MBS Review Advisory Committee

Time-Tiered Primary Care Working Group

Draft final report

September 2026

Contents

Summary

Time-tiered Medicare Benefits Schedule (MBS) items are a series of items that are based on the time a provider spends with a patient. Time-tiered MBS items for primary care services make up around 30% of all MBS services delivered and are the most used MBS items in primary care. In 2025, total MBS expenditure across primary care service types for levels A–E, after-hours and nurse practitioner (NP) services[1] was around $7.7 billion.

The arrangements for time-tiered MBS items for primary care services are complex. The MBS includes more than 300 time-tiered items across 5 time-tiers (levels A to E) for primary care services provided by general practitioners (GPs), medical practitioners, prescribed medical practitioners (PMPs) and nurse practitioners (NPs). Although some of these MBS items are for specific purposes or conditions, others relate to the same or similar clinical services provided – for example, in different locations, during different hours or by different practitioners.

Besides their complexity, other potential issues related to time-tiered MBS items that have been raised include lower per-minute rates for longer services, fee anomalies related to indexation and a lack of time-tiered MBS items for some services. Further, there are several inconsistencies across similar MBS items.

Time-tiered Working Group

In August 2024, the Medicare Benefits Schedule Review Advisory Committee (MRAC) endorsed a review of primary care time-tiered MBS items. The time-Tiered Primary Care Working Group (TTWG) was established to lead the review and report its findings to the MRAC.

The TTWG comprised MRAC members and departmental representatives. The group included a health policy researcher, a consumer, general practitioners, a nurse practitioner, as well as other medical specialists (see Members).

The TTWG acknowledged the large amount of work coinciding with this review and the group's considerations and recommendations – for example, universal patient access to bulk-billing incentives and the establishment of the Bulk Billing Practice Incentive Program (BBPIP). Additionally, the TTWG noted the Strengthening Medicare Taskforce's recommendation that funding arrangements for primary care move to a blended funding model, with a long-term goal of 60:40 ratio of fee for services to other payments.

The TTWG supports these recommendations and notes that:

- transition to blended funding models will take time
- the MBS will remain central to the fee-for-service component of any blended funding model.

Therefore, the consideration and recommendation of the TTWG will contribute to modernising the MBS for primary care in parallel to broader reforms.

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[1] Primary care services types A–E include all GP, prescribed medical practitioner and medical practitioner items for levels A–E across all modes and locations (excluding after-hours items). The after-hours types include after-hours items and nurse practitioner time-tiered attendance (all modes) are included in the nurse practitioner services primary care service type.

The TTWG met 8 times between 2024 and 2026.

Time-tiered principles and recommendations

The TTWG considered that the Medicare Benefits Schedule (MBS) – Australia's fee-for-service remuneration model – will remain important and relevant for our healthcare system in the future. Therefore, to ensure that the MBS underpins contemporary and holistic care to patients that meets their individual care needs, this report seeks the adoption of 5 key principles for items which should be applied to time-tiered attendances in primary care. The report also provides a range of recommendations to align current MBS time-tiered items with these key principles.

Preliminary estimates suggest that, if fully implemented, the recommendations of this review (excluding recommendation 12) could reduce the number of time-tiered attendance items from more than 300 to around 150. Implementation of recommendation 12, which is a long-term recommendation, has the potential to further reduce the total number of items to less than 100.

Recommendation 1

That the government adopt 5 key principles to be applied when developing new, or revising existing, MBS items for primary care:

Principle 1 – Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items

Principle 2 – MBS benefits for time-tiered items should be equitable to support patient access to primary care services that meet their individual clinical needs

Principle 3 – MBS time-tiered attendance items and their regulatory requirements should be consistent unless there is a defined clinical need for variation, such as where the services sit outside of the standard scope of practice for a GP

Principle 4 – MBS after-hours arrangements should be streamlined and aligned across primary care

Principle 5 – MBS primary care items should be adequately supported by, but not replicate or replace, non-MBS funding mechanisms

MyMedicare clinics

The TTWG noted concerns from some organisations about linking MBS claiming to MyMedicare registered clinics. This requirement would exclude NP-led practices. However, the TTWG highlighted that MyMedicare clinics are accredited and therefore are proven to meet certain standards. The principle of MyMedicare is to improve continuity of care. The TTWG maintained that including MyMedicare registration would ensure patient safety and continuity of care, which was a focus of the TTWG's discussions and therefore recommendations. The TTWG recognised that there may be additional work by the Government to better include NP-led practices, but this is out of scope for this review.

Principle 1 – Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items

Non-Directive Pregnancy Counselling services

Non-Directive Pregnancy Counselling (NDPC) training is currently required to access the NDPC MBS items. However, NDPC training is now a component of the Pregnancy and Reproductive Health unit of the Royal Australian College of General Practitioners

(RACGP) fellowship curriculum. As a result, all general practitioners (GPs) who attained RACGP fellowship under the current curriculum maintain an NDPC training credential. For practitioners who did not complete this training, NDCP training is available as Continuing Professional Development (CPD). Ongoing CPD training is not required to maintain the credentialling.

Given the availability of general time-tiered consultation items, the TTWG considered that there is little justification for separate MBS items that recognise qualifications that are:

- within the standard scope of practice of the relevant profession (for example, standard GP training)

or

- recognise CPD-level training with no ongoing CPD requirements.

Acupuncture services

Time-tiered acupuncture items were introduced to the MBS in 1984. Acupuncture items replicate both the clinical requirements and service durations of levels B, C and D attendance items, but stipulated that acupuncture be provided as part of the attendance. This review incorporates the post-implementation review of changes to acupuncture items in 2022 at the recommendation of the MBS review Taskforce.

The current fee structure provides financial incentives for endorsed acupuncture practitioners to use attendance, not acupuncture, items for the service.

The TTWG noted that use of MBS acupuncture services has been declining since 2016–17. Although some of these decreases are likely attributable to the impacts of the COVID-19 pandemic, service levels did not rebound and have continued to decline.

Removing acupuncture items would help streamline the MBS and increase patient benefits.

Recommendation 2

To enable the delivery of non-directive pregnancy support counselling and acupuncture services under general time-tiered attendance items, standalone MBS items for these services should be ceased.

Bloodborne virus, and sexual and reproductive health services

Unlike the standard telehealth consultation items, bloodborne virus, and sexual and reproductive health (BBVSRH) service items are not subject to the ‘eligible telehealth practitioner (also known as the ‘12 month’ or ‘established clinical relationship’) requirements. The TTWG noted that the MRAC’s objective of exempting these services from the eligible telehealth practitioner rule could be achieved by including BBVSRH services in the general exemptions to this rule. This would allow GPs, PMPs and NPs to use general telehealth attendance items to provide these services to any patient and the standalone items to cease.

Recommendation 3

To enable the delivery of telehealth services for bloodborne viruses and sexual and reproductive health services under general time-tiered attendances, standalone items for these services should be replaced with a new exemption to the ‘patient’s eligible telehealth practitioner’ requirement (also known as the ‘12-month rule’) to ensure ongoing patient access to these services. The current standalone items could therefore cease.

Antenatal attendance items

MBS item 16500 and its telehealth equivalents cover routine face-to-face antenatal attendances. These items are used in both primary care and by specialist obstetricians. The TTWG only considered the use of these items in primary care, consistent with the scope of this review.

The TTWG noted that the fees for the antenatal attendance MBS items are not time-tiered and their use in primary care is decreasing. In addition, from 2018–19 to 2022–23, most antenatal attendance services claimed in primary care were not co-claimed with another MBS item.

Currently, the MBS benefit for an antenatal attendance is around 6% higher than a level B attendance. However, currently, the existence of the antenatal attendance item precludes GPs from claiming level C, D or E attendance items when they conduct an antenatal attendance longer than 20 minutes, which pay significantly higher benefits than the antenatal attendance items.

The TTWG considered that the decreasing use of antenatal items may indicate that practitioners are instead using time-tiered general attendance MBS items, which may better reflect the time spent by practitioners providing antenatal health care.

The TTWG also recognised that, while the antenatal attendance can be claimed with single bulk-billing incentives, general attendance MBS items (level B and above) are eligible for a triple bulk-billing incentive payment. The expansion of bulk-billing incentives to all Medicare-eligible patients and the introduction of the Bulk-billing Practice Incentive Program (BBPIP) on 1 November 2025 has increased the significance of this difference. Unlike general attendance items, antenatal attendances are not eligible services for the purpose of the BBPIP.

The TTWG considered these bulk-billing changes and co-claiming rates, and concluded that primary care practices and practitioners will not be financially disadvantaged by the recommendation to exclude GP access to antenatal items. To better support comprehensive antenatal health care, practitioners working in a primary care setting should have access to the full suite of time-tiered general attendance MBS items for antenatal attendances. Obstetricians would continue to have access to the antenatal attendance MBS items.

Recommendation 4

To enable the delivery of comprehensive antenatal care under general time-tiered attendance items, GPs and other medical practitioners working in general practice should be ineligible for MBS antenatal item 16500 and its telehealth equivalents (MBS items 91853 and 91858).

Principle 2 – MBS benefits for time-tiered items should be equitable, to support patient access to primary care services that meet their individual clinical needs

Fee-per-minute rates for general attendance MBS items

The MBS fees for time-tiered items result in a higher per-minute rate for shorter items, and the fee per minute decreases as the consultation length increases. The TTWG considered that this fee structure incentivises shorter consultations, and disadvantages patients who need, and practitioners who provide, longer consultations.

MBS data also revealed gender equity issues, as female GPs are more likely to provide longer consultations than their male counterparts. In addition, female patients are more likely to use longer consultations than male patients.

The TTWG recognised that there is a role for both long and short consultations, and that the length of a consultation should be guided by clinical need. The group also acknowledged that there is a relatively higher administrative workload associated with shorter consultations than longer consultations, and that a small 'flag fall' effect on short consultations is reasonable. However, the TTWG considered the current per-minute differences between short and longer consultations is too great. The TTWG considered a number of options for achieving this, including:

- simply increasing the fee for levels C, D and E
- the Australian Medical Association's (AMA's) proposal for 7 time-tiers
- time blocks with a flag fall for the initial block.

The TTWG concluded that there are several approaches that could achieve the objective. However, given the complexity of changing the overall time-tiered framework (for example, as per the AMA proposal), the TTWG acknowledged that increasing the fees for levels C–E is the option that could be implemented fastest. However, doing so would not preclude longer term changes to the time-tiered structure.

Recommendation 5

MBS benefits for time-tiered items should equitably support appropriate and varied consultation lengths to ensure patients can access care that meets their individual clinical needs.

Bulk-billing incentives structure

The TTWG considered that the current bulk-billing incentives structure exacerbates the lack of financial incentives for longer consultations compared to shorter consultations. Bulk-billing incentives should not provide additional structural incentives for shorter consultations.

Recommendation 6

Bulk-billing incentives should be based on a percentage of the MBS fee for the service that is bulk-billed to avoid furthering the disproportionate remuneration of shorter consultations when compared to longer consultations.

Rural loadings for bulk-billing incentives are appropriate and should be retained under this approach.

Bulk-billing incentives for nurse practitioners

Currently, bulk-billing incentives are only available for services provided by a medical practitioner. In the context of supporting GP-led multidisciplinary teams, the TTWG supported extending bulk-billing incentives to NPs working in MyMedicare practices. This would both support the NP workforce in general practice settings and encourage general practices to engage more NPs. It would also support improved continuity of care for patients by encouraging a broader range of professions within a general practice.

