RACGP
Royal Australian College of General Practitioners

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Heart Foundation
National Hypertension Taskforce
GPO Box 9966
Brisbane QLD 4001

Email: guidelines@heartfoundation.org.au
Attn: Alice.Cameron@heartfoundation.org.au

Dear Guideline Development Group,

Re: Heart Foundation draft Australian Guideline for the Diagnosis and Management of Elevated Blood Pressure and Hypertension in Adults consultation submission

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback on the Heart Foundation's draft *Australian Guideline for the Diagnosis and Management of Elevated Blood Pressure and Hypertension in Adults*.

The RACGP strongly supports the development of an updated national hypertension guideline and acknowledges the considerable work undertaken by the Guideline Development Group. The draft guideline reflects a substantial body of work and introduces a number of significant changes to the diagnosis and management of hypertension in Australia. The following feedback focuses on areas where the guideline's clarity, consistency and clinical utility could be further strengthened, particularly in relation to cardiovascular risk assessment, priority populations, ongoing management and implementation considerations.

Recommendations for antihypertensive drug therapy

- Whilst the guideline provides a sound discussion of treatment considerations for adults aged 18-44 years, the wording of some recommendations and flowcharts may inadvertently create the impression that pharmacotherapy should routinely be initiated following a diagnosis of hypertension. The RACGP recommends the guideline clearly states that pharmacological treatment would not generally be indicated in younger adults in the absence of significant additional cardiovascular risk factors or blood pressure exceeding 180 mmHg. Greater alignment between the text, recommendations and flowcharts would support consistent implementation and reduce the risk of unnecessary treatment.
- Table 22 separates elevated blood pressure into two treatment bands (120-129 and/or 80-89 mmHg and 130-139 and/or 80-89 mmHg), whereas elsewhere in the guideline elevated blood pressure is defined as a single category (120-139 and/or 80-89 mmHg). This inconsistency may create uncertainty for clinicians when determining the most appropriate management approach for patients with elevated blood pressure. The distinction is further complicated by the use of the same diastolic blood pressure range across both categories despite different systolic thresholds. Clarification of the rationale for this approach, or alignment with the broader blood pressure classification framework used elsewhere in the guideline, would improve clarity and support consistent treatment decisions.
- Clear rationales should be provided for the blood pressure thresholds at which pharmacotherapy is to be *considered* or *initiated* across each 5-year CVD risk category (Section 8.2). Some clinicians may find the recommendations and supporting text in Section 8.2 confusing because the 2023 Australian Guideline for Assessing and Managing Cardiovascular Disease Risk does not specify the blood pressure levels required to initiate antihypertensive treatment. The RACGP encourages the

Guideline Development Group to provide clear explanations with supporting evidence for the treatment thresholds set for each risk group. Supporting evidence for when to initiate pharmacotherapy for adults at intermediate cardiovascular risk is lacking on page 83. There also appears to be limited evidence on when to *consider* pharmacotherapy.

- Clarification is also required regarding the rationale for maintaining separate treatment thresholds for systolic and diastolic blood pressure. The guideline should clearly articulate the evidence for distinct thresholds and explain how clinicians should interpret situations where systolic and diastolic values indicate different treatment pathways. Greater context on the evidence base would improve clinician understanding and support more consistent application in practice.

Urinary protein screening pathway

- The recommended approach to urinary protein assessment appears to begin with dipstick testing before progressing to quantitative assessment. This differs from the general principle underpinning many screening programs, whereby a sensitive initial test is used to identify potential abnormalities before further investigation or confirmatory testing. Clarification of the rationale for this sequencing may be helpful, as urine albumin-creatinine ratio (ACR) testing is generally more sensitive for detecting albuminuria and may identify abnormalities that are not detected by dipstick testing. The RACGP encourages the Guideline Development Group to provide further justification for this approach or reconsider the recommended testing sequence.

