



Review of MBS Health Assessment Services

Findings and recommendations for reform

December 2025



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Summary

Health assessment services, progressively introduced to Medicare since the 1990s, aim to support the delivery of preventative health care within targeted population groups. Informed by recommendations from the Medicare Benefits Schedule (MBS) Review Taskforce, the Department of Health, Disability and Ageing has undertaken a review to consider the alignment of health assessment items with contemporary clinical practice and to identify barriers or challenges to delivering effective preventative care to patients under current health assessment items.

The review found that, while there is little published evidence to demonstrate the impacts of general, broad-based assessments on overall patient outcomes, published evidence supports the effectiveness of many sub-components of health assessments when targeted in accordance with clinical guidance across a patient's lifecycle. However, current item age stratifications and age-based clinical requirements do not consistently align with current clinical guidance or require updating to reflect current national screening programs and recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).

Additionally, while the review identified strong sector recognition of the value of health assessment items in delivering comprehensive preventative care, there continues to be only modest patient and provider use of the items, with low rates of repeat use by patients where they are available annually. Key limiters identified include the current complexity of item requirements, which may restrict providers' flexibility to deliver services that meet a patient's individual clinical needs and generate increased provider concern regarding potential MBS non-compliance, and a lack of sector awareness of the items and their application. The potential impact of condition specific health assessment items on care fragmentation was also highlighted.

Review outcomes lend support to the continuation of MBS health assessment items within relevant patient groups and, where indicated in clinical guidance, the expansion of these items to broader population groups who would benefit from focused preventative care activities at relevant stages throughout their lifecycle. This includes item simplification where possible, such as through the amalgamation and improved targeting of condition specific health assessments focusing on mid-life.

It is important to note that a 'one size fits all' approach to health assessments is unlikely to effectively meet the broad needs of patients, including patients who are experiencing specific life events, such as humanitarian entrants or former defence force personnel. To this end, the review proposes a range of reform approaches to ensure MBS health assessment items deliver high value, evidence based preventative care, now and into the future.

Initial, short-term reform, agreed by Government, will commence from 1 March 2026. This includes item updates to reflect current screening and vaccines advice (Recommendation 3) and improved alignment with clinical guidance of age stratifications and age-based clinical requirements for Aboriginal and Torres Strait Islander health assessments (Recommendation 7).

Recommendations for reform

The review makes a number of recommendations to maintain and improve the delivery and impact of MBS health assessment services in primary care, and to support increased uptake of the items within practice:

Recognising the importance of health assessments in enabling proactive preventative patient care

1. Retain the time-tiered structure for MBS health assessment items with:
 - The requirements for health assessments for residents of aged care facilities, people with intellectual disability, older persons, refugees and veterans to be reviewed in line with the recommendations below, and
 - Future arrangements for other currently eligible groups to be considered as part of Recommendation 8.
2. Retain stand-alone health assessments for Aboriginal and Torres Strait Islander patients, with the item requirements to be revised as set out in subsequent recommendations.

Ensuring item alignment with current clinical guidance, now and in the future

3. Update current MBS health assessment items to reflect the current cervical screening testing protocols and ATAGI recommended vaccines¹.
4. Where necessary, update the clinical requirements for MBS health assessment services to align with current clinical guidance. For example, update current requirements for the older persons' health assessment to include consideration of patient frailty.
5. Ensure that item requirements are structured in such a way that the risk of future misalignment with updated clinical guidance is minimised, noting that this may result in reduced specificity in regulation and additional detail in guidance material that can be more readily updated as required.
6. As part of the Government's digital health delivery agenda:
 - explore the integration and reporting of clinical information system (CIS) "encounter record" coding for greater insights on patients accessing health assessments
 - commission development of CIS compatible templates to support provider completion of clinically relevant and regulatory compliant health assessments
 - explore standardisation of a primary care data collection to supplement MBS information and generate insights into patient care pathways, care needs and outcomes.

¹ Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 March 2026).

Strengthening the targeting and availability of health assessment items

7. Align age ranges and clinical requirements for Aboriginal and Torres Strait Islander health assessments with the current edition of the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*.²
8. Replace the current MBS health assessment items for menopause and perimenopause, chronic disease risk, type 2 diabetes risk and heart health into a single mid-life assessment to be conducted using the time-tiered health assessment items. This should be accompanied by improved data collection reforms (Recommendation 6).
9. Extend temporary MBS items for heart health assessments until 30 June 2028 to enable the continuation of these services until the implementation of the proposed mid-life assessment.³
10. Ensure that age-based patient eligibility requirements and frequency of service for time-tiered health assessment items better reflect preventative care needs across a patient's lifespan.

Optimising resourcing structures to encourage workforce participation in MBS preventative care services

11. Ensure regulatory arrangements for health assessments enable flexible multidisciplinary care processes for primary care staff involved in developing a health assessment, including options for distance supervision, and consideration of the impacts of MBS 'personal attendance' arrangements on health assessment services.
12. Recognise the time spent by GPs engaging with residential aged care staff and patients' families and carers for the purposes of a health assessment conducted in this setting, whether through either the MBS or other funding sources.
13. Provision of funding, preferably through non-MBS mechanisms such as blended funding models, to general practice and Aboriginal Community Controlled Health Organisation (ACCHO) to support low intensity group services for patients who have had preventative care activities identified within a health assessment. For example, nurse or Aboriginal and Torres Strait Islander health worker led health education sessions on nutrition, cholesterol reduction or smoking cessation.

Establishing new ways of delivering health assessment services, especially in areas of workforce shortage

14. The department to undertake additional work to determine whether health assessment items should be extended to nurse practitioners once the final clinical requirements have been determined in areas of workforce shortage.
15. Taking into account the specific requirements of future health assessment items, and the MBS telehealth principle, determine whether telehealth items should be introduced for health

² Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 March 2026).

³ Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 July 2025).

assessments, including consideration of non-GP patient end support services to assist physical examination of a patient.

16. Where telehealth items already exist, align patient access requirements with their face-to-face equivalents.

Improving patient and sector awareness of, and engagement in, MBS health assessment services

17. Develop awareness and information materials targeted towards consumers and providers to illustrate the benefits of preventative care from health assessment services.
18. Develop clear communication materials around correct clinical and billing requirements as health assessments are updated, to educate providers and build their confidence in delivering health assessments to patients.

Health assessment services within primary care

Background

Health assessment items have been progressively introduced to Medicare since the 1990s to support general practitioners (GPs) and prescribed medical practitioners (PMPs) working in general practice to deliver targeted preventative care to patients. Under these items, providers undertake a comprehensive evaluation of a patient's health and wellbeing and consider whether preventative care and education may be of benefit to the patient.

Health assessment services were originally introduced as stand-alone items for each patient cohort targeted. In line with recommendations from the *MBS Review of Primary Care Items* (2009), the items were consolidated and simplified in 2010 to the current time-tier structure: brief, standard, long and prolonged health assessments. Untimed items for health assessments for Aboriginal and Torres Strait Islander people (MBS items 715 and 228) were also introduced at this time.

The item descriptors for general attendance items (Level B – Level D) were also amended in 2010 to explicitly include the provision of 'appropriate preventive health care' to better support patient access to preventive based clinical activities.

Further changes to the items occurred in 2015 with the cessation of the Healthy Kids Check and in 2019 with the introduction of temporary stand-alone items for heart health assessments. Temporary items for menopause and perimenopause health assessments also commenced on 1 July 2025.

Table 1: MBS Health Assessment types, eligibility, and availability

Assessment Name	Patient Eligibility	Service Type	Availability
Aboriginal and Torres Strait Islander Peoples Health Assessment	Child less than 15 years People aged between 15 years and 54 years People aged 55 years and older	Untimed	Once every nine months
Type 2 diabetes risk assessment	People aged 40-49 years with a high risk of developing type 2 diabetes	Time-tiered	Once every three years
Chronic disease risk assessment	People aged 45-49 years at risk of developing chronic disease	Time-tiered	Once only
Older persons health assessment	People aged 75 years and older	Time-tiered	Annually
Residential Aged Care Facility (RACF) - comprehensive medical assessment	Permanent RACF residents	Time-tiered	On admission to a facility, then annually
Intellectual disability – comprehensive medical assessment	People living with an intellectual disability	Time-tiered	Annually

Assessment Name	Patient Eligibility	Service Type	Availability
Refugee and other humanitarian entrant health assessment	Humanitarian entrants holding a relevant visa type	Time-tiered	Once only
Veterans' health assessment	Former serving members of the Australian Defence Force	Time-tiered	Once only
Heart health assessment	People aged 30 years and older	20+ minutes	Annually
Menopause and perimenopause health assessment	Patients experiencing premature ovarian insufficiency, early menopause, perimenopause or menopause symptoms	20+ minutes	Annually

While there is great diversity in service structure, eligibility, fees, and task requirements, the clinical focus of MBS health assessment types predominantly fall within two distinct categories:

- targeted health assessments for patients who may be at risk of developing a specific condition if assessment and intervention is delayed, for example patients at risk of type 2 diabetes, and
- comprehensive medical assessments for patients who may have preventative care measures overlooked in standard consultations, for example people living with intellectual disability, people aged 75 years and over and permanent residents of aged care facilities.

Review of MBS health assessment services

Whilst there has been expansion in the groups eligible for Medicare health assessments, specific MBS item requirements for existing services have remained largely unchanged. Over this time, Australia's population has undergone significant change, growing older and experiencing considerable increases in the prevalence of chronic conditions. Medicare has also undergone change over this time with the introduction of MBS items for telehealth services and extended consultations, as well as items to support nurse practitioners and allied health practitioners to deliver services under the MBS, and an increased focus on preventative care activities within general attendances.

