Review of Medicare Benefits Schedule (MBS) Health Assessment Items

Australian Government, Department of Health and Aged Care

Asthma Australia Submission, October 2024

ABOUT ASTHMA AUSTRALIA

Asthma is a respiratory condition that affects nearly 2.8 million Australians, with children being the most impacted. Asthma is responsible for at least one Australian death every day, making it a serious health concern. More than 30,000 people are hospitalised each year due to asthma, yet at least 80% of these hospitalisations are considered potentially avoidable.

Despite the prevalence of asthma, it is often misunderstood, causing fear and anxiety for those living with the condition. Asthma Australia has been the leading charity for people with asthma and their communities for over 60 years.

The challenges of climate change, unhealthy air, and health inequity make it more important than ever for people with asthma to have a voice. We search for new and progressive approaches to challenge the status quo. Our work is grounded in evidence and centred on the experiences of people affected by asthma. We believe by listening to those living with asthma, designing solutions with them, and influencing change, people with asthma can live freely, unrestricted by their asthma.

INTRODUCTION

Asthma Australia welcomes the opportunity to provide feedback on the Discussion Paper on the Review of MBS Health Assessment Items (the Review).[1]

Since the 1990s, health assessments have been introduced to deliver preventive care in general practice, aiming to comprehensibly evaluate consumer health and wellbeing and provide education and support to help prevent the development and exacerbation of diseases.[2] Optimising preventive care (primary, secondary and tertiary) should be a critical aim of Australia's healthcare system as it provides significant opportunities to support people to live healthier lives and participate fully in their work, studies and communities. Preventive care is also important for the health of the healthcare system itself as more people than ever are living longer and with chronic disease and depending on its services.[3] In 2022, an estimated 14.2 million (61%) of people in Australia lived with at least one chronic condition,[4] including just under 2.8 million (11%) people with asthma.[5] Responding to the healthcare needs of this growing population is placing significant pressure on an already squeezed healthcare system. According to the Australian Government, every dollar invested in preventive health saves an estimated $14.30 in healthcare and other costs. [6] Further, 38% of the burden of disease could be prevented by reducing modifiable risk factors such as smoking, obesity and physical inactivity.[7] As we set out in this submission, there are also significant opportunities to optimise asthma care that would lead to better health outcomes to thereby reduce demand on the healthcare system.

The Discussion Paper has identified many ways in which MBS health assessment items could be improved. As per the Discussion Paper's three options for reform (baseline, moderate and restructure) Asthma Australia's submission aligns with a moderate approach. In our submission, we provide detailed feedback in relation to reforming the Chronic Disease Risk Assessment. This includes how the assessment could help to prevent the progression of asthma to moderate and severe, life-threatening stages by optimising asthma care for people with asthma. We also recommend that MBS health assessments better reflect clinical evidence in relation to the onset of asthma in middle age, particularly for females, by expanding the age eligibility. We highlight the importance of including additional risk factors within the assessment to help address health inequities and deliver person-centred and holistic care in the assessment. In relation to the additional proposals suggested within a moderate approach, Asthma Australia supports expanding scope of practice to enable additional members of the primary healthcare workforce to undertake health assessments but we do not support limiting availability of health assessments to MyMedicare registered practices. Finally, we outline the importance of having access to appropriate diagnostic testing in primary care to support the findings of MBS health assessment items and their role in identifying and managing chronic disease.

Asthma Australia welcomes the Review and its ambition to ensure health assessments are fit-for-purpose and able to deliver effective preventive care as intended.[8] We would welcome further discussion on amending the health assessments to better accommodate asthma risks.

ASTHMA PREVALENCE AND IMPACT

Asthma is a chronic condition with high prevalence and burden of disease in Australia. One in nine people have asthma in Australia (around 2.8 million people) and it is the fourth most commonly reported chronic condition.[9] In 2022, asthma was the 8th leading contributor to the overall burden of disease in Australia, having risen from 10th place in 2003.[10] Asthma is the leading cause of burden of disease for children aged 5–14 years.

