Australian Government
Department of Health and Aged Care

Discussion Paper

Review of MBS Health Assessment items

July 2024

Overview

A review by the Department of Health and Aged Care of the efficacy and effectiveness of health assessment items under the Medicare Benefits Schedule (MBS) has identified areas where the items may no longer fully address the needs of patients or reflect contemporary clinical practice environments and activities.

Health assessment items have been progressively introduced to Medicare since the 1990s to facilitate the delivery of targeted preventative care to patients within primary care. 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. 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.

Whilst there has been expansion in the groups eligible for health assessments, specific MBS item requirements for these services have remained largely unchanged. This has led to some clear examples where the regulatory requirements of the health assessment items no longer align with current clinical guidance or practice. For example, the regulatory requirements for assessing a patient's vaccination status under several health assessments do not fully reflect immunisations listed on the National Immunisation Program Schedule, or current COVID-19 arrangements.

A 2023 systematic (literature) review by Bond University's Institute for Evidence Based Healthcare indicated that there is little published evidence to demonstrate the impact of general, broad-based health assessments on overall patient health outcomes. However, available evidence does support the effectiveness of select sub-components of MBS health assessments when these components are targeted in accordance with current clinical guidance. Bond University noted that current MBS item requirements, targeted patient cohorts and service intervals do not consistently reflect current guidance.

With regards to item use, analyses of 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 marginal repeat use of the services where available annually. 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. For example, data suggests around 16% of Aboriginal and Torres Strait Islander people go on to claim their first GP Management Plan (GPMP) or mental health treatment plan (MHTP) within the two months following a health assessment.

The Department has identified a range of options aimed at modernising health assessments and strengthening the effectiveness of targeted preventative care under Medicare. This consultation paper presents key findings from the review to date and central elements of

proposed options to inform stakeholder feedback on the future of MBS health assessment services.

Background

Medicare health assessment items

Medicare health assessment items support general practitioners and prescribed medical practitioners[1] working in general practice to deliver a comprehensive evaluation of a patient's health and wellbeing, and consider whether preventative care and education may be of benefit to the patient. These services are available to a range of targeted patient cohorts at varying service intervals (see Table 1). There is great diversity in the item structure, fees, and task requirements, which is complex for providers and patients.

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 preventive 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 (RACF).

Health assessment service types fall into three categories (Table 1):

- annual health assessments for Aboriginal and Torres Strait Islander people (First Nations people)
- time-tiered health assessments
- Heart Health Assessments

Complete requirements for health assessment items, including regulatory requirements, are at Attachment A.

[1] A "prescribed medical practitioner" is a medical practitioner who is not a general practitioner, specialist, or consultant physician (often referred to as an Other Medical Practitioner, OMP or non-vocationally registered general practitioner)

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	Untimed	Once every nine months
	People aged between 15 years and 54 years.		
	People aged 55 years and over		
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
Aged Care Facility resident - comprehensive medical assessment	Permanent residents of residential aged care facilities	Time-tiered	On admission to a RACF[2], then annually
Intellectual disability – comprehensive medical assessment	People living with an intellectual disability	Time-tiered	Annually
Refugees and other humanitarian entrants health assessment	Humanitarian entrants holding a relevant visa type	Time-tiered	Once only
Veteran's health assessment	Former serving members of the Australian Defence Force	Time-tiered	Once only
Heart health assessment[3]	People aged 30 years and older	20+ minutes	Annually

Review of MBS Health Assessment Items

Following recommendations from the MBS Review Taskforce (Attachment B)[4], 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 include:

- alignment of health assessment items with contemporary clinical practice

[2] Where a comprehensive health assessment has not been provided in another RACF facility in the last 12 months.
[3] Heart health assessments are temporary items under the MBS and are available until 30 June 2025.
[4] Full Taskforce recommendations, including rationales can be found within the *Medicare Benefits Schedule Review Taskforce Report on Primary Care* at: www.health.gov.au.

- ensuring consistency between different health assessment services
- identifying barriers or challenges to delivering effective preventive care to patients via the current health assessment items.

The review comprises three components: a systematic review of evidence, an analysis of MBS health assessment data and stakeholder consultation.

Systematic Review of Evidence

The department commissioned the Institute for Evidence Based Healthcare at Bond University to undertake a systematic (literature) review on the evidence and efficacy of health assessment services within primary care. Final findings from this review were delivered to the department in 2023 (Attachment C).

Following Bond University feedback that there remained insufficient published evidence on the efficacy of general, broad based health assessments and their impact on overall patient health outcomes, the systematic review refocussed its examination on evidence for the individual sub-components of general health assessments. Guided by the Royal Australian College of General Practitioners' (RACGP) *Guidelines for preventative activities in general practice 9th Edition* (the 'Red Book'), sub-components considered included:

- absolute cardiovascular risk
- blood pressure
- cholesterol
- smoking (and cessation assistance)
- physical activity
- diabetes risk
- obesity and overweight
- hearing
- vision
- excessive alcohol use
- osteoporosis
- falls risk

The review identified that five of the above sub-components have direct evidence supporting their routine use when targeted appropriately: absolute cardiovascular risk, blood pressure, cholesterol, smoking and physical activity.

In addition, five sub-components were identified as having sufficient linked evidence to support their use, noting that the delayed detection of the relevant risks would likely have significant impacts on the health outcomes and/or quality of life of patients: diabetes risk, obesity and overweight, hearing, vision and screening for excessive alcohol use.

Evidence from the review suggested that conducting routine osteoporosis and falls risk assessments as part of health assessments has limited benefits, unless used to encourage patients to increase their physical activity as a preventative measure.

For each of the sub-components identified, the systematic review identified clinically appropriate starting and stopping ages for each assessment and assessment interval periods

(Attachment D). This included consideration of where these timings may differ for specific sub-populations, such as for Australia's First Nations people.

