



Women and Cardiovascular Disease in Australia

September 2026

Foreword

Cardiovascular disease causes far more deaths among Australian women than breast cancer. However, the risk factors in women are often overlooked and under-recognised. Pathology data can help strengthen the safety net around women's heart health by identifying risk factors earlier.

Each year, Healius Pathology Network processes more than 18 million pathology episodes. With collection centres and laboratories across Australia, we see the results behind millions of clinical decisions each year, including the key biomarkers that together indicate a woman's cardiometabolic health.

Female specific factors, like hypertensive disorders of pregnancy, gestational diabetes, polyendocrine metabolic ovarian syndrome (PMOS) and early menopause, enhance women's cardiovascular risk across the lifespan and all of them typically arise before formal assessment occurs after the age of 45. That history is an important piece of the conversation about a woman's heart health.

This sits alongside a well-recognised gender gap in the diagnosis and management of cardiovascular disease. Cardiovascular disease is still commonly understood as a male condition; however, it now causes more deaths among Australian women than breast cancer.

Protecting women's heart health depends on a combination of things working together: Test results that identify risk early; a history that captures reproductive and hormonal life stages; and the tools to bring them together.

Healius Pathology Network welcomes the Ministerial Expert Panel's focus on women's cardiovascular health in 2026. Pathology can provide valuable insights to this work because it is often the earliest signal available before symptoms appear, including inherited risk that is present from birth.

Pathology is an integral part of the safety net around women's heart health. It works best when it is used in the context of a woman's life and history.



"Unfortunately, early-stage risk enhancers in women are often ignored until a woman has a cardiac event."

That's why our efforts are focused on leveraging pathology data to identify trends and risk factors, alongside other work in GP education, including development of a cardiometabolic screening tool for GPs.

The following report draws on de-identified insights from our testing across Australia to highlight that:

- pathology testing can identify the clinically silent abnormalities in glucose regulation, lipids and kidney function that contribute to cardiovascular risk; and
- markers of cardiometabolic risk rise through midlife and into older age.

We are committed to supporting better cardiovascular outcomes for women, through the quality of our testing, the education we provide to clinicians and the insights we can share with those shaping policy.

Dr Renu Vohra

*Chief Medical Officer
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Closing the gap in women's cardiovascular health

Key insights from this report

Cardiovascular disease remains a major health issue for Australian women.

In 2024, approximately 20,200 Australian women died from cardiovascular disease, representing almost one in four female deaths.

Women's cardiovascular risk develops across the life course.

Pregnancy complications, reproductive history, menopause and women-predominant conditions provide important information in addition to established cardiovascular risk factors.

Earlier recognition creates opportunities for prevention.

Blood pressure, clinical history, formal cardiovascular risk assessment and targeted pathology testing can identify clinically silent and potentially modifiable risk.

Pathology data show a substantial cardiometabolic burden among Australian women undergoing testing.

Abnormalities in glucose regulation, lipids and kidney function are common and become increasingly prominent with age.

Risk is not distributed equally.

Socioeconomic disadvantage is associated with a greater burden of cardiovascular and metabolic risk, reinforcing the need for an equity-focused approach to prevention.

Important evidence and access gaps remain.

Women remain under-represented or insufficiently analysed in areas of cardiovascular research, while tests capable of identifying hidden inherited risk, such as Lp(a), are not currently specifically funded through Medicare.

A coordinated life-course approach offers an opportunity to improve outcomes.

Better awareness, earlier risk assessment, appropriate pathology testing, stronger women-specific research and collaboration between government, primary care, pathology and community health can strengthen cardiovascular prevention for Australian women.



Women and cardiovascular disease in Australia

Cardiovascular disease (CVD) refers to diseases and conditions affecting the heart and blood vessels, including coronary heart disease, stroke and heart failure.^[1] Coronary heart disease alone caused 6,122 deaths among women, approximately 17 each day, and almost twice as many deaths as breast cancer in the same year.^[2,3,4]

Despite this burden, heart disease in women remains under-recognised, under-diagnosed and under-researched, with heart disease still commonly perceived as predominantly affecting men. This perception can influence awareness, recognition of symptoms, presentation for care, investigation and treatment.^[4,8]

National attention to women's cardiovascular health is increasing. The National Women's Health Strategy 2020–2030 emphasises prevention, equity and a life-course approach, while the Ministerial Expert Panel on Women's Health has identified cardiovascular health as its first priority area.^[5,6]



Cardiovascular risk across women's lives

Burden of cardiovascular disease in women

Cardiovascular disease remains a major cause of illness and death among Australian women. In 2024, CVD was the underlying cause of approximately 20,200 deaths in women, almost one in four female deaths^[2]. Women share the established cardiovascular risk factors seen in men, while pregnancy, reproductive history, hormonal transitions and women-predominant conditions can provide additional important information across the life course. These factors do not establish cardiovascular disease and should supplement, rather than replace, formal cardiovascular risk assessment.^[7-9]

Common cardiovascular risk factors

Established risk factors include increasing age, smoking, high blood pressure, adverse lipid levels, diabetes, chronic kidney disease, excess adiposity, physical inactivity, adverse dietary patterns and a family history of premature cardiovascular disease.