This high prevalence and burden of disease has a significant impact on individuals and communities in Australia. **People with asthma experience poorer health outcomes and quality of life**.[11] They may live for a long period of time with disability associated with asthma, and experience reduced participation in employment, education, care responsibilities, sports and social events. **It also has a significant impact on Australia's health care system.** In 2022-23, there were 31,107 hospitalisations for asthma, of which 91% were considered potentially preventable.[12] Children are much more likely than adults to be hospitalised for asthma, with over 17,000 children with asthma hospitalised in 2022. [13] Approximately 400 people die each year in Australia due to asthma[14] and there were 467 deaths due to asthma in 2022.[15]

A 2015 report, the Hidden Cost of Asthma, found asthma cost the healthcare system $1.2 billion, lost productivity due to asthma cost $1.1 billion, and the burden of asthma disease amounted to a cost of $24.7 billion.[16]

Further, in 2020-21, **78% of people with asthma aged 45 and over had at least one other chronic condition**:[17]

- 42% had arthritis (compared with 26% without asthma)
- 33% had back problems (compared with 23% without asthma)
- 31% had heart, stroke, and vascular disease (compared with 22% among people without asthma)
- 20% had mental and behavioural conditions (compared to 11% among people without asthma)
- 14% had (chronic obstructive respiratory disease (COPD) (compared to 1.9% among people without asthma)
- 13% had osteoporosis or osteopenia (compared to 7.6% among people without asthma).

OUR SUBMISSION

Asthma Australia's response aligns to the moderate approach outlined in the Discussion Paper to reform MBS health assessments items. In our submission, we first set out our feedback to some of the general proposals in the Discussion Paper in relation to clinical guidelines, the availability of health assessments and scope of practice. Next, we provide more detailed feedback about changes Asthma Australia would like to see to the Chronic Disease Risk Assessment in particular, but also to some of the other health assessments. Finally, we outline the importance of ensuring that primary care can deliver diagnostic testing to support the findings of health assessments.

GENERAL PROPOSALS IN THE DISCUSSION PAPER

CLINICAL GUIDELINES AND REVIEW

The moderate approach includes updating clinical requirements to better align with current guidelines as per the baseline approach. However, it is not clear from the Discussion Paper whether the moderate approach also includes the consideration of mechanisms to ensure that the clinical requirements of health assessment items do not become out of date and instead can incorporate new innovations and evidence as they emerge. For clarity, we support incorporating a review mechanism for this purpose (e.g. agreed process, including regularity of review).

AVAILABILITY OF HEALTH ASSESSMENTS

Currently, the general regulatory requirements governing MBS health assessments state that 'a health assessment must be performed by the patient's usual general practitioner, if reasonably practicable', while the Discussion Paper asks whether the availability of health assessments should be linked to MyMedicare. Continuity of care is an important consideration in the delivery of primary care in relation to consumer care experiences and health outcomes. However, restricting health assessments to a consumer's general practitioner or general practice by requiring linkage to MyMedicare may be unhelpful for a range of reasons, including that:

- The ability to be able to attend different practices or practitioners is valuable to consumers, particularly when consumers are finding it increasingly difficult to see a GP due to high demand and cost. Restricting this ability may deepen existing health inequities given access to GPs can be more limited in lower income, regional, rural and remote areas.[18]
- Choice in practice or practitioner is helpful as consumers might find that a new practice or practitioner is able to provide a new perspective on their issues and needs and provide different/better treatment approaches and solutions to them.
- As the Discussion Paper highlights, engagement with health assessments varies within general practice and among general practitioners so again choice of practice and practitioner supports consumers being able to access providers that do offer health assessment items.