Multidisciplinary and team-based care communication

- While the guideline appropriately recognises the importance of multidisciplinary and team-based care (Section 5.2.1), it provides limited guidance on communication and information sharing between healthcare professionals. To support continuity of care and informed clinical decision-making, the guideline should emphasise the importance of timely communication from allied health professionals to a patient's usual GP, and outline the key information that should be conveyed. Where assessments or interventions are undertaken by another healthcare professional, communication should include sufficient clinical context, such as the methodology used, results obtained, recommendations made and any follow-up actions. This information should be communicated through secure electronic systems to enable GPs to appropriately interpret findings, understand the care provided and coordinate ongoing management.

Follow-up and monitoring

- While the draft guidelines provide comprehensive recommendations for diagnosis and initiation of treatment, there is less emphasis on ongoing management and monitoring of hypertension. Because hypertension can require long-term management in primary care, more explicit guidance regarding monitoring of renal function, including urine ACR testing, and surveillance for end-organ damage will be helpful. While Table 26 includes annual monitoring for end-organ damage, consideration could be given to explicitly referencing vision monitoring as part of this assessment, given the importance of eye health in patients with hypertension and its particular relevance for Aboriginal and Torres Strait Islander peoples. Strengthening these aspects of the guideline would better support the longitudinal care of patients with hypertension in general practice.

Emerging therapies

- Advances in genomics and precision medicine may increasingly influence antihypertensive prescribing in the future and could be included as an emerging therapy. As the evidence base evolves, genomic testing may support more personalised treatment selection by identifying therapies that are more or less likely to be effective for individual patients. If included, the guideline should

make it clear that any application of precision medicine approaches should be based on an individual's clinical and genomic characteristics, rather than assumptions about treatment response based on a particular population group (e.g., Aboriginal and Torres Strait Islander status).

Priority populations

- The guideline's priority populations framework would benefit from further refinement. While the intent to recognise groups that experience poorer health outcomes or barriers to care is commendable, it is not always clear how the designation of a group as a "priority population" translates into practical guidance for clinicians. For example, transgender and gender-diverse people are identified as a priority population, yet there are no corresponding practice points specific to this group. Similarly, women are identified as a priority population, despite representing more than half of the Australian population, while the associated guidance focuses largely on reproductive health and provides limited consideration of other life stages and risk factors. Consideration could also be given to whether other populations, including people experiencing socioeconomic disadvantage and people with disability, warrant greater recognition within the guideline.
- The rationale underpinning the selection of some priority populations and associated risk factors is not always clear, and the "key consideration" column in Table 2 does not consistently provide a comprehensive description of the burden of disease, risk factors and barriers to care experienced by each group. For example, some key considerations focus on disease prevalence, while others focus on behavioural risk factors or access to care. Higher smoking prevalence is highlighted for rural and remote communities but not for Aboriginal and Torres Strait Islander peoples. Greater transparency regarding the evidence and considerations used to inform Table 2, together with a more comprehensive and consistent approach to describing the key issues affecting each population group, would strengthen the table and improve its utility for clinicians.
- The discussion of priority populations also gives limited consideration to intersectionality. The draft guidelines largely consider population groups in isolation, when in practice, many patients belong to multiple population groups simultaneously, and the interaction between these factors may have a significant influence on cardiovascular risk, health outcomes, access to care and treatment decisions. Greater recognition of these intersecting factors would better reflect the realities of clinical practice and better support person-centred care.