Recommendation 7

Bulk-billing incentives should be available for nurse practitioner services when the consultation is provided to a patient who is registered through MyMedicare with the practice that provides the service.

Principle 3 – MBS items and their requirements should be consistent, unless there is a defined clinical need for variation

Simplification and consistency of time-tiered items

The complexity of time-tiered items has increased over time for several reasons. The TTWG agreed that the clinical services provided under these items are appropriate and needed, but the group also considered that the current MBS structures could be improved. The TTWG agreed that simplification of wording and consistency of duration of time-tiers would benefit all Medicare users.

Recommendation 8

Undertake work to standardise language used in item descriptors (for example describing the time-tiers for items) wherever possible across primary care items.

Time-tiered items for different provider types and service delivery modes

Some of the differences currently seen across time-tiered items directly impact consumers. For example, the length of levels of A–E consultations vary across provider types (for example, between general practitioners and PMPs) and delivery modes (for example, telephone and video/face to face for PMPs). The TTWG did not consider there to be clinical justification for different lengths of time-tiers for consultation items depending on provider type and mode of service in primary care settings.

Recommendation 9

Align the duration of MBS time-tiers across all relevant primary care provider types and items.

Fees for equivalent MBS items

The TTWG noted the difference in MBS fees between general attendance time-tiered MBS items and their equivalents caused by the staggered reintroduction of indexation and considered that this should be addressed, if the relevant items continue.

Recommendation 10

Address the current differences in MBS fees between general attendance time-tiered items and equivalent time items caused by the staggered reintroduction of indexation to the MBS.[2]

Service provider types and qualifications

The MBS is first and foremost a patient benefit scheme, but it can also support broader health policy objectives, including workforce policy. The TTWG supported the continuation of MBS fees based on professional qualifications in primary care settings, including maintaining the distinction between specialist GPs (and those in specialist GP training) and other medical practitioners who do not hold specialist qualifications working in general practice settings.

Currently, there are different time-tiered MBS benefits for GPs, NPs and PMPs. Further, PMP MBS benefits differ by location. These differences could adversely affect patients

[2] Impacted items:
- Group A7: Acupuncture and non-Specialist Items (193,195,197, 199)
- Group A20: GP mental health treatment (GP 2700, 2701; PMP – 272, 276) and telehealth equivalents (GP – 92112, 92113; PMP – 92118, 92119)
- Group A36: Eating disorder services (GP – 90250, 90251; PMP – 90254, 90255) and telehealth equivalents (GP – 92146, 92147; PMP – 90150, 92151)

through increased out-of-pocket costs. The TTWG considered that MBS benefits for PMPs should, in all instances, be at least commensurate to the MBS benefits for NPs, noting that this is not the current case for PMPs working in Modified Monash Area 1. Maintaining this equivalent would also require that these items be indexed as part of the annual MBS indexation.

Recommendation 11

Review MBS benefits for time-tiered consultations for medical practitioners (excluding GPs), for example Group A2 items and equivalents, and, at a minimum, increase the item benefits to be at least in line with the equivalent items for nurse practitioners.

The TTWG also noted that replicating items for different provider types contributes to the complexity of the MBS, by both increasing the number of items and increasing opportunities for inconsistencies and discrepancies between those items. The TTWG recognised that this has been the preferred approach to recognising different providers historically, but members saw merit in further considering alternative approaches to structuring items where equivalent clinical services are provided, especially where the fees for one provider are a fixed percentage of the fees for another provider.

Recommendation 12

To support system simplification, consider the progressive transition to a single set of time-tiered consultation items with an appropriate fee modifier linked to the provider's qualifications and/or provider type to replace the current approach of creating parallel sets of items.

Requirements for Mental Health Skills Training

As noted previously, the TTWG queried the ongoing need for separate MBS items where a service:

- is within the usual scope of practice the relevant profession

or

- a continuing professional development– (CPD-) level qualification without ongoing CPD requirements to maintain the credential.

The TTWG supported different MBS fees based on practitioner qualifications and endorsements linked to their registration. However, the TTWG did not support MBS items that recognise CPD training.

Therefore, the TTWG did not consider it appropriate to have separate MBS items with different fees for Mental Health Treatment Plan items that depend on whether the GP has done Mental Health Skills Training. This training is now part of GP training to obtain fellowship and the TTWG considered this additional training requirement to be redundant.

Recommendation 13

Recognising that level 1 mental health skills training is now a core component of general practitioner training, differential fees and separate items for medical practitioners with or without 'Mental Health Skills Training' should be removed from mental health treatment plan and eating disorder treatment and management plan items.

Location-specific services

The MBS fees for location-specific attendance items are administratively complex. Currently, separate sets of MBS items for GPs and other medical practitioners are available to provide time-tiered attendances in consulting rooms, out-of-consulting rooms and in residential aged care during standard hours and after-hours. These MBS items cover equivalent clinical services; however, each has different rules and fee structures. In contrast, NPs have a single set of attendance items that are location agnostic.

The TTWG recognised that it is important for the MBS to support:

- services for patients outside of consulting rooms (for example, in their homes) and in residential aged care
- continuity of care for these patients.

The TTWG supported higher MBS benefits for services delivered outside of consulting rooms compared to in consulting rooms because there are additional costs and complexities associated with providing services outside of consulting rooms. In addition, providing services in residential aged care is assisted by additional support compared to, for example, that available in a patient's private home. Therefore, an aged care service is unlikely to be more complex than a home visit, and a higher renumeration for aged care services compared to other out of consulting room locations is unjustified.

The TTWG also considered that there are roles for the whole primary care team, and that some services could be provided by non-medical members of the team, such as NPs and practice nurses.

The TTWG supported streamlining the arrangements for out-of-room services and recommended moving to a fee-loading approach for out-of-room services. Under this approach, a standard consultation item would be used in conjunction with an additional percentage loading paid if the service is delivered in a location other than consulting rooms. The TTWG considered that loading items should apply to GP, PMP and NP attendance items. To support continuity of care, the TTWG considered it appropriate for out-of-room loading to be linked to a patient's MyMedicare registration, including for NPs.

Recommendation 14

The MBS fees for services provided outside of consulting rooms (for example, home visits) be at least commensurate with the MBS fees for equivalent services provided in residential aged care.

Recommendation 15

The current MBS items for services provided outside of consulting rooms and in residential aged care be replaced with fee loading items for consistency. The fee loading items would only be available when the patient is registered through MyMedicare with the practice that provides the service.

The loading items should apply to consultations provided by NPs on the same basis that they are available to medical practitioners.

Principle 4 – MBS after-hours arrangements should be streamlined and aligned across primary care

After-hours primary care services

The current after-hours arrangements are complex, with 45 MBS items for non-urgent services and a further 6 MBS items for urgent after-hours services. The TTWG

considered the main reasons for after-hours care, which are varied but generally include urgency, convenience and access for patients.

The TTWG considered simplifying the after-hours items by removing the distinction between urgent and non-urgent services and instead focusing on the time and location of the service. The group preferred an approach that moves away from standalone after-hours consultation items and instead uses fee modifiers. Under this approach, a percentage loading would be applied to the standard consultation items for a service that is provided out of hours. The same percentage loading would apply across all consultation items. The TTWG proposed that multiple loading items could apply to a single consultation. For example, an after-hours service provided out of consulting rooms would attract both the after-hours and out of rooms loadings.

Recommendation 16

Current after-hours items be replaced with a fee loading. The loading would apply to any service that is provided in the after-hours period.

Recommendation 17

The loading for after-hours services should be applied to:

- face to face general attendance items for primary care
- telehealth (video and phone) attendance items when delivered by the patient's eligible telehealth practitioner
- nurse practitioner attendance items.

Start time for after-hours

Currently, after-hours definitions differ depending on when the service is delivered in or out of consultation rooms. The TTWG considered that start times for after-hours services should be aligned, regardless of the location of the service. The location of the practice from which the service is provided should be used to determine whether the service is provided after-hours (relevant to telehealth services).

The TTWG supported a start time of 6 pm on weekdays for after-hours services based on various relevant award wage determinations.

Recommendation 18

The definition of the MBS after-hours period for primary care be aligned across all locations and commence at 6 pm on weekdays.

Note that recommendation 20 addresses urgent after-hours items.

Recommendation 19

The MBS regulations should specify that the time zone at the location of the practice is to be used when determining if a service is provided after-hours.

Urgent after-hours items

The TTWG noted the significant and continuing decrease in the overall use of urgent after-hours MBS items since 2015. However, the telehealth items for urgent after-hours services in the unsociable hours have rapidly increasing uptake.

Urgent after-hours items are intended to support patients that should not wait until the next day for treatment but are not urgent enough to require hospital treatment. To ensure

that the MBS underpins contemporary and holistic care to patients that meets their individual care needs, the TTWG supported applying a higher loading to services provided in the unsociable hours of 11 pm to 7 am than those applied for services provided from 6 pm to 11 pm. As a result, the TTWG supported removing the current MBS items for urgent after-hours services and replacing them with the higher rate loading MBS item.

Recommendation 20

The current urgent after-hours MBS items be replaced with a higher rate loading item that applies between the hours of 11 pm and 7 am daily (unsociable hours). The unsociable hours loading should only be available for telehealth services if the patient is registered with MyMedicare with the practice providing the service. The current suite of urgent after-hours MBS items could therefore cease.

After-hours bulk-billing incentives

Two bulk-billing incentive MBS items (10992 and 75872) specifically apply to after-hours attendances outside of consulting rooms where the medical practitioner is based in Modified Monash (MM) 1 and delivers the service in MM 2–7. These items pay the equivalent of the current MM 2 bulk-billing incentives for other services.

In the context of the broader review, including the proposed introduction of an after-hours loading for telehealth items, the TTWG supported ceasing these items. To replace them and ensure appropriate renumeration, the TTWG supported that medical practitioners use the bulk-billing incentives that are generally applicable when using attendance items.

Recommendation 21

When providing after-hours care, medical practitioners can use the same bulk-billing incentives that are applicable when using standard attendance items. This will replace the need for after-hours bulk-billing incentive MBS items 10992 and 75872, which can only be claimed with a limited number of after-hours items. MBS items 10992 and 75872 can cease.

Principle 5 – MBS primary care items should be adequately supported by non-MBS mechanisms

During its discussions, the TTWG recognised that data collection to inform policy could be improved. However, data collection is not a sufficient justification for separate MBS items. Other mechanisms of data collection should be considered as the primary mechanism for data collection on issues such as reason for visit, prevalence of specific conditions, and the overall health and wellbeing of the population.

In addition, other reviews, including the Review of General Practice Incentives, have highlighted the need for better availability of primary care data. This will be increasingly important as the primary care system transitions to a blended payment model, which will result in MBS billing data becoming less representative of a practice's overall activity.

Recommendation 22

The Government should ensure the funding of appropriate and contemporary data collections to inform primary care policy and funding reform.

Support for the general practice team

The TTWG recognised that there is benefit in supporting other members of the general practice team, such as practice nurses, to support patients in their home and thus

contribute to continuity of care. The TTWG supported funding for the team members to undertake home visits but acknowledged that this may not suit a fee-for-service model (such as the MBS).

Recommendation 23

Consideration be given to a mechanism to support out of consulting rooms services provided by other members of the general practice team, such as practice nurses, whether through the MBS or another funding mechanism.

