]	2021 – 2030	Funding for diabetes[a]-related research decreased by 35% from 2015 to 2022, despite increasing prevalence – the number of Australians living with diabetes[a] has increased by approximately 220% since 2000.[49,50]
Target(s) not attained	National Strategic Action Plan for Heart Disease and Stroke[51]	2020 - not specified	Despite declining prevalence since the 1980s, CVD and stroke still cost the economy AUD 12.7 billion and AUD 6.2 billion annually.[52]
Target(s) not attained	National Hypertension Taskforce of Australia[53]	2020 – 2030	Hypertension control rate of 34% is significantly lower than the target of 70%.[54]
Target(s) not attained	Australia Dietary Guidelines[55]	2013 – not specified	96% of adults did not meet the recommended serves of fruit and vegetables in 2022.[56]

Target(s) attained

Progressing towards target(s)

Target(s) not attained

[a] Refers to diabetes inclusive of type 1 diabetes, type 2 diabetes and gestational diabetes

The cost of cardio-renal-metabolic (CRM) conditions to Australia

$14.3 billion AUD

spent on CVD from 2022-23[40]

$9.9 billion AUD

spent on CKD from 2020-21[46]

$3.4 billion AUD

spent on diabetes from 2020-21[40]

35%

extra welfare payouts increase due to ischemic heart disease[44]

58%

increase in lost income tax revenue[44]

Australia spent around $82 billion AUD on chronic conditions (including CRM conditions) in 2022-23, amounting to almost 50% of all disease spending in that year.[57]

From 2020 to 2021, CVD cost the Australian health system $14.3 billion AUD, amounting to almost 10% of the total allocated budget for the health system.[58] In 2024, Australians lost an estimated 685,000 years of healthy life (DALY) due to CVD.[59]

Chronic kidney disease (CKD) is estimated to cost Australia $9.9 billion AUD in 2021, or about $5,000 AUD per person with CKD. Costs rise sharply as the disease progresses – from around $50 AUD per person in the early stages to over $182,000 AUD per person once it reaches kidney failure.[60]

Diabetes[a] also places a major burden on the health system, costing about $3.4 billion AUD in 2020–21. This constitutes 2.3% of all disease-related health spending that year.[61]

The indirect costs of these conditions are also significant. Due to ischemic heart disease, extra welfare payouts by the government are projected to increase by 35% from $106 million AUD (US $102 million) in 2015 to $143 million AUD (US $138 million) in 2030. Lost income tax revenue could increase by 58% from $74 million AUD (US $71 million) to $117 million AUD (US $113 million) within the same period.[62] Similarly, the cost of CKD is also substantial. Estimates suggest that CKD cost the Australian economy $9.9 billion AUD in 2021, amounting to nearly $5,000 AUD per person living with CKD, with the cost increasing to over $182,000 AUD per person with kidney failure. Out of the $9.9 billion AUD, productivity costs including absenteeism, presenteeism, reduced employment and premature mortality was the costliest component, constituting just over 52% of the total cost.[63] Diabetes[a] has been estimated to cost the government $5.64 billion AUD per annum.[64]

Additionally, 63% of Australians lost their job after being diagnosed with liver cancer, and individuals with liver cancer are the least likely of all cancer patients to become re-employed within 2 years – only 13.5% are able to regain employment.[65] All of these data demonstrate the dire impact of chronic disease on Australia both financially and socially.

[a] Refers to diabetes inclusive of type 1 diabetes, type 2 diabetes and gestational diabetes

Gaps and Challenges

Australia faces a significant and growing burden of cardio-renal-metabolic (CRM) diseases, including cardiovascular disease, chronic kidney disease, type 2 diabetes (T2D), obesity, metabolic associated fatty liver disease (MAFLD) and metabolic-associated steatotic liver disease (MASH), which disproportionately affect vulnerable populations such as the Aboriginal and Torres Strait Islander communities.[66] To holistically improve cardio-renal-metabolic (CRM) care, Australia must unify existing strategies, address the various determinants of health, and focus on early detection and targeted interventions for high-risk groups.

Policy gaps in addressing cardio-renal-metabolic (CRM) diseases

Australia's National Framework for Chronic Conditions focuses primarily on prevention but lacks specific policy targets for cardio-renal-metabolic (CRM) conditions. While disease-specific policies exist, the linkages between related diseases are not emphasized. Obesity, despite being a major contributor to the national disease burden, has historically not been viewed as a medical condition deserving the same level of attention as other non-communicable diseases, limiting the scope of prevention and care initiatives.[67] Similarly, MASH is not included in existing policies and guidelines despite its growing relevance in Australia. This fragmented approach has led to missed opportunities for coordinated action against cardio-renal-metabolic (CRM) multimorbidity.