Aboriginal and Torres Strait Islander health considerations

Consistency with the RACGP–NACCHO National guide to preventive healthcare for Aboriginal and Torres Strait Islander people (National Guide)

- The draft guideline recommends blood pressure rescreening at least every three years for adults aged 18-39 with a prior optimal reading (Section 6.1, page 32). For Aboriginal and Torres Strait Islander people, the recommendation should align with the National Guide which recommends annual blood pressure assessment for all Aboriginal and Torres Strait Islander adults aged 18 years and over, as part of the Kidney Health Check.[1]

Practice points

- The RACGP welcomes the inclusion of Aboriginal and Torres Strait Islander-specific practice points and considerations throughout the guidelines. This approach acknowledges the inequities in health

[1] See Chapter 18 of the National Guide: National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners. National guide to preventive healthcare for Aboriginal and Torres Strait Islander people: Recommendations. 4th edition. East Melbourne, Vic: RACGP, 2024 [cited 16 October 2026]. Available from: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/national-guide.

outcomes experienced by the Aboriginal and Torres Strait Islander and supports culturally safe, equitable and responsive care.

- Given the time constraints faced by GPs, practice points should be practical, specific and readily applicable during consultations to provide clinicians with meaningful and actionable guidance. Some practice points reflect principles that are broadly applicable to all patients and provide limited guidance that is specific to Aboriginal and Torres Strait Islander patients. For example, the physical activity practice point (page 78) advises that advice should be individualised and consider cultural context, preferred language and capacity to engage. While this reflects good clinical practice, this practice point would apply to most patients. Where possible, practice points should be specific, practical and reference existing national guidance and best practice resources, such as the National Guide.[2]
- Practice points should also support patient-centred care by recognising that clinical decisions are often influenced by patient preference, local context and community-specific considerations. For example, recommendations such as measuring blood pressure in the presence of an Aboriginal and Torres Strait Islander Health Practitioner (page 46) may not be appropriate in all circumstances. The involvement of an Aboriginal and Torres Strait Islander Health Practitioner will depend on patient preference, existing relationships, local service arrangements, and community-specific considerations, including kinship and family relationships.
- The RACGP recommends the inclusion of the *Finding your way* shared decision-making model developed by the NSW Agency for Clinical Innovation to support culturally appropriate, patient-centred conversations between health professionals and Aboriginal and Torres Strait Islander patients.[3]

Cardiovascular risk assessment

- The RACGP supports the guideline's recognition that the cardiovascular disease risk calculator may underestimate risk for some Aboriginal and Torres Strait Islander peoples and clinical judgement may therefore be required when assessing overall cardiovascular risk (page 54). Given that risk reclassification may directly influence decisions regarding the initiation of antihypertensive treatment, the RACGP considers this guidance warrants inclusion as a dedicated practice point to increase its prominence within the guideline. The RACGP also notes that any increased cardiovascular disease risk should be understood within the context of individual clinical, psychosocial and socioeconomic circumstances and broader social determinants of health, rather than being interpreted as an inherent characteristic of Aboriginal and Torres Strait Islander status.

Recording Aboriginal and Torres Strait Islander status

- The guideline could highlight the importance of accurately identifying and recording Aboriginal and Torres Strait Islander status within the patient's medical record. Appropriate identification facilitates access to a range of existing supports that may assist in the management of hypertension, including Aboriginal and Torres Strait Islander Health Assessments, Medicare-supported allied health services, Aboriginal Health Practitioner and practice nurse follow-up services, and the PBS Closing the Gap Co-payment Program. Recognising these mechanisms within the guideline may assist clinicians improve access to multidisciplinary care, reduce cost barriers to treatment and support better health outcomes for Aboriginal and Torres Strait Islander patients.

[2] See Chapter 2 of the National Guide for guidance on healthy eating, physical activity, smoking cessation and alcohol use for Aboriginal and Torres Strait Islander people.
[3] NSW Agency for Clinical Innovation. Yarning to make health decisions together [Internet]. Sydney: NSW Health, 2021 [cited 16 October 2026]. Available from: https://aci.health.nsw.gov.au/shared-decision-making.