Consultation and feedback review process

The TTWG considered presentations from several medical peak organisations to inform its review. A targeted consultation took place in July 2025, which reflected the positions agreed to and recommendations from up to and including meeting 4 (24–25 February 2025).

The TTWG carefully considered all feedback to inform this report.

Principles and recommendations

To ensure the MBS underpins contemporary and holistic care to patients that meets their individual care needs, this report seeks the adoption of 5 key principles for items which should be applied to time-tiered attendances in primary care. The report also provides a range of recommendations to align current MBS time-tiered items with these key principles.

The following recommendations are subject to public consultation and, once finalised, subject to acceptance by the Government.

Recommendation 1

That the government adopt 5 key principles to be applied when developing new, or revising existing, MBS items for primary care:

- Principle 1. Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items
- Principle 2. MBS benefits for time-tiered items should be equitable to support patient access to primary care services that meet their individual clinical needs
- Principle 3. MBS time-tiered attendance items and their regulatory requirements should be consistent unless there is a defined clinical need for variation, such as where the services sit outside of the standard scope of practice for a GP
- Principle 4. MBS after-hours arrangements should be streamlined and aligned across primary care
- Principle 5. MBS primary care items should be adequately supported by, but not replicate or replace, non-MBS funding mechanisms

Principle 1 – Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items

Recommendation 2

To enable the delivery of non-directive pregnancy support counselling and acupuncture services under general time-tiered attendance items, standalone MBS items for these services should be ceased.

Recommendation 3

To enable the delivery of telehealth services for bloodborne viruses and sexual and reproductive health services under general time-tiered attendances, standalone items for these services should be replaced with a new exemption to the ‘patient’s eligible telehealth practitioner’ requirement (also known as the ‘12-month rule’) to ensure ongoing patient access to these services. The current standalone items could therefore cease.

Recommendation 4

To enable the delivery of comprehensive antenatal care under general time-tiered attendance items, GPs and other medical practitioners working in general practice should be ineligible for MBS antenatal item 16500 and its telehealth equivalents (MBS items 91853 and 91858).

Principle 2 – MBS benefits for time-tiered items should be equitable, to support patient access to primary care services that meet their individual clinical needs

Recommendation 5

MBS benefits for time-tiered items should equitably support appropriate and varied consultation lengths to ensure patients can access care that meets their individual clinical needs.

Recommendation 6

Bulk-billing incentives should be based on a percentage of the MBS fee for the service that is bulk-billed to avoid furthering the disproportionate remuneration of shorter consultations when compared to longer consultations.

Rural loadings for bulk-billing incentives are appropriate and should be retained under this approach.

Recommendation 7

Bulk-billing incentives should be available for nurse practitioner services when the consultation is provided to a patient who is registered through MyMedicare with the practice that provides the service.

Principle 3 – MBS items and their requirements should be consistent, unless there is a defined clinical need for variation

Recommendation 8

Undertake work to standardise language used in item descriptors (for example describing the time-tiers for items) wherever possible across primary care items.

Recommendation 9

Align the duration of MBS time-tiers across all relevant primary care provider types and items.

Recommendation 10

Address the current differences in MBS fees between general attendance time-tiered items and equivalent time items caused by the staggered reintroduction of indexation to the MBS.[3]

Recommendation 11

Review MBS fees for time-tiered consultations for medical practitioners (excluding GPs), for example Group A2 items and equivalents, and, at a minimum, increase the item fees to be at least in line with the equivalent items for nurse practitioners.

Recommendation 12

To support system simplification, consider the progressive transition to a single set of time-tiered consultation items with an appropriate fee modifier linked to the provider's

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[3] Impacted items:

- Group A7: Acupuncture and non-Specialist Items (193,195,197, 199)
- Group A20: GP mental health treatment (GP 2700, 2701; PMP – 272, 276) and telehealth equivalents (GP – 92112, 92113; PMP – 92118, 92119)
- Group A36: Eating disorder services (GP – 90250, 90251; PMP – 90254, 90255) and telehealth equivalents (GP – 92146, 92147; PMP – 90150, 92151)

qualifications and/or provider type to replace the current approach of creating parallel sets of items.

Recommendation 13

Recognising that level 1 mental health skills training is now a core component of general practitioner training, differential fees and separate items for medical practitioners with or without 'Mental Health Skills Training' should be removed from mental health treatment plan and eating disorder treatment and management plan items.

Recommendation 14

The MBS fees for services provided outside of consulting rooms (for example, home visits) be at least commensurate with the MBS fees for equivalent services provided in residential aged care.

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The current MBS items for services provided outside of consulting rooms and in residential aged care be replaced with fee loading items for consistency. The fee loading items would only be available when the patient is registered through MyMedicare with the practice that provides the service.

The loading items should apply to consultations provided by NPs on the same basis that they are available to medical practitioners.

Principle 4 – MBS after-hours arrangements should be streamlined and aligned across primary care

Recommendation 16

Current after-hours items be replaced with a fee loading. The loading would apply to any service that is provided in the after-hours period.

Recommendation 17

The loading for after-hours services should be applied to:

- face to face general attendance items for primary care
- telehealth (video and phone) attendance items when delivered by an eligible telehealth practitioner
- Nurse Practitioner attendance items.

Recommendation 18

The definition of the MBS after-hours period for primary care be aligned across all locations and commence at 6 pm on weekdays.

Recommendation 19

The MBS regulations should specify that the time zone at the location of the practice is to be used when determining if a service is provided after-hours.

Recommendation 20

The current urgent after-hours MBS items be replaced with a higher rate loading item that applies between the hours of 11 pm and 7 am daily (unsociable hours). The unsociable hours loading should only be available for telehealth services if the patient is registered with MyMedicare with the practice providing the service. The current suite of urgent after-hours MBS items could therefore cease.

Recommendation 21

When providing after-hours care, medical practitioners can use the same bulk-billing incentives that are applicable when using standard attendance items. This will replace the need for after-hours bulk-billing incentive MBS items 10992 and 75872, which can only be claimed with a limited number of after-hours items. MBS items 10992 and 75872 can cease.

Principle 5 – MBS primary care items should be adequately supported by non-MBS mechanisms

Recommendation 22

The Government should ensure the funding of appropriate and contemporary data collections to inform primary care policy and funding reform.

Recommendation 23

Consideration be given to a mechanism to support out of consulting rooms services provided by other members of the general practice team, such as practice nurses, whether through the MBS or another funding mechanism.

Acronyms

BBPIP	Bulk-billing Practice Incentive Program
CPD	Continuing Professional Development
Department	Australian Government Department of Health, Disability and Ageing
Government	Australian Government
GP	general practitioner
MBS	Medicare Benefits Schedule
MM	Modified Monash (area)
MRAC	Medicare Benefits Schedule Review Advisory Committee
NP	nurse practitioner
PMP	prescribed medical practitioner
RACGP	Royal Australian College of General Practitioners
TTWG	Time-Tiered Working Group

Background

Time-tiered Medicare Benefits Schedule (MBS) items are a series of items that are based on the time a provider spends with a patient. Time-tiered MBS items for primary care services make up around one-third of all MBS services delivered and are the most used MBS items in primary care. In 2025, total MBS expenditure across primary care service types for levels A–E, after-hours and nurse practitioner (NP) services[4] was around $7.7 billion.

The arrangements for time-tiered MBS items for primary care services are complex. The MBS includes more than 300 time-tiered items across 5 time-tiers (levels A to E) for primary care services provided by general practitioners (GPs), medical practitioners, prescribed medical practitioners (PMPs) and nurse practitioners (NPs). Although some of these MBS items are for specific purposes or conditions, others relate to the same or similar clinical services provided – for example, in different locations, during different hours or by different practitioners.

Besides their complexity, other potential issues related to time-tiered MBS items that have been raised include lower per-minute rates for longer services, fee anomalies related to indexation and a lack of time-tiered MBS items for some services. Further, there are several inconsistencies across similar MBS items.

In December 2020, the MBS Review Taskforce published its final reports on primary care, which included a recommendation to 'undertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (levels A–D)'. (Level E items – for general attendance services lasting 60 minutes or more – were introduced on 1 November 2023, so were not considered by the Taskforce.)

In March 2023, the *Independent Review of Medicare Integrity and Compliance* report noted the complexity of the MBS and recommended that the Government 'consider restructuring the design and composition of MBS number with a time-based backbone together with additional specific intervention and procedure codes…'.

Time-tiered Primary Care Working Group

In August 2024, the Medicare Benefits Schedule Review Advisory Committee (MRAC) endorsed a review of primary care time-tiered MBS items. The time-Tiered Primary Care Working Group (TTWG) was established to lead the review and report its findings to the MRAC.

Members

The TTWG comprised MRAC members, including in the roles of Chair and consumer representative, as well as departmental officers:

- Professor Adam Elshaug, Health Services and Policy Research (Chair)
- Dr Jason Agostino, General Practice, Epidemiology and Indigenous Health

[4] Primary care services types A–E include all GP, prescribed medical practitioner and medical practitioner items for levels A–E across all modes and locations (excluding after-hours items). The after-hours types include after-hours items and nurse practitioner time-tiered attendance (all modes) are included in the nurse practitioner services primary care service type.

- Dr Imogen Colton, Departmental Policy Officer
- Adjunct Associate Professor Chris Helms, Nurse Practitioner (to July 2025)
- Ms Alison Marcus, Consumer
- Associate Professor Elizabeth Marles, General Practice and Indigenous Health
- Dr Sue Masel, Rural General Practice
- Dr Neil Meulman, General Surgery (December 2024 to September 2025)
- Associate Professor Andrew Singer, Principal Medical Adviser
- Dr Clare Skinner, Emergency Medicine
- Professor Rosalie Viney, Health Economics Research.

The review aimed to ensure that the MBS framework for primary care time-tiered MBS items remained fit for purpose in a contemporary clinical context by considering:

- consistency across MBS items and with broader health policy objectives
- options to streamline the number of MBS items
- if the existing time-tiers appropriately supported contemporary clinical practice
- if certain MBS items that were not time-tiered should be incorporated into the time-tiered structure.

Scope

The review focused on the framework for time-tiered items in the MBS rather than performing an item-by-item analysis. The following categories of MBS items were outside the scope of the review:

- time-tiered health assessments, as all health assessment items were under separate review
- MBS items announced as ceasing
- time-tiered MBS items used by practitioners outside of primary care (for example, specialists or consultant physicians), except where non-GP specialists have access to MBS items that are primarily for general practice.

Meetings

The TTWG met on 8 occasions: 4 September 2024, 16 October 2024, 2 December 2024, 24–25 February 2025, 4 June 2025, 3 September 2025, 9 December 2025 and 25 May 2026.

Time-tiered Working Group considerations and recommendations

The time-tiered framework is an extremely complex framework, with more than 300 MBS items for primary care across 5 time-tiers. Many time-tiered MBS items are similar, and there are complex claiming rules and inconsistencies among the items. The Time-tiered Working Group (TTWG) considered that patients, individual practitioners, practices and Government would all benefit from simplifying the time-tiered framework.

The TTWG acknowledged the large amount of work coinciding with this review and the group's considerations and recommendations – for example, universal patient access to bulk-billing incentives and the establishment of the Bulk Billing Practice Incentive Program (BBPIP). Additionally, the TTWG noted the Strengthening Medicare Taskforce's recommendation that funding arrangements for primary care move to a blended funding model, with a long-term goal of 60:40 ratio of fee for services to other payments.