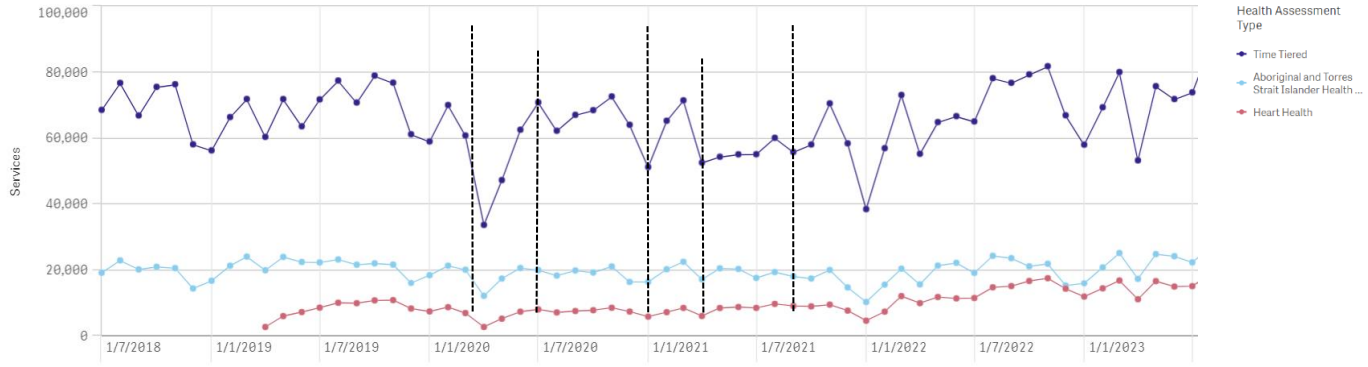
The systematic review highlighted that, while many of the evidence based sub-components are reflected in current MBS health assessment items, the items do not consistently align with current clinical guidance.

Analysis of MBS Health Assessment Data

> 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 formal health assessment items only.

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 2022-23.[5]



Analysis of data on the uptake and utilisation of MBS health assessment items 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%

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

received more than one service over these years, despite the service being available annually to this target group.[6]

- 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.[7]
- less than 25% of the eligible First Nations population accessed an Aboriginal and Torres Strait Islander Health Assessment in 2022-23.[8] While 60% of these patients had received between two to six prior assessments between 2012-2022, data indicates the likelihood of First Nations patients receiving a health assessment or reassessment decreases as the patient's age increases. Of note, the majority of First Nations people who received a health assessment were younger patients, particularly patients aged 0 to 4 years old.
- 1.2% of estimated eligible patients accessed an MBS Heart Health Assessment (HHA) in 2022-23, the year which had the greatest number of heart health services delivered.[9] 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

[6] 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#:~:text=There%20are%20about%20450%2C000%20people%20with%20intellectual%20disability%20in%20Australia.
- 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#Sex.

[7] Based on MBS claims data for patients 75+ years in age and 2021 population data outlined in:

- Australian Bureau of Statistics (ABS), 2021 Population: Census, Information on sex and age, https://www.abs.gov.au/statistics/people/population/population-census/2021#data-downloads.
- Australian Institute of Health and Welfare, People using aged care, 2023, https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#Aged%20care%20use%20and%20age.

[8] Based on MBS claims data and 2021 First Nations 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#:~:text=Media%20releases-,Key%20statistics,under%2015%20years%20of%20age.

[9] Based on 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.

health assessment in 2022-23.[10] 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 prescribed medical practitioners delivered at least one time-tiered health assessment service each financial year.[11] 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. For example:

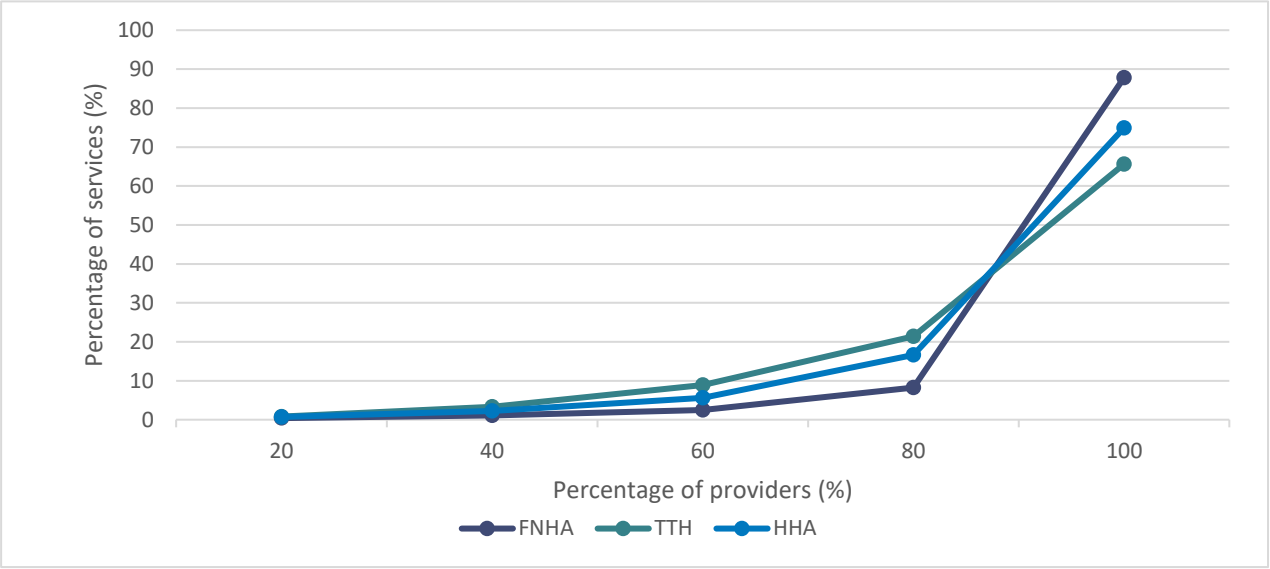
- between 2018-19 and 2022-23, 33% of providers delivered the majority (83%) of time-tiered health assessment services, with 4.7% of providers delivering nearly one third (30.1%) of all time-tiered services
- between 2018-19 and 2022-23, 20% of providers of Aboriginal and Torres Strait Islander Health Assessments delivered 88% of services
- between 2019 and 2022-23, 20% of providers of heart health services delivered 80% of services.