- Some GPs have told us that some consumers can find it helpful to see other healthcare practitioners for health assessments as they may find it hard to talk to their usual GP about some health or personal issues, given their familiarity or the dynamics of their relationship with them (e.g. due to living in small regional or rural communities).

Subsequently, Asthma Australia does not support linking the availability of health assessments to MyMedicare or a consumer's usual GP or practice.

RECOMMENDATION 1: Do not link the availability of health assessments to MyMedicare or a patient's usual general practitioner or practice.

SCOPE OF PRACTICE

Asthma Australia supports expanding access to health assessment items to other healthcare professionals (e.g. nurse practitioners) for the same reasons as outlined in section on the availability of health assessments. Additionally, this will enable many primary care healthcare professionals to work to their full scope of practice, providing benefits that include:

- Optimising healthcare funding by effectively and efficiently deploying the skills of all healthcare professionals. This, for example, will allow GPs to deliver care only they are trained to do and thereby potentially see more patients, while nurse practitioners and Aboriginal HealthCare Workers can in turn deliver aspects of the health assessments that they have been trained to do.
- Facilitating greater job satisfaction and workforce retention.[19]
- Supporting the health workforce to use the full spectrum of their training and skills, in which they have significantly invested. An Australian Primary Healthcare Nurses Association survey showed that 32% of primary healthcare nurses said that their skills were underused in practice.[20]
- Maximising the application of every healthcare professional's skillset to thereby use resources more effectively and efficiently and support a happier workforce, should result in improved consumer experiences and outcomes too.

RECOMMENDATION 2: Expand access to MBS health assessment items to other healthcare professionals within primary care settings.

CHRONIC DISEASE RISK ASSESSMENTS

Chronic Disease Risk Assessments have significant potential as a preventive tool in the primary care system. Targeting people in their middle age where the risk increases of developing a range of chronic conditions and comorbidities, including asthma, heart disease and diabetes, is likely to help

some people reduce their risk of developing these diseases and others with chronic disease to better manage them and prevent their exacerbation. For example, there is growing evidence that the National Health Service (NHS) Health Check[1] in England offered to all people between 40-74 years old is reducing risk and improving health outcomes relating to chronic diseases.[21] However, according to the Discussion Paper, less than 10% of patients who are estimated to be eligible for a Chronic Disease Risk Assessment or a Type 2 Diabetes accessed a relevant health assessment in 2022-23, and uptake has declined since July 2018.[22]

In this section, we first set out how Chronic Health Risk Assessment are a key opportunity for healthcare practitioners to engage with people with asthma about their asthma control to ensure that their asthma care is optimised. We next respond to the Discussion Paper proposals to amend the age cohort and service frequency of the Chronic Disease Risk Assessment. Finally, we recommend additional changes to optimise the efficacy of the Chronic Disease Risk Assessment, particularly in relation to health inequities relating to asthma risk.

OPTIMISE ASTHMA CARE

Many people with asthma do not currently benefit from the full range of medicines and interventions that are proven to work to help control their asthma and avoid escalated symptoms and healthcare needs. For example:

1. **Australian data shows that less than 20% of consumers are being dispensed preventer medicine at a rate consistent with therapeutic use**.[23] Regular inhaled preventer medication is the most important medication in asthma care. It reduces the risk of asthma attacks and the need for emergency care and improves overall health and quality of life.[24] Consumers need more education about the importance of preventers in their control of asthma and overall health and wellbeing.
2. **Up to 90% of people with asthma do not use their inhaler correctly and hence will deliver little to none of the medicine to their lungs**.[25] Inhaled asthma medicines are only effective if they are used properly. However, inhaler devices can be challenging to use and require instruction and review to ensure that they are being used correctly. This high margin for error in asthma medicine administration is unique to asthma care and is too often overlooked by healthcare professionals supporting people with asthma, many of whom do not know how to teach correct inhaler device technique.[26]
3. **There is an over-reliance on reliever medicine to the detriment of consumers' health.** Reliance on short-acting reliever therapy (Short-acting beta-agonists, SABAs) is common among people with asthma. While for most people with asthma, relievers are an important medicine to temporarily relieve asthma symptoms and help gain control of asthma, their overuse increases the risk of an asthma attack, and is a risk factor for hospitalisation and death for people with asthma.[27]Evidence suggests that using just three or more SABA inhalers a year increases flare-ups, and six or more increases the risk of death.[28] Consumers require more education about the appropriate use of SABAs.
4. **There is an overreliance on oral corticosteroids (OCS) in asthma care**. OCS are the cornerstone of managing acute asthma attacks until symptom control has been regained, while some people

