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It's time to invest in our future: include early promotion of optimal child growth as part of general practice funding schemes

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ABSTRACT

Promoting optimal growth and establishing health behaviours in early childhood is critical for preventing chronic disease risk. General practice is a key setting for early childhood health promotion; however, in Australia, there are systemic barriers to embedding prevention in practice, including a lack of Medicare Benefits Schedule (MBS) items to publicly fund preventive health checks. We propose the implementation of MBS items for staged child health promotion checks aligned with childhood immunisation visits to enhance access to affordable, accessible preventive care in general practice. We believe there is a strong case to include universal checks for the promotion of optimal growth for children aged 0–5 years in the MBS.

Keywords: child, general practice, health behaviours, health promotion, infant, Medicare, obesity prevention, primary health care.

KEY POINTS

- Early childhood is a critical window for promoting optimal growth.
- There are system-level barriers to embedding early childhood health promotion in general practice, including limited time, funding and supporting resources.
- There is an urgent need to expand the Australian Medicare Benefits Schedule to include universal and routine health promotion checks throughout early childhood.

The importance of promoting optimal child growth in early childhood

The first 5 years of life, henceforth referred to as early childhood, is a critical stage of child growth and development, and can lay the foundations for lifelong health. Health behaviours, including dietary intake, physical activity, sedentary behaviour and sleep, are established in early childhood and may influence a child's healthy growth.[1] However, only 28% of Australian children aged 2–3 years meet recommended fruit and vegetable intakes, and only 17% of 2–5-year-olds meet recommendations for physical activity and sedentary behaviour.[2,3] If unhealthy behaviours are adopted and persist, they can increase future risk of chronic disease in adulthood.[1]

In 2025, the World Health Organization (WHO) extended the Global Nutrition Targets from 2025 to 2030. Among them is a strengthened target to reduce and maintain overweight prevalence among children aged <5 years to <5% by 2030.[4] This global commitment to early intervention and health promotion is mirrored in Australian policy, including the National Preventive Health Strategy 2021–2030[5] and the National Obesity Strategy 2022–2032.[6] Achieving the National Obesity Strategy's goal of reducing childhood and adolescent overweight and obesity from 25% to 20% by 2030 could save AU$7.44 billion in lifetime obesity-related healthcare costs and premature mortality.[7] Investing in early childhood health promotion activities is, therefore, crucial to reducing potentially avoidable costs to the healthcare system and addressing inequality in childhood health.

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Evidence of effectiveness of promoting optimal child growth in early childhood

Early childhood is a critical window for promotion of optimal child growth and health behaviours. The body of evidence regarding the effectiveness of programs that promote nutrition and physical activity during early childhood is inconsistent. A 2025 Cochrane review examined the effectiveness of interventions designed to prevent obesity in children aged 2–4 years, finding that interventions incorporating dietary and physical activity components result in small reductions in body mass index (BMI) *z*-score in the medium and long term.[8] In contrast, a 2025 individual participant data meta-analysis examined the effectiveness of early childhood obesity prevention interventions commenced in the first year of life, and found that they did not significantly impact children's BMI *z*-score or health behaviours at age 2 years.[9]

Some individual early prevention programs, such as Healthy Beginnings and the INFANT program in Australia, have demonstrated effectiveness in reducing obesity-related risk behaviours and improving child health outcomes.[10–13] In addition, a health literacy–informed digital intervention conducted in the USA improved child weight-for-length trajectory across the first 24 months of life and reduced childhood obesity at 24 months.[14] However, these programs were evaluated within a research setting and ran for a discrete period, and cannot reach children beyond the studies. There is a pressing need to integrate and scale up evidence-based messages from such programs into existing healthcare systems, work which has already been piloted or implemented. Through the process of research translation of these programs, we have identified a gap in engaging general practice professionals in early childhood obesity prevention in their routine practice.

The imperative to integrate promotion of optimal child growth in general practice

The WHO has called for a primary healthcare approach to the prevention and management of obesity in childhood. Within the context of healthcare services, it proposes that prevention should be incorporated into existing healthcare systems in early childhood.[15] In the Australian context, general practice plays a crucial role in promoting optimal health behaviours and monitoring growth in early childhood, such activities being consistent with guidelines endorsed by the Royal Australian College of General Practitioners.[16] In Australia, >13,000 nurses[17] and ~40,000 general practitioners (GPs) work in Australian general practice; they saw almost 1.5 million children aged 0–4 years in 2024–2025.[18] Consistent with the WHO vision of a primary healthcare approach to promoting optimal child growth in the early years,[15] general practice is an important setting to integrate early childhood health promotion activities. However, there are many barriers and challenges to early intervention in Australian general practice, including time pressures, consultation costs and a lack of practical tools to support preventive care,[19–21] with many of these barriers reported by primary health professionals internationally.[22–25] Practitioners and caregivers have also highlighted challenges engaging in discussion of child health behaviours and growth, including concerns about receptiveness, stigma and impact on rapport.[22,26]