[10] 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.
- AIHW- Diabetes: Australian facts, 2021, https://www.aihw.gov.au/reports/diabetes/diabetes/contents/total-diabetes/type-2-diabetes#_Toc97889422.

[11] 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.

Figure 2: Services per provider for time-tiered health assessment services (2018-19 to 2022-23).



Length of consultations

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 health assessment items and have been in decline since 2016,[12] when items for the healthy kids check were ceased. 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).[13]

[12] MBS data.
[13] MBS data.

Table 2: Time tiered services delivered per item from 2016-17 to 2021-22.

Assessment type (Item)	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Total
Brief (701,224)	47,026	44,204	40,702	33,852	28,095	24,586	218,465
Standard (703,225)	185,480	185,287	186,866	178,296	166,043	154,832	1,056,804
Long (705,226)	211,834	221,410	230,407	224,157	225,306	217,826	1,330,940
Prolonged (707,227)	319,899	335,661	355,066	335,400	336,202	316,715	1,998,943
Total	764,239	786,562	813,041	771,705	755,646	713,959	**4,605,152**

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 bases, with the exception of Australia's most remote communities (Table 3). While the majority of time-tiered health assessments are provided in metropolitan areas, on a per capita basis the rates of health assessment in metropolitan areas are slightly lower than in regional and rural areas.

Table 3: Uptake of time tiered health assessment services by rurality in 2022-23.

Modified Monash Model location	Population residing in MMM area in 2021[14]	Number of people received a TTHA*	Percentage of people receiving 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	-

* Time-tiered health assessment

Similarly, a patient's socio-economic status (as indicated by the Socio-Economic Indexes for Areas - 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

[14] 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.

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 over 6% in more advantaged socioeconomic areas (see Table 4).

Table 4: Patient uptake of time-tiered and heart health assessment services by SEIFA category (2018-19 to 2022-23).[15]

Patient SEIFA category	Population by SEIFA category	Patient uptake of TTHA	SEIFA proportion TTHA %	Patient uptake of HHA	SEIFA proportion HHA %
1	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
10	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. Medicare items for the development of GPMPs and MHTPs are 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 accessed a GPMP and/or MHTP for the first time following the completion of an Aboriginal and Torres Strait Islander Health Assessment

[15] Based on MBS data and Australian Bureau of Statistics Census data sets (via TableBuilder).

- between 2016-17 and 2022-23, around 12.5% of patients accessed a GPMP and/or MHTP for the first time following their time-tiered health assessment service
- between 2018-19 and 2022-23, 7% of patients accessed a GPMP and/or MHTP for the first time following their heart health assessment service.

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.

Table 5: First uptake of GPMP or MHTP within two months following a health assessment service (2016-17 to 2022-23).[16]

Patient Age	GPMP claimed	MHTP claimed	GPMP and MHTP claimed	Total plans	Total patients[17]	% 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

[16] Includes all health assessment. Based on MBS data.
[17] Total number of patients who accessed an MBS health assessment.

Other considerations

Supporting care continuity

Where reasonably practicable, a health assessment must be performed by the patient's usual general practitioner or prescribed medical practitioner. Opportunities to further strengthen continuity of care arrangements for these services, such as restricting the billing of some or all health assessment items/types to a patient's enrolled MyMedicare practice, will be considered under the review.

Scope of practice

Health assessment items are currently available to general practitioners and prescribed medical practitioners working in general practice. Practice nurses (including nurse practitioners), Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners[18] may assist the medical practitioner to perform the health assessment in accordance with accepted medical practice.

Currently, there are no separate health assessment items available for independently practicing nurse practitioners, nor are there any MBS items specific to nurse practitioners that focus on targeted disease prevention.

In line with the recommendations of the Strengthening Medicare Taskforce, the review is considering the extent to which the current arrangements support health professionals to work to their full scope of practice.

Options for change

As outlined above, there is significant scope to improve the operation of the MBS primary care arrangements to support preventative health and early intervention. Potential options range from minimal change to bring the requirements of the existing health assessment items in line with current clinical guidance, to a broad restructuring of the arrangements.

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[18] As per *Health Insurance (General Medical Services Table) Regulations 2021*, "practice nurse " means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the Act applies.

"Aboriginal health worker " means a person: (a) who holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualification; and (b) who is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

"Aboriginal and Torres Strait Islander health practitioner " means a person: (a) who is registered under a law of a State or Territory as an Aboriginal and Torres Strait Islander health practitioner; and (b) who is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

Importantly, these approaches are not mutually exclusive and it is not a requirement that the same approach be taken for all health assessment items. For example, a different approach may be appropriate for some (or all) cohorts that receive comprehensive medical assessments but not for cohorts that receive one off assessments.

Stakeholders are invited to provide feedback on the below suggested approaches and information provided in this Discussion Paper through department's Consultation Hub.

Stakeholder feedback, together with available evidence, will inform the department's advice to Government. Any changes to the MBS health assessment items will require consideration by Government through Budget processes and, if agreed, subsequent regulatory changes.

Minimum approach – update clinical services to remove/update references to requirements that no longer align with clinical practice

The department considers that these changes are the minimum necessary to ensure health assessment items continue to be relevant. If more extensive changes are recommended, all health assessments will still need to be reviewed to ensure the clinical requirements align with contemporary clinical guidance and remain current.