[1] The NHS health check assesses lifestyle risk factors such as diet, physical activity, smoking and alcohol, and physical risk factors like high blood pressure, blood sugar and cholesterol with the aim of preventing cardiovascular disease (CVD), dementia, respiratory disease and some cancers.

require OCS daily to maintain control of severe asthma. Although OCS provide fast-acting relief of asthma symptoms, they have significant adverse effects, including increased risk of heart disease, renal impairment, cardiovascular disease, blood clots, diabetes, obesity, stomach ulcers, osteoporosis, cataracts, mood disorders and decreased bone density leading to fractures.[29] The risk of developing these toxic side effects have been shown to significantly increase after a cumulative lifetime dose of 1000 mg prednisolone-equivalent (some as low as 500 mg).[30] Significant caution should therefore be taken when prescribing and using OCS ,yet Australian dispensing data demonstrates overuse of and overreliance on OCS for asthma management.[31] Asthma Australia is currently leading work on OCS Stewardship.

5. **Only 28% of people with asthma have a written asthma action plan**.[32] An asthma action plan is evidenced as one of the most effective interventions to support people with asthma by guiding their actions in response to a change in their asthma control and condition.[33] All healthcare professionals need to be aware of the importance of asthma action plans so they can help support consumers to appropriately consult it when their symptoms escalate.

In addition, too few people with asthma have an annual asthma review with their general practitioner as recommended by Australian asthma guidelines.[34] The Chronic Disease Risk Assessment could therefore provide a timely opportunity for healthcare practitioners to engage with people with asthma about their asthma control to ensure they are optimising their care, and subsequently their health and life outcomes. To this end, healthcare practitioners will require support to ensure they are aware of, and are effectively applying, Australian asthma guidelines.

RECOMMENDATION 3: Increase professional development opportunities for healthcare practitioners on asthma care and treatment as per Australian guidelines to support the optimisation of asthma care in general practice.

AMEND AGE COHORTS

The current age cohort for Chronic Disease Risk Assessment of 45-49 years old is an extremely limited age cohort. Additionally, it overlooks clinical data showing that many people develop chronic conditions earlier than 45 years old and after 49 years old.[35] For example, eight in ten people of all ages in Australia lived with at least one chronic condition in 2022, including 31.5% of people aged 15-44 years and 13.9% of the same age cohort lived with two or more chronic conditions.[36] The NHS Health Check has a much broader age cohort of 40-74 years that better reflects clinical evidence. In addition, economic modelling from a 2021 review of the program found that lowering the age eligibility to 30 years old is likely to reduce absolute health inequality and recommended lowering the age cohort.[37]

The table below shows the prevalence of asthma by age and sex in Australia, indicating females experience a greater burden of asthma than males over the life course. [38] Females are more likely to have asthma, experience severe asthma symptoms and die from asthma.[39]

Proportion of people with asthma by age and sex, 2022[40]		
Age (in years)	**Males (%)**	**Females (%)**
0-14*	10.1	6.2
15-24	8.4	12.3
25-34	9.2	10.5
35-44*	9.8	15.8
45-54	9.9	14.3
55-64*	8.6	15.3
65-74	9.3	13.7
75 years and over	10.7	12.7
*difference between males and females is statistically significant		

Given the significant increase in asthma prevalence among females from 35-44 years old, and slight increase for males of the same age suggests Chronic Disease Risk Assessments could be a valuable prevention tool for this age cohort too by helping to identify and manage risk, optimise asthma care and control in people with asthma as well as to potentially diagnose asthma Subsequently, Asthma Australia recommends **lowering the age eligibility for the Chronic Disease Risk Assessment to 35 years**.