The prevalence, impact and recognition of these risk factors can differ between women and men and may also change across different stages of a woman's life.^[7,8]

Women-specific and women-predominant cardiovascular risk factors

Traditional risk factors

- Age
- Smoking
- High blood pressure
- High LDL cholesterol
- Diabetes
- Chronic kidney disease
- Excess weight
- Physical inactivity
- Poor diet
- Family history of early cardiovascular disease



Disparities in traditional risk factors

- Risk may appear differently
- Become more important at different life stages
- Be less readily recognised
- Delayed assessment
- Missed opportunities for prevention

Women-specific and women-predominant factors

- Hypertensive disorders of pregnancy, such as pre-eclampsia or gestational hypertension
- Gestational diabetes
- Preterm birth
- Premature or early menopause
- Polyendocrine metabolic ovarian syndrome (PMOS)
- Recurrent pregnancy loss
- Autoimmune inflammatory disease
- Migraine with aura
- Previous cancer treatment that may affect heart health, including some chemotherapy, targeted therapies or radiotherapy



Pregnancy and reproductive history

Pregnancy provides an important window into a woman's future cardiovascular health.

Hypertensive disorders of pregnancy, including pre-eclampsia and gestational hypertension, are associated with increased subsequent risks of chronic hypertension and cardiovascular disease. Gestational diabetes is associated with later development of type 2 diabetes and increased cardiovascular risk.

Preterm birth, stillbirth, placental abruption and delivery of a small-for-gestational-age infant have also been associated with subsequent maternal cardiovascular disease, although the strength of evidence varies between outcomes.^[7–9]

A history of these complications should prompt review of established and modifiable cardiovascular risk factors. Australian guidelines recommend a thorough pregnancy history, annual blood-pressure assessment and regular review of other cardiovascular risk factors following hypertensive disorders of pregnancy, particularly early-onset pre-eclampsia.^[7]

Menopause and midlife risk

Premature ovarian insufficiency generally refers to loss of ovarian function before 40 years of age, while early menopause generally refers to menopause between 40 and 44 years.

Menopause before 45 years of age is associated with increased subsequent cardiovascular risk. Midlife and the menopause transition therefore provide an important opportunity to reassess blood pressure, lipids, glucose regulation and other established cardiovascular risk factors.^[7,10,11]

Menopause itself should not be regarded as a single cause of cardiovascular disease, but rather as part of the broader life-course assessment of cardiovascular risk.

Polyendocrine metabolic ovarian syndrome

Polyendocrine metabolic ovarian syndrome (PMOS), previously known as polycystic ovary syndrome (PCOS), is commonly associated with insulin resistance, dysglycaemia, adverse lipid patterns, hypertension and excess adiposity.

These abnormalities can contribute to increased lifetime cardiovascular risk. Whether PMOS independently predicts cardiovascular events after full adjustment for conventional cardiovascular risk factors remains uncertain. The clinical priority is therefore early identification and management of the accompanying modifiable risk factors.^[8,9,12,24]

Other relevant health factors

Systemic lupus erythematosus and rheumatoid arthritis are chronic inflammatory conditions that can accelerate atherosclerosis and increase cardiovascular risk. Migraine with aura is also associated with an increased risk of vascular events, particularly ischaemic stroke. These conditions are more common in women and may provide additional information when assessing cardiovascular risk.^[8]

Previous cancer treatment can also affect cardiovascular health. Anthracycline chemotherapy and HER2-targeted therapies may damage heart muscle, while chest radiotherapy can contribute to later coronary and valvular heart disease.^[8]

Recurrent pregnancy loss, infertility and assisted reproductive treatment have also been associated with later cardiovascular disease. They may reflect underlying vascular, metabolic or inflammatory factors, although the evidence is less consistent than for hypertensive pregnancy disorders, gestational diabetes and early menopause.^[8,9]

Early detection and assessment

Early detection of cardiovascular disease requires a comprehensive clinical assessment, including a detailed medical history, evaluation of established cardiovascular risk factors such as lifestyle habits, body weight, and blood pressure, as well as targeted pathology testing.