Noting this recommendation, the TTWG considered that the Medicare Benefits Schedule (MBS) – Australia's fee-for-service remuneration model – will remain important and relevant for our healthcare system in the future. Therefore, to ensure that the MBS underpins contemporary and holistic care to patients that meets their individual care needs, this report seeks the adoption of 5 key principles for items which should be applied to time-tiered attendances in primary care. The report also provides a range of recommendations to align current MBS time-tiered items with these key principles.

The MRAC reviewed and endorsed this report and recommendations out of session on 25 August 2026.

The following recommendations are the subject of public consultation and, once finalised, subject to acceptance by the Government. It should also be noted that the Government is responsible for setting appropriate fees for MBS items.

Preliminary estimates suggest that, if fully implemented, the recommendations of this review (excluding recommendation 12) could reduce the number of time-tiered attendance items from more than 300 to around 150. Implementation of recommendation 12, which is a long-term recommendation, has the potential to further reduce the total number of items to less than 100.

This report includes the most recent data available, which in many cases is 2024–25 data. By the time this report is finalised and published, it will include updated 2025–26 data.

Recommendation 1

That the Government adopt 5 key principles to be applied when developing new, or revising existing, MBS items for primary care:

- Principle 1 – Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items
- Principle 2 – MBS benefits for time-tiered items should be equitable to support patient access to primary care services [that meet their individual clinical needs]
- Principle 3 – MBS time-tiered attendance items and their regulatory requirements should be consistent unless there is a defined clinical need for variation, such as where the services sit outside of the standard scope of practice for a GP

- Principle 4 – MBS after-hours arrangements should be streamlined and aligned across primary care
- Principle 5 – MBS primary care items should be adequately supported by, but not replicate or replace, non-MBS funding mechanisms

Principle 1 – Condition-specific consultation items should be minimised in primary care settings to allow practitioners to deliver holistic, clinically relevant care to patients through appropriate time-tiered items

When forming its recommendations for time-tiered items, the TTWG focused on ensuring that primary care is adequately funded to provide whole-of-person care. The TTWG considered that the ability to treat the whole patient is core to the speciality of general practice.

Noting that general attendance items can be used when no other item applies, the TTWG therefore aimed to avoid a fragmented system that incentivised attendances for certain conditions or encouraged multiple appointments.

In addition, the TTWG noted that, although some condition or treatment-specific time-tiered items had different fees to the general attendance items, the general time-tiered attendance items attract triple bulk-billing incentives, condition or treatment-specific items do not.

The overarching view of the TTWG was that in a time-tiered system the MBS benefits for consultations should reflect the time spent with the patient, rather than the condition(s) of the patient.

Pregnancy support counselling and acupuncture services

Non-Directive Pregnancy Counselling services

Non-directive pregnancy counselling (NDPC) was introduced into the MBS in 2006. Medical practitioner items are available for GPs and PMPs who have completed NDPC training to deliver NDPC attendances lasting at least 20 minutes. GPs and prescribed medical practitioners (PMPs) who have not completed the training can deliver equivalent services using general attendance items.

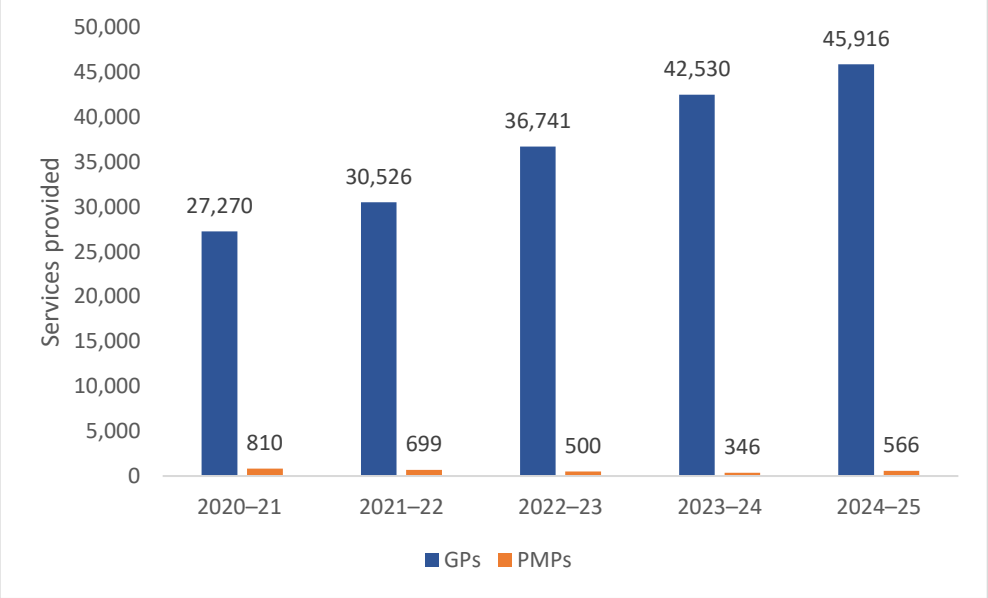
The TTWG noted that the NDPC training required to access the NDCP items is now a component of the Pregnancy and Reproductive Health unit of the Royal Australian College of General Practitioners (RACGP) fellowship curriculum. As a result, all general practitioners (GPs) who attained RACGP fellowship under the current curriculum maintain an NDPC training credential. For the following practitioners, NDCP training is available as a 3-hour (Australian College of Rural and Remote Medicine; ACRRM) or a 4-hour (RACGP) Continuing Professional Development (CPD):

- RACGP fellows who attained fellowship before 2023
- ACRRM fellows (core generalist)
- prescribed medical practitioners (PMPs).

Ongoing CPD training is not required to maintain the credentialling.

The TTWG noted that MBS claiming of NDPC items continues to increase, with total GP services experiencing an average annual growth rate of 14% (see Figure 1).

Figure 1: Non-Directive Pregnancy Counselling services delivered, 2020–21 to 2024–25



GP = general practitioner; PMP = prescribed medical practitioner

Given the availability of general time-tiered consultation items, the TTWG considered that there is little justification for separate MBS items that recognise qualifications that are:

- within the standard scope of practice of the relevant profession (for example, standard GP training)

or

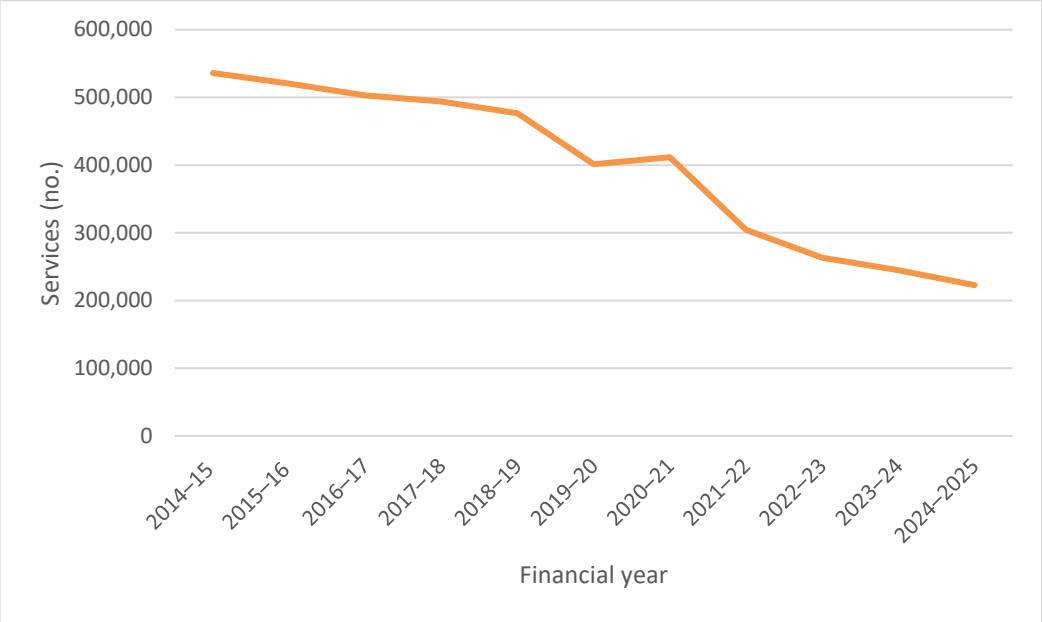
- recognise CPD-level training with no ongoing CPD requirements.

Acupuncture services

Time-tiered acupuncture items were introduced to the MBS in 1984. Acupuncture items replicate both the clinical requirements and service durations of levels B, C and D attendance items, but stipulated that acupuncture be provided as part of the attendance. This review incorporates the post-implementation review of changes to acupuncture items in 2022 at the recommendation of the MBS Review Taskforce.

The TTWG noted that use of MBS acupuncture services been declining since 2016–17 (Figure 2), including a significant drop in services in 2021–22. This is likely attributable to the impacts of the COVID-19 pandemic, but service levels did not rebound after the pandemic. Acupuncture services continued to decline after changes were implemented on 1 November 2022, with total services falling by 18.2% between 2022–23 and 2024–25 (Figure 2). During this time, claims for the most delivered acupuncture service (MBS item 193) decreased by 27.5%, and MBS item 195 (for in-hospital acupuncture services) was claimed only 4 times.

Figure 2: Acupuncture services claimed (MBS items 193, 195, 197 and 199), 2014–15 to 2024–25



The number of providers billing acupuncture items, and the average number of acupuncture services billed per provider, also decreased between 2020–21 and 2023–24. GP bulk-billing rates for acupuncture services have also decreased since 2021–22.

Regarding the continued decline after changes were implemented on 1 November 2022, the TTWG considered that multiple factors, including changes to the acupuncture endorsement model and the potential provision of acupuncture within general care, have contributed to the decline.

The TTWG also noted that time-tiered attendance items for GPs attract a higher MBS benefit than the equivalent acupuncture items. Further, where a service is bulk-billed, the general attendance items attract a triple bulk-billing incentive while the acupuncture items attract single bulk-billing incentives. Given the higher renumeration for attendance items, it is possible that GPs with an endorsement for acupuncture are also using attendance items, rather than the acupuncture items, when providing acupuncture services.[5]

After reviewing these data, the TTWG questioned the ongoing purpose and value of maintaining specific MBS acupuncture items. Removal of all acupuncture items would support streamlining the MBS and increase the benefits received by patients because the regulatory barriers to the use of attendance item would be removed.

The TTWG acknowledged that either Medical Board of Australia (MBA) endorsement, or Chinese Medicine Board of Australia (CMBA) recognition, in acupuncture is required to bill the MBS acupuncture items. Medical practitioners with an endorsement or registration in acupuncture would be able continue to describe themselves as ‘acupuncturists’ in accordance with the MBA and CMBA’s guidelines and have access to time-tiered items to deliver acupuncture services if this recommendation were adopted.

[5] Due to the nature of MBS item utilisation data, it is not possible to identify the number of acupuncture treatments delivered under general attendance items.

Recommendation 2

To enable the delivery of non-directive pregnancy support counselling and acupuncture services under general time-tiered attendance items, standalone MBS items for these services should be ceased.