Sex hormones have been found to be partly responsible for asthma inequities between the sexes and help to explain sex-related differences in asthma over the life course.[41] In relation to the Chronic Disease Risk Assessment, this includes the impact and risk of asthma and its symptoms on women during **perimenopause and menopause**. The following section is limited by the binary approach to sex in research on menopause and asthma and, therefore, we refer to women in this section. However, improving healthcare for menopause and perimenopause is also a critical issue for transgender, intersex and non-binary people who may also experience perimenopause and menopause.

Most women reach menopause between the ages of 45 and 55.[42] In Australia, the average age to reach menopause is 51 to 52.[43] Women can experience perimenopause 8-10 years before the menopause.[44] Although research into asthma, perimenopause and menopause has identified many gaps, inconsistencies and confounders (e.g. comorbidities), recent research developments have begun to provide a picture of how perimenopause and menopause may affect women's respiratory systems and asthma, including the role of sex hormones.[45] While further research is needed, findings suggest the following important insights:

- There is a significant decline of lung function during perimenopause and post-menopause.[46]
- Perimenopausal and postmenopausal women are at higher risk of adult-onset asthma or current asthma than non-menopausal women.[47]
- Perimenopausal, menopausal and postmenopausal women have increased risk of respiratory symptoms and/or asthma exacerbations.[48]
- There is an association between the use of HRT and new-onset asthma.[49] However, a recent study reported a reduced risk of asthma onset and lower asthma incidence in women using HRT, suggesting the link between HRT and the increased impact on asthma is not clear.[50]
- The effects of sex hormones on asthma symptoms and its progression are complex and are poorly understood. More research is needed.[51]

In addition, adult-onset asthma can be difficult to diagnose, is often misdiagnosed and treated incorrectly (e.g. doctors may diagnose older consumers with chronic obstructive pulmonary disease

(COPD) due to their age).[52] It is also harder to control.[53] As with its expansion to a younger cohort, enabling access to the Chronic Disease Risk Assessment to an older cohort may help to identify and manage risk, optimise asthma care and control in people with asthma as well as to potentially diagnose asthma.

Given these issues, Asthma Australia recommends that the **age eligibility for the Chronic Disease Risk Assessment also be raised to at least 55 years old**.

RECOMMENDATION 4: Widen the age eligibility for the Chronic Disease Risk Assessment to 35-55 years old to better reflect clinical evidence concerning the age-related development of chronic conditions.

STRATIFY SERVICE FREQUENCY

Asthma Australia supports the stratification of service frequency for the Chronic Disease Risk Assessment **according to the patient's level of risk** so that those with higher risk are invited back for reassessment more frequently. We support the use of clinical judgement to determine risk levels and frequency in practice.

RECOMMENDATION 5: Stratify service frequency of Chronic Disease Risk Assessments according to the patient's level of risk.

ASSESS ADDITIONAL RISK FACTORS

Additional 'specific risk factors' should be added to the regulatory requirements for the Chronic Disease Risk Assessment. Currently, the regulatory requirements include:

a) lifestyle risk factors (for example smoking, physical inactivity, poor nutrition or alcohol misuse); and
b) biomedical risk factors (for example high cholesterol, high blood pressure, impaired glucose metabolism or excess weight); and
c) a family history of a chronic disease.