No single laboratory test, or combination of abnormal test results, is sufficient to independently diagnose cardiovascular disease.

Pathology findings should always be interpreted within the context of the individual's overall cardiovascular and metabolic risk profile, alongside clinical assessment and other relevant risk factors.

Formal Australian CVD risk assessment

For primary prevention in people without known cardiovascular disease, the 2023 Australian cardiovascular disease risk guideline recommends assessment at the following ages:^[7]

Assessment age ranges

Population	Recommended approach
All people	Assess CVD risk from age 45 to 79 years
People with diabetes	Assess CVD risk from age 35 to 79 years
First Nations people	Assess individual risk factors at 18–29; use the calculator at 30–79 years

The Australian CVD Risk Calculator estimates a person's five-year risk of a cardiovascular event as:

- Low: less than 5%

- Intermediate: 5% to less than 10%
- High: 10% or greater.

Risk assessment incorporates factors including age, sex at birth, smoking status, systolic blood pressure, total-cholesterol-to-HDL cholesterol ratio, diabetes, cardiovascular medicines, postcode and atrial fibrillation.

Additional information is incorporated for people with diabetes, including HbA1c, duration of diabetes, urine albumin-to-creatinine ratio, eGFR, BMI and insulin use.^[7]

Targeted history in women

Cardiovascular assessment in women should also consider:

- Hypertensive disorders of pregnancy, including pre-eclampsia and gestational hypertension
- Gestational diabetes
- Preterm birth, stillbirth or placental complications
- Premature ovarian insufficiency or menopause before age 45
- Polyendocrine Metabolic Ovarian Syndrome (PMOS) or PCOS
- Recurrent pregnancy loss or infertility
- Autoimmune inflammatory disease or migraine with aura
- Previous cardiotoxic cancer treatment, including anthracyclines, HER2-targeted therapy or chest radiotherapy

These histories may identify women who require earlier or more comprehensive assessment, but they do not themselves establish cardiovascular disease or automatically change an Australian calculated cardiovascular risk category.^[7–9]

How pathology can identify hidden cardiometabolic risk

Pathology testing can identify clinically silent abnormalities in glucose regulation, lipids and kidney function that contribute to cardiovascular risk.

Testing should be selected according to the clinical question and interpreted alongside blood pressure, smoking status, diabetes, family history, medicines, pregnancy and reproductive history and formal cardiovascular risk assessment.

Cardiometabolic disease explained

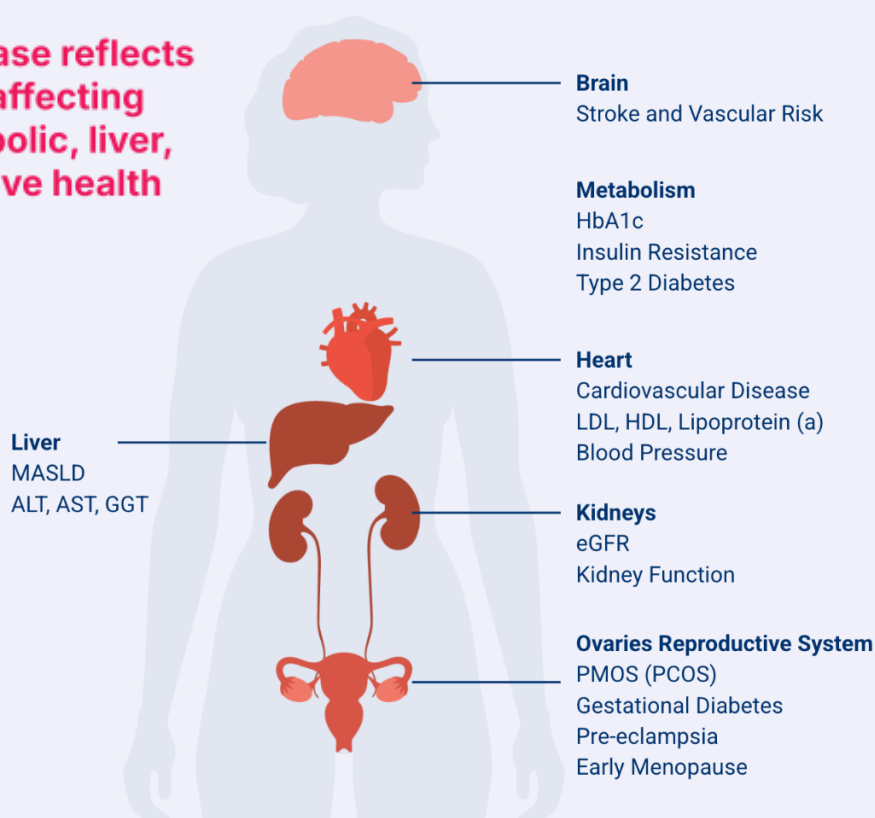
Cardiometabolic disease is not a single diagnosis. In this report, the term is used descriptively to describe interconnected cardiovascular, kidney and metabolic conditions and their shared drivers.