Primary care models have also expanded with the introduction of some elements of blended funding, changes in health technologies and, more recently, the introduction of the patient registration model MyMedicare.

Following recommendations from the MBS Review Taskforceⁱ, the department commenced a review of all MBS health assessment services to consider the efficacy and effectiveness of these interventions within primary care. Key areas of consideration included:

- alignment of health assessment items with contemporary clinical practice
- ensuring consistency between different health assessment services
- identifying barriers or challenges to delivering effective preventative care to patients via the current health assessment items.

The review comprised three components: a systematic (literature) review of evidence, an analysis of MBS health assessment utilisation data and stakeholder consultation.

Systematic review

The department commissioned Bond University's Institute for Evidence-Based Healthcare to undertake a systematic (literature) review of evidence regarding the efficacy and effectiveness of MBS health assessment services in primary careⁱⁱ. The systematic review indicated, while certain activities delivered under health assessments have clear value, there is little published evidence to demonstrate the impact of general, broad-based health assessments on overall patient health outcomes.

The longitudinal impacts of health assessments, which are at their core a holistic multi-component episode of care, are difficult to evaluate as composite entities. This becomes even more problematic when attributing the impacts of potential additional benefits, such as continuity of care, the contribution of overall patient satisfaction with care provided and intergenerational assessment. While acknowledging that evidence on these assessments continues to grow over time, the systematic review noted that its findings on general, broad-based health assessments were inconclusive due to evidence limitations.

Noting this, the systematic review identified strong evidence to support the effectiveness of select sub-components of health assessments in improving health outcomes, when these subcomponents are targeted in accordance with clinical guidance: absolute cardiovascular risk, measurement of blood pressure, measurement of cholesterol, smoking cessation assistance, and increase in physical activity (particularly for falls prevention in the elderly) (see [Table 2](#)).

Additionally, the systematic review identified linked evidence to support the inclusion of additional sub-components in health assessments, noting delayed detection of relevant risks would likely have significant impacts on the health outcomes and/or quality of life of patients: diabetes risk assessment, obesity and overweight, hearing assessment, vision assessment, and screening for excessive alcohol use.

While many of the evidence-based sub-components are reflected in current MBS health assessment items, the systematic review noted current patient eligibility and service intervals for these items do not consistently align with current clinical guidance, limiting their potential effectiveness.

Overviews of evidence summaries for each health assessment component are at [Appendix A](#).

Additionally, the systematic review identified areas for procedural changes to the items where nomenclature or foci of complementary national programs has changed over time. This includes the commencement of cervical screening under the national screening program (replacing Papanicolaou smear processes) and current ATAGI vaccine recommendations.

Table 2: Review of evidence regarding the efficacy and effectiveness of MBS health assessment services in primary care

Health assessment component	Age to start assessments	Intervals between assessments	Sub-population starting age or assessment interval	Certainty of evidence [^]	Strength of advice for or against the use of this component
Cardiovascular risk	> 40 years	Low risk: every 10 yrs; intermediate risk: every 5 yrs; high risk: every 2 yrs	Start 10 years earlier for Aboriginal and Torres Strait Islander people	High	Strong for
In middle aged and older adults, a CVD risk assessment appears warranted as part of a general health assessment . Use of the absolute cardiovascular risk assessment approach directs treatment to those most likely to benefit.					
Blood pressure	> 21 years	Every 2-3 years	Start earlier for Aboriginal and Torres Strait Islander people	High	Strong for
High certainty evidence shows that detecting and treating high blood pressure in adulthood reduces cardiovascular events .					
Cholesterol or lipids	> 45 years	Every 3 years	Start 10 years earlier for Aboriginal and Torres Strait Islander people	High	Strong for
Detection and management of abnormal blood lipids in adult reduces the risk of all-cause mortality and major cardiovascular events .					
Diabetes	40 years	Low risk: every 5 yrs; Moderate risk: every 3 yrs; High risk: every 8 months	Start earlier for Aboriginal and Torres Strait Islander people (from 18 years)	Moderate	Conditional for
Earlier detection and management of diabetes in adults may reduce the risk of all-cause mortality, cause-specific mortality, cardiovascular events, or other diabetic complications .					
Smoking	All ages	Opportunistic	Assess Aboriginal and Torres Strait Islander people more frequently	High	Strong for
High certainty evidence shows identifying and offering brief advice and support increases quit rates long term. There is less direct evidence, but reasonable linked evidence that it reduces the health impacts of smoking such as CVD events and lung cancer .					
Alcohol use	> 15 years	Every 2-4 years	unclear	Low	Conditional for
Interventions to reduce alcohol intake did not improve mortality, CVD events or blood pressure in people with hypertension, but reduced blood pressure in people with mixed hypertension statuses. Counselling interventions in people who screen positive for unhealthy alcohol use are associated with reductions in use and that reduction in alcohol intake may reduce cardiovascular risk .					

Health assessment component	Age to start assessments	Intervals between assessments	Sub-population starting age or assessment interval	Certainty of evidence [^]	Strength of advice for or against the use of this component
Physical (in)activity	All ages	Every 2 years	Assess Aboriginal and Torres Strait Islander people and other high-risk groups annually	Moderate	Conditional for
Moderate certainty evidence shows exercise provides modest reductions in blood pressure across the range of baseline blood pressures, results in small improvements in HDL cholesterol in healthy adults or adults at risk of cardiovascular disease and reduces falls and falls related fractures .					
Obesity and overweight	All ages	Every 2 years	Assess Aboriginal and Torres Strait Islander and Pacific islander people every 12 months	Moderate to Low	Conditional for
In people screened for obesity there is no difference in weight change at 12 months between referral to a weight management program and support and advice. Behavioural interventions and weight reducing diets in overweight or obese adults reduces weight, BMI, waist circumference, total and LDL cholesterol, fasting glucose, and blood pressure. Linked evidence has found that reduction in weight reduces obesity related morbidity.					
Falls risk	70 years	unclear	unclear	Moderate	Weak against
The bulk of recent evidence strongly suggests that, for adults in the community, comprehensive falls risk assessment alone or as part of a multicomponent intervention does not significantly reduce incidence of falls or fractures or time to first event (fall or fracture) when compared to usual care. Multicomponent interventions indicate that exercise alone or exercise advice even in the absence of a falls risk assessment or intervention is the most effective strategy to reduce falls.					
Osteoporosis	50-60 years	every 5-10 years	May benefit high-risk people	High	Strong against
Osteoporosis risk assessment in community dwelling individuals (predominantly women) with or without an intervention does not reduce incident fractures overall but may benefit women and men at high baseline risk.					
Hearing	>60 years	every 2-3 years	Start earlier for Aboriginal and Torres Strait Islander people	Moderate	Weak for
Given the impact hearing loss can have on the health and quality of life of the aging population, our findings suggest that assessing hearing with a single question or whisper test every 2-3 years starting at age 60 and referring to hearing aid could help preserve quality of life in the elderly population.					
Vision	>60 years	every 2-3 years	Start earlier for Aboriginal and Torres Strait Islander people	Moderate	Weak for
Vision assessment in asymptomatic people does not appear to improve longer term vision outcomes. However, given the steep increase in vision impairment with advanced age and the impact that delay in detecting vision impairment and blindness can have on the health and quality of life of the aging population, our findings suggest that assessing vision every 2-3 years starting at age 60 and referring to vision services could help preserve quality of life in the elderly population.					

Health assessment uptake and use

The department acknowledges that preventative care activities are a core component of general consultations (Level A-E attendances). Data presented below represents services delivered via specific MBS health assessment items only.

MBS claims information from 2018-19 to 2022-23 suggests there is only modest patient and provider engagement with health assessment services, with limited uptake of health assessment services by current patient target groups and low rates of use of the services where available annually. However, when considered with provider utilisation rates, data suggests that where a provider is familiar with the items, the items play a strong role in preventative care activities of a practice. This is supported by qualitative evidence (see 'Consultations' below) which identified strong item utility in practices with a focus on patients targeted under current items, such as those living with intellectual disability or in residential aged care.

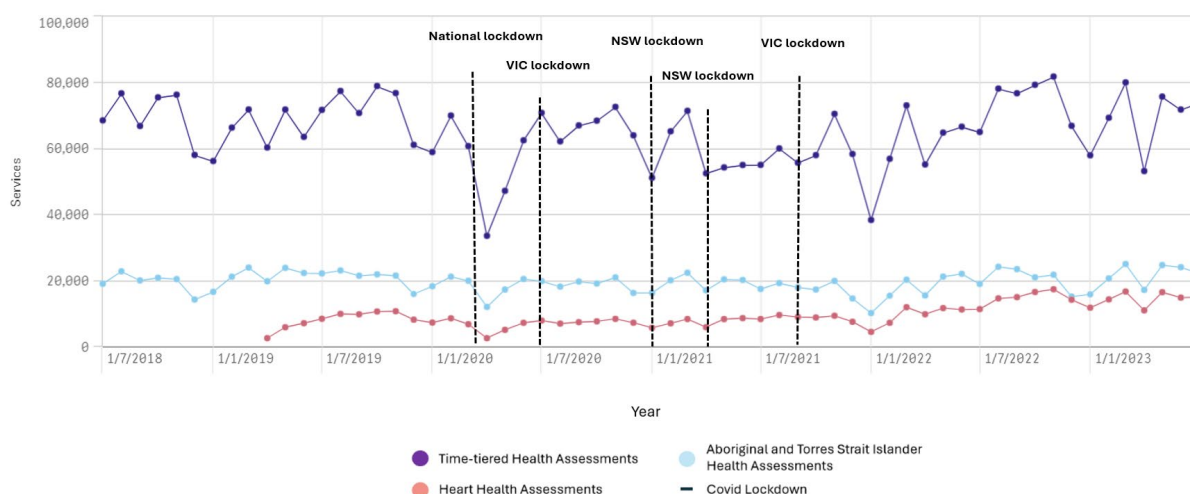
Available data does suggest the items may have a role in supporting earlier disease identification and/or formal management under the MBS in some patient groups.