Bloodborne virus, and sexual and reproductive health services

Telehealth items for blood borne viruses and sexual and reproductive health (BBVSRH) were introduced to the MBS in 2021 as temporary items. There are 24 time-tiered BBVSRH items for GPs and PMPs to provide these services via video and phone. Unlike the standard telehealth consultation items, BBVSRH items are not subject to the 'eligible telehealth practitioner' (also known as the '12 month' or 'established clinical relationship') requirements. There are no equivalent face-to-face items.

The MRAC's Post-Implementation Review of Telehealth recommended that the BBVSRH be made permanent and remain exempt from the 'eligible telehealth practitioner' requirements. This recommendation has been implemented.

The TTWG considered that the availability of telehealth BBVSRH services from a medical practitioner other than the patient's eligible telehealth practitioner is appropriate.

However, in the context of this review's objective of streamlining the MBS, the TTWG noted that the MRAC's objective of exempting these services from the eligible telehealth practitioner rule could be achieved by including BBVSRH services in the general exemptions.[6] This would allow GPs, PMPs and NPs to use general telehealth attendance items to provide these services to any patient. The standalone MBS items for BBVSRH services could thus cease.

Recommendation 3

To enable the delivery of telehealth services for bloodborne viruses and sexual and reproductive health services under general time-tiered attendances, standalone items for these services should be replaced with a new exemption to the 'patient's eligible telehealth practitioner' requirement (also known as the '12-month rule') to ensure ongoing patient access to these services. The current standalone items could therefore cease.

Antenatal attendance items

MBS item 16500 covers routine face-to-face antenatal attendances, and MBS items 91853 and 91858 were added in 2020 and cover the equivalent telehealth and telephone services (as a result of the COVID-19 pandemic). These items are used in both primary care and by specialist obstetricians. This TTWG only considered the use of these items in primary care, consistent with the scope of this review.

The TTWG noted that, before this review, general practice stakeholders had raised concerns the fees for the antenatal attendance MBS items remain the same regardless

[6] Exemptions to the 'eligible telehealth practitioner' requirements currently apply to people under 12 months of age, people experiencing homelessness, people in COVID-19 isolation or quarantine because of a state or territory health order, a person receiving a service for a medical or nurse practitioner located at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Services, and a person who is in a natural disaster area.

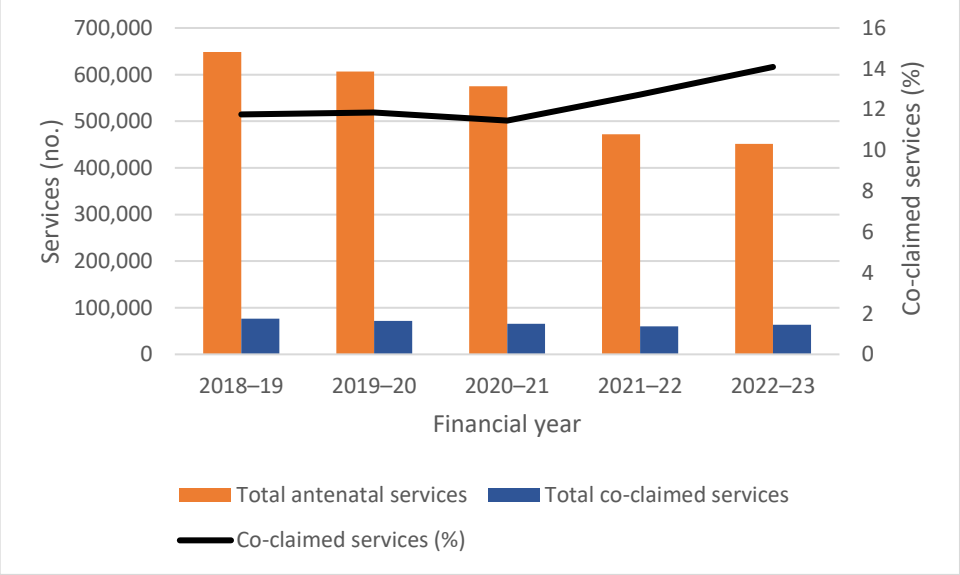
of the length of the consultation (that is, the items are not time-tiered). It was also noted that the use of these items in primary care is decreasing (Figure 3).

From 2018–19 to 2022–23, most antenatal attendance services claimed in primary care were not co-claimed with another MBS item. For example, in 2022–23, 86% of antenatal attendance services claimed were not co-claimed with another MBS item (excluding bulk-billing incentives). Importantly, although the proportion of antenatal attendances items co-claimed with another item has increased, the number of co-claimed attendances has remained stable. The increasing proportion of co-claiming is due to a reduction in the overall use of the antenatal attendance items.

The most frequently co-claimed service in 2022–23 was MBS item 23, a general attendance item (Figure 4), which was co-claimed with less than 4.5% of antenatal attendances in primary care. The next most commonly co-claimed items were MBS item 4001 for non-directive pregnancy counselling, MBS item 73806 for pregnancy testing, MBS item 36 for level C attendances and MBS item 55703 for ultrasound at less than 12 weeks gestation.

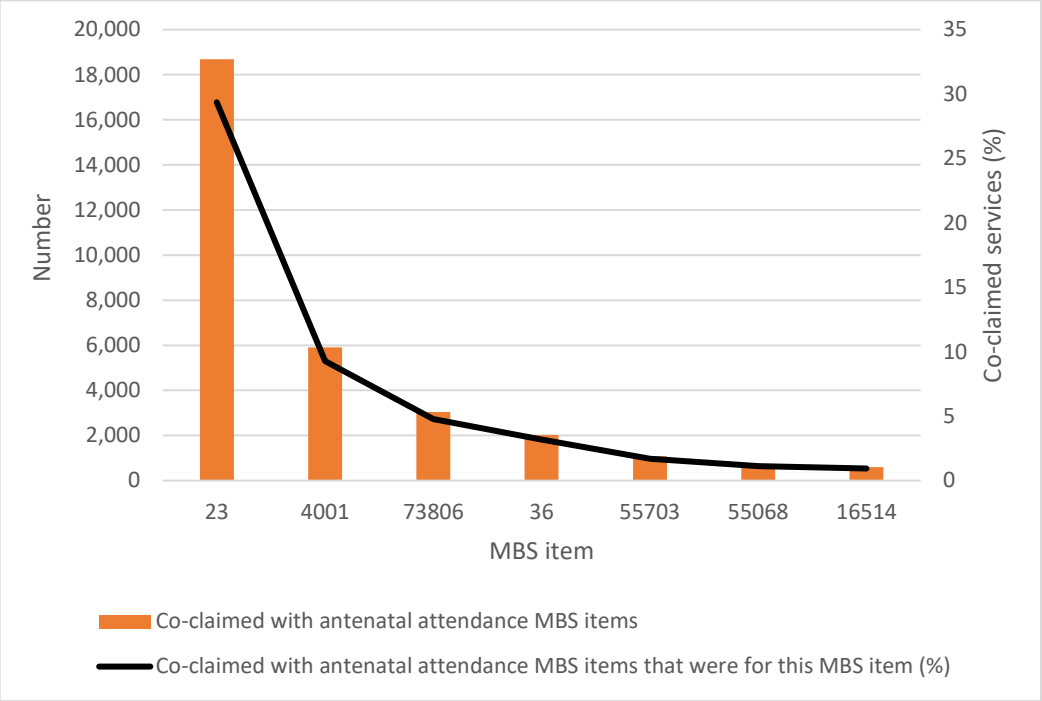
The TTWG also noted that, while the bulk-billing rate for item 16500 in general practice was 60.9% in 2023–24, bulk-billing incentives were only claimed with 12.8% of services, reflecting the proportion of women of reproductive age who were eligible for bulk-billing incentives at that time.[7]

Figure 3: Use of antenatal attendance MBS items 16500, 91853 and 91858 in primary care, 2018–19 to 2022–23



[7] Since 1 November 2025 all Medicare-eligible people have been eligible for bulk-billing incentives.

Figure 4: MBS items most frequently co-claimed with antenatal attendance MBS items 16500, 91853 and 91858 in primary care, 2022–23



The TTWG noted that, currently, the MBS benefit for an antenatal attendance is around 6% higher than a level B attendance. However, currently, the existence of the antenatal attendance item precludes GPs from claiming level C, D or E attendance items when they conduct an antenatal attendance longer than 20 minutes, which pay significantly higher benefits than the antenatal attendance items.

As of 1 July 2026, the benefit for MBS items 16500, 91853 and 91858 was $48.00 when provided out of hospital.[8] Since MBS item 16500 was introduced more than 30 years ago, there have been substantial changes in the antenatal health care provided during primary care consultations, and an antenatal attendance likely takes longer than it did in the past.

The TTWG considered the decreasing use of the antenatal attendance MBS items in primary care suggested the items were no longer fit for purpose in primary care. The TTWG recognised that the decreasing use may indicate practitioners are instead using time-tiered general attendance MBS items, which may better reflect the time spent by practitioners providing antenatal health care. For example, as of 1 July 2026, MBS item 36 – a level C general attendance MBS item for attendances lasting at least 20 minutes but less than 40 minutes– had a benefit of $87.10.

The TTWG also recognised that, although the antenatal attendance can be claimed with single bulk-billing incentives, general attendance MBS items (level B and above) are eligible for a triple bulk-billing incentive payment. The expansion of bulk-billing incentives to all Medicare-eligible patients and the introduction of the Bulk-billing Practice Incentive Program (BBPIP) on 1 November 2025 has increased the significance of this difference (see Table 1). Unlike general attendance items, antenatal attendances are not eligible services for the purpose of the BBPIP.

[8] The MBS fee for these items is $56.45. 75% and 85% benefits are available depending on whether the service is provided in or out of hospital.

Table 1: Comparison of Government payments for an antenatal attendance, level B and level C for a bulk-billed patient in Modified Monash 1 areas

MBS benefit		**Antenatal attendance**	**Level B (item 23)**	**Level C (item 36)**
MBS benefit (out of hospital)		$48.00	$45.05	$87.10
If the service is bulk-billed	Bulk-billing incentive benefit	$7.50	$22.40	$22.40
	Total MBS benefit paid	**$55.50**	**$67.45**	**$109.50**
If the practice participates in BBPIP	Contribution to quarterly BBPIP payment	Nil	$5.63	$10.89
	Total government payment	**$55.50**	**$73.08**	**$120.39**

During targeted consultation, stakeholders also flagged that, if antenatal items are removed, they will not be able to co-claim these services with other attendances. However, the recommendation, if adopted, would allow GPs to claim a higher time-tier MBS item for longer consultations. In addition, practitioners would still be able to co-claim other items in accordance with MBS billing rules. The data also show that MBS item 16500 is rarely co-claimed. Therefore, the TTWG considered its recommendation will allow better access and more appropriate rebates for patients.

The TTWG considered that, to better support comprehensive antenatal health care, GPs and other medical practitioners working in a primary care setting should have access to the full suite of time-tiered general attendance MBS items for antenatal attendances. The TTWG suggested that this could be achieved by amending the antenatal attendance MBS items to exclude medical practitioners working in primary care.

If the TTWG's recommendation was adopted, obstetricians would continue to have access to the antenatal attendance MBS items.

Recommendation 4

To enable the delivery of comprehensive antenatal care under general time-tiered attendance items, GPs and other medical practitioners working in general practice should be ineligible for MBS antenatal item 16500 and its telehealth equivalents (MBS items 91853 and 91858).