The cardiovascular–kidney–metabolic framework recognises the interaction between adiposity, diabetes and other metabolic risk factors, chronic kidney disease and cardiovascular disease. Liver disease is closely related to these metabolic pathways but should not be assumed to form part of every formal cardiovascular–kidney–metabolic definition.^[13]

Insulin resistance, dysfunctional or excess adiposity, inflammation, dyslipidaemia, hyperglycaemia and kidney dysfunction can interact across organ systems.

This supports assessment of a person's overall cardiovascular–kidney–metabolic profile rather than interpretation of individual laboratory results in isolation.^[13]

Cardiometabolic disease reflects interconnected risks affecting cardiovascular, metabolic, liver, kidney and reproductive health



Lipid profile

A lipid profile measures total cholesterol, triglycerides and HDL cholesterol, with LDL cholesterol and non-HDL cholesterol commonly calculated from these measurements.

For Australian cardiovascular risk estimation, the ratio of total cholesterol to HDL cholesterol is used in the Australian CVD Risk Calculator.

LDL cholesterol remains clinically important for lipid management, but an isolated LDL or HDL cholesterol result is not a substitute for overall cardiovascular risk assessment.^[7]

HbA1c

HbA1c reflects average blood glucose over approximately the previous two to three months and is used to support diagnosis of diabetes and monitor longer-term glycaemic control.

Abnormal glucose regulation and diabetes are important cardiovascular risk factors. Laboratory results should be interpreted in the context of previous results, known diabetes and treatment status.^[19]

Kidney function: eGFR and uACR

Kidney disease and cardiovascular disease are closely interconnected.

Estimated glomerular filtration rate (eGFR) provides an estimate of kidney filtration, while urine albumin-to-creatinine ratio (uACR) can identify kidney damage even when eGFR remains preserved.

Both provide important information about kidney and cardiovascular risk and form part of contemporary cardiovascular risk assessment.^[7,20]

Liver function tests and metabolic liver disease

ALT, AST and GGT are non-specific markers that may become abnormal with liver injury, alcohol exposure, medicines or metabolic dysfunction.

Abnormal liver enzymes do not themselves diagnose metabolic dysfunction-associated steatotic liver disease (MASLD), and liver enzymes can remain normal in people with MASLD.^[16–18]

MASLD commonly occurs in association with cardiometabolic risk factors and is associated with type 2 diabetes, cardiovascular disease and chronic kidney disease, particularly where fibrosis or broader metabolic dysfunction is present.

The evidence for these associations is stronger than evidence that liver enzymes provide additional cardiovascular risk prediction beyond established risk factors.^[16,17]

Abnormal ALT, AST or GGT should therefore prompt appropriate evaluation of liver and metabolic health rather than be interpreted as standalone cardiovascular risk categories.

Combined abnormalities

When abnormalities in glucose, lipids, kidney function and liver-related markers occur together, they may indicate a greater overall cardiometabolic burden.

Evidence from populations with prediabetes and diabetes suggests that different patterns of metabolic abnormalities may be associated with different clinical outcomes.

However, the incremental predictive value of liver enzymes beyond established cardiovascular risk factors has not been clearly demonstrated, particularly in Australian women.

These findings should therefore be interpreted as part of the overall cardiometabolic profile rather than as a separate or validated cardiovascular risk score.^[13–15]

Lipoprotein(a): an important hidden inherited risk

Lipoprotein(a), or Lp(a), is an LDL-like lipoprotein particle with an additional protein called apolipoprotein(a). Lp(a) levels are largely genetically determined and usually remain relatively stable throughout life. Elevated Lp(a) is an independent and causal risk factor for atherosclerotic cardiovascular disease and is also associated with calcific aortic valve disease. Importantly, elevated Lp(a) may not be identified through routine cholesterol testing.^[21, 23]

A 2024 US registry study found that high Lp(a) was independently associated with an increased risk of a first acute myocardial infarction, regardless of the number of standard modifiable cardiovascular risk factors. The additional risk associated with high Lp(a) was comparable with having approximately two additional standard modifiable risk factors.^[22]

Women comprised 45% of the study population; however, the primary analysis did not report the association between Lp(a) and myocardial infarction separately for women and men. This illustrates an important issue in women's cardiovascular research: substantial female participation does not necessarily translate into sex-specific analysis of outcomes.^[22]

In Australia, Lp(a) testing is not currently covered by a dedicated Medicare Benefits Schedule rebate, which may limit access to testing and identification of this otherwise hidden inherited cardiovascular risk.^[23]



Insights from Healius pathology testing data

Analysis of Healius pathology testing* provides an opportunity to examine cardiometabolic abnormalities among large numbers of Australian women undergoing testing.