Baseline changes under this approach

- Clinical requirements would be updated to better align with current guidelines, without changing the overall scope of the individual assessments. For example, checking of vaccination status would be aligned to current guidance, and references to tests that are no longer performed (e.g. papanicolaou smears) would be updated or removed as appropriate.
- Consideration of mechanisms to reduce the risk of the clinical requirements of health assessment items becoming out of date.

Possible additional changes under this approach

- Consider whether the availability of health assessments should be linked to MyMedicare.
- Consider whether all existing health assessments remain relevant given the target patient cohorts, current clinical practice and other changes to the MBS.
- Consider expanding access to health assessment items to other health professionals (e.g. nurse practitioners).

What would not change

- Eligible patient cohorts.
- Scope of current health assessments (e.g. the addition of new requirements for individual health assessments).

- Frequency of services.
- Overarching rules for health assessments (e.g. ability of practice nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners to assist in performing health assessments in accordance with accepted medical practice).

Moderate approach – updating patient cohorts and frequency of assessment

In addition to updating clinical requirements as for the minimum approach, this option would seek to better align eligible patient cohorts and frequency of assessment with current clinical evidence and guidelines.

Baseline changes under this approach

- Amend the age cohorts for the chronic disease and type 2 diabetes health assessments to better align with clinical guidance.
- Amend the service frequency for the chronic disease and type 2 diabetes health assessments to better align with clinical guidance.

Possible additional changes under this approach

- Noting the similarity in risk factors consider combining the chronic conditions health assessments (chronic disease, type 2 diabetes, and heart health) into a single health assessment with relevant assessments, patient cohorts, and frequency of assessment.
- Consider the addition of new clinical requirements for specific health assessments in line with current clinical evidence and guidelines. For example, the 10th edition of the RACGP's Guidelines for preventative activities in general practice includes new guidance in relation to frailty for older adults.
- Consider whether service frequency could be stratified according to the patient's level of risk.
- New health assessments for additional patient cohorts. For example, the MBS Review Taskforce recommended consideration be given to health assessments for people on release from prison and children in out of home care.

What would not change

- Overall structure of the items.

Restructuring approach

This approach would involve moving away from the current model of health assessment and introducing a new item structure.

A range of options could be considered, including but not limited to:

- Considering whether existing health assessments have the most appropriate item structure. For example, whether any of the existing time-tiered health assessment items (e.g. comprehensive health assessments for residential aged care) be more appropriate as stand-alone items like the Aboriginal and Torres Strait Islander health assessment.

- Where specific risk assessment or other tools are available, considering whether health assessment items should be retained or general attendance be used, and introduce new co-claim items for completing the assessment. For example, consider whether the health assessment for people with an intellectual disability should be removed but introduce a new co-claim item that could be used if the Adult Comprehensive Health Assessment Program (CHAP) is completed. This would allow assessments to be undertaken over more than one visit, with all consultation time billable to the MBS, and for eligible patients would allow triple bulk billing incentives to be claimed.

The department is open to all suggestions for the potential restructure of health assessment items.

Attachment A

MBS Health Assessment Items - Regulatory Requirements

The following table states the regulatory requirements for each MBS health assessment service as per the Health Insurance (General Medical Services Table) Regulations 2021 and Health Insurance (Section 3C General Medical Services – Heart Health Assessment No.2) Determination 2019.

General Regulatory Requirements

2.15.1 Restrictions on items in Group A14

Items 701 to 715 apply only to a service provided in the course of a personal attendance by a single general practitioner on a single patient.

2.15.14 Restrictions on health assessments for Group A14

(1) A health assessment mentioned in an item in Group A14 must not include a health screening service.

(2) A separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

(3) A health assessment must be performed by the patient's usual general practitioner, if reasonably practicable.

(4) Practice nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners may assist general practitioners in performing a health assessment, in accordance with accepted medical practice, and under the supervision of the general practitioner.

(5) For the purposes of subclause (4), assistance may include activities associated with:

(a) information collection; and

(b) at the direction of the general practitioner--provision to patients of information on recommended interventions.

(6) In this clause: "*health screening service* " has the same meaning as in subsection 19(5) of the Act.

Type 2 Diabetes Risk Assessment

2.15.2 (1)(a) a Type 2 Diabetes Risk Evaluation, in accordance with clause 2.15.4, for a patient who:

(i) is at least 40 years old and under 50 years old; and

(ii) has a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool; and

(iii) is not an in-patient of a hospital;

2.15.4 Type 2 Diabetes Risk Evaluation

(1) A Type 2 Diabetes Risk Evaluation must include:

(a) a review of the risk factors underlying a patient's high risk score as identified by the Australian Type 2 Diabetes Risk Assessment Tool; and

(b) initiating interventions, if appropriate, to address risk factors or to exclude diabetes.

(2) The Type 2 Diabetes Risk Evaluation for a patient must also include:

(a) assessing the patient's high risk score as determined by the Australian Type 2 Diabetes Risk Assessment Tool (to be completed by the patient within 3 months before performing the Type 2 Diabetes Risk Evaluation); and

(b) updating the patient's history and performing physical examinations and clinical investigations; and

(c) making an overall assessment of the patient's risk factors and the results of examinations and investigations; and

(d) initiating interventions, if appropriate, including referrals and follow-up services relating to the management of any risk factors identified; and

(e) giving the patient advice and information, including strategies to achieve lifestyle and behaviour changes if appropriate.

(3) A Type 2 Diabetes Risk Evaluation must not be provided more than once every 3 years to an eligible person.

(4) For this clause, ***risk factors*** includes:

(a) lifestyle risk factors (for example smoking, physical inactivity or poor nutrition); and

(b) biomedical risk factors (for example high blood pressure, impaired glucose metabolism or excess weight); and

(c) a family history of a chronic disease.

Chronic Disease Risk Assessment

2.15.2(1)(b) a 45 year old Health Assessment, in accordance with clause 2.15.5, for a patient who is:

(i) at least 45 years old and under 50 years old; and

(ii) at risk of developing a chronic disease; and

(iii) not an in-patient of a hospital or a care recipient in a residential aged care facility.