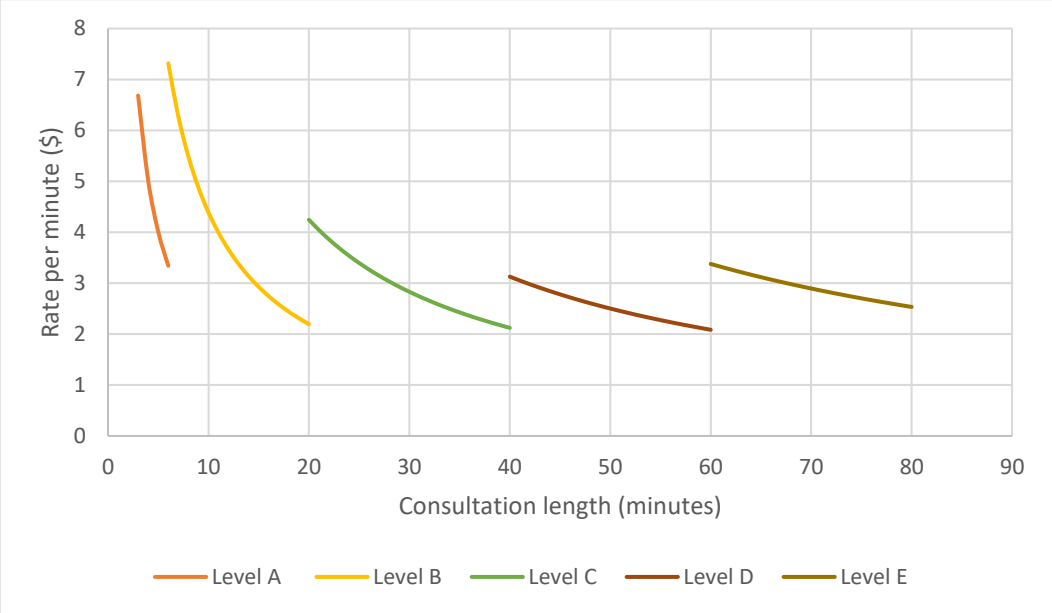
Principle 2 – MBS benefits for time-tiered items should be equitable, to support patient access to primary care services that meet their individual clinical needs

The TTWG considered MBS item fees and MBS utilisation data from the Department to inform the recommendations for principle 2.

Fee-per-minute rates for general attendance MBS items

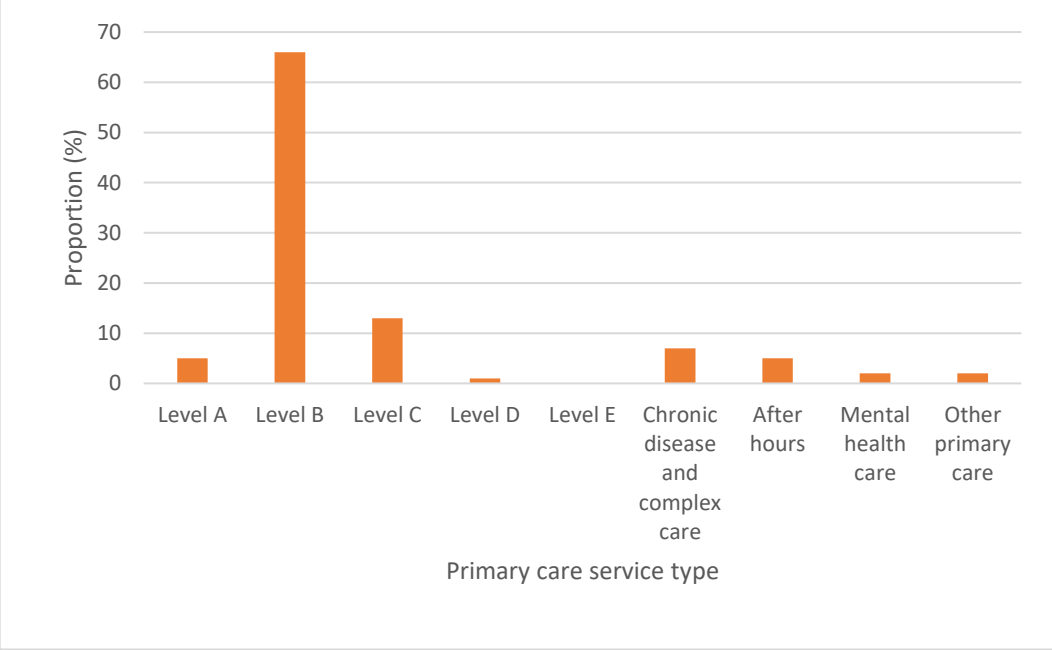
The fee-per-minute rates for levels C, D and E general attendances as of 1 July 2025 were lower than those for levels A and B general attendances (Figure 5 and Table 1).

Figure 5: Fee-per-minute rates for general attendance MBS items as of 1 July 2025



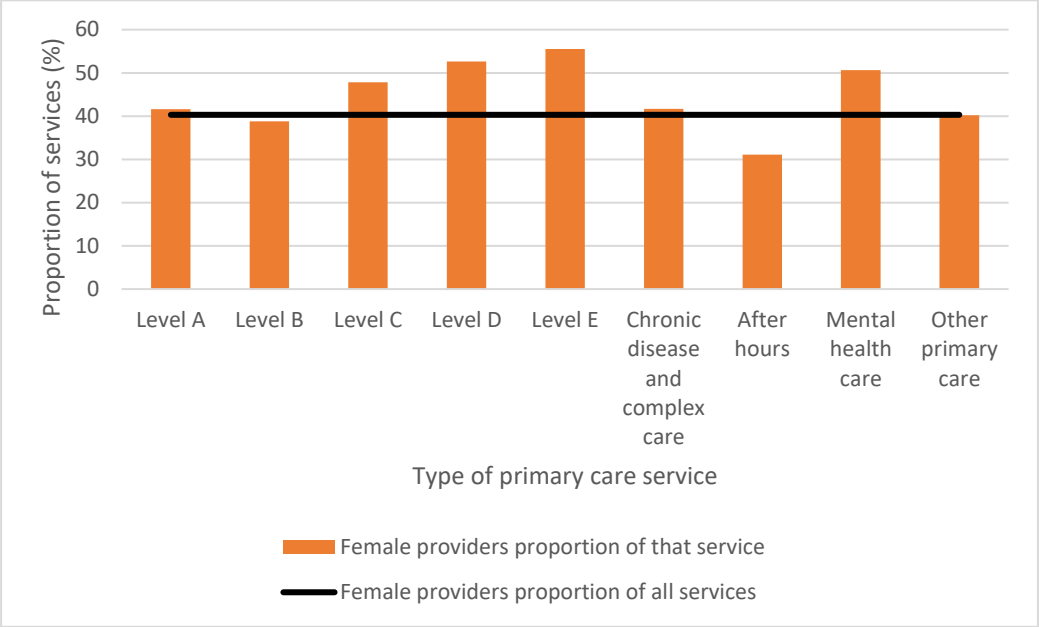
In 2023–24, 66% of the services provided by GPs were level B general attendances (Figure 6).

Figure 6: Services provided by general practitioners by primary care service type, 2023–24



The TTWG also considered that the current fee structure raised gender equity issues for both patients and providers. In 2023–24, female GPs provided 40.3% of total non-referred attendance services provided by GPs, 47.8% of level C general attendances and 52.6% of level D general attendances (Figure 7). Further, female patients accounted for 55.8% of MBS item 23 (level B) claims and 65.5% of MBS item 123 (level E) claims.

Figure 7: Proportion of non-referred attendance services provided by general practitioners (GPs) that were provided by female GPs, 2023–24



The TTWG considered that GPs may be disincentivised from providing longer consultations (such as levels C and D) when appropriate because of such MBS items attracting lower fee-per-minute rates. The TTWG also considered that the lower fee-per-minute rates for levels C and D general attendances could disincentivise GPs from bulk-billing these MBS items.

The TTWG also recognised that, compared with the proportion of total non-referred attendance services that are provided by female GPs, the proportion of levels C and D general attendances that are provided by female GPs is high. The TTWG recognised that female GPs provide a larger proportion of the longer (levels C and D) general attendance consultations than their male counterparts (compared to total non-referred attendance services). The group noted that this presents equity issues because of the lower fee-per-minute rates for these MBS items.

The TTWG recognised that there is a role for both long and short consultations, and that the length of a consultation should be guided by clinical need. The group also acknowledged that there is a relatively higher administrative workload associated with shorter consultations than longer consultations. As a result, it is reasonable to expect a small 'flag fall' effect on short consultations. However, the TTWG considered the current per-minute differences between short and longer consultations is too great. The TTWG considered a number of options for achieving this, including:

- simply increasing the fee for levels C, D and E
- the Australian Medical Association's (AMA's) proposal for 7 time-tiers
- time blocks with a flag fall for the initial block.

The TTWG concluded that there are several approaches that could achieve the objective. However, given the complexity of changing the overall time-tiered framework (for example, as per the AMA proposal), the TTWG acknowledged that increasing the fees for levels C–E is the option that could be implemented fastest. However, doing so would not preclude longer term changes to the time-tiered structure.

The TTWG considered that evaluation of any changes to fee-per-minute rates after their implementation would be important to understand their impact on patients, individual GPs and GPs as a workforce.

Recommendation 5

MBS fees-per-minute for time-tiered items should equitably support appropriate and varied consultation lengths to ensure patients can access care that meets their individual clinical needs.

Bulk-billing incentives structure

The TTWG also considered that the current bulk-billing incentives structure exacerbates the lack of financial incentives for longer consultations compared to shorter consultations. The TTWG supports bulk-billing incentives and scaling incentives according to remoteness. However, bulk-billing incentives should not provide additional structural incentives for shorter consultations.

Recommendation 6

Bulk-billing incentives should be based on a percentage of the MBS fee for the service that is bulk-billed to avoid furthering the disproportionate remuneration of shorter consultations when compared to longer consultations.

Rural loadings for bulk-billing incentives are appropriate and should be retained under this approach.

Bulk-billing incentives for nurse practitioners

Currently, bulk-billing incentives are only available for services provided by a medical practitioner. In the context of supporting GP-led multidisciplinary teams, the TTWG supported extending bulk-billing incentives to NPs working in MyMedicare practices. This would both support the NP workforce in general practice settings and encourage general practices to engage more NPs. It would also support improved continuity of care for patients by encouraging a broader range of professions within a general practice.

The TTWG noted consultation feedback that the requirement for the bulk-billing incentive to be linked to MyMedicare would exclude nurse practitioner–led practices. However, the TTWG highlighted that MyMedicare clinics are accredited and therefore are proven to meet certain standards. The TTWG maintained that including MyMedicare registration would ensure patient safety and continuity of care, which was a focus of the TTWG's discussions and therefore recommendations (also see Targeted consultation).

Recommendation 7

Bulk-billing incentives should be available for nurse practitioner services when the consultation is provided to a patient who is registered through MyMedicare with the practice that provides the service.

Principle 3 – MBS items and their requirements should be consistent, unless there is a defined clinical need for variation

Simplification and consistency of time-tiered items

The complexity of time-tiered items has increased over time for several reasons, including recognising new services, such as telehealth or mental health items, and adding an additional time-tier (level E). The TTWG agreed that the clinical services provided under these items are appropriate and needed, but the group also considered that the current MBS structures could be improved.