Ambiguous implementation plans

Although national strategies have been established to address chronic disease, a key barrier to progress is the lack of detailed implementation plans that translate policy into tangible actions and measurable outcomes. Most policy documents articulate broad goals and priorities but fall short on operational detail, clear targets, timelines, and accountability mechanisms.

For example, more than two years after the launch of the National Diabetes Strategy 2021–2030, no comprehensive implementation plan has been published, and the monitoring and evaluation framework remains iterative and vague.[68] Similar gaps exist for other cardio-renal-metabolic (CRM) related strategies, including those for chronic kidney disease (CKD) and cardiovascular disease (CVD). Without operational detail and measurable indicators, it is challenging to drive coordinated action across sectors or track progress toward national targets.

Despite the establishment of national strategies to address the chronic disease burden in Australia, the absence of implementation plans to translate these policies into tangible actions and outcomes hinders progress towards improving chronic disease outcomes. While national policy documents articulate the goals and priorities, they generally lack the operational detail and accountability mechanisms to effect proper implementation. Despite it being more than 2 years since the launch of the National Diabetes Strategy 2021– 2030, no implementation plan has been published, and the monitoring and evaluation framework is described to be iterative.[69] A comprehensive implementation plan which includes clear targets and timelines, as well as measurable indicators are essential to effectively address type 2 diabetes (T2D) nationally, as with other chronic diseases. Without clear implementation plans, policies run the risk of remaining aspirational rather than facilitate tangible improvements in the prevention, management and care of patients with chronic disease.

Poor public awareness of cardio-renal-metabolic (CRM) diseases

Despite the growing prevalence and threat to the population, awareness of how cardio-renal-metabolic (CRM) diseases are interconnected, and how the presence of one increases the risk of developing another remains limited.[70] Many Australians are unaware of the risk factors and early warning signs, leading to late diagnoses and costly treatments. To cope with the increasing burden of chronic disease, preventive strategies including public education campaigns, lifestyle interventions, and regular health screenings should be a priority.[71] This would also align with the wider vision that "all Australians live healthier lives through effective prevention and management of chronic conditions", as stated in the National Strategic Framework for Chronic Conditions.[72]

Care and funding fragmentation

With about 50% of Australians having at least one chronic condition, more require care beyond the scope of traditional specialist care, making care fragmentation a common problem.[73] Patients with both diabetes[a] and chronic kidney disease (CKD) often miss out on care that aligns with the recommended standards, including routine HbA1c checks and albuminuria screening. Many of them also struggle to meet targets for blood glucose and blood pressure control.[74] This issue is exacerbated by funding fragmentation due to the complex division of responsibilities among the Commonwealth, state governments, and the non-profit and private sectors, leading to siloed services.[75]

[a] Refers to diabetes inclusive of type 1 diabetes, type 2 diabetes and gestational diabetes

Insufficient resources to address increasing disease burden

Shortages in health workforce supply is a key issue in Australia. It was reported that more than four in five health professional occupations were in shortage in 2023.[76] In primary care, time constraint has been identified as the biggest barrier to the detection of chronic kidney disease. General practitioners (GPs), often constrained by factors such as limited consultation time and insufficient funding, may struggle to prioritize screening for CKD, which can lead to gaps in the application of clinical guidelines.[77]

Additionally, while the number of people living with diabetes has increased by 32% over the past decade, funding for diabetes[a] and related research has decreased by 35% over the same period.[78] Allocating adequate resources for research and care advancement can holistically improve early detection, care and treatment of diabetes, as with other chronic disease.