2.15.5 45 year old Health Assessment

(1) A 45 year old Health Assessment is an assessment for a patient if the patient, in the clinical judgement of the attending general practitioner based on the identification of a specific risk factor, is at risk of developing a chronic disease.

(2) The 45 year old Health Assessment must include:

(a) information collection, including taking a patient's history and performing examinations and investigations, as required; and

(b) making an overall assessment of the patient; and

(c) initiating interventions or referrals, as appropriate; and

(d) giving health advice and information to the patient.

(3) The general practitioner providing the assessment is responsible for the overall health assessment of the patient.

(4) A 45 year old Health Assessment must not be given more than once to an eligible person.

(5) In this clause:

"chronic disease " means a disease that has been, or is likely to be, present for at least 6 months, including asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition.

"specific risk factors " includes:

(a) lifestyle risk factors (for example smoking, physical inactivity, poor nutrition or alcohol misuse); and

(b) biomedical risk factors (for example high cholesterol, high blood pressure, impaired glucose metabolism or excess weight); and

(c) a family history of a chronic disease.

Older Person's Health Assessment

2.15.2(1)(c) an Older Person's Health Assessment, in accordance with clause 2.15.6, for a patient who is:

(i) at least 75 years old; and

(ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

2.15.6 Older Person's Health Assessment

(1) An Older Person's Health Assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological and social function.

(2) An Older Person's Health Assessment must include:

(a) personal attendance by a general practitioner; and

(b) measurement of the patient's blood pressure, pulse rate and rhythm; and

(c) assessment of the patient's medication; and

(d) assessment of the patient's continence; and

(e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and

(f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and

(g) assessment of the patient's psychological function, including the patient's cognition and mood; and

(h) assessment of the patient's social function, including:

(i) the availability and adequacy of paid, and unpaid, help; and

(ii) whether the patient is responsible for caring for another person.

(3) An Older Person's Health Assessment must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations about matters covered by the health assessment; and

(c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

(4) An Older Person's Health Assessment must not be provided more than once every 12 months to an eligible person.

Aged Care Facility Resident - Comprehensive Medical Assessment

2.15.2(1)(d) a Comprehensive Medical Assessment, in accordance with clause 2.15.7, for a patient who is a care recipient in a residential aged care facility.

2.15.7 Comprehensive Medical Assessment for care recipient in a residential aged care facility

(1) A Comprehensive Medical Assessment of a care recipient in a residential aged care facility includes an assessment of the resident's health and physical and psychological function.

(2) A Comprehensive Medical Assessment must include:

(a) a personal attendance by a general practitioner; and

(b) taking a detailed patient history of the resident; and

(c) conducting a comprehensive medical examination of the resident; and

(d) developing a list of diagnoses and medical problems based on the medical history and examination; and

(e) giving a written copy of a summary of the outcomes of the assessment to the residential aged care facility for the resident's medical records.

(3) A Comprehensive Medical Assessment must also include:

(a) making a written summary of the Comprehensive Medical Assessment; and

(b) giving a copy of the summary to the residential aged care facility; and

(c) offering the resident a copy of the summary.

(4) A Comprehensive Medical Assessment may be provided:

(a) on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided in another residential aged care facility in the last 12 months; and

(b) at 12 month intervals after that assessment.

(5) A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose, but must be claimed separately.

Intellectual Disability – Comprehensive Medical Assessment

2.15.2(1)(e) a health assessment, in accordance with clause 2.15.8, for a person with an intellectual disability, if the patient is not an in-patient of a hospital or a care recipient in a residential aged care facility;

2.15.8 Health assessment for a person with an intellectual disability

(1) A health assessment for a person with an intellectual disability is an assessment of:

(a) the patient's physical, psychological and social function; and

(b) whether any medical intervention and preventive health care is required.

(2) The health assessment for a person with an intellectual disability must include the following matters to the extent that they are relevant to the patient:

(a) checking dental health (including dentition);

(b) conducting an aural examination (including arranging a formal audiometry if an audiometry has not been conducted within the last 5 years);

(c) assessing ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within the last 5 years);

(d) assessing nutritional status (including weight and height measurements) and a review of growth and development;

(e) assessing bowel and bladder function (particularly for incontinence or chronic constipation);

(f) assessing medications including:

(i) non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications; and

(ii) advice to carers on the common side-effects and interactions; and

(iii) consideration of the need for a formal medication review;

(g) checking immunisation status (including influenza, tetanus, hepatitis A and B, measles, mumps, rubella and pneumococcal vaccinations);

(h) checking exercise opportunities (with the aim of moderate exercise for at least 30 minutes each day);

(i) checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required;

(j) considering the need for breast examination, mammography, papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) checking for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy) and arranging for investigation or treatment as required;

(l) assessing risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication and fracture history) and arranging for investigation or treatment as required;

(m) for a patient diagnosed with epilepsy--reviewing seizure control (including anticonvulsant drugs) and considering referral to a neurologist at appropriate intervals;

(n) screening for thyroid disease at least every 2 years (or yearly for patients with Down syndrome);

(o) for a patient without a definitive aetiological diagnosis--considering referral to a genetic clinic every 5 years;

(p) assessing or reviewing treatment for co-morbid mental health issues;

(q) considering timing of puberty and management of sexual development, sexual activity and reproductive health;

(r) considering whether there are any signs of physical, psychological or sexual abuse.

(3) A health assessment for a person with an intellectual disability must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment; and

(c) offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report; and

(d) offering relevant disability professionals (if the general practitioner considers it appropriate and the patient or, if appropriate, the patient's carer, agrees) a copy of the report or extracts of the report.

(4) A health assessment for a person with an intellectual disability must not be provided more than once every 12 months to an eligible person.