The review acknowledges the limitations of current data sets to capture the use of health assessment services in general practice. The below analysis is based on MBS claims processing data which provides information on item uptake by patient age, sex and geographic location. However, for time-tiered health assessment services, MBS claims processing data cannot readily identify the type of assessment provided (e.g. veterans' health assessment, chronic disease risk assessment).

Service utilisation

Between 2018-19 and 2022-23, a total of **5,598,371 MBS health assessment services** have been accessed by **3,097,789 patients** (see Figure 1), with **39,631 practitioners** delivering at least one service. Item use dropped between 2020 and 2021 in line with increased COVID-19 infection periods in the community and associated national and state lockdowns, with modest variation in service delivery occurring between 2018 and 2019 (Figure 1).

Figure 1: Services by month by health assessment type between 2018-19 and 2022-23ⁱⁱⁱ



Analysis of data on uptake and utilisation of MBS health assessment item data suggests there is only limited uptake of the services within identifiable target patient cohorts, with very low repeat use of the services where a patient may access an assessment annually. For example:

- less than 13.4% of estimated patients aged <40 years living with an intellectual disability in Australia accessed a health assessment service between 2016-17 and 2022-23. Of those patients who did receive a health assessment service, only 2.3% received more than one service over these years, despite the service being available annually to this target group.^{iv}
- while around 78% of estimated patients aged ≥75 years accessed at least one health assessment service between 2018-19 to 2022-23, only 4.8% received the service annually over the five years, despite the service being available every 12 months to this target group.^v
- less than 25% of eligible people accessed an Aboriginal and Torres Strait Islander health assessment in 2022-23.^{vi} While 60% of these patients had received between two to six prior assessments between 2012-2022, data indicates the likelihood of Aboriginal and Torres Strait Islander patients receiving a health assessment or reassessment decreases as the patient's age increases. Of note, the majority of Aboriginal and Torres Strait Islander people receiving health assessments are younger patients, particularly patients aged 0 to 4 years old.
- 1.2% of estimated eligible patients accessed a heart health assessment in 2022-23, the year which had the greatest number of heart health assessments delivered.^{vii} Between 2019 and 2023, there was a repeat assessment rate of only 11.1%, despite these assessments being available annually.
 - Patients accessing heart health assessments were more likely to be in age ranges generally ineligible for other MBS health assessment services, with patients aged 50-74 years receiving a greater proportion of heart health assessment services compared to other eligible age cohorts.
- less than 10% of patients aged 40 to 49 years who are estimated to be eligible for a type 2 diabetes or a chronic disease risk evaluation service accessed a time-tiered health assessment in 2022-23.^{viii} Uptake of health assessment services by this age cohort has also been in decline since July 2018.

Provider uptake

Between 2018-19 and 2022-23, an average of 73% of total registered GPs and PMPs delivered at least one time-tiered health assessment service each financial year.^{ix} Approximately 57% of total providers delivered at least one Aboriginal and Torres Strait Islander health assessment over this time.

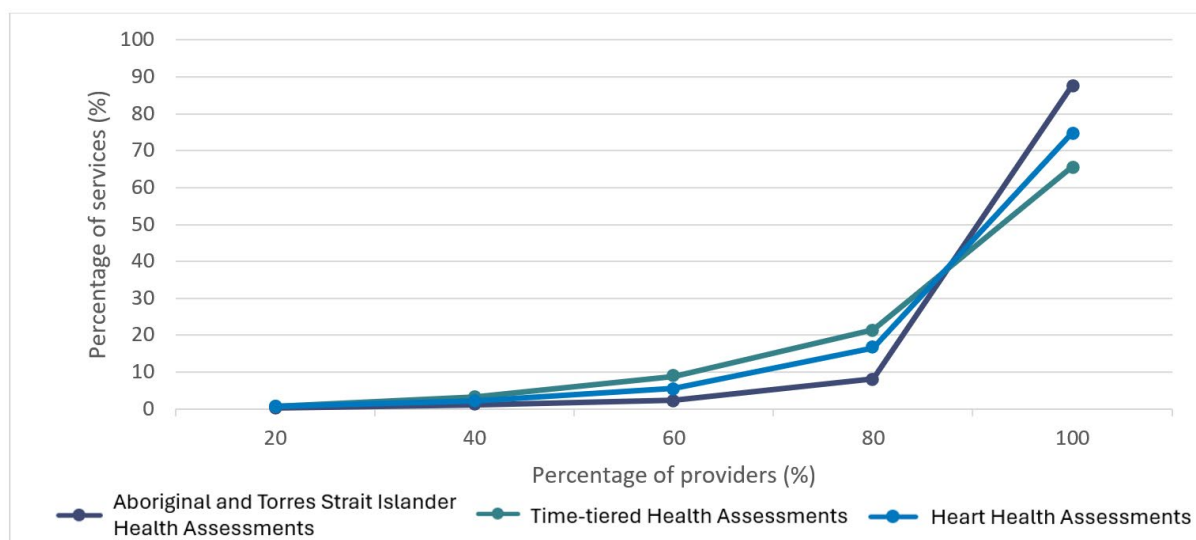
In addition, approximately 45% of all providers have delivered at least one heart health assessment service since the items commenced in April 2019.

Data indicates there is significant variation in the number of health assessment services delivered by individual providers, suggesting wide variation in provider and/or GP practice engagement with MBS health assessment items (see Figure 2). For example:

- between 2018-19 and 2022-23, 33% of providers delivered the majority (83%) of time-tiered health assessment services, with 4.7% of providers delivering nearly one third (30.1%) of all time-tiered health assessment services

- between 2018-19 and 2022-23, 20% of providers of Aboriginal and Torres Strait Islander health assessments delivered 88% of services,
- between 2018-19 and 2022-23, 20% of providers of heart health services delivered 80% of services.

Figure 2: Percentage of health assessment services delivered by percentage of providers (2018-19 to 2022-23)



Consultation lengths

Item utilisation data indicates time-tiered health assessment services are predominantly delivered through long (at least 45 minutes) and prolonged (at least 60 minutes) time-tiered consultations (items 705 and 707, or equivalent). Long and prolonged items are more frequently accessed by older Australians aged 75 years and over.

Brief consultations (under 30 minutes - item 701 or equivalent) are the least utilised assessment items and have been in decline since 2016,^x following the 2015 cessation of the healthy kids check. However, brief consultations remain the most frequently used service by 40–49 year olds (patients eligible for type 2 diabetes and chronic disease risk assessments).^{xi}

Table 3: Time-tiered services delivered per item from 2016-17 to 2022-23

Assessment Type (item)	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total
Brief (701, 224)	47,026	44,204	40,702	33,852	28,095	24,586	26,934	245,399
Standard (703, 225)	185,480	185,287	186,866	178,296	166,043	154,832	173,696	1,230,500
Long (705, 226)	211,834	221,410	230,407	224,157	225,306	217,826	256,410	1,587,350
Prolong (707, 227)	319,899	335,661	355,066	335,400	336,202	316,715	399,615	2,398,558
Total	764,239	786,562	813,041	771,705	755,646	713,959	856,655	5,461,807

Demographic trends

For time-tiered health assessments, the proportion of patients receiving one or more health assessment service within each rurality classification appears relatively consistent on a per capita basis, with the exception of remote communities (Table 4). While the majority of time-tiered health assessments are provided in metropolitan areas, the rates of health assessment on a per capita basis are slightly lower in metropolitan areas than in regional and rural areas.

Table 4: Uptake of time-tiered health assessment (TTHA) services by rurality in 2022-23

Modified Monash Model location	Population residing in MMM area in 2021 ^{xii}	Number of people received a TTHA	Percentage of people received a TTHA
MMM-1 (Metropolitan Areas)	16,562,074	577,034	3.48%
MMM-2 (Regional Centres)	2,088,256	86,737	4.15%
MMM-3 (Large Rural Towns)	1,509,139	66,058	4.37%
MMM-4 (Medium Rural Towns)	922 965	42,130	4.56%
MMM-5 (Small Rural Towns)	1,687,796	73,716	4.36%
MMM-6 (Remote Communities)	270,545	5,383	1.99%
MMM-7 (Very Remote Communities)	179 638	1,926	1.07%
Total	23,220,413	852,984	-

Similarly, a patient's socio-economic status (SEIFA) appears to have only limited influence on patient access to heart health assessment services, with the proportion of patients within each SEIFA group using the services remaining relatively stable. However, there are greater impacts of socio-economic status on the overall use of time-tiered health assessments with uptake being greatest amongst those most disadvantaged (over 10%) and steadily declining to 6% in the most advantaged socio-economic areas (see Table 5).