The findings reinforce three important themes:

- cardiometabolic abnormalities are common among women undergoing testing
- the burden increases with age and
- abnormalities frequently occur across more than one metabolic or organ-system domain.

Women's prevalence by age groups

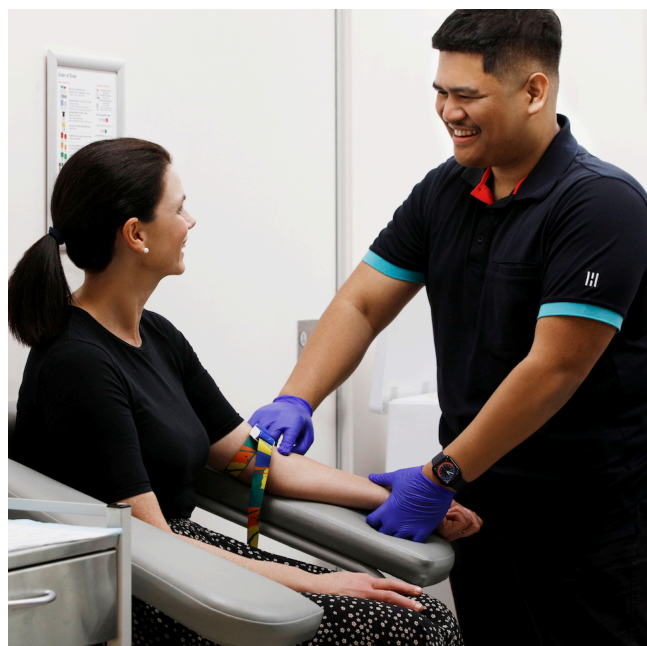
Among female testing episodes with an assessable HbA1c result, 23.0% met the project's combined pre-diabetes/diabetes-range threshold (HbA1c $\geq 6.0\%$).

This proportion increased across age groups, from 6.9% at 18–39 years to 12.8% at 40–49, 21.6% at 50–59, 30.5% at 60–69, 36.2% at 70–79 and 38.3% at 80–120 years.

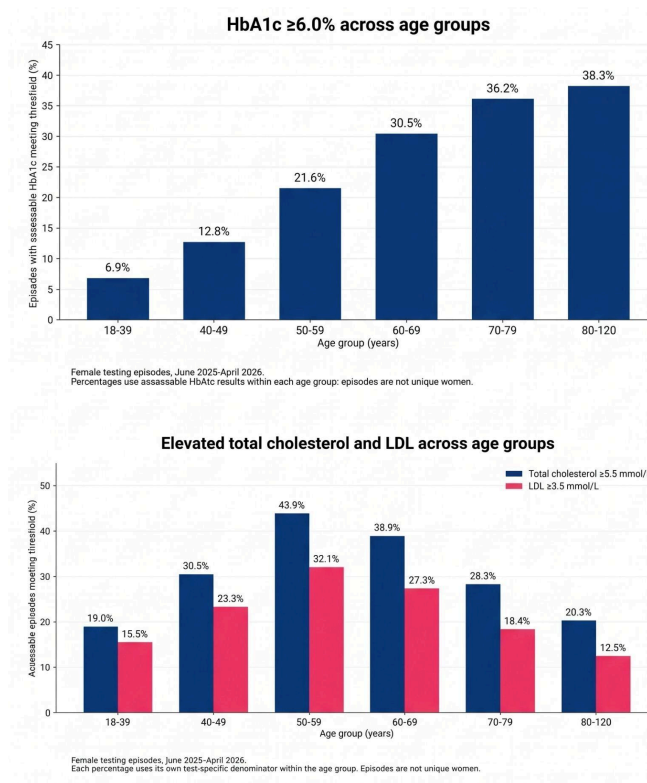
Lipid abnormalities were also common: total cholesterol was elevated (≥ 5.5 mmol/L) in 31.2%, LDL was elevated (≥ 3.5 mmol/L) in 22.5%, and HDL was low (< 1.3 mmol/L) in 22.4% of assessable episodes.

Elevated LDL was most frequent at ages 50–59, affecting 32.1%. Reduced eGFR (< 60 mL/min/1.73 m²) occurred in 9.9% overall, increasing from 0.4% at ages 18–39 to 1.0% at 40–49, 2.7% at 50–59, 8.0% at 60–69, 21.8% at 70–79 and 47.7% at 80–120 years.