Refugees And Other Humanitarian Entrants Health Assessment

2.15.2(1)(f) a health assessment , in accordance with clause 2.15.9, for a patient who:

(i) is a refugee or humanitarian entrant, with eligibility for Medicare; and

(ii) either:

(A) holds a relevant visa that the person has held for less than 12 months at the time of the assessment; or

(B) first entered Australia less than 12 months before the assessment is performed; and

(iii) is not an in-patient of a hospital or a care recipient in a residential aged care facility.

(2) In this clause:

"relevant visa " means any of the following visas granted under the Migration Act 1958 :

(a) Subclass 070 Bridging (Removal Pending) visa;

(b) Subclass 200 (Refugee) visa;

(c) Subclass 201 (In-country Special Humanitarian) visa;

(d) Subclass 202 (Global Special Humanitarian) visa;

(e) Subclass 203 (Emergency Rescue) visa;

(f) Subclass 204 (Woman at Risk) visa;

(g) Subclass 695 (Return Pending) visa;

(h) Subclass 786 (Temporary (Humanitarian Concern)) visa;

(i) Subclass 866 (Protection) visa.

2.15.9 Health assessment for a refugee or other humanitarian entrant

(1) A health assessment for a refugee or other humanitarian entrant is the assessment of:

(a) the patient's health and physical, psychological and social function; and

(b) whether preventive health care and education should be offered to the patient to improve their health and physical, psychological or social function.

(2) A health assessment for a refugee or other humanitarian entrant must include:

(a) a personal attendance by a general practitioner; and

(b) taking the patient's history; and

(c) examining the patient; and

(d) performing or arranging any required investigations; and

(e) assessing the patient, using the information gained in paragraphs (b), (c) and (d); and

(f) developing a management plan addressing the patient's health care needs, health problems and relevant conditions; and

(g) making or arranging any necessary interventions and referrals.

(3) A health assessment for a refugee or other humanitarian entrant must also include:

(a) keeping a record of the health assessment; and

(b) offering to provide the patient with a written report of the health assessment.

(4) A health assessment for a refugee or other humanitarian entrant must not be provided to a patient more than once.

Veteran's Health Assessment

2.15.2(1)(g) an Australian Defence Force Post-Discharge GP Health Assessment, in accordance with clause 2.15.10, for a patient who:

(i) is a former member of the Permanent Forces (within the meaning of the Defence Act 1903) or a former member of the Reserves (within the meaning of that Act); and

(ii) has not already received such an assessment.

2.15.10 Australian Defence Force Post-discharge GP Health Assessment

(1) An Australian Defence Force Post-discharge GP Health Assessment is an assessment of:

(a) a patient's physical and psychological health and social function; and

(b) whether health care, education or other assistance should be offered to the patient to improve the patient's physical or psychological health or social function.

(2) The assessment must be performed by the patient's usual doctor.

(3) The assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.

(4) The assessment may be performed using the ADF Post-discharge GP Health Assessment Tool, as existing on 1 July 2020.

Note 1: The ADF Post-discharge GP Health Assessment Tool could in 2021 be viewed on the Department of Veterans' Affairs' At Ease website (http://at-ease.dva.gov.au).

Note 2: Other assessment tools mentioned in the Department of Veterans' Affairs' Mental Health Advice Book may be relevant. The Mental Health Advice Book could in 2021 be viewed on the Department of Veterans' Affairs' At Ease website (http://at-ease.dva.gov.au).

(5) The assessment must include taking a history of the patient that includes the following:

(a) the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;

(b) the patient's social history, including relationship status, number of children (if any) and current occupation;

(c) the patient's current medical conditions;

(d) whether the patient suffers from hearing loss or tinnitus;

(e) the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;

(f) the patient's smoking, if applicable;

(g) the patient's alcohol use, if applicable;

(h) the patient's substance use, if applicable;

(i) the patient's level of physical activity;

(j) whether the patient has bodily pain;

(k) whether the patient has difficulty getting to sleep or staying asleep;

(l) whether the patient has psychological distress;

(m) whether the patient has posttraumatic stress disorder;

(n) whether the patient is at risk of harm to self or others;

(o) whether the patient has anger problems;

(p) the patient's sexual health;

(q) any other health concerns the patient has.

(6) The assessment must also include the following:

(a) measuring the patient's height;

(b) weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;

(c) measuring the patient's waist circumference;

(d) taking the patient's blood pressure;

(e) using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;

(f) either:

(i) making the further assessment mentioned in paragraph (e); or

(ii) referring the patient to another medical practitioner who can make the further assessment;

(g) documenting a strategy for improving the patient's health;

(h) offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures.

(7) The doctor must keep a record of the assessment.

(8) In this clause:

"*usual doctor*", in relation to a patient, means a general practitioner employed by a medical practice:

(a) that has provided at least 50% of the primary health care required by the patient in the last 12 months; or

(b) that the patient anticipates will provide at least 50% of the patient's primary health care requirements in the next 12 months.

First Nations People Health Assessment

2.15.3 Application of item 715

(1) Item 715 applies to the following health assessments:

(a) an Aboriginal and Torres Strait Islander child health assessment, in accordance with clause 2.15.11, for a patient if the patient is:

(i) under 15 years old; and

(ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

(b) an Aboriginal and Torres Strait Islander adult health assessment, in accordance with clause 2.15.12, for a patient if the patient is:

(i) at least 15 years old and under 55 years old; and

(ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

(c) an Aboriginal and Torres Strait Islander Older Person's Health Assessment, in accordance with clause 2.15.13, for a patient if the patient is:

(i) at least 55 years old; and

(ii) not an in-patient of a hospital or a care recipient in a residential aged care facility.

(2) For the purpose of item 715, a person is of Aboriginal or Torres Strait Islander descent if the person identifies as being of that descent.