These are all important risk factors to the development of chronic diseases, including asthma. For example, risk factors for developing asthma include genetics, exposures in utero and across the life course, and birth outcomes while risk factors specific to triggering asthma symptoms include viral respiratory infections, hormonal changes, some medications, exposure to tobacco smoke, strong odours and chemicals, physical exercise and mental health issues.[54] However, to support a person-centred, holistic and health equity approach in the assessment, additional **risk factors relating to the social, environmental, cultural and commercial determinants of health should be included**. Assessment of these risk factors might help to identify elevated risk in relation to developing and triggering asthma, for example through:

- local environment and exposure to air pollution (e.g. wood heater, bushfires and vehicle emissions),

- poor housing conditions (e.g. presence of mould, harmful energy sources like gas and extreme internal temperatures) and
- socio-economic background (e.g. challenging working life conditions and economic circumstances)

Additionally, Asthma Australia supports the proposal to **combine the chronic disease, type 2 diabetes and heart health assessments** as many risk factors are common among chronic diseases and many people develop comorbidities as they age**.** Currently, the delivery of disease-specific assessments whereby an individual is assessed through the lens of one disease may limit a practitioner's ability to be able to view a person and their needs holistically. It may reduce the potential of an assessment to highlight and prevent other chronic conditions and optimise consumer education opportunities, reflecting a missed opportunity to maximise outcomes in this engagement with a consumer. A holistic assessment of risk factors considering a range of chronic conditions would likely optimise provider, practitioner and consumer time and investment and support a more person-centred approach to care delivery.

RECOMMENDATION 6: Include social, environmental, cultural and commercial determinants of health as specific risk factors in the regulatory requirements for the Chronic Disease Risk Assessment.

RECOMMENDATION 7: Combine the chronic disease, type 2 diabetes and heart health assessments to provide a holistic and person-centred assessment of a consumer's risks and needs.

OTHER HEALTH ASSESSMENTS

There is an opportunity to improve the efficacy of some of the other health assessments provided by ensuring that they appropriately cover risk factors and consumer needs relating to asthma. These include the Aboriginal and Torres Strait Islander Adult Health Assessment, the Aboriginal and Torres Strait Islander Older Person's Health Assessment, the Intellectual Disability Comprehensive Medical Assessment, the Aged Care Facility Resident Comprehensive Medical Assessment and the Older Person's Health Assessment. First Nations peoples, people with a disability and older people are important population groups in relation to asthma:

- **Aboriginal and Torres Strait Islander peoples.**[55] Colonisation and its legacy have resulted in health inequities for First Nations peoples. In relation to asthma, around 16% of First Nations people reported having asthma (16%) in 2018-19, making asthma the third most prevalent long-term condition.[56] Aboriginal and Torres Strait Islander people experience higher hospitalisations and a higher death rate due to asthma compared to non- Aboriginal and Torres Strait Islander populations.[57]Asthma is higher in First Nations females (18%) compared to males (13%).
- **People with disability**.[5] In 2022, people living with disability were more likely than those with no disability to have asthma (17.0% compared to 8.0%).[58]
- **Older people**. Although asthma prevalence is highest in adults in their middle age, there is a higher asthma mortality rate amongst older adults. In 2022, there were 467 deaths with

asthma as an underlying cause in Australia (299 females and 168 males)[59] and 45% of these deaths were in women aged over 75 years.[60]

Currently, the regulatory requirements of the above-mentioned health assessments do not specifically mention asthma or respiratory examinations, thereby missing a significant opportunity to better support people with asthma by ensuring that their asthma care is optimised (as per our feedback above on Chronic Disease Risk Assessments – Optimise Asthma Care). Additionally, they do not include the range of risk factors that should be considered in relation to asthma set out in the section concerning Chronic Disease Risk Assessment risk factors (e.g. social, environmental, cultural and commercial determinants of health). The Review should consider **how to better incorporate these points in each of the respective health assessments,** with the Aboriginal and Torres Strait Islander Child Health Assessment providing a good example of how this can be done. The framework for this assessment is comprehensive in the risk factors and the examinations it presents for consideration by the healthcare practitioner and is likely to uncover any respiratory issues or risk factors as a result.