The TTWG highlighted the following inconsistencies across various MBS items:

- differences in the time-tiers for GPs, NPs and PMPs
- inconsistencies in the way items are described and the detail of the requirements
- several ways of describing the time-tiers used throughout the MBS using slightly different language, such as ‘at least x minutes’, ‘not less than’ and ‘more than’
- inconsistencies between the specific times for each time-tier by provider type, and sometimes mode.

The TTWG agreed that simplification of wording and consistency of duration of time-tiers would benefit all Medicare users.

Recommendation 8

Undertake work to standardise language used in item descriptors (for example describing the time-tiers for items) wherever possible across primary care items.

Time-tiered items for different provider types and service delivery modes

Some of the differences current seen across time-tiered item do not impact clinical care, but others do directly impact consumers. For example, the length of levels of A–E consultations vary across provider types and modes (see Table 2). The TTWG did not consider there to be clinical justification for different lengths of time-tiers for consultation items depending on provider type and mode of service in primary care settings.

Table 2: Variation in the duration of levels A–E consultations for different primary care provider types for professional attendance items in standard hours

Level	General practitioner	Prescribed medical practitioner	Nurse practitioner
A	F2F and video: straightforward task Telephone: less than 6 minutes	F2F and video: not more than 5 minutes Telephone: less than 6 minutes	Straightforward task
B	F2F and video: at least 6 minutes and less than 20 minutes Telephone: less than 6 minutes	F2F and video: more than 5 minutes but not more than 25 minutes Telephone: at least 6 minutes	At least 6 minutes and less than 20 minutes
C	At least 20 minutes	More than 25 minutes but not more than 45 minutes	At least 20 minutes
D	At least 40 minutes	More than 45 minutes but not more than 60 minutes	At least 40 minutes
E	At least 60 minutes	More than 60 minutes	At least 60 minutes

F2F = face to face

Recommendation 9

Align the duration of MBS time-tiers across all relevant primary care provider types and items.

Fees for equivalent MBS items

The TTWG recognised the fee discrepancies between time-tiered general attendance MBS items and some equivalent MBS items caused by the staggered reintroduction of indexation of MBS rebates from 2017. For example, as of 1 July 2026, the fee for MBS item 36 (a professional attendance by a GP at consulting rooms lasting at least 20 minutes) was $87.10, whereas the fee for MBS item 197 for an attendance for acupuncture was $85.80.

The TTWG noted the difference in MBS fees between general attendance time-tiered MBS items and their equivalents caused by the staggered reintroduction of indexation and considered that this should be addressed, if the relevant items continue.

Recommendation 10

Address the current differences in MBS fees between general attendance time-tiered items and equivalent time items caused by the staggered reintroduction of indexation to the MBS.[9]

Service provider types and qualifications

The MBS is first and foremost a patient benefit scheme, but it can also support broader health policy objectives, including workforce policy. In general practice, the MBS has been used to support workforce policies since at least the mid-1990s, when the distinction between GPs and other medical practitioners (now PMPs) was introduced.

The TTWG supported the continuation of MBS fees based on professional qualifications in primary care settings, including maintaining the distinction between specialist GPs (and those in specialist GP training) and medical practitioners who do not hold specialist qualifications working in general practice settings. However, this needs to be considered alongside the additional complexity this creates in the schedule, and the impact on of the different fee structures on patients (see Table 3).

The MBS benefits for equivalent general attendance items for PMPs, vary by location (Table 3). In Modified Monash (MM) areas 2–7, PMPs have access to the Group A7 Subgroup 2 attendance items, for which MBS benefits are set at 80% of the equivalent GP MBS benefits. In MM 1, the same service is provided using the Group A2 items, which are not subject to annual indexation of the MBS. As a result, the benefit the patient receives for a level B equivalent service in MM2–7 is 80% of the GP fee, and in MM 1 it is less than 50% of the equivalent GP fee. This difference in benefits could adversely affect patients through increased out-of-pocket costs.

While not within the scope of this review, the TTWG notes that the Group A2 items are also used by non-GP specialists (in all MM areas), when providing an unreferred service.

Table 3: MBS benefits by provider type, 2026–27

Level	General practitioner	Prescribed medical practitioner		Nurse practitioner
		MM 1	MM 2–7	
A	$20.55	$11.00	$16.50	$12.75
B	$45.05	$21.00	$35.95	$27.80
C	$87.10	$38.00	$69.70	$52.55
D	$128.35	$61.00	$102.65	$77.55
E	$207.90	$98.40	$166.30	$117.20

MM = Modified Monash area

The TTWG considered that MBS benefits for PMPs should, in all instances, be at least commensurate to the MBS benefits for NPs, noting that this is not the current case for

[9] Impacted items:
- Group A7: Acupuncture and non-Specialist Items (193,195,197, 199)
- Group A20: GP mental health treatment (GP 2700, 2701; PMP – 272, 276) and telehealth equivalents (GP – 92112, 92113; PMP - 92118, 92119)
- Group A36: Eating disorder services (GP – 90250, 90251; PMP - 90254, 90255) and telehealth equivalents (GP – 92146, 92147; PMP - 90150, 92151)

PMPs working in MM 1. Maintaining this equivalent would also require that these items be indexed as part of the annual MBS indexation.

Recommendation 11

Review MBS benefits for time-tiered consultations for medical practitioners (excluding general practitioners) – for example, Group A2 items and equivalents – and, at a minimum, increase the item benefits to be at least in line with the equivalent items for nurse practitioners.

The TTWG also noted that replicating items for different provider types contributes to the complexity of the MBS, by both increasing the number of items and increasing opportunities for inconsistencies and discrepancies between those items.

While the TTWG recognised that this has been the preferred approach to recognising different providers historically, it saw merit in further considering alternative approaches to structuring items where equivalent clinical services are provided, especially where the fees for one provider are a fixed percentage of the fees for another provider.

Recommendation 12

To support system simplification, consider the progressive transition to a single set of time-tiered consultation items with an appropriate fee modifier linked to the provider's qualifications and/or provider type to replace the current approach of creating parallel sets of items.

Requirements for Mental Health Skills Training

As noted previously, the TTWG queried the ongoing need for separate MBS items where a service:

- is within the usual scope of practice the relevant profession

or

- a CPD-level qualification without ongoing CPD requirements to maintain the credential.

Currently, there are separate MBS items for preparing a Mental Health Treatment Plan, and for preparing and reviewing an Eating Disorder Treatment and Management Plan for GPs and PMPs with and without mental health skills training. Apart from training requirements, the only difference between the items for those with and without mental health skills training is the MBS fee. Importantly, these MBS items allow the GP/PMP to put in place a plan and refer the patient for treatment service. They are not items for treating the patient's condition.

Mental health skills training has been a core component of the RACGP fellowship curriculum since 2023. For others, mental health skills training is available through General Practice Mental Health Standards Collaboration (GPMHSC) as part of CPD. There are no ongoing CPD requirements to maintain the credential.

The TTWG supported different MBS fees based on practitioner qualifications and endorsements linked to their registration. However, the TTWG did not support MBS items that recognise continuing professional development training.

Therefore, the TTWG did not consider it appropriate to have separate MBS items with different fees for Mental Health Treatment Plan and Eating Disorder Treatment and Management Plan items that depend on whether the GP has done Mental Health Skills Training. The TTWG acknowledged that, originally, this may have been an important

inclusion to encourage GPs to undertake the training. However, this training is now part of GP training to obtain fellowship and the TTWG considered this additional training requirement to be redundant.

In contrast, the TTWG noted that Focused Psychological Strategies Training (also provided by the GPMHSC) allows GPs and PMP to access MBS items to provide treatment through the focused psychological strategies and eating disorder treatment items. This Focused Psychological Strategies Training:

- is not within the usual scope of practice for GPs/PMPs (other than rural generalists with advanced skills in mental health)
- requires ongoing CPD (every 3 years) to maintain the credential.

The TTWG therefore support retaining the additional training and credentialling for focused psychological strategies and eating disorder treatment items.

Recommendation 13

Recognising that level 1 mental health skills training is now a core component of general practitioner training, differential fees and separate items for medical practitioners with or without 'Mental Health Skills Training' should be removed from Mental Health Treatment Plan and Eating Disorder Treatment and Management Plan items.

Location-specific services

Currently, separate sets of MBS items for GPs and other medical practitioners are available to provide time-tiered attendances in consulting rooms, out-of-consulting rooms and in residential aged care during standard hours and after-hours. These MBS items cover equivalent clinical services; however, each has different rules and fee structures (Table 4). In contrast, NPs have a single set of attendance items that are location agnostic.

Table 4: Fee structures for MBS items by location and time of day

Location	Standard hours	After-hours
Aged care home	Flag fall applies for the first patient seen	Derived fee applies for all patients seen
Outside of consulting room, but not aged care homes	Derived fee applies for all patients seen	Derived fee applies for all patients seen

The TTWG recognised that it is important for the MBS to support:

- services for patients outside of consulting rooms (for example, in their homes) and in residential aged care
- continuity of care for these patients.

The TTWG also recognised that, compared to services provided in consulting rooms, there are additional costs and complexities associated with providing services outside of consulting rooms. The TTWG thus supported continuing higher MBS benefits for services delivered outside of consulting rooms compared to in consulting rooms for this reason.

The TTWG acknowledged that services provided in residential aged care and other locations can be highly complex, but the TTWG also highlighted the additional supports available in residential aged care compared to, for example, a patient's private home.

Therefore, the TTWG did not consider services delivered in residential aged care to be more complex than other locations, such as home visits, and therefore did not consider the higher MBS fees for residential aged care visits relative to other out-of-consulting room visits to be justified.

The TTWG noted current evidence suggesting that the current MBS arrangements are not adequately supporting patients that would benefit from out-of-room services:

- Anecdotal evidence indicates that many residential aged care homes have difficulty accessing general practice services for their patients.
- MBS data indicated that out-of-room services have been in steady decline for more than 10 years. While the expansion of telehealth services in March 2020 has allowed some patients to access their practitioner through this mode, there are still significant numbers of people who require care in the home. This includes those with disabilities, older people living in their own private home for longer, and palliative care patients.

The TTWG also considered that there is a role for the entire primary care team in relation to services outside of consulting rooms. The group also noted that some services could be provided by non-medical members of the team, such as NPs and practice nurses (see also recommendation 23).

The TTWG supported streamlining the arrangements for out-of-room services. Therefore, the TTWG supported moving to a fee-loading approach for out-of-room services (similar to recommendations 16 and 17; see After-hours primary care services). Under this approach, a standard consultation item (such as MBS item 23) would be used in conjunction with an additional percentage loading paid if the service is delivered in a location other than consulting rooms. The TTWG considered that loading items should apply to GP, PMP and NP attendance items.

The TTWG also noted the importance of continuity of care for many people that access services outside of rooms, whether in residential aged care or their own home. To support continuity of care, the TTWG considered it appropriate for out-of-room loading to be linked to a patient's MyMedicare registration, including for NPs.

The TTWG acknowledged that there may be policy justification for additional incentives to ensure the provision of services in certain locations, such as residential aged care, but considered that any such incentives should be provided through non-MBS funding mechanisms.

Recommendation 14

The MBS fees for services provided outside of consulting rooms (for example, home visits) be at least commensurate with the MBS fees for equivalent services provided in residential aged care.

Recommendation 15

The current MBS items for services provided outside of consulting rooms and in residential aged care be replaced with fee loading items for consistency. The

loading items would only be available when the patient is registered through MyMedicare with the practice that provides the service.