Tailored interventions for vulnerable populations

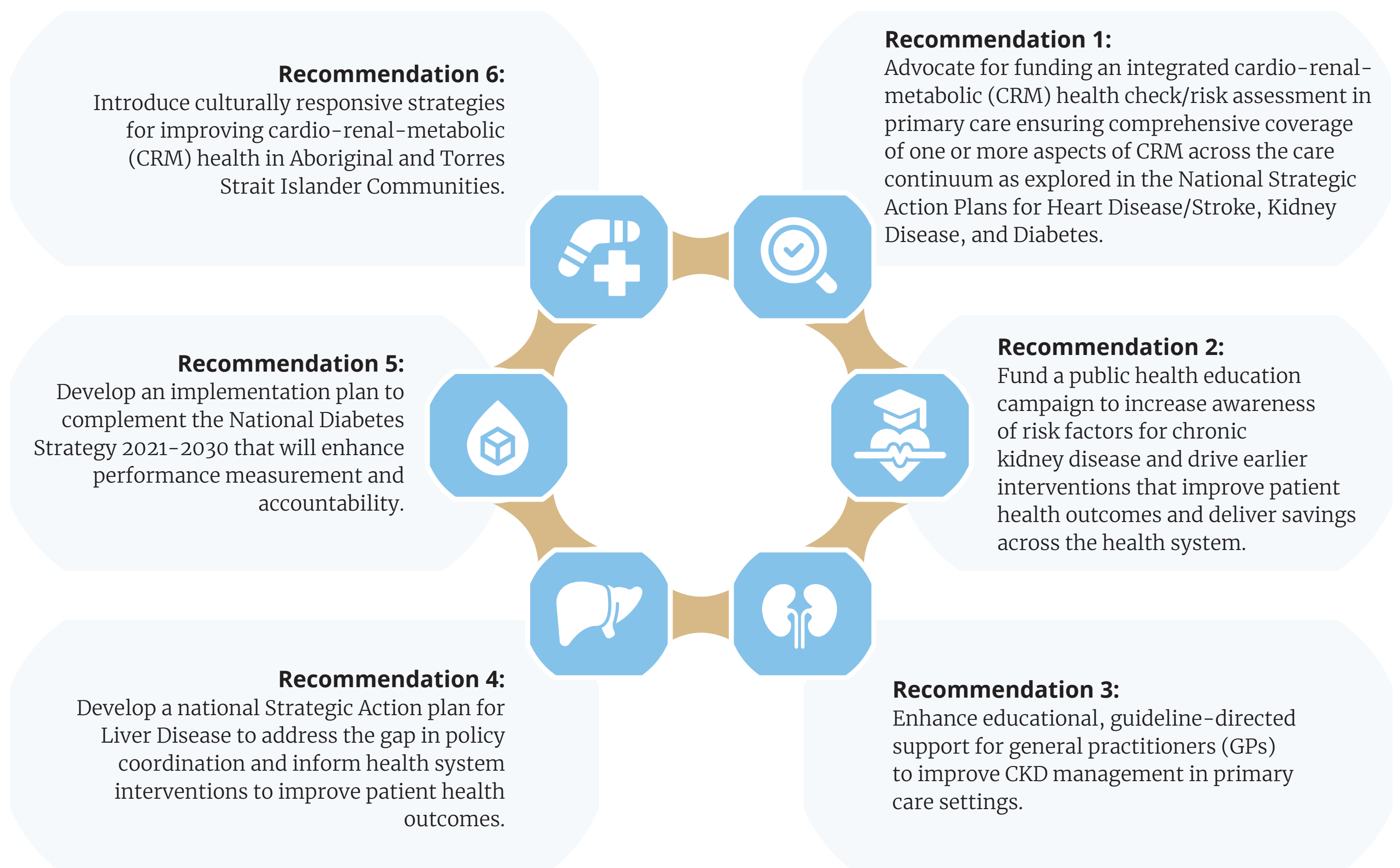
Aboriginal and First Nations communities experience disproportionately higher rates of cardio-renal-metabolic (CRM) diseases compared to non-Indigenous communities.[79] This disparity contributes to significant gaps in life expectancy, with First Nations people expected live approximately eight to nine years less than their non-indigenous counterparts.[80] According to the Australian Institute of Health and Welfare (AIHW), First Nations Australians are three times (17% compared to 6.1%) more likely to have diabetes[a] than non-Indigenous Australians.[81] Given the complex interplay of social determinants, historical marginalization, and systemic barriers that hinder care, implementing culturally tailored interventions to improve health outcomes of vulnerable populations such as the First Nations communities is crucial.

[a] Refers to diabetes inclusive of type 1 diabetes, type 2 diabetes and gestational diabetes

Recommendations

Learning from international best practices

Internationally, countries such as Taiwan and France have begun to address these challenges by legislating for multi-disciplinary care teams, integrating digital health solutions, and introducing value-based payment models that support coordinated, long-term management of cardio-renal-metabolic (CRM) conditions. In contrast, Australia's implementation and funding approaches remain fragmented, limiting the potential for systemic improvement and better health outcomes. In summary, closing these gaps will require Australia to prioritize the development of detailed, costed implementation plans for all cardio-renal-metabolic (CRM)-related strategies, ensure adequate and sustained funding for research and workforce development, and reform payment models to incentivize integrated, patient-centered care. Without these changes, national targets for cardio-renal-metabolic (CRM) conditions will remain out of reach, and the burden of disease will continue to grow.