Finally, Asthma Australia notes that asthma prevalence amongst people from culturally and linguistically diverse backgrounds (CALD) increases the longer people stay in Australia, in relation to people born overseas compared to people born in Australia.[9] There may be an opportunity, therefore, to provide support to CALD communities in relation to health education and promotion about conditions like asthma, as well as accessible care and support to treat them, in the Refugees and Other Humanitarian Entrants Health Assessment.

RECOMMENDATION 8: Add a requirement to assess asthma in all MBS health assessments.

RECOMMENDATION 9: Consider how to incorporate assessment of common risk factors for asthma and other chronic diseases and a range of examinations, including respiratory examinations, in the regulatory requirements of:

- **the Aboriginal and Torres Strait Islander Adult Health Assessment,**
- **the Aboriginal and Torres Strait Islander Older Person's Health Assessment,**
- **the Intellectual Disability Comprehensive Medical Assessment,**
- **the Aged Care Facility Resident Comprehensive Medical Assessment and,**
- **the Older Person's Health Assessment.**

DIAGNOSTIC TESTING IN PRIMARY HEALTHCARE

The Discussion Paper outlines how the data on the uptake of GPMPs and MHTPs following a health assessment indicates that there is a role for health assessments in identifying and managing disease. For people with suspected asthma, it is important to undertake appropriate diagnosis using specialised diagnostic testing as both over-diagnosis and under-diagnosis of asthma are common.[61]

Diagnosis is a critical tool in the secondary prevention of asthma and effective diagnosis can help to:

- Ensure people with asthma can:
    - more quickly access appropriate treatment and reduce under and over medication,
    - more effectively manage their symptoms to prevent exacerbations, and

  - minimise the use of rescue therapies (e.g. reliever inhalers and OCS) and therefore resulting side effects.
- Ensure people who have similar symptoms but who do not have asthma can access appropriate diagnosis and treatment for their symptoms.
- Prevent the deterioration of asthma and conditions with similar symptoms.
- Optimise the use of healthcare services and medicines to minimise unnecessary expenditure and waste.
- Optimise the use of consumer resources (e.g. time, agency and income) in their care journey.

There are many diagnostic tests that can be undertaken to help diagnose asthma accurately, however, they are not widely available to the general population.

These diagnostic tests include spirometry, which in 2018 received a higher rebated MBS item from the Medical Services Advisory Committee (MSAC) to encourage its use in general practice. This followed MSAC's acknowledgement of the importance of spirometry in confirming the diagnosis of asthma and chronic obstructive pulmonary disease (COPD), and recognition that these conditions are both under- and over-diagnosed with detrimental health outcomes for patients.[62] However, despite the rebate increase, the implementation and uptake of spirometry in primary healthcare has declined.[63] The level of the rebate, and other issues with spirometry, including workforce training and low confidence in interpreting the results in some practices, need to be resolved to improve its uptake.[64] Funding for spirometry should accurately reflect the costs in delivering this service, including the time and expertise required to complete high quality tests, as well as consumables and maintenance of equipment.[65]

In addition, there are a range of diagnostic technologies that can help to accurately diagnose and monitor asthma. They each have their advantages, such as speed and ease of use, and provide clinicians with unique information that is useful to make critical clinical decisions and to more effectively distinguish and diagnose comorbid conditions. However, they are rarely available in primary care despite being critical tools to improving asthma and respiratory disease diagnosis and resulting treatment plans.

Asthma Australia would like to see the Review of MBS Health Assessments consider the importance of the **provision of appropriate diagnostic testing in primary care as part of a prevention and early intervention approach and to support the findings of MBS health assessments and their role in identifying and managing disease.**

RECOMMENDATION 10: Consider the provision of effective diagnostic testing in primary care to support the findings of MBS health assessments and their role in identifying and managing disease.

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