The loading items should apply to consultations provided by nurse practitioners on the same basis that they are available to medical practitioners.

Principle 4 – MBS after-hours arrangements should be streamlined and aligned across primary care

After-hours primary care services

The current after-hours arrangements are complex, with 45 MBS items for non-urgent services and a further 6 MBS items for urgent after-hours services. The TTWG considered the main reasons for after-hours care, which are varied but generally include urgency, convenience and access for patients. Patients aged over 85 year and those under 5 years are largest users of MBS after-hours services according to MBS data.

The TTWG also noted that the environment for after-hours primary care services has changed since the MBS Review Taskforce reviewed the after-hours items:

- Services such as the HealthDirect GP hotline, 1800MEDICARE, state and territory virtual ED services and Medicare Urgent Care Clinics have been introduced or expanded.
- The Taskforce's recommendations relating to MBS items for urgent after-hours services have been implemented.
- Telehealth services have become a permanent feature of the MBS, although after-hours telehealth items are limited to urgent services in the unsociable period (11 pm to 7 am).

Members discussed the role of telehealth in after-hours services, including the potential for telehealth to provide high-quality primary care and the important of existing relationships between patients and providers to maintain continuity of care.

Use of after-hours MBS items has remained steady since 2021–22, at around 7.7 million services per year, which is significantly lower than the peak in usage of 12.3 million after-hours services in 2017–18. The TTWG acknowledged that where after-hours consultations are not urgent, patients could also be using other services, such as HealthDirect GP hotline/1800MEDICARE, to relieve pressure from general practice and after-hours services.

The TTWG also noted that the issue of declining per minute rates for longer consultations during 'standard' hours (see Fee-per-minute rates for general attendance MBS items) is exacerbated in the after-hours period. For example, the after-hours level A item (MBS item 5000) fee is 168% of its standard-hours equivalent (item 3), but the after-hours level D item (MBS item 5060) is 110% of it standard-hours equivalent (MBS item 44).

In considering these issues, the TTWG was aware of the findings of the 2023–24 Review of After-Hours Primary Care Policy and Programs.[6] The Review identified the features of an ideal after-hours system as one that:

- provides consumers with the care they need at the right time and place
- provides quality after-hours care with assurance of continuity of care, irrespective of postcode
- is culturally safe and appropriate, and meets the complex and unique needs of First Nations people

- has funding settings that incentivise high-quality cost-effective services
- supports consumers to engage with their regular primary care provider
- improves providers' quality of life through better planning and managing after-hours care demand, reducing the time spent on-call.

To address these issues, the TTWG considered simplifying the after-hours items by removing the distinction between urgent and non-urgent services, and instead focusing on the time and location of the service.

The group preferred an approach that moves away from standalone after-hours consultation items and instead uses fee modifiers. Under this approach, a percentage loading would be applied to the standard consultation items (for example, MBS item 23) for a service that is provided out of hours. The same percentage loading would apply across all consultation items.

The TTWG also considered that expanding the range of services that receive higher MBS benefits in the after-hours period would be beneficial. In particular, the TTWG supported applying the after-hours fee modifier to the equivalent telehealth items (phone and video), as long as the established clinical relationship rules apply to the telehealth consultation items to support continuity of care. The TTWG noted that extending after-hours loading to telehealth services where there is an established clinical relationship is consistent with MRAC's findings in its Telehealth Post-Implementation Review final report.

The TTWG also supported extending the after-hours fee to attendance items for NPs, to support patient access.

The TTWG considered that – under its proposed framework – multiple loading items could apply to a single consultation. For example, an after-hours service provided out of consulting rooms would attract both the after-hours and out of rooms loadings.

Recommendation 16

Current after-hours items be replaced with a fee loading. The loading would apply to any service that is provided in the after-hours period.

Recommendation 17

The loading for after-hours services should be applied to:

- face-to-face general attendance items for primary care
- telehealth (video and phone) attendance items when delivered by the patient's eligible telehealth practitioner
- nurse practitioner attendance items.

Start time for after-hours

Currently after-hours MBS items for consultations apply from:

- 8 pm on a weekday and 1 pm on a Saturday in consulting rooms
- 6 pm on weekdays and 12 pm (noon) on Saturdays delivered outside of consulting rooms.

The TTWG considered that start times for after-hours services should be aligned, regardless of the location of the service. In addition, given the availability of telehealth services (including telehealth items currently available for urgent after-hours services),

the location of the practice from which the service is provided should be used to determine whether the service is provided after-hours.

The TTWG noted from various relevant award wage determinations that the cost of providing a service increases from 6 pm. Accordingly, the TTWG supported a start time of 6 pm on weekdays for after-hours services.

Recommendation 18

The definition of the MBS after-hours period for primary care be aligned across all locations and start at 6 pm on weekdays.

Note that recommendation 20 addresses urgent after-hours items during the unsociable period.

Recommendation 19

The MBS regulations should specify that the time zone at the location of the practice is to be used when determining if a service is provided after-hours.

Urgent after-hours items

The TTWG has considered the review of MBS time-tiered items for primary care, which incorporated the post-implementation review of the 2018 changes to urgent after-hours items. The TTWG has reviewed the use of urgent after-hours following those changes, and the 2020 introduction of telehealth items for the unsociable after-hours period (11 pm to 7 am).

The TTWG noted the significant and continuing decrease in the overall use of urgent after-hours items since 2015. However, the telehealth items for urgent after-hours services in the unsociable hours have rapidly increasing uptake. These items' usage is still relatively low compared to other GP items, but the claiming data suggest that the telehealth items are playing a different role in providing services to patients than the equivalent face-to-face items.

The TTWG acknowledged that the urgent after-hours items are intended to support patients that should not wait until the next day for treatment, but are not urgent enough to require hospital treatment. Therefore, the TTWG considered that the need for ongoing support of urgent after-hours general practice care, especially in the unsociable hours, still exists. Recalling its commitment to ensuring that the MBS underpins contemporary and holistic care to patients that meets their individual care needs, the TTWG supported applying a higher loading to services provided in the unsociable hours of 11 pm to 7 am than those applied for services provided from 6 pm to 11 pm. This means that the current MBS items for urgent after-hours services could be removed.

The TTWG considered that telehealth access in the unsociable hours can improve access to services for some patients. However, the TTWG recalled the MRAC's findings in the Telehealth Post-Implementation Review final report and considered that telehealth is most effective where continuity of care exists. To support MRAC's previous findings, the TTWG recommended that the application of the higher unsociable hours loading to telehealth services when the patient access the service through the practice where they are registered through MyMedicare only. The 'standard' after-hours loading would apply where the patient is not registered with MyMedicare (where eligible).

Recommendation 20

The current urgent after-hours MBS items be replaced with a higher rate loading item that applies between the hours of 11 pm and 7 am daily (unsociable hours). The unsociable hours loading should only be available for telehealth services if the patient is

registered with MyMedicare with the practice providing the service. The current suite of urgent after-hours MBS items could therefore cease.

After-hours bulk-billing incentives

Two bulk-billing incentive MBS items (10992 and 75872) specifically apply to after-hours attendances outside of consulting rooms if the medical practitioner is based in MM 1 but delivers the service in MM 2–7. These items pay the equivalent of the current MM 2 bulk-billing incentives for other services.

In the context of the broader review, including the proposed introduction of an after-hours loading for telehealth items, the TTWG supported ceasing these items. To replace them and ensure appropriate renumeration, the TTWG supported that medical practitioners use the bulk-billing incentives that are generally applicable when using attendance items.

Recommendation 21

When providing after-hours care, medical practitioners can use the same bulk-billing incentives that are applicable when using standard attendance items. This will replace the need for after-hours bulk-billing incentive MBS items 10992 and 75872, which can only be claimed with a limited number of after-hours items. MBS items 10992 and 75872 can cease.

Principle 5 – MBS primary care items should be adequately supported by non-MBS mechanisms

Data collection

The TTWG considered MBS utilisation data from the Department to inform its recommendations, where possible. However, throughout its discussions, the TTWG recognised that data collection could be improved. The Bettering the Evaluation and Care of Health (BEACH) project collected data about general practice from 1998 to 2016. Although valuable at the time, this dataset is outdated.

In addition, recognising the challenges associated with the current complexity of the MBS, and privacy issues associated with condition-specific items, data collection is not a sufficient justification for separate MBS items. Other mechanisms of data collection should be considered as the primary mechanism for data collection on issues such as reason for visit, prevalence of specific conditions, and the overall health and wellbeing of the population.

The TTWG notes that several other reviews, including the Review of General Practice Incentives, have highlighted the need for better availability of primary care data. This will be increasingly important as the primary care system transitions to a blended payment model, which will result in MBS billing data becoming less representative of a practice's overall activity.

Recommendation 22

The Government should ensure the funding of appropriate and contemporary data collections to inform primary care policy and funding reform.

Support for the general practice team

As noted in previous section, the TTWG recognised that there is benefit in supporting other members of the general practice team, such as practice nurses, to support patients in their home. The TTWG supported funding for the team members to undertake home

visits, but acknowledged that this may not suit a fee-for-service model (such as the MBS). This may be more appropriately addressed through a non-MBS funding mechanism.

Recommendation 23

Consideration be given to a mechanism to support out of consulting rooms services provided by other members of the general practice team, such as practice nurses, whether through the MBS or another funding mechanism.

Consultation and feedback review process

The TTWG carefully considered all presentations and consultation feedback to inform this report.

Presentations

The TTWG considered presentations from the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the Australian Medical Association and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to inform its recommendations.

Targeted consultation

A draft consultation paper was prepared for targeted consultation, which reflected the positions agreed to and recommendations from up to and including meeting 4 (24–25 February 2025).

The participants in the targeted consultation were:

- Royal Australian College of General Practitioners
- Australian College of Rural and Remote Medicine
- Australian College of Nurse Practitioners
- Australian Medical Association
- Rural Doctors Association of Australia
- National Aboriginal Community Controlled Health Organisation.

The TTWG noted concerns from some organisation about linking MBS claiming to MyMedicare registered clinics. This requirement would exclude nurse practitioner–led practices. However, the TTWG highlighted that MyMedicare clinics are accredited and therefore are proven to meet certain standards. The principle of MyMedicare is to improve continuity of care. The TTWG maintained that including MyMedicare registration would ensure patient safety and continuity of care, which was a focus of the TTWG's discussions and therefore recommendations. The TTWG recognised that there may be additional work by the Government to better include nurse practitioner–led practices, but this is out of scope for this review.

Appendix Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies, and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MBS Continuous Review is supported by the MBS Review Advisory Committee (MRAC). The Committee's role is to provide independent clinical, professional and consumer advice to Government on:

1. opportunities to improve patient outcomes in instances where a health technology assessment by the Medical Services Advisory Committee (MSAC) is not appropriate
2. the safety and efficacy of existing MBS items
3. implemented changes to the MBS, to monitor benefits and address unintended consequences.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health, Disability and Ageing's MRAC webpage.

MBS Continuous Review guiding principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
  - recognising the central role of General Practice in coordinating care
  - facilitating communication through General Practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
  - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)

- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient healthcare needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that General Practice general practitioners are specialists in their own right. Usage of the term ‘General Practice’, both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-healthcare-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through Government announcement.

Information will also be made available on Department of Health, Disability and Ageing website, including MBS Online, and departmental newsletters.