Table 5: Patient uptake of time-tiered health assessment (TTHA) and heart health assessment (HHA) services by SEIFA category (2018-19 to 2022-23)^{xiii}

Patient SEIFA category	Population by SEIFA category	Patient uptake of TTHA	SEIFA proportion TTHA %	Patient uptake of HHA	SEIFA proportion HHA %
1 (least advantaged)	2,524,779	264,988	10.5	40,650	1.6
2	2,525,255	272,019	10.8	46,999	1.9
3	2,524,902	255,020	10.1	46,085	1.8
4	2,524,796	241,971	9.6	47,022	1.9
5	2,525,080	226,898	9	46,908	1.9
6	2,525,002	214,718	8.5	46,076	1.8
7	2,525,084	202,468	8	44,798	1.8
8	2,525,064	194,499	7.7	44,842	1.8
9	2,525,220	185,495	7.3	41,506	1.6

Patient SEIFA category	Population by SEIFA category	Patient uptake of TTHA	SEIFA proportion TTHA %	Patient uptake of HHA	SEIFA proportion HHA %
10 (most advantaged)	2,524,598	167,501	6.6	36,659	1.5
Total	25,249,776	2,225,577	-	441,545	-

Evidence for the role of health assessments in disease identification and/or management

Data suggests that, while introduced as a preventative care measure, MBS health assessment services may assist in the formal management of newly identified or previously known conditions within eligible patient groups. At the time of data analysis, Medicare items were available for the development of GP Management Plans (GPMPs)⁴ and Mental Health Treatment Plans (MHTPs), and were restricted to patients living with a chronic condition or mental health disorder. MBS data indicates a proportion of patients went on to receive their first GPMP or MHTP within two months following a health assessment service. This suggests a correlation between the conduct of a health assessment service and the commencement of the formal management of a patient's condition under MBS pathways. For example:

- between 2016-17 and 2022-23, 16.2% of patients who received an Aboriginal and Torres Strait Islander health assessment went on to receive a GPMP and/or MHTP for the first time
- between 2016-17 and 2022-23, around 12.5% of patients who received a time-tiered health assessment went on to receive a GPMP and/or MHTP for the first time
- between 2018-19 and 2022-23, 7% of patients who accessed a heart health assessment service went on to receive a GPMP and/or MHTP for the first time.

While GPMP services were the most commonly accessed items for the above, a small percentage of patients (1.5%) accessed both a GPMP and a MHTP.

⁴ On 1 July 2025, GP Management Plans and Team Care Arrangements were replaced with the new GP chronic condition management plan framework.

Table 6: First uptake of GPMP or MHTP within two months following a health assessment service (2016-17 to 2022-23)^{xiv}

Patient Age	GPMP claimed	MHTP claimed	GPMP and MHTP claimed	Total plans	Total patients ^{xv}	% uptake
0-4	5,104	925	74	6,103	248,866	2.45
5-9	4,624	2,707	208	7,539	120,776	6.24
10- 14	4,223	3,506	229	7,958	112,795	7.06
15-19	4,538	3,743	237	8,518	105,232	8.09
20-24	5,623	3,466	291	9,380	95,472	9.82
25-29	6,437	3,163	308	9,908	91,698	10.81
30-34	7,798	2,800	350	10,948	93,561	11.70
35-39	9,010	2,313	341	11,664	94,976	12.28
40-44	23,664	4,362	760	28,786	244,355	11.78
45-49	59,556	10,784	1,885	72,225	686,402	10.52
50-54	15,041	2,152	402	17,595	158,624	11.09
55-59	13,675	1,822	331	15,828	151,327	10.46
60-64	12,170	1,316	216	13,702	142,465	9.62
65-69	10,649	867	96	11,612	134,205	8.65
70-74	9,623	673	74	10,370	128,714	8.06
75-79	92,225	5,439	589	98,253	889,893	11.04
80-84	63,514	2,875	276	66,665	641,200	10.40
85+	63,472	1,928	227	65,627	536,655	12.23

Stakeholder consultation

Public consultation on health assessment services, including on preliminary findings from the systematic review and the analysis of item utilisation, was undertaken between 22 July 2024 to 30 September 2024. Submissions were received from 118 individuals and organisations (64 survey responses and 54 written submissions). In addition, targeted workshops were conducted with key stakeholders to facilitate structured dialogue with the sector on the role of health assessments in contemporary patient care.

Consultation respondents (written submissions only) and participants from the targeted workshops are listed at [Appendix B](#).

Ensuring a proactive approach to patients' holistic health care needs

The consultation provided additional insight into the clinical value of health assessments and signalled strong sector support for the continuation of the items within general practice, with 80 per cent of survey respondents identifying current health assessments support preventative care. A key element of this support was respondents' consistent observation that MBS health assessment services promote a proactive approach to identifying and responding to a patient's biopsychosocial health needs, as compared to patient-initiated consultations for more acute or subacute issues.

Health assessments provide protected, extended consultations to explore complex health problems and strategise a treatment pathway, including social prescribing to assist the patient with their healthcare. Protected, extended consultation times permit practitioners to perform comprehensive reviews with vulnerable patients, who are the chief cohort targeted through health assessments and the patients most likely to possess the most complex of health concerns. (Australian Medical Association – AMA)

Allowing time for a specific assessment of activities of daily living and whole-body systems is useful for assessment needs and providing preventative and proactive management, rather than waiting for health problems to become established. (Royal Australian College of General Practitioners – RACGP)

[Health assessments] allow for a complete review of the person's functioning and health trajectory, and opportunities to support them and to prevent further illness and decline. (Australian Association of Gerontology - AAG)

Stakeholders further highlighted the role of health assessments in providing structured opportunities to address activities often missed or incompatible with general consultations. For example, conversations regarding advanced care planning activities, or exploring with frail elderly patients whether care interventions would likely be of benefit, or come with high risk of harm, discomfort or inconvenience which are not acceptable to the patient or the treating provider.^{xvi}

Observational studies suggest that the health assessment program may be effective in reducing functional decline and mortality and may delay admission to residential aged care. Health assessments have also been associated with a subsequent increase in medication review, chronic disease management, immunization, and diagnostic investigation. (Australian Association of Gerontology – AAG)

Healthcare expenditure frequently escalates substantially in the last 12 months of life, and a preventative/early intervention focus must avoid low value healthcare interventions performed on those with limited life expectancy. (Australian and New Zealand Society for Geriatric Medicine – ANZSGM)

This was also reported for patients living with intellectual disability, who may have issues reporting their symptoms or any changes in their function due to cognitive and communication difficulties.

There have been studies that have shown that if you assess the hearing and vision of people with intellectual disability, there's a high prevalence of hearing and vision impairments to 60-70% or even more, but many of those are not reported either by the person themselves or their carers Doing targeted health assessments picks up [these issues]... Similarly, with mental health conditions. (Workshop participant, Intellectual Disability Stakeholder Workshop)

People with intellectual disability experience more than twice the rate of avoidable deaths, twice the rate of emergency department and hospital admissions, higher rates of unrecognised or poorly treated physical and mental health conditions, lower rates of preventative healthcare... There is strong research of the importance of an annual health

assessment for people with intellectual disability. (Workshop participant, Intellectual Disability Stakeholder Workshop)

Stakeholders also observed the items formalise a process that provides patients with an understanding of their health and wellbeing and encourages them to engage proactively as managers of their own health. This was further explored with regard to assessment services for Aboriginal and Torres Strait Islander people, with stakeholders observing the items were of significant importance to continuity and cultural care, fostering patient connections with services so that they feel comfortable to go back when in need of health care or advice.

Enabling a person-centred approach to preventative care

Stakeholders consistently acknowledged that preventative care is not a 'one size fits all' model and Medicare support for these activities should enable a person-centred approach where providers can meet the individual needs of patients in their care. While acknowledging variability in requirements across items, key sector groups noted many health assessments currently over-regulate required clinical activities, working against a provider's ability to meet individual patient needs.

How much is the role of the MBS compared to the role of clinical [guidelines]?... [The department needs to] pitch MBS descriptors appropriately to give a bit of guidance, but not be a tick-a-box exercise, because these are supposed to be broad health assessments based on clinical judgement [and] appropriate best practice clinical guidelines. (Workshop participant, Overarching Stakeholder Workshop)

The perceived negative impacts of current item requirements on practice were varied, ranging from provider reluctance to deliver services under the items due to regulatory burden, to encouraging provider delivery of services via a 'check box' approach that fails to engage patients in active care.

As the administrative burden associated with health assessments increases, this becomes a barrier to their uptake. As such, they can offer little incentive to provide a structured approach to early detection and prevention of chronic disease. This is occurring in the context of an MBS system that already favours acute care. (RACGP)

Doctors don't use them is fear of being audited as the requirements are very complex. (Survey response)

More time required to discuss prevention methods rather than worrying about ticking all boxes and fearing compliance. (Survey response)

The National Aboriginal Community Controlled Health Organisation built further on this issue, noting the current items for Aboriginal and Torres Strait Islander people are not only 'lengthy, confusing', but often do not align with high quality preventative health activities recommended in evidence-based guidelines.

In contrast, a number of stakeholders whose work focuses on specific disease or patient age groups sought for greater disease diagnostic detail in the items. For example, requiring consideration of estimated glomerular filtration rates and urine albumin-creatinine ratio when assessing patients' diabetes, kidney disease and CVD risk, and frailty, sarcopenia and Mini-Mental State Examination assessments for older patients. Other stakeholders sought increased tailoring of health assessment

items to support the effective delivery of the services within specific population groups, such as LGBTIQ+ communities.