GGT was the most frequently elevated liver marker examined, at 20.1% (> 35 U/L), compared with 11.3% for ALT (> 35 U/L) and 12.2% for AST (> 30 U/L).



Raised HbA1c and reduced eGFR became more frequent with age, while elevated total cholesterol and LDL were most frequent at ages 50–59, reinforcing midlife and older age as important periods for cardiovascular assessment. However, pathology data do not usually capture pregnancy history, menopause timing, PMOS, autoimmune disease or treatment exposure. The observed pathology results should therefore be interpreted as one component of women's cardiovascular risk rather than a complete measure of that risk.

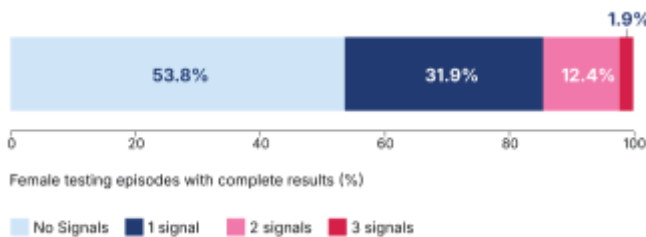


*Based on a dataset of more than one million de-identified female pathology testing episodes. Each analysis includes episodes with assessable results for the relevant tests.

Comorbidities

A material proportion of female pathology testing episodes had more than one cardiometabolic risk signal. Among episodes with complete HbA1c, kidney function and liver enzyme results, **31.9%** had an abnormality in one domain, **12.4%** in two and **1.9%** in all three. Each domain counted as one signal, regardless of how many liver enzymes were raised. These findings describe co-occurring biochemical abnormalities, not confirmed diagnoses.

Co-occurring glucose, kidney and liver abnormalities



Signals counted: raised HbA1c ($\geq 6.0\%$); reduced eGFR (< 60 mL/min/1.73 m²); and raised liver enzymes (ALT > 35 , AST > 30 or GGT > 35 U/L; one signal for the liver domain).

Percentages reflect female testing episodes with all five results assessable. Lipids are excluded. "No signals" means no glucose, kidney or liver abnormalities at the specified thresholds—not absence of cardiovascular risk.

Source: Healius pathology analysis; June 2025–April 2026; ages 18–120 years. Testing episodes are not necessarily unique women. Findings are not confirmed diagnoses or estimates of population prevalence.

Socio-economic disparities

Lower socio-economic status is associated with higher prevalence of many modifiable CVD risk factors, including pre-diabetes and diabetes, smoking, untreated hypertension, poorer diet, lipid abnormality and lower levels of physical activity.^[2]

Our previously published Healius' Diabetes Watch report shows that cardiometabolic disease burden is not evenly distributed across Australia. Using HbA1c results by federal electorate with a socioeconomic overlay, the report highlights a clear gap between more affluent and lower-income communities.

The current analysis of female testing episodes shows a similar socioeconomic gradient.

As shown in the table below, diabetes-range HbA1c results occurred in 21% of assessable episodes in the most disadvantaged areas, compared with 11% in the least disadvantaged areas.

HbA1c findings by socioeconomic quintile

HbA1c category	Pre-diabetes Range	Diabetes Range
Q1	9%	21%
Q5	7%	11%

Rounded percentages of female episodes with classifiable HbA1 within each quintile. Pre-diabetes range: 6.0–<6.5%; diabetes range: $\geq 6.5\%$. Unadjusted; biochemical ranges are not diagnoses.

Pre-diabetes-range results were also more frequent, at 9% and 7%, respectively.

A geographic disparity was evident as shown in the table below, which draws on the Modified Monash Model's definition of whether a location is metropolitan, rural, remote or very remote. Diabetes-range results occurred in 23% of assessable episodes in areas designated as remote or very remote combined, compared with 15% in metropolitan areas, while pre-diabetes-range results were similar at 8%.

These findings show how pathology data, interpreted alongside age structure, testing patterns and population health data, can help identify communities for further assessment and targeted prevention.

HbA1c findings by remoteness

HbA1c category	Pre-diabetes Range	Diabetes Range
MMM1 Metropolitan	8%	15%
MMM6-7 combined remote/very remote	8%	23%

Rounded percentages of classifiable female episodes; MMM6-7 counts pooled. Pre-diabetes range: 6.0–<6.5%; diabetes range: $\geq 6.5\%$. Unadjusted; not diagnoses. Unique MMM assignments only. June 2025–April 2026; ages 18–120.

Healius' work underway to support women's heart health

Beyond our critical role in diagnostic pathology, we believe we have a broader responsibility to help improve health outcomes for Australians through education, information and awareness.

