

REVENUE INTELLIGENCE

Beyond Medicare

Revenue models and opportunities in Australian
general practice

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RESEARCH SOURCES

References for all cited sources are maintained in the Medius Global research notebook. Readers can access the full source list, including legislation, government publications and peer-reviewed literature used in this report, at notebooklm.google.com.

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How this report was produced

The source material for this report spans legislation, MBS item documentation, Commonwealth departmental publications, AHPRA guidance, state revenue office rulings, peer-reviewed literature, RACGP publications, industry body reports and named trade press with dated references. Every factual claim, statutory reference and quantitative assertion was verified against a named primary or authoritative secondary source before inclusion. Claims that could not be verified are flagged as such in the text.

We built the knowledge base for this report using Google NotebookLM to index and audit source collections by domain, and Claude Cowork, an AI agent, to cross-reference claims, identify gaps and flag unverified material.

AI assistance does not change the verification requirement. Citation errors from AI research tools are common: wrong authors, wrong years, wrong findings. Every AI-assisted output was checked against source material. Where a claim could not be verified against a primary source, it was removed or flagged.

The practical reality is that a report of this scope, across this many policy and regulatory domains, would not be feasible without AI tooling. That is stated plainly so readers can assess the method rather than assume a traditional research process that is no longer how this kind of work is produced.

How to use this report

Revenue model viability depends on your practice's billing model, geography, patient demographics and workforce. Not every model covered here is viable for every practice. Use the table below to identify which sections are most relevant to your situation, then read those in full before assessing options.

Section 1.11 (private health insurer entry) is included for completeness and is not a practice revenue stream.

Your practice situation	Sections most relevant
Fully bulk billing or assessing the BBPIP switch	1.2, 1.3, 1.4, 1.5, 1.9, 1.10, 5.2, 5.5
Mixed or private billing, not switching	1.1, 1.2, 1.6, 1.7, 1.8, 5.2
Near a residential aged care facility	1.4, 1.10
Regional or rural (MMM 3–7)	1.10, 5.3, 5.5, 5.6
Multi-site or group operator	1.2, 2.7, 4.1, 4.3, 4.4
Considering sale or succession within two years	4.1, 4.2, 4.3, 4.4, 5.5
Low MyMedicare enrolment	1.4, 1.5, 1.10
Considering adding a subspecialty	1.7, 1.8
Training-accredited practice	5.3, 5.6
Operating a rural or remote practice	1.10, 5.3, 5.5, 5.6

Contents

Executive summary	7
Section 1 – Revenue models within and adjacent to Medicare	9
1.1 Subscription and direct primary care models	9
1.2 BBPIP and the bulk billing decision	9
1.3 Chronic disease management	10
1.4 MyMedicare registration and financial benefits	11
1.5 Direct-to-consumer and platform telehealth	12
1.6 Employer and corporate wellness contracts	13
1.7 Medico-legal and insurance examination work	13
1.8 Subspecialty revenue layers	13
Section 2 – Structural barriers and go-to-market constraints	25
Section 3 – International models with Australian applicability	28
Section 4 – Practice acquisition, consolidation and group operating models	30
4.1 Practice acquisition and consolidation	30
4.2 GP practice valuation	30
4.3 Due diligence beyond financials	31
4.4 ACCC mandatory merger regime	31
Section 5 – Workforce attraction and retention as a revenue lever	32
Section 6 – Trends affecting revenue model viability	35

Executive summary

Headline numbers

\$4.5B Private equity health care acquisitions in Australia, 2022	24% GP practice owners intending to sell within 12 months (RACGP Health of the Nation 2024)	3,700+ Practices enrolled in BBPIP following the November 2025 expansion
6,400 Projected GP FTE shortfall by 2040 (RACGP National Workforce Strategy 2025–30)	40% GPs using AI scribes by November 2025 (up from 22% in August 2024)	\$246 vs \$42 Cost per UCC visit vs standard GP consult

The November 2025 bulk-billing incentive expansion produced the largest quarterly increase in the national bulk-billing rate on record and enrolled 3,412 practices in BBPIP within weeks of the program's extension to all Australians. Simultaneously, the GPACI aged care incentive reached maturity, the MyMedicare registration architecture locked chronic disease management items to enrolled practices, and Queensland enacted a blanket payroll tax exemption for GP wages.

These moves have reset the revenue question for Australian GP practice owners. BBPIP rewards fully bulk-billing practices with a 12.5% revenue uplift. It also sharpens the cost of partial private billing, since any departure from full bulk billing forfeits the incentive entirely. The decision is now a structured one, not a matter of clinical preference.

Beyond Medicare maps all material revenue models currently available to Australian GP practices: what is operating at scale, what is conditional on geography, workforce or credentialing, and what is structurally constrained by legislation or regulation. It assesses each model for income potential, capital requirement, credentialing pathway and demand profile. It covers the regulatory barriers that limit private billing, international models with partial applicability, the acquisition and consolidation environment, the workforce economics that constrain every growth plan, and the trends most likely to affect model viability through to 2030.

Revenue model viability at a glance

Revenue model	Key metric	Current status
Subscription (DPC)	\$45/month × 600 patients = \$27,000/month	Operating (single compliant operator)
BBPIP bulk billing	12.5% practice incentive	Operating (3,412 practices enrolled)
GPCCMP chronic care	10.49% of total MBS billing	Operating (new items July 2025)
Telehealth	23% of GP consultations	Operating (ECR applies)
Corporate/employer	\$333M industry revenue	Conditional (competitive)
Medico-legal/IME	\$800–\$4,400 per report	Conditional (subspecialty required)
Subspecialty layers	8 clinical areas; practice selects	Conditional (varies by area)
Nurse/AH integration	WIP max \$137,375/year	Operating (WIP funded)
MyMedicare incentives	10% patient uptake	Operating (underutilised)
GPACI aged care	\$430/enrolled RACH patient/year	Operating (MyMedicare required)
Private health insurer	Structural barrier	Constrained (legislative)

Key: BBPIP: Bulk Billing Practice Incentive Program. DPC: direct primary care. ECR: existing clinical relationship. GPACI: General Practice in Aged Care Incentive. GPCCMP: GP Chronic Condition Management Plan. WIP: Workforce Incentive Program.

SECTION 1

Revenue models within and adjacent to Medicare

1.1 Subscription and direct primary care models

A compliant subscription model generates \$27,000 per month from subscriptions alone at \$45 per patient across a panel of 600 patients. Subscription revenue goes to the practice; GPs keep all consultation fees. Evercare grew from approximately 2,000 patients in 2018 to over 100,000 by 2023, with plans for 60 clinics by 2030.

Cleanbill data identifies at least 98 medical centres offering bulk billing to non-concession adult patients subject to a membership or subscription fee, with monthly fees typically ranging from \$20 to \$65. Several also charge a separate annual or one-off administration fee. The compliance question under the *Health Insurance Act 1973* (Cth) turns on whether the subscription is a condition of access to bulk-billed services. *LHMU v MJA* and subsequent ATO guidance establish that a subscription model is compliant where Medicare-eligible services are bulk-billed without requiring subscription membership.

The revenue arithmetic for the compliant version: at \$45 per patient per month, a panel of 600 patients brings in \$27,000 per month or \$324,000 annually in subscription revenue, before consultation billings. This sits entirely outside MBS and is not subject to Medicare compliance.

1.2 BBPIP and the bulk billing decision

BBPIP adds 12.5% to MBS revenue for fully bulk-billing practices, split 50:50 between providers and practice. Government messaging has conflated the incentive with unconditional bulk billing rate increases, but BBPIP is conditional on full bulk billing of all eligible MBS services at the registered practice.

The structural choice for practice owners has sharpened. RSM's February 2026 analysis noted that government messaging has created patient expectations of bulk billing as a norm in areas where it was previously uncommon. For practice owners, the decision now means comparing BBPIP gains with the revenue limits of bulk billing, considering patient demographics, payroll tax position and competitive context.

BBPIP: WHAT IT REQUIRES

Practices registered for BBPIP

BBPIP requires bulk billing for all eligible MBS services at the registered practice. It does not prevent private billing at associated sites under separate provider numbers. The 12.5% uplift applies to the bulk-billed services at the registered site only.

Practices not registered for BBPIP

Review your fee schedule against what a BBPIP practice in the same area now earns per consultation. The 12.5% incentive changes the comparison between private billing revenue and bulk billing revenue in areas with high bulk-billing competition.

Indexation is the tail risk on either side. The economic value of the incentive depends on MBS rebates moving with real costs over time, which the historical record does not support.

1.3 Chronic disease management – GPCCMP, Health Assessments and Home Medication Reviews

Chronic disease management items account for 10.49% of all MBS billings, up from 9.32% in 2022. Approximately 4.1 million Australians have two or more chronic conditions; this is the patient cohort that generates GPCCMP items.

The old items – GP Management Plans, Team Care Arrangements and their review items – were replaced by the GP Chronic Condition Management Plan (GPCCMP) and its review items in the 2025 budget. From 1 July 2025, preparing a GPCCMP or GPCCMP review combines what was previously billed separately as a GP Management Plan and Team Care Arrangement.

NOTE ON AUDIT RISK

Many GPs are anxious that their rates of GP Chronic Condition Management Plans (GPCCMP) or their review Health Assessments or Home Medication Reviews are too high and may attract Medicare audit. The reverse is more often true: most GPs underclaim these items because they are not confident in the documentation requirements. Any practice with chronically ill patients

and low GPCCMP rates relative to patient demographics is likely leaving legitimate revenue on the table, not over-claiming. Standard documentation protocols and peer-reviewed audit tools are available through the RACGP.

Patients registered with MyMedicare must access GPCCMP items through their registered practice, creating a direct financial incentive for practices to actively manage enrolment. The allied health referral elements remain a significant per-patient revenue driver through associated pathology, allied health and medication reviews.

Health assessments and Home Medication Reviews are two further Medicare-funded revenue streams in this category. Health assessments have four time tiers – some of this time can be delegated to practice nurses or Aboriginal and Torres Strait Islander health workers. Eligible groups include: people aged 75 and older; type 2 diabetes risk evaluation (40–49 years); people aged 45–49 at risk of developing chronic disease; residents of residential aged care facilities; people with an intellectual disability; refugees and other humanitarian entrants; and veterans (one-off assessment).

The business opportunity relates not just to the rebate but to the ability to delegate tasks to the practice nurse, increasing the number of patients the GP can service during the same period. Home Medication Reviews (HMR) involve a GP referral to an accredited pharmacist who reviews the patient's medications in their home and provides a report. The GP charges a review consultation from the MBS items, and the pharmacist charges the Commonwealth separately.

1.4 MyMedicare registration and financial benefits

80% of GP practices are registered for MyMedicare. As of March 2025, roughly 10% of the population had enrolled. That gap between practice registration and patient enrolment is the primary opportunity: practices that actively enrol patients unlock financial benefits that do not apply to non-enrolled patients.

MyMedicare enrolment unlocks four financial benefits: triple bulk billing incentives on longer telehealth consultations (Level C, D and E video items; Level C and D phone items); access to longer MBS-funded telephone consultation items (35+ and 60+ minutes); GPCCMP chronic disease management items tied to the enrolled practice from 1 July 2025; and GPACI eligibility at \$430 per enrolled residential aged care patient per year.

From 1 July 2025, chronic condition management plan items are attached to the patient's registered practice. A practice that has not actively enrolled its chronic disease patients will lose those items to whichever practice the patient subsequently registers with. GPACI compounds this: a practice interested in the aged care income stream cannot access it without MyMedicare registration for each eligible patient.

The enrolment gap has a specific cause. Only 33% of Medicare card-holding Australians had heard of MyMedicare in early 2025. The enrolment rate is low not because patients are refusing to enrol, but because most practices have not run an active enrolment process. As of March 2025, approximately 2.6 million patients were enrolled across 6,469 registered practices, averaging roughly 400 enrolled patients per practice