Recommendation 1: Advocate for funding an integrated cardio-renal-metabolic (CRM) health check/risk assessment in primary care ensuring comprehensive coverage of one or more aspects of CRM across the care continuum as explored in the National Strategic Action Plans for Heart Disease/Stroke, Kidney Disease, and Diabetes.

1.1 Interconnected cardio-renal-metabolic (CRM) care narrative

Advocate for a connected cardio-renal-metabolic (CRM) care narrative in consultation with key stakeholders, including patient advocacy groups.

1.2 Strategic linkages in policy

Focus the strategy on unifying approaches and strengthening execution of these linkages along service pathways.

1.3 Incentive structures for bundled testing

Promote bundled testing for cardio-renal-metabolic (CRM) conditions via a screening bundle for high-risk patients as a single Medicare Benefits Schedule (MBS) item (e.g., annual diabetes care including HbA1c, lipid profile, eGFR, and uACR).

1.4 Pay-for-Performance screening incentives

Link screening bundles with Pay-for-Performance bonuses for primary care and introduce quality-based bonuses for institutions meeting benchmarks such as:

- % of patients ≥40 screened for diabetes, CKD, and heart failure (HF) in the last 12 months.
- % of CKD patients with albuminuria testing and BP control.
- % of HF admissions with NT-proBNP or echocardiogram completed.

1.5 GP empowerment and upskilling

Provide clear guidelines for managing CKD alongside other metabolic conditions to empower GPs to act as central coordinators of care for complex multimorbid patients.

1.6 Multidisciplinary team-based care

Promote collaboration among various healthcare providers (e.g., specialists, nurse practitioners, dietitians) to deliver holistic, patient-centered care.

1.7 Measurable targets and evaluation

Incorporate clear, quantitative goals into cardio-renal-metabolic (CRM) strategies to enable effective tracking and accountability of care improvements.

Recommendation 2: Fund a public health education campaign to increase awareness of risk factors for chronic kidney disease and drive earlier interventions that improve patient health outcomes and deliver savings across the health system.

2.1 Improve public awareness of CKD

Public awareness of CKD is low with around 50% of Australians undiagnosed by primary care physicians, and 25% of Australians are diagnosed so late that they are nearing the end stage of kidney disease, missing the chance to slow disease progression.[82]

Leverage existing resources such as the Kidney Early Evaluation Program (KEEP) – a free, community-based health screening initiative by the National Kidney Foundation that also provides educational materials – to enhance public awareness and understanding of CKD.[83]

2.2 Incorporate CKD screening into routine screening programs[84]

Include CKD screening into existing routine and opportunistic health screening programs (including point of care screening) to improve early detection and optimize resources.

2.3 Design and implement targeted community screening programs to improve equitable access to screening and diagnostic tools among high-risk groups

Launch focused screening initiatives for populations that are more vulnerable to chronic disease such as rural and indigenous communities. Refer to prior successful evidence-based approaches (e.g. Kidney Evaluation for You (KEY) pilot) which has facilitated improved diagnostic outcomes.[85]

Recommendation 3: Enhance educational, guideline-directed support for general practitioners (GPs) to improve CKD management in primary care settings.

3.1 Utilize kidney trajectory charts to facilitate clinical decisions

Provide GPs with eGFR percentile plotting charts by age to support clinical decision-making. Studies of Australian GPs using these charts found that they improved guideline adherence and awareness of clinically relevant kidney issues, facilitating more appropriate follow-up planning.[86] Kidney trajectory charts can also be a useful tool for GPs to communicate with patients regarding their functional status and discuss health priorities.[87]

3.2 Adopt supportive technology to optimize GP time allocation and workflows

Focus the strategy on unifying approaches and strengthening execution of these linkages along service pathways.

3.3 Enhance GP education and training

Provide continuous professional development on CKD management, including but not limited to management guidelines, risk assessment, and appropriate referral criteria, to empower GPs to better manage CKD patients and ensure consistent delivery of high-quality care.

3.4 Build multidisciplinary care teams to improve CKD management in primary care

Strengthen primary care networks by involving primary healthcare nurses, diabetes educators and allied health professionals to assist with risk identification, early detection, and patient engagement.

Recommendation 4: Develop a national Strategic Action plan for Liver Disease to address the gap in policy coordination and inform health system interventions to improve patient health outcomes.

4.1 Integrate MASH into the national non-communicable disease framework

MAFLD (Metabolic Associated Fatty Liver Disease) screening should be integrated into existing metabolic screening programs to facilitate early identification and management of liver-related conditions, particularly among high-risk individuals. Additionally, liver cancer policies should incorporate continuous monitoring from the fibrosis stage, ensuring that disease progression is closely tracked and timely interventions can be implemented to improve outcomes.