In the area of cardiovascular disease in women, we are advancing a number of initiatives aimed at strengthening the healthcare safety net and addressing the recognised gap in diagnosis and treatment outcomes for women.

Through increased awareness, community engagement, clinician education and targeted health initiatives, we are working to ensure more women receive timely diagnosis and appropriate care.

Digital tools for GPs

Delivered through our Medway digital platform, our Diabetes Audit digital tool for GPs is designed to drive awareness and early interventions around managing cardio-metabolic risk factors. We are working to expand this tool to include more biomarkers for assessment of cardiovascular risk.

Pathology-led education

Through our partnership with the Royal Australian College of General Practitioners (RACGP), Healius Pathology Network offers free CPD education for General Practice with evidence-based, pathology-led education designed to strengthen clinical decision-making and support quality patient care.

Our cardiovascular disease in women course, addresses common questions about risk assessment, monitoring and misconceptions surrounding cardiovascular disease in women.

Sharing population level health data

Healius is also committed and able to use de-identified aggregated pathology data to share population health insights with the Department of Health and other industry bodies to support more targeted policy development based on where risk is concentrated and where prevention efforts should be prioritised.

Leveraging our national collection centre footprint for patient awareness

Our national collection centre network is also a platform to amplify patient awareness of early screening for cardiometabolic disease. Healius Pathology Network has the largest number of collection centres in regional, rural and remote Australia, meaning that we have the opportunity to target education materials and raise awareness of risk in the areas carrying the highest disease burden. These community touchpoints can encourage patients to speak with their GP about cardiovascular, diabetes, kidney and liver risk factors and the value of timely testing.

Supporting future research

Healius is supportive of advancing research into cardiometabolic diseases and has offered support to the initiative undertaken by National Echo Database (NEDA) through the University of Notre Dame in establishing a National Critical Research Data infrastructure linking Cardiac imaging, Cardiometabolic, Kidney, and Pathology Records with outcomes across Australia.

Stronger evidence, representative data and collaboration across pathology, primary care, research and policy can help translate population insights into practical tools for earlier detection and better outcomes.



education.healius.com.au/course/cardiovascular-disease-in-women



Role of *Digital Health* in reducing the burden of chronic disease

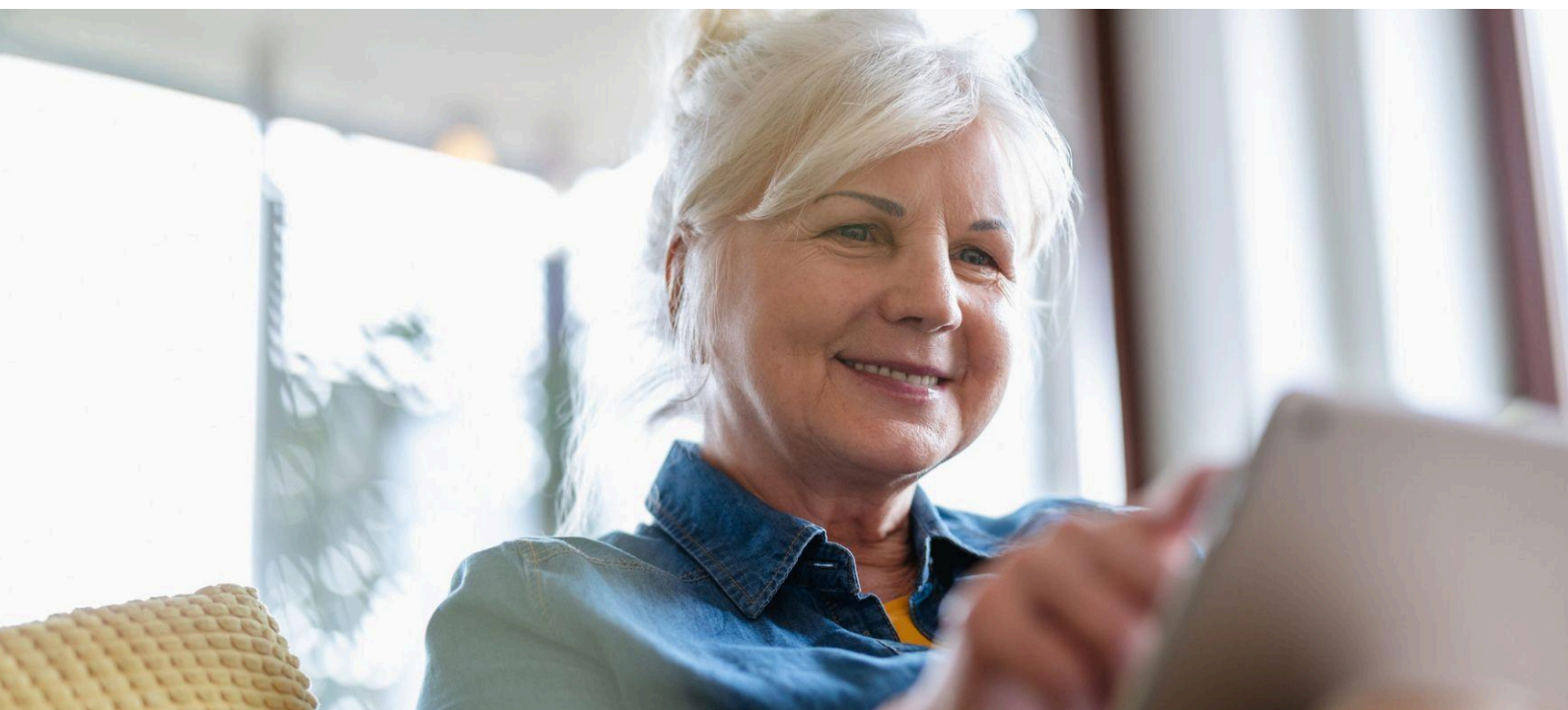
Healius' digital technology agenda is strongly aligned to ongoing work by the Australian Department of Health, Disability and Ageing and the Australian Digital Health Agency to enable the sharing of health information between healthcare participants quickly and securely.