Also suggested was requiring the use of select evidence-based tools in health assessments, or the reproduction of these tools in item descriptors, such as the *Adult Comprehensive Health Assessment Program (CHAP)* tool and the *Australian guideline and calculator for assessing and managing cardiovascular disease risk*. However, a number of stakeholders raised concerns regarding the blanket use of prescribed tools, noting variation in academic endorsement of some instruments.

Feedback also noted current patient eligibility arrangements for health assessment items limit providers' abilities to appropriately target preventative care activities, with many stakeholders viewing the eligibility arrangements as 'arbitrary' and at intervals where prevention and/or early intervention activities are limited.

While many health assessments are designed to be used at specific ages to screen for chronic diseases as a preventative approach, this approach fails to consider the premature ageing of cohorts who live with the impact of diversity characteristics, such as identifying as Aboriginal or Torres Strait Islander, people living with HIV/AIDS, and older people leaving prison. For these groups, an age-related review fails to take into [account] their unique health needs that are influenced by environment and other factors rather than biological ageing. (AAG)

The 50-74 age group is largely overlooked. This represents a potential missed opportunity to intervene at a time when disease management and lifestyle factors can have a considerable impact on the ageing trajectory. (ANZSGM)

We recommend that the current age range be lowered for vulnerable groups at higher risk [of type 2 diabetes]. The prevalence of type 2 diabetes is higher in some culturally and linguistically diverse communities in Australia, particularly for people originating from the Pacific Islands, Middle East, South Asia and Africa. People from these communities are also at higher risk of hospitalisation for certain diabetes-related complications, including lower limb amputations and renal replacement therapy. (Diabetes Australia)

We recommend that type 2 diabetes risk assessments be available more frequently for people with a prior diagnosis of gestational diabetes... Women who have previously been diagnosed with gestational diabetes are seven times more likely to develop type 2 diabetes later in life. Children born to mothers with gestational diabetes are also at higher risk of developing obesity and type 2 diabetes later in life. (Diabetes Australia)

Respondents also reported that issues impacting older persons commenced earlier than current item eligibility for this population group (75 years), as is reflected in both the systematic review outcomes and current clinical guidance. For example, the *RACGP Guidelines for preventive activities in general practice* (Red Book) currently advises practitioners to consider opportunistic assessment of patients for atrial fibrillation, frailty and dementia from 65 years, with routine screening for osteoporosis from 55 years^{xvii}.

Feedback also identified patient groups who are not currently targeted under MBS health assessment items but experience significant health risk factors that would benefit from a focused

assessment approach. These include prisoners on release from incarceration, women experiencing perimenopause or menopause⁵ and Medicare-eligible children in out of home care.

Noting the prevalence of individual risk factors for disease and injury and broad difference in patient risk profiles, feedback acknowledged that setting a specific age commencement date for a population would likely be subjective and open to dispute. To this end, many stakeholders sought consideration of whether a risk-based approach to patient eligibility to health assessments may be appropriate, which considered preventative care activities across a patient's life cycle.

Regular evidence-based health assessments should be available to patients of all ages, with recommended intervals varying depending on healthcare need... This is preferable to singling out specific conditions upon which to base eligibility, which creates a hierarchy of diseases and is open to debate. (RACGP)

Going with the person-centred approach might work quite well and in restructuring... [General Practitioners] could make people eligible through their own decision making or risk assessments, rather than having standardised brackets or age brackets. (Workshop participant, Overarching Stakeholder Workshop)

Make them more broad and holistic, verses requiring a decision matrix at the clinical level to discern who is eligible and what activities are required based on their age verses based on their risk generally. (Survey response)

To this end, a central focus of feedback was establishing a more appropriate balance for the items that continued to ensure Medicare funding is directed to good clinical practice, while acknowledging that items themselves are not clinical guidelines and should not attempt to reproduce or regulate all potential elements of clinical decision making that could be required of practitioners.

Resourcing comprehensive preventative care in general practice

Stakeholders consistently identified that the higher value of rebates for health assessment items (as compared to items for general attendances) is a key enabler for comprehensive preventative care within general practice.

For many practices, health assessments would be financially unavailable if the MBS items were not available. (RACGP)

Health assessment services were also viewed as a key avenue for funding multidisciplinary team-based care within general practice. This is due to regulations for health assessment items specifically allowing practice nurses, Aboriginal health workers and Aboriginal Torres Strait Islander health practitioners to assist in the completion of a health assessment, when under the supervision of the medical practitioner.

⁵ MBS items for menopause and perimenopause health assessments were announced after the conclusion of review consultations (2025-26 Budget).

Health assessments support the employment of practice nurses and the sustainable creation of multidisciplinary care teams... allowing patients to receive wraparound care from a range of healthcare professionals. (RACGP)

We're doing a lot of team-based care that is unfunded by Medicare. [Health Assessments] at least open the door to some funding... Level A and level E is never going to do that. (Workshop participant, Aboriginal and Torres Strait Islander Services Stakeholder Workshop)

Care fragmentation

Feedback noted that disease specific health assessment services do not align with the provision of comprehensive, holistic patient care and may create fragmentation and/or unnecessary duplication in care delivered.

Health assessments should remain general and non-specific. The AMA considers structuring health assessment items specific to disease does not align with the provision of comprehensive GP care. It is impractical on a system level and our clinicians advise this approach does not bring about the intended patient health outcomes. (AMA)

To illustrate, stakeholders noted, at the time of the consultation, the MBS includes three condition specific health assessment items available to patients in, or from, mid-life: the type 2 diabetes risk evaluation (40-49 years), a health assessment for chronic disease risk (45-49 years) and the heart health assessment (from 30 years). However, many of the health conditions considered in this context share common risk factors and often have common treatment approaches.

There is strong evidence that these chronic conditions frequently co-exist and combining these into a single health check would mean that individuals can receive more effective care for multiple conditions that may affect them. Globally, there is a much stronger focus on a unifying approach to kidney, diabetes, cardiovascular care and this is reflected throughout international guidelines and recommendations. This approach reflects the common underlying pathophysiology and aligns well with new treatments, such as SGLT-2 inhibitors, ns-MRA & GLP1-RA, that have evidence and/or [Therapeutic Goods Administration] indications for use across multiple conditions. (Kidney Foundation)

In addition to cardiovascular diseases such as stroke and heart disease, many Australians are impacted by other chronic diseases including type 2 diabetes and chronic kidney disease. Importantly, all these diseases share common risk factors and often have common treatment approaches, such as the management of high blood pressure... Therefore, expanding the current Heart Health Assessment to a comprehensive chronic disease risk assessment, which could include a determination of type 2 diabetes and chronic kidney disease risk, in addition to [cardiovascular disease] risk, could be considered. (Stroke Foundation)

[Combining] chronic disease, type 2 diabetes and heart health checks into one health assessment item... could streamline the [health assessment] environment while still allowing patients clinically appropriate access to comprehensive assessments. (AMA)

Some disease specific groups questioned a unified approach, noting that the management of chronic conditions is not a one size fits all approach and that separate MBS items for type 2 diabetes and

heart health are used by organisations to promote and monitor the early detection and early management of these conditions.

Having a dedicated heart health assessment item (not integrated within the broader health assessment items) is essential to enable tracking of [cardiovascular disease] risk assessment in Australian primary care... Combining multiple chronic disease assessments into one single item might hinder our ability to track specific activity within each disease group. Additionally, a generic chronic disease check may not resonate with the Australian community who are more likely to engage in preventative checks that are disease specific. (Heart Foundation of Australia)

Overall, it is crucial that type 2 diabetes remains a distinct health assessment item due to its escalating prevalence... By prioritising diabetes screening and management, the MBS health assessment items have the potential to improve patient outcomes and quality of life, and contribute to a healthier population overall. (Diabetes Australia)

On a broader level, feedback also noted the potential role of MyMedicare in reducing overall care fragmentation and enhancing continuity of patient care over time. However, stakeholders cautioned that restricting the delivery of health assessment services to patients who are registered with MyMedicare, and receive the service from their registered practice, may act as a barrier to appropriate care.

There are multiple reasons why MyMedicare registration would be a barrier to high quality Health Checks

- *A Health Check is often performed on a person who is infrequently attending health services e.g. young men. These patients have frequently not met the requirements for MyMedicare registration.*
- *A Health Check can be an appropriate first consultation for a new patient. With the patient's consent, a Health Check can be a high-quality consultation [with] a patient who has just changed town or practice. The Health Check provides an opportunity to think holistically about the patient's needs and understand their priorities.*
- *Health Checks are important preventive activities for transient clients. People who are moving frequently between communities often have high healthcare needs and can have complex social needs such as homelessness. With the patient's consent, a Health Check can be an important activity to identify their needs, even if they are not a regular client of the service. (National Aboriginal Community Controlled Health Organisation – NACCHO)*

To this end, feedback supported the introduction of item restrictions requiring patients who are registered with MyMedicare to access a health assessment service from the practice they are registered with. However, stakeholders maintain health assessments should continue to remain available to patients who do not wish to or are unable to register with a practice under MyMedicare.

Nurse practitioners, practice nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners

As noted above, stakeholders acknowledged the value of multidisciplinary care and that health assessment services provide one of the main avenues for team-based care within general practice.

However, stakeholders remain relatively divided as to the role of medical and non-medical provider groups in delivering health assessment services in the primary care setting.

Medical groups maintain that MBS health assessment items should continue to support the central role of general practitioners in delivering comprehensive and coordinated patient care, noting aspects of health assessments such as interpretation of family history, medication and immunisation queries align with the scope of practice of GPs.