Hypertension burden

- The epidemiological data presented within the guideline may not fully reflect the disproportionate impact of hypertension on Aboriginal and Torres Strait Islander peoples. While the reported prevalence of hypertension among Aboriginal and Torres Strait Islander adults is 33%, compared with 39% in the general population, age-standardised analyses indicate that Aboriginal and Torres Strait Islander adults are 1.3 times more likely to have high blood pressure than non-Indigenous Australians.[4] Hypertension prevalence is higher among Aboriginal and Torres Strait Islander people across all age groups between 18 and 54 years of age and evidence suggests hypertension may be significantly underdiagnosed across the Aboriginal and Torres Strait Islander population.[4] Including this additional contextual information would strengthen the rationale for the Aboriginal and Torres Strait Islander considerations included throughout the guideline.

Guideline implementation considerations

- The guideline introduces several important changes to current hypertension management, including screening for primary aldosteronism at the time of diagnosis, lower treatment thresholds, initiation of combination pharmacotherapy, shorter up-titration timelines and more detailed recommendations for lifestyle interventions. While these recommendations reflect emerging evidence and evolving approaches to hypertension care, their implementation will require substantial change management and may necessitate changes to established clinical practice and workflows.

Use of automated office blood pressure measurements

- The RACGP supports the recommendation to utilise automated office blood pressure measurements using validated upper-arm devices. Although this approach has the potential to improve the accuracy and consistency of blood pressure assessments, implementation is likely to have practical implications for healthcare services involved in blood pressure screening and monitoring. Many practices and healthcare settings may need to invest in additional equipment and, in some cases, modify clinical workflows or allocate dedicated space to facilitate automated blood pressure measurement. Consideration should be given to the resource implications associated with broader uptake of this recommendation.

Support for primary care

- While implementation sits with practices and service providers, the Heart Foundation may wish to consider the practical implications of these changes for primary care when finalising the guideline. Education and awareness-raising activities, including clinician and patient education, practical guidance, decision-support tools and other implementation resources, would help GPs and other healthcare professionals integrate these recommendations into routine care.
- The RACGP anticipates that implementation of the guidelines may require updates to key clinical resources, including its *Guidelines for Preventive Activities in General Practice* (Red Book),[5] National Guide, and associated educational materials. Subject to organisational priorities and funding availability, the RACGP may explore opportunities to update these resources to support consistent and effective adoption across general practice.

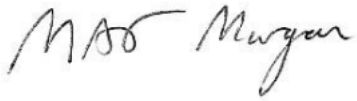
[4] Australian Institute of Health and Welfare & National Indigenous Australians Agency. Measure 1.07 High blood pressure, Aboriginal and Torres Strait Islander Health Performance Framework website [Internet]. Canberra: Australian Institute of Health and Welfare & National Indigenous Australians Agency, 2026 [cited 12 October 2026]. Available from: https://www.indigenoushpf.gov.au/measures/1-07-high-blood-pressure.

[5] The Royal College of General Practitioners. Guidelines for preventive activities in general practice, 10th edition [Internet]. Melbourne: The Royal College of General Practitioners; 2025 [cited 16 October 2026]. Available from: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/preventive-activities-in-general-practice/about-the-red-book.

- The RACGP would encourage the Heart Foundation to seek RACGP endorsement of the final hypertension guidelines. Endorsement would support future promotion of the guideline through RACGP educational, clinical and professional development activities.[6]

The RACGP thanks the Heart Foundation for the opportunity to provide feedback. If you have any queries regarding this submission, please contact Mr Stephan Groombridge, Head of e-Health, Quality Care & Standards on (03) 8699 0544 or at stephan.groombridge@racgp.org.au.

Yours sincerely



Prof Mark Morgan

Chair, RACGP Expert Committee – Quality Care

[6] Please visit the RACGP website for information on the endorsement process: The Royal College of General Practitioners [Internet]. Melbourne: The Royal College of General Practitioners; c2026. The endorsement and approval process for clinical resources; 2026 [cited 22 October 2026]. Available from: https://www.racgp.org.au/the-racgp/governance/endorsement