An Australian needs assessment conducted with primary health professionals revealed that clinicians recognise the importance of embedding early childhood obesity prevention in general practice.[19] However, the prioritisation of acute health concerns meant that discussions of child health behaviours in this setting were often limited to those prompted by presenting clinical concerns. Limited scope for preventive care due to time pressures and lack of remuneration were two further critical barriers.[19] In addition, the skills of general practice nurses appear to be underused in supporting change in child health behaviours, as their time is dedicated to other clinical activities and there are no Medicare Benefits Schedule (MBS) item numbers to fund preventive child health care delivered by general practice nurses in Australia.[27,28] Historically, general practice nurses had increased scope for involvement in preventive health care as part of the Healthy Kids Check, which was introduced in 2008 and involved a preventive health check that coincided with the 4-year-old immunisation visit.[29] As part of this check, there were MBS item numbers that GPs and general practice nurses could use to remunerate the assessments, including growth monitoring and provision of health promotion information.[29] Funding for the Healthy Kids Check was rescinded in the 2015–2016 federal budget due to perceived underutilisation.[30] With the end of this funding, general practice professionals lost an important opportunity to engage in preventive care in early childhood.

Call for inclusion of early promotion of child growth as part of general practice funding schemes

Australia has a system of universal child health and development checks delivered by maternal, child and family health nurses in the first 5 years of life. However, engagement with the maternal, child and family health nursing services declines as children get older.[31,32] In addition, not all families choose to engage with these services. In particular, some families from culturally and linguistically diverse backgrounds may preferentially seek care from a GP due to lack of familiarity with maternal, child and family health nurses, and preference for continuity of care from a family doctor who can communicate in their preferred language.[32–34]

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Thus, it is important that there is scope for embedding health promotion and early intervention across health settings, including in general practice. Currently, the Australian Medicare system does not provide specific rebates for universal childhood obesity prevention-related services. Holistic child health assessment items are limited to specific populations, including Aboriginal and/or Torres Strait Islander children and families eligible for a Family Tax Benefit (based on an income test).[35,36] Services, such as maternal health education, infant and toddler nutrition, and physical activity programs, and family lifestyle interventions are not consistently funded through Medicare, leaving many families without appropriate access to preventive care. Including universal and routine health promotion checks in the MBS schedule is crucial to reducing child health inequality in Australia.

The WHO Commission on Ending Childhood Obesity recommended a range of multi-level and multi-sector strategies to address childhood obesity, one of which is the support of health behaviours in early life.[37] Therefore, we call for the Australian Federal Government to expand the MBS to include new MBS items to remunerate comprehensive consultations for child health checks related to monitoring and promoting infant feeding practices (i.e. responsive feeding, appropriate timing of solid introduction), dietary intake, physical activity, sedentary behaviour, sleep, and growth monitoring. Embedding holistic child health checks and monitoring, rather than solely focusing on growth and weight-based measures, presents an opportunity to provide strengths-based and tailored early intervention and health promotion.[20] Additional subsidised early access to experienced nurses, allied health professionals including dietitians, and specialists such as paediatricians for at-risk families is also crucial. GPs should also be encouraged and supported to refer their clients to evidence-based prevention programs in the community. For example, the INFANT program is available in >60% of local government areas in Victoria, and components of the Healthy Beginnings program have been embedded in child and family health services in several Local Health Districts in New South Wales.[38] However, further resourcing is needed to expand the reach of evidence-based prevention programs that offer a valuable referral pathway for general practice professionals.

It is important that the roll out of MBS items for universal and routine child health promotion checks is informed by an understanding of the barriers that may have led to underutilisation of the Healthy Kids Check.[39] To facilitate uptake of these checks, we propose aligning health promotion checks with existing child health care occurring in general practice, particularly immunisation. Integrating checks throughout early childhood may also serve to overcome the perception that health promotion activities are occurring too late to facilitate early intervention, as this was a criticism of the Healthy Kids Check occurring only at age 4 years.[39] Learning from the experience of the Healthy Kids Check, including research demonstrating that training for general practice professionals could improve uptake of the check,[40] we suggest a staged pilot of the implementation of the proposed MBS items, accompanied by training and support for GPs and general practice nurses around how to conduct child health checks. Our experience developing and delivering a series of free early childhood nutrition webinars for primary health professionals suggests that such training may be acceptable to general practice professionals.[41] However, there is a need for sustained funding for general practice professional education to overcome barriers to engaging in preventive care. Additionally, with the increasingly multicultural population of Australia, cultural competence training will require cross-sector collaborations, including training on early growth and child development for different cultural contexts, attitudes, and practices in the general practice curriculum. In addition, workforce development in general practice should ensure early childhood health promotion for Aboriginal and/or Torres Strait Islander families focuses on connecting children to their culture, supporting families, and improving access to culturally appropriate education and care.[42]

Promoting optimal child growth and health in early childhood must be a priority, as reflected in the proverb 'prevention is better than cure'. Australia cannot afford to wait until children develop obesity-related illnesses before acting. Australian health care must shift from a treatment-focused model to one that prioritises early prevention and health promotion. Implementing MBS items for staged child health promotion checks is not just a health policy issue, but also an economic imperative, and an investment in our future. Medicare must evolve to prioritise prevention, ensuring all families, regardless of their cultural and socioeconomic position, can access the support they need. With rising healthcare costs and worsening childhood obesity trends, the time to act should be now.

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