Scope of practice for health assessment items should not be broadened... GPs have the broadest diagnostic and initial health management range of any practitioner. As such, they are best placed to coordinate and review patient pathways, from diagnosis to treatment, including oversight of multidisciplinary team care. GPs are specifically trained in the generalist skills to deliver the complex consultations that support longitudinal care. (AMA)

While the coordinated care and supportive services rendered to GPs by practice nurses and other team members are essential to the quality of healthcare general practices provide, the AMA cannot support fragmenting the provision of health assessments by broadening the scope of eligibility for health assessment provision. Effective coordination can already be achieved through practice collaboration and structured referrals. (AMA)

The RACGP does not support any changes to health assessment that would...expand the scope of practice of other healthcare providers that sit outside of multidisciplinary team that includes a GP, or who are not trained to independently conduct assessments. (RACGP)

This was echoed in the response from the National Centre of Excellence in Intellectual Disability Health, who emphasised the valuable role nurse practitioners play in conducting health assessment where general practitioners are not readily available, but sought for nurse practitioners to liaise with a general practitioner to complete full examinations and to make referrals.

Alternatively, many stakeholders supported changes to health assessment services to better reflect the clinical and therapeutic interactions nurses and other providers have with patients. This included exploring options to channel funding of these services outside of the MBS and/or the expansion of current items to nurse practitioners.

Nurses and midwives have the qualifications, knowledge, and scope of practice to undertake complex assessments and should be able to access MBS items that are within their scope of practice, without the oversight of a general practitioner (GP). Ideally health assessments would be available through block or salaried models of funding and include nurses and midwives working in aged care facilities, community health centres and facilities such as nurse-led walk-in centres and specialised registered nurses, such as women's health nurses. This would increase access to affordable, preventative care and early intervention. (Australian Nursing and Midwifery Federation – ANMF)

NACCHO received consistent feedback that Nurse Practitioners are appropriately trained to delivery of high-quality health assessments and preventive health advice. Nurse Practitioners are employed across several services within ACCHOs multidisciplinary primary care teams. Particularly within this team environment and supported by Aboriginal and Torres Strait Islander staff, Nurse Practitioners have the appropriate skills to deliver evidenced-based

prevention and there should be no requirement for medical officer review in addition to their assessment. (NACCHO)

Capacity of GPs is diminishing to undertake these assessments which take some time to complete, especially in underserved areas, raising the potential for clinic nurses to assist with the completion of health assessments. Carey and colleagues found there is no standard approach to health assessments, and that most of the assessment items could be completed by clinic nurse. (Australian Association of Gerontology)

Also raised in feedback was the potential expansion of current providers able to assist general practitioners to complete a health assessment, such as through the inclusion of Aboriginal and Torres Strait Islander nurses and midwives.

Stakeholders also sought consideration of potential new funding for practice nurse or Aboriginal health worker led low intensity, group follow up services following a health assessment. For example, the delivery of culturally safe group services with Aboriginal and Torres Strait Islander people on areas such as smoking cessation, diabetes management and nutritional group support, or group services on nutrition for older Australians and pre-diabetic patients.

Preventative care data collection

Feedback noted that, as a benefits administration system, the MBS is significantly limited with regard to patient surveillance, unable in general to capture clinical information as to a patient's reasons for receiving a service or the specific health conditions or needs addressed during this service. This has particular impacts for MBS items for time-tiered health assessment services (MBS items 701-707 and 224-227), which can each be used to bill six different types of health assessments.

To improve data capture and monitoring of services delivered, some stakeholder groups sought for time-tiered health assessment items to be further disaggregated, with separate stand-alone or time-tiered item numbers for each population group targeted.

[Reintroduce] a specific item number for health assessments in people with intellectual disability.... [A] key action of the [National Roadmap for Improving the Health of People with Intellectual Disability] is to "establish a system for measuring the uptake of annual health assessments for people with intellectual disability." This is essential to allow monitoring the uptake of health assessments in this vulnerable population as a priority under the Roadmap, and aligns with the Roadmap's recommendation for research, data and measurement to support continuing improvement. (National Centre for Excellence in Intellectual Disability)

Nursing groups also noted that current MBS data failed to appropriately capture nurse participation in the development of health assessments.

MBS data is not reflective of contemporary practice, in the billing is predominantly aligned with GP activity which creates the health care delivered to patients by nurses and all of other professionals as invisible. (Australian Primary Health Care Nurses Association)

While stakeholders acknowledged the importance of data in optimising the value of the health system, many stakeholders remained equivocal as to MBS or non-MBS pathways for service data collection, with many seeking additional simplification of the current items (see [Care fragmentation](#)).

Health assessments in residential aged care settings

Stakeholders identified comprehensive health assessments for older Australians were a key activity for practitioners and an area of increasing complexity as patients transitioned to residential aged care with multiple care needs. Feedback noted current limitations of health assessment items to recognise indirect care provided by general practitioners and broader support staff in these settings.

[the current system requires] improved remuneration of health assessment items to recognise the considerable amount of time spent by GPs on indirect patient care. This could include speaking with the family, other telephone calls, and liaison with facility clinical and care staff (including care conferencing), all of which can help to avoid unnecessary hospital utilisation. (ANZSGM)

Patients in residential aged care are often living with multiple and complex morbidities, significant physical and cognitive decline as well as mental health concerns and polypharmacy. Accordingly, practitioners delivering health assessments in these settings undertake significant collaboration with the patient's broader multidisciplinary health care team, including facility staff and the patient's family. As time-tiered health assessments are personal attendance items, for which only time a patient is receiving active attention is included, much of this work falls outside of current funding streams.

Multidisciplinary case conferencing items are available to support general practitioner participation in care conferences, but only where a minimum of two other care providers take part, such as allied health professionals and home and community service providers. While a patient's family may participate in a case conference, unpaid carers of the patient are not counted toward minimum participant numbers.

Other stakeholder observations

Stakeholders noted the potential of telehealth to address care for patients in rural and remote communities, who often experience issues accessing a general practitioner. This included telehealth patient end support items for nurses and Aboriginal health workers assisting in the delivery of the health assessment service. Currently, only health assessments for Aboriginal and Torres Strait Islander people may be delivered via telehealth.

Many people are required to leave community for extended periods, for example, to attend boarding school. In these contexts, patients may want to engage their regular healthcare provider who they have a trusting relationship with to conduct a Health Check. In these contexts, telehealth supports high-quality primary care with continuity of care for patient and provider. (NACCHO)

Social prescribing was also consistently highlighted by stakeholders as a key element of disease prevention and management, especially within the health assessment context.

Discussion and recommendations for reform

The review makes a number of recommendations to improve the delivery and impact of MBS health assessment services and to support increased uptake of the items within practice. Recommendations fall primarily within the following six themes:

1. Recognising the importance of health assessments in enabling proactive preventative patient care
2. Ensuring item alignment with current clinical guidance, now and in the future
3. Strengthening the targeting and availability of health assessment items
4. Optimising resourcing structures to encourage workforce participation in MBS preventative care services
5. Establishing new ways of delivering health assessment services, especially in areas of workforce shortage
6. Improving patient and sector awareness of, and engagement in, MBS health assessment services

Theme 1: Recognising the importance of health assessments in enabling proactive preventative patient care

The review recognises findings from the systematic review and sector observations support the continuation of health assessments, noting the role of the assessments in promoting a proactive approach to identifying and responding to a patient's biopsychosocial health needs. Additionally, the review recognises that the current time-tier structure of health assessments, together with untimed items for health assessments for Aboriginal and Torres Strait Islander people, supports practitioners to flexibly deliver holistic, patient centred care.

Recommendations

1. Retain the time-tiered structure for MBS health assessment items with:
 - The requirements for health assessments for residents of aged care facilities, people with intellectual disability, older persons, refugees and veterans to be reviewed in line with the recommendations below, and
 - Future arrangements for other currently eligible groups to be considered as part of Recommendation 8.
2. Retain stand-alone health assessments for Aboriginal and Torres Strait Islander patients, with the item requirements to be revised as set out in subsequent recommendations.

Theme 2: Ensuring item alignment with current clinical guidance, now and in the future

The review recognises the volume and complexity of requirements under MBS health assessment items and notes there is scope to reduce this, consistent with the current program of work to streamline and modernise Medicare health care arrangements. This is of particular importance when considering the unintended impacts of health assessment regulation on providers' individual clinical decision-making abilities, health system complexity and the efficient delivery of services.

The review supports the progression of only minor changes to current MBS health assessment clinical requirements in the immediate term to ensure item alignment with broader clinical guidance such as the *Guidelines for preventive activities in general practice* ('Red Book'), while enabling local adaptation and application where appropriate. For example, the introduction of a frailty assessment when undertaking a health assessment for older Australians, reflecting the 2024 addition of this activity within the Red Book.

The review recommends further simplification of MBS health assessment requirements should also be explored to address the impact of complex item descriptors on providers' clinical decision-making abilities (see also [Theme 3](#)).

Review outcomes also acknowledge that the components of effective health assessments will change over time as innovations and new evidence emerge, as where patient demographics and care needs change. However, given the regulatory nature of the MBS, health assessment items cannot readily adapt to evolutions in clinical practice and may lead to the items becoming out of date within a short period of time. To this end, options to improve the 'future proofing' of these items should be explored, including how MBS regulations and guidance materials best support item alignment with clinical guidance over time.

The review notes current limitations in the availability of health assessment data and the potential implications of item simplification on this issue. As outlined in the *Digital Health Blueprint 2023–2033*^{xviii}, investment in data collection, analysis and infrastructure, along with the use and reuse of this data, will optimise the value of the health system and reduce low-value care. As the MBS's core function is as an administrative tool for the regulation of patient subsidies, the review considers it poorly suited to support service delivery and outcome measurement. It lacks the necessary clinical context for service delivery and outcomes, such as patient diagnoses, test results, observation measurement and prescribing instructions. Additionally, increasing administrative complexity of MBS items to enhance data collection would likely attract significant criticism from both medical and patient groups.

The review acknowledges patient level data is routinely collected by practices through clinical information systems (CIS) and shared to Primary Health Networks (PHNs), supported by incentives such as the Practice Incentives Program Quality Improvement (PIP QI) incentive. Currently this de-identified data is used for local analysis and service planning, identifying key priority areas and quality improvement activities. However, the lack of standardisation in the way data is structured and captured across differing CIS and inconsistency in what is shared to PHNs makes it difficult to compare.

Given the vast majority of Australian general practices are actively using CIS^{xix}, non-MBS investment to better standardise and harness this data to monitor patient use and uptake of preventative care services should be considered within the department's digital health delivery agenda.

A number of procedural MBS changes requiring immediate action were also identified through the review. These changes relate to the replacement of outdated clinical tests referenced in regulation with modern requirements (for example, Papanicolaou smears), and the alignment of vaccinations cited in health assessment services with current ATAGI recommendations.

Recommendations

3. Update current MBS health assessment items to reflect the current cervical screening testing protocols and ATAGI recommended vaccines⁶.
4. Where necessary, update the clinical requirements for MBS health assessment services to align with current clinical guidance. For example, update current requirements for the older persons' health assessment to include consideration of patient frailty.
5. Ensure that item requirements are structured in such a way that the risk of future misalignment with updated clinical guidance is minimised, noting that this may result in reduced specificity in regulation and additional detail in guidance material that can be more readily updated as required.
6. As part of the Government's digital health delivery agenda:
 - explore the integration and reporting of clinical information system (CIS) "encounter record" coding for greater insights on patients accessing health assessments
 - commission development of CIS compatible templates to support provider completion of clinically relevant and regulatory compliant health assessments
 - explore standardisation of a primary care data collection to supplement MBS information and generate insights into patient care pathways, care needs and outcomes.

Theme 3: Strengthening the targeting and availability of health assessment items

The review identified several areas where current targeting and/or availability of health assessment services remains suboptimal. This includes instances where:

- patient age or risk-based eligibility for time-tiered health assessment items does not align with current evidence
- patient age stratifications for preventative care services for Aboriginal and Torres Strait Islander people do not align with current clinical guidance.

For example, MBS health assessment items for Aboriginal and Torres Strait Islander people tailor preventative health activities across three age domains: children (birth to less than 15 years), adults (between 15 years and 54 years) and older persons (aged 55 years and over). However, current national guidance (*National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*) suggests these activities be further tailored across five age domains: infants and preschool (birth-5 years), primary school age (5-12 years), adolescents and young people (12-24 years), adults (25-49 years) and older people (50+ years).

In addition, the review found high levels of support for the amalgamation of current disease-specific items into a holistic assessment service which focuses on broader risk factors associated with mid-life. This includes current health assessment items for chronic disease risk, type 2 diabetes risk and

⁶ Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 March 2026).

heart health assessment, as well as newer health assessment items for menopause and perimenopause.

Overall, the review found the benefits of a flexible, holistic approach outweighed a condition specific approach to health assessments, especially for conditions that share multiple common risk factors, such as cardiovascular disease and type 2 diabetes. In these instances, having multiple health assessments addressing the same or similar underlying risk factors for specific conditions increases the potential for duplication of assessments and confusion for patients. Efficiencies arising from a more flexible approach that removes duplication allow for a broader population to be supported through health assessments. This better aligns with clinical guidance and allows assessments over time, including as life stages, such as menopause, change disease risk.

The review recognises that some condition-specific organisations oppose the broad-based item approach, noting this approach may impact on disease and 'brand' recognition they have built within the community and sector. While condition-based campaigning and 'brand' recognition is valuable for population awareness and action, condition-specific items are not essential for health promotion. Organisations will be able to promote mid-life health assessments for patients' health needs and risks relating to conditions such as heart health, diabetes, perimenopause and menopause.

Maintaining condition-specific items and further disaggregating time-tier assessments to improve data capture and monitoring of uptake among targeted cohorts should not be a reason to obstruct a more efficient mid-life assessment. While the review recognises the importance of data collection, the MBS is fundamentally an administrative payment system and does not capture clinical information. Health assessments in line with the current condition-specific items would also be occurring in general consultations and are therefore not currently reflected in specific item claiming data. Alternative mechanisms outside of the MBS should be considered, in line with Recommendation 6 of this Review, to support a more complete and accurate understanding of preventative care delivery across the health system.

The review findings also acknowledge the benefits of encouraging flexible preventative care activities that are delivered throughout a patient's lifecycle, as compared to specific age or life intervals. Moving forward, MBS and non-MBS mechanisms to support such a model should be prioritised, building on the objectives of MyMedicare and similar reforms. The expansion of health assessment items to additional target groups, such as children in out-of-home care and people on release from custodial care, should be considered in this context.

Specific population cohorts who would benefit from the continuation of current targeted one-off or annual assessments were also recognised by the review. For example, annual comprehensive medical assessments for older patients and patients with intellectual disability, who often have more complex needs and may be at increased risk of diagnostic overshadowing under usual care arrangements. Additionally, one-off health assessments that target the particular needs of refugees or former serving members of the Australian Defence Force, many of whom are newly connecting with the Medicare system.

The review findings also suggest additional MBS and non-MBS supports are required for assessment services delivered to patients with more complex needs, such as patients living with intellectual disability or a cognition disorder such as dementia who may require multiple attendances to complete a health assessment service.

Recommendations

7. Align age ranges and clinical requirements for Aboriginal and Torres Strait Islander health assessments with the current edition of the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*.⁷
8. Replace the current MBS health assessment items for menopause and perimenopause, chronic disease risk, type 2 diabetes risk and heart health into a single mid-life assessment to be conducted using the time-tiered health assessment items. This should be accompanied by improved data collection reforms (Recommendation 6).
9. Extend temporary MBS items for heart health assessments until 30 June 2028 to enable the continuation of these services until the implementation of the proposed mid-life assessment.⁸
10. Ensure that age-based patient eligibility requirements and frequency of service for time-tiered health assessment items better reflect preventative care needs across a patient's lifespan.

Theme 4: Optimising resourcing structures to encourage workforce participation in MBS preventative care services

The review identified significant support for the role of non-GP practice staff in preventative health care, including the development of health assessments. However, current Medicare guidance and regulations for health assessment items may be inadequate or unnecessarily restrict non-GP practice staff from delivering services to their full scope of practice.

Current regulation enables practice nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers to assist in the delivery of health assessments under the supervision of the treating medical practitioner. However, 'supervision' is not defined under regulation and may lead to unnecessary personal oversight of activities within non-GP practice staff's scope of practice (for example, taking of a patient's blood pressure). Additionally, health assessment items are identified as personal attendances under regulation, which require the services to be delivered by a single general practitioner on a single patient.

The review also recognised the limited recognition of indirect care delivered to patients within residential aged care facilities, such as GP liaison with a patient's family and facility staff to complete and implement the agreed outcomes of a health assessment. While MBS items for multidisciplinary case conferencing are available, these items require a minimum of three participants and likely have limited utility for health assessments in these settings.

The review highlighted the need for more flexible arrangements to allow GPs to be remunerated for time spent delivering health assessment services to aged care residents when the patient is not present. For example, time spent discussing the patient's health status with aged care nursing staff or patients' families. The review also acknowledges the participation of aged care staff in health assessments may not be adequately recognised in staffing levels.

⁷ Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 March 2026).

⁸ Recommendation agreed by the Government in the 2025-26 Budget (implementation 1 July 2025).

Review outcomes also noted limitations in low-intensity follow up care for time-tiered health assessment services, such as practice-led group services delivering education on priorities and goals identified within an assessment. Similarly, while individual follow-up MBS services are available for Aboriginal and Torres Strait Islander people, there are no items for low-intensity group-based services which may support culturally appropriate care.

Recommendations

11. Ensure regulatory arrangements for health assessments enable flexible multidisciplinary care processes for primary care staff involved in developing a health assessment, including options for distance supervision, and consideration of the impacts of MBS 'personal attendance' arrangements on health assessment services.
12. Recognise the time spent by GPs engaging with residential aged care staff and patients' families and carers for the purposes of a health assessment conducted in this setting, whether through either the MBS or other funding sources.
13. Provision of funding, preferably through non-MBS mechanisms such as blended funding models, to general practice and Aboriginal Community Controlled Health Organisation (ACCHO) to support low intensity group services for patients who have had preventative care activities identified within a health assessment. For example, nurse or Aboriginal and Torres Strait Islander health worker led health education sessions on nutrition, cholesterol reduction or smoking cessation.

Theme 5: Establishing new ways of delivering health assessment services, especially in areas of workforce shortage

The review notes the limited delivery of health assessment services to patients in remote and very remote communities and acknowledges continued workforce constraints within these areas.

Review findings acknowledge the role of telehealth in supporting patient access to medical services, and that telehealth items for Aboriginal and Torres Strait Islander health assessments were introduced during the COVID-19 pandemic. While the efficacy of remote services was not specifically considered under the review, the review is cognisant of MBS telehealth principles outlined within the MBS Review Advisory Committee's *Telehealth Post-Implementation Review Final Report*^{xx}. These principles support funding for the safe and high-quality use of telehealth, but notes telehealth is not suitable when hands-on clinical assessment is needed, particularly in cases where the clinician requires a lot of different information or needs to assess complex factors to make a diagnosis.

To this end, the review supports the potential expansion of telehealth health assessment services, but notes team-based models that support the remote completion of required physical examinations be further explored prior to any expansion, such as the use of telehealth patient end supports.

The role of the broader health workforce in supporting equitable access to preventative care services should also be explored. For example, nursing colleges have called for the introduction of MBS health assessment items for nurse practitioners, noting this would support practitioners to work to their full scope of practice and help eliminate barriers preventing patients from seeing a practitioner of this type. Alternatively, medical groups continue to advise against an expansion of this type, noting

aspects of health assessments remain aligned with general practice including interpretation of family history, medications and immunisation queries.

The review also acknowledges that, unlike their equivalent face-to-face items, telehealth items for Aboriginal and Torres Strait Islander health assessments are available to residents of aged care facilities. Introduced as part of broader measures to reduce patient deconditioning during the COVID-19 pandemic, these items were made available within aged care to facilitate resident referrals to relevant physiotherapy and exercise physiology services.

In line with other MBS items related to COVID-19 deconditioning, it is recommended that access to MBS telehealth items for Aboriginal and Torres Strait Islander health assessments be realigned with the equivalent face-to-face items.

Recommendations

14. The department to undertake additional work to determine whether health assessment items should be extended to nurse practitioners once the final clinical requirements have been determined in areas of workforce shortage.
15. Taking into account the specific requirements of future health assessment items, and the MBS telehealth principle, determine whether telehealth items should be introduced for health assessments, including consideration of non-GP patient end support services to assist physical examination of a patient.
16. Where telehealth items already exist, align patient access requirements with their face-to-face equivalents.

Theme 6: Improving patient and sector awareness of, and engagement in, MBS health assessment services

The review identified that a key factor impacting consumer and provider uptake of health assessment services was limited understanding of the items' availability, utility and billing arrangements.

Recommendations

17. Develop awareness and information materials targeted towards consumers and providers to illustrate the benefits of preventative care from health assessment services.
18. Develop clear communication materials around correct clinical and billing requirements as health assessments are updated, to educate providers and build their confidence in delivering health assessments to patients.

ⁱ The Department of Health and Aged Care, MBS Review Taskforce Report on Primary Care, 2020, <https://www.health.gov.au/resources/publications/taskforce-final-report-primary-care>

ⁱⁱ Bond university (unpublished) report

ⁱⁱⁱ Note: MBS monthly statistics are highly variable and lower service numbers in the December-January period are consistent with long term pre-COVID trends.

^{iv} Based on MBS claims data for patients <40 years in age, and estimated Intellectual Disability population data for 2022 and 2018 as outlined in:

- The Department of Health, National Roadmap for Improving the Health of People with Intellectual Disability, 2022, <https://www.health.gov.au/our-work/national-roadmap-for-improving-the-health-of-people-with-intellectual-disability>.
- Australian Institute of Health and Welfare, People with a disability in Australia, 2022, <https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability>.

^v Based on MBS claims data for patients 75+ years in age and 2021 population data outlined in:

- Australian Bureau of Statistics, 2021 Population: Census, Information on sex and age, <https://www.abs.gov.au/statistics/people/population/population-census/2021>.
- Australian Institute of Health and Welfare, People using aged care, 2023, <https://www.gen-agedcaredata.gov.au/topics/people-using-aged-care>.

^{vi} Based on MBS claims data and 2021 Aboriginal and Torres Strait Islander total population (984,000) as outlined in:

- Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians, 2021, <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release>.

^{vii} Based in MBS claims data and:

- Australian Bureau of Statistics: Census of Population and Housing: Snapshot of Australia data summary, 2021, dataset.
- Australian Bureau of Statistics: Census of Population and Housing: Health data summary, 2021, dataset.

^{viii} Based on MBS data and 2021 populations estimates for patients at risk of chronic disease, including type 2 diabetes.

- Australian Bureau of Statistics Census data - Census of Population and Housing: Health data summary, 2021.
- Australian Institute of Health and Welfare, Diabetes: Australian facts, 2021, <https://www.aihw.gov.au/reports/diabetes/diabetes/contents/how-common-is-diabetes/type-2-diabetes>.

^{ix} Based on MBS data and workforce estimates within the Department of Health and Aged Care, General Practice Workforce providing Primary Care services in Australia, <https://hwd.health.gov.au/resources/data/gp-primarycare.html>.

^x Based on MBS data.

^{xi} Based on MBS data.

^{xii} Population data obtained from Versace, Vincent L., *National analysis of the Modified Monash Model, population distribution and a socio-economic index to inform rural health workforce planning*, The Australian Journal of Rural Health, vol.29.

^{xiii} Based on MBS data and Australian Bureau of Statistics Census data sets (via TableBuilder).

^{xiv} Includes all health assessment. Based on MBS data.

^{xv} Total number of patients who accessed an MBS health assessment.

^{xvi} New South Wales Agency for Clinical Innovation (2019), *Over-diagnosis and over-treatment in the frail elderly*, www.aci.health.nsw.gov.au/_data/assets/pdf_file/0003/561846/ACI-Aged-Frailty-elderly-report.pdf

^{xvii} Royal Australian College of General Practitioners (2024), *RACGP aged care clinical guide – ‘Silver Book’*

^{xviii} Cheah, R. et al (2024), *Using primary care data for research: What are the issues and potential solutions?*, Australian Journal of General Practice Vol. 53, No. 6

^{xx} The Department of Health and Aged Care, MBS Review Advisory Committee Report on Telehealth Post-Implementation Review, 2024, <https://www.health.gov.au/resources/publications/mbs-review-advisory-committee-telehealth-post-implementation-review-final-report>
<https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-final-report-primary-care-report-on-primary-care.pdf>

Appendix A – Evidence summaries

Prepared for the Department of Health and Aged Care by the Institute for Evidence-Based Healthcare, Bond University, Australia, 2022

Provided as an attachment.

Appendix B – Submissions and workshop attendees

Submissions

Aboriginal Health Council of Western Australia	Inclusion Australia
Aboriginal Medical Services Alliance Northern Territory	Indigenous Allied Health Australia
Aged and Community Care Providers Association	Institute for Evidence-Based Healthcare – Bond University
Allergy and Lung Health Unit - University of Melbourne	Institute for Urban Indigenous Health
Allied Health Professions Australia	Kidney Health Australia
Asthma Australia	LGBTIQ+ Health Australia
AstraZeneca	Lung Foundation Australia
Australian and New Zealand Society for Geriatric Medicine	Medibank Private
Australian Association of Gerontology	Medtronic
Australian Association of Psychologists Inc	Moorditj Koort Aboriginal Corporation
Australian College of Midwives	National Aboriginal Community Controlled Health Organisation
Australian College of Nurse Practitioners	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Australian College of Nursing	National Centre for Aboriginal and Torres Strait Islander Wellbeing Research - Australian National University
Australian Commission on Safety and Quality in Health Care	National Centre of Excellence in Intellectual Disability Health
Australian Dental and Oral Health Therapists Association	National Heart Foundation of Australia
Australian Dental Association	National Hypertension Taskforce
Australian Healthcare & Hospitals Association	Njernda Aboriginal Corporation
Australian Medical Association	North Western Melbourne Primary Health Network
Australian Nursing and Midwifery Federation	Optometry Australia
Australian Pain Society	Palliative Care Outcomes Collaboration
Australian Physiotherapy Association	Pharmacy Guild of Australia
Australian Primary Health Care Nurses Association	Primary Health Network - Brisbane South
Australian Social Prescribing Institute of Research and Education	Primary Health Network - Northern Queensland
Baker Heart and Diabetes Institute	Queensland Aboriginal and Islander Health Council
Blackburn Clinic	Queensland Centre of Excellence in Autism and Intellectual Disability Health
Bollen Health	Queensland Nurses and Midwives' Union
Bupa	Refugee Health Network Queensland
Cancer Council Australia	Royal Australian College of General Practitioners
Carbal Medical Services	SPHERE Centre for Research Excellence
Danila Dilba Health Service	Stroke Foundation
Dental Health Services Victoria	Tasmanian Department of Health
Department of Home Affairs	The Obesity Collective
Diabetes Australia	Wuchopperen Health Service
Doctors for the Environment Australia	Individual respondents: Consumers (1), Medical practitioners (30), Nurse practitioners and practice nurses (7), Researchers (1), Allied health practitioners (2), Other (4)
Go Gentle Australia	
Health Consumers Tasmania	
Heart Support	
Hearts4heart	
Her Heart	

Workshop attendees

Aboriginal Health Council of South Australia
Aboriginal Health Council of Western Australia
Aboriginal Medical Services Alliance Northern Territory
Allied Health Professions Australia
Australian Aged Care Collaboration
Australian College of Nurse Practitioners
Australian College of Nursing
Australian Indigenous Doctors Association
Australian Medical Association
Australian Nursing and Midwifery Federation
Centre for Intellectual Disability
Centre for Disability Studies, University of Sydney
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Consumer Health Forum
Dementia Australia
Inclusion Australia
Indigenous Allied Health Australia
National Centre for Aboriginal and Torres Strait Islander Wellbeing Research, Australian National University
National Aboriginal Community Controlled Health Organisation
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
National Centre of Excellence in Intellectual Disability Health, University of New South Wales
Queensland Centre for Intellectual Disability and Developmental Disability
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Rural Doctors Association of Australia