4.2 Identify liver cancer as a priority within the existing national cancer plan by specifically addressing and highlighting the cruciality of screening and early detection

In addition to improving health outcomes, this approach would also align with Area of Focus 3 of the National Aboriginal and Torres Strait Islander Cancer Framework, which emphasizes the need for timely cancer screening and early diagnosis to improve outcomes and reduce disparities in cancer care.

4.3 Strengthen screening and detection efforts

Standardize and incorporate liver health assessments, such as liver function tests and ultrasounds, into routine screening protocols for individuals with metabolic conditions. Doing so will improve early detection and allow for more effective management of liver-related diseases.

4.4 Develop national guidelines for the management of MASH

Design national clinical guidelines for the prevention, early detection, and management of MASH within the broader context of non-communicable diseases (NCDs). These guidelines should emphasize the critical role of primary care providers in identifying at-risk individuals and delivering timely screening, intervention, and coordinated care.

4.5 Increase public awareness and education of MASH

Launch national public health campaigns that clearly communicate the link between CVD, obesity, and T2D to MASH and the increased risk of progression to liver cancer. Campaigns should focus on the pillars of prevention, lifestyle modification, and early detection. To complement these, educational resources should be developed for patients and healthcare providers to increase the awareness of the connection between the various NCDs and liver cancer, reinforcing the need for regular screening for at-risk populations.

4.6 Allocate dedicated funding for the full MASH care continuum by earmarking resources from both the cancer and NCD budgets to ensure adequate resources for prevention, early detection, management, and research in the long-term

Clear budgets should be allocated for MASH-related liver health promotion, screening initiatives, and research into liver cancer prevention. These can be strategically obtained from the NCD budget for public education and awareness programs on MASH, and from the cancer budget for initiatives targeting hepatocellular carcinoma (HCC) prevention, detection, and treatment.

Recommendation 5: Develop an implementation plan to complement the National Diabetes Strategy 2021-2030 that will enhance performance measurement and accountability.

5.1 Develop a policy implementation plan with clear deadlines and targets

The taskforce should develop a policy implementation plan, including clear deadlines to drive timely action and ensure accountability. Targets should align and complement national goals.

5.2 Set measurable targets to guide implementation

Incorporate clear, quantitative indicators to track progress, referencing national policy benchmarks and WHO guidelines to ensure global alignment and consistency.

5.3 Develop a national diabetes research agenda

Create a coordinated national research strategy to address the growing diabetes burden, address declining funding trends, and support advancements in prevention, early detection, and treatment of diabetes through sustained research and funding.

Recommendation 6: Introduce culturally responsive strategies for improving cardio-renal-metabolic (CRM) health in Aboriginal and Torres Strait Islander Communities.

6.1 Strengthen primary and preventative care

Expand access to culturally safe, community-led health services that integrate cardiology, nephrology, and endocrinology. Increase funding for routine screening of hypertension, diabetes, and chronic kidney disease (CKD), and embed Indigenous Health Workers and navigators in primary care to boost engagement and treatment adherence.

6.2 Address social and environmental determinants

Address the root causes of poor health by implementing food security initiatives, improving housing and infrastructure to reduce overcrowding, and developing employment and education programs to reduce socioeconomic inequalities that drive cardio-renal-metabolic (CRM) disease risk.

6.3 Enhance workforce capacity and cultural competency

Invest in training and employing more indigenous healthcare professionals across key disciplines, including general practice, nephrology, cardiology, and endocrinology. Mandate cultural safety training in all health education and continuous professional development to improve care quality and patient trust.

6.4 Improve access to specialist and acute care

Expand telehealth services in remote areas to enhance access to specialist care. Strengthen referral pathways between primary care and hospitals for advanced cardio-renal-metabolic (CRM) disease management and ensure that Medicare and Pharmaceutical Benefits Scheme (PBS) adequately support evidence-based treatments tailored to the needs of indigenous communities.

6.5 Promote Community-Led Health Education and Awareness

Fund and support indigenous-led campaigns on cardiovascular, kidney, and metabolic health. Involve community leaders in delivering culturally relevant health messages and integrate traditional knowledge with modern health education into school-based programs.

6.6 Foster research, data collection, and policy integration

Support indigenous-led research to assess the effectiveness of cardio-renal-metabolic (CRM) related interventions and improve data collection on indigenous health disparities to inform policy. Ensure that cardio-renal-metabolic (CRM) related strategies are aligned with the National Aboriginal and Torres Strait Islander Health Plan's principles of self-determination and community leadership.

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