Our digital health solutions, such as our doctor and patient facing Medway suite of applications, are well-positioned to empower customers to have greater visibility and control over health data, reducing unnecessary pathology testing by sharing results across providers, enabling clinicians to make more informed decisions for their patients, and using real time data to help prevent and manage chronic health issues that drive healthcare expenditure.

As digital health systems become more interconnected and patients increasingly rely on online sources, the clinical accuracy and context of information have never been more important. Pathology data remains one of the most trusted sources of health information, playing a critical role in translating symptoms and uncertainty into evidence-based insight.

Healius sees a clear opportunity to strengthen the reliability of this environment by ensuring that trusted clinical data is made available across digital health solutions deployed by the government, as well as private actors using national interoperability standards such as FHIR.

Healius is committed to, and welcomes practical opportunities to collaborate with the Australian Government on interoperability initiatives where health data is used responsibly in an AI-enabled future to reduce the burden of cardio-metabolic disease through early interventions in primary care.



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Authors



Dr Renu Vohra

MBBS MD FRCPA

Chief Medical Officer

Dr Renu Vohra joined Healius as a Clinical Microbiologist at QML Pathology in 2004, before being appointed as Pathologist in Charge of Microbiology and Immunology in 2009. She was appointed as the Chief Medical Officer for Healius Pathology Network in June 2021 and is also the Medical Director for QML Pathology. As Chief Medical Officer, Renu has clinical oversight over the Healius Pathology network and leads Healius' Clinical Advisory Committee.

Dr Vohra obtained a Doctor of Medicine in Microbiology from the University of Delhi, India in 1994 and commenced training as a Pathologist in Australia in 1997. In 2000, she gained her fellowship with the Royal College of Pathologists Australasia (FRCPA).



Dr Johan Conradie

MBCHB FCPATH(Chem) FRCPA

Medical Director and Head of Chemical Pathology, Western Diagnostic Pathology

Dr Johan Conradie graduated from the University of Pretoria, South Africa in 1998. He completed his training in Chemical Pathology through the University of Witwatersrand and the New Johannesburg Academic Hospital. In 2007, Dr Conradie joined Western Diagnostic Pathology (WDP) as a Chemical Pathologist.

In 2012 he was appointed the Director of Chemistry, Toxicology with WDP.



Prasad Arav

Group Executive,

Digital and Technology

Prasad Arav joined Healius in 2021 and is currently the Group Executive for Digital Technology, and Strategy. In his role, Prasad is responsible for the CIO function as well as building Digital Health products that underpin service experiences for doctors and patients, laboratory workflows, and clinical decisions. He is passionate about using data and technology to help minimise the burden of disease through early and prevention focused interventions in primary care. Prasad is a graduate from the University of New South Wales and has over 20 years of experience in technology-focused executive roles and management consulting.



The Healius Pathology Network incorporating

Abbott Pathology SA | Dorevitch Pathology VIC | Lavery Pathology NSW & ACT
QML Pathology QLD | TML Pathology TAS | Western Diagnostic Pathology WA & NT
Gastrolab | Genomic Diagnostics | IQ Pathology | Kossard Dermatopathologists | Vetnostics Pathology