2.15.11 Aboriginal and Torres Strait Islander child health assessment

(1) An Aboriginal and Torres Strait Islander child health assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care, education and other assistance should be offered to the patient, or the patient's parent or carer, to improve the patient's health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander child health assessment must include:

(a) a personal attendance by a general practitioner; and

(b) taking the patient's history, including the following:

(i) mother's pregnancy history;

(ii) birth and neo-natal history;

(iii) breastfeeding history;

(iv) weaning, food access and dietary history;

(v) physical activity engaged in;

(vi) previous presentations, hospital admissions and medication use;

(vii) relevant family medical history;

(viii) immunisation status;

(ix) vision and hearing (including neo-natal hearing screening);

(x) development (including achievement of age-appropriate milestones);

(xi) family relationships, social circumstances and whether the patient is cared for by another person;

(xii) exposure to environmental factors (including tobacco smoke);

(xiii) environmental and living conditions;

(xiv) educational progress;

(xv) stressful life events experienced;

(xvi) mood (including incidence of depression and risk of self-harm);

(xvii) substance use;

(xviii) sexual and reproductive health;

(xix) dental hygiene (including access to dental services); and

(c) examination of the patient, including the following:

(i) measurement of the patient's height and weight to calculate the patient's body mass index and position on the growth curve;

(ii) newborn baby check (if not previously completed);

(iii) vision (including red reflex in a newborn);

(iv) ear examination (including otoscopy);

(v) oral examination (including gums and dentition);

(vi) trachoma check, if indicated;

(vii) skin examination, if indicated;

(viii) respiratory examination, if indicated;

(ix) cardiac auscultation, if indicated;

(x) development assessment, to determine whether age-appropriate milestones have been achieved, if indicated;

(xi) assessment of parent and child interaction, if indicated;

(xii) other examinations as indicated by a previous child health assessment; and

(d) performing or arranging any required investigation, in particular considering the need for the following tests:

(i) haemoglobin testing for those at a high risk of anaemia;

(ii) audiometry, especially for school age children; and

(e) assessing the patient using the information gained in the child health assessment; and

(f) making or arranging any necessary interventions and referrals, and documenting a strategy for the good health of the patient; and

(g) both:

(i) keeping a record of the health assessment; and

(ii) offering the patient, or the patient's parent or carer, a written report on the health assessment, with recommendations on matters covered by the health assessment (including a strategy for the good health of the patient).

2.15.12 Aboriginal and Torres Strait Islander adult health assessment

(1) An Aboriginal and Torres Strait Islander adult health assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care, education and other assistance should be offered to the patient to improve their health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander adult health assessment must include:

(a) personal attendance by a general practitioner; and

(b) taking the patient's history, including the following:

(i) current health problems and risk factors;

(ii) relevant family medical history;

(iii) medication use (including medication obtained without prescription or from other doctors);

(iv) immunisation status, by reference to the appropriate current age and sex immunisation schedule;

(v) sexual and reproductive health;

(vi) physical activity, nutrition and alcohol, tobacco or other substance use;

(vii) hearing loss;

(viii) mood (including incidence of depression and risk of self-harm);

(ix) family relationships and whether the patient is a carer, or is cared for by another person;

(x) vision; and

(c) examination of the patient, including the following:

(i) measurement of the patient's blood pressure, pulse rate and rhythm;

(ii) measurement of height and weight to calculate the patient's body mass index and, if indicated, measurement of waist circumference for central obesity;

(iii) oral examination (including gums and dentition);

(iv) ear and hearing examination (including otoscopy and, if indicated, a whisper test);

(v) urinalysis (by dipstick) for proteinuria;

(vi) eye examination; and

(d) performing or arranging any required investigation, in particular considering the need for the following tests:

(i) fasting blood sugar and lipids (by laboratory-based test on venous sample) or, if necessary, random blood glucose levels;

(ii) papanicolaou smear;

(iii) examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those 15 to 35 years old);

(iv) mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral); and

(e) assessing the patient using the information gained in the health assessment; and

(f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

(3) An Aboriginal and Torres Strait Islander adult health assessment must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment (including a simple strategy for the good health of the patient).

2.15.13 Aboriginal and Torres Strait Islander Older Person's Health Assessment

(1) An Aboriginal and Torres Strait Islander Older Person's Health Assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must include:

(a) personal attendance by a general practitioner; and

(b) measurement of the patient's blood pressure, pulse rate and rhythm; and

(c) assessment of the patient's medication; and

(d) assessment of the patient's continence; and

(e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and

(f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and

(g) assessment of the patient's psychological function, including the patient's cognition and mood; and

(h) assessment of the patient's social function, including:

(i) the availability and adequacy of paid, and unpaid, help; and

(ii) whether the patient is responsible for caring for another person; and

(i) an examination of the patient's eyes.

(3) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment; and

(c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Hearth Health Assessment

Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a eligible practitioner at consulting rooms lasting at least 20 minutes and including:

(a) collection of relevant information, including taking a patient history; and

(b) a basic physical examination, which must include recording blood pressure and cholesterol; and

(c) initiating interventions and referrals as indicated; and

(d) implementing a management plan; and

(e) providing the patient with preventative health care advice and information.

For any particular patient, a health assessment is not applicable:
(a) more than once in a 12 month period,
(b) if, prior to a service, the patient has been provided another health assessment service within the previous 12 months, excluding a First Nations health assessment.

Attachment B

MBS Review Taskforce Findings: General Practice and Primary Care Clinical Committee (2020)

Recommendation 5 – Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines

This recommendation proposes that a process be established to gather evidence on the effectiveness and frequency of Health Assessments with a focus on at-risk populations, including using data at a Primary Health Network (PHN) level based on existing groups eligible for Health Assessments, and commissioning studies on the evidence for Health Assessments for new at-risk groups.

Recommendation 7 – Strengthen the quality of current Health Assessments and expand at-risk groups who are eligible for Health Assessments

This recommendation proposes changing the descriptors and explanatory notes for items 701, 703, 705, 707 and 715 to expand eligibility to new at-risk populations and modify existing populations to better align with clinical and service needs.

Attachment C

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

Prepared by:
Institute for Evidence-Based Healthcare,
Bond University, Australia

Executive summary

Opportunistic health assessment, including targeted clinical assessment and the promotion of health maintenance behaviour, is generally accepted to be part of routine preventative care in general practice. A health assessment is an in-depth assessment of a patient, aimed at identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life. The term health assessment is broader than screening as it includes symptomatic conditions that a patient has not discussed to a GP, whereas screening is focused on asymptomatic undetected conditions or risk factors. There are several specific health assessment items funded under the current Medicare Benefits Schedule (MBS), such as for diabetes and cardiovascular disease (CVD) risk. Additionally, patients' overall health and disease risk profiles are routinely evaluated in general practice via general consultations (Level A-D attendances).

A 2018 evidence review of health assessments commissioned by the MBS Review Taskforce concluded there was little evidence that non-specific health checks (general broad-based untargeted health assessments) lead to improved patient outcomes, and modest evidence that CVD risk assessments lead to improved CVD risk factor control. However, what was less clear was the impact of health assessments on morbidity and mortality. Whilst a Cochrane review of health assessments has been updated since the completion of the Taskforce's review, the overall findings have not substantially changed, with little published evidence to demonstrate any impact on overall health outcomes for general broad based health assessments.

In light of the above, this report aims to assess and summarise the evidence for specific components of the current health assessment MBS items for preventive care, which are recommended in current national guidelines: cardiovascular risk assessment, blood pressure, cholesterol, smoking, diabetes, obesity and overweight, alcohol, physical activity, falls risk, osteoporosis, hearing and vision. These components are routinely reflected in existing MBS health assessment items, however, unlike the whole-of-life focus of national guidelines, eligibility for the MBS items remains limited to specific age based or population cohorts. To achieve this, any existing high-quality up-to-date reviews were sought and summarised or updated. Additionally, evidence for each health assessment activity's optimal starting and stopping age, appropriate interval between assessments, and evidence for specific recommendations for subpopulations, such as Aboriginal and Torres Strait Islander People, were searched.

Five of the health assessment components have sound evidence to support routine use: calculated estimate of absolute cardiovascular risk, measurement of blood pressure, and cholesterol, smoking cessation assistance, and increase in physical activity (particularly for falls prevention in the elderly). A further five components (diabetes risk assessment, obesity and overweight, hearing, vision assessments, and screening for excessive alcohol use) did not have strong direct evidence, however, had sufficient linked evidence to provide support for inclusion as delayed detection would likely to have significant impacts on the health outcomes and/or quality of life of patients. The evidence suggested there was little benefit for two activities as routine assessments: assessing osteoporosis and falls risk assessment (other than promoting physical activity).

There was no explicit and direct evidence to suggest any substantial changes to the current MBS age eligibility criteria for health assessments, best repeat interval, or recommendations for subpopulations of interest. Therefore, we used the framework of the RACGP Guidelines for Preventive Activities in the general practice age references for most assessment components. The key conclusions arising from this review are as follows:

1. Non-specific health assessments do not appear to improve overall health outcomes.
2. Some - but far from all - specific health assessments components can improve health outcomes when targeted appropriately.
3. The set of effective health assessment components is likely to change with time as innovations and new evidence emerge.
4. The interval between assessment components should generally be between 2 and 5 years.
5. Health assessments are particularly important for patients who often have preventive measures overlooked in usual consultations, e.g., those with intellectual disability or serious mental health problems.
6. For some higher risk populations, an earlier starting age may be appropriate for some health assessments, for example, cardiovascular risk assessment in the Aboriginal and Torres Strait Islander population.
7. Health assessments as a holistic multi-component episode of care are difficult to evaluate as composite entities and potential benefits relating to continuity of care, contribution overall satisfaction with care and general wellbeing, intergenerational assessment and record updates, which may all be relevant outcomes, are out of scope for this review.

Note: The current national programs for breast, bowel, and cervical cancer screening are centrally organised. While cancer screening services are separate to MBS Health Assessment items, a reminder to the patient of the importance of these, and answering patients' questions, could be included as part of a health assessment. Screening for cancers outside these programs is not routinely recommended.

Attachment D

Summary of Findings

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

Prepared by:
Institute for Evidence-Based Healthcare,
Bond University, Australia

Overview of evidence summaries for health assessment components No.	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
1.	**Cardiovascular risk**	> 40 years	Low risk: every 10 yrs; intermediate risk: every 5 yrs; high risk: every 2 yrs	Start 10 years earlier for ATSI 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.						
2.	**Blood pressure**	> 21 years	Every 2-3 years	Start earlier for ATSI people	High	Strong for
High certainty **evidence** shows that detecting and treating high blood pressure in adulthood **reduces cardiovascular events**.						
3.	**Cholesterol or lipids**	> 45 years	Every 3 years	Start 10 years earlier for ATSI people	High	Strong for
Detection and management of abnormal blood lipids in adult **reduces the risk of all-cause mortality and major cardiovascular events.**						
4.	**Diabetes**	40 years	Low risk: every 5 yrs; Moderate risk: every 3 yrs; High risk: every 8 months	Start earlier for ATSI 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**.						
5.	**Smoking**	All ages	Opportunistically	Assess ATSI 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.**						

6.	**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.**

7.	**Physical (in)activity**	All ages	Every 2 years	Assess ATSI 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.**

8.	**Obesity and overweight**	All ages	Every 2 years	Assess ATSI and Pacific islander people every 12months	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.**

9.	**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.**

10.	**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.

11.	**Hearing**	>60 years	every 2-3 years	Start earlier for ATSI 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.**

12.	**Vision**	>60 years	every 2-3 years	Start earlier for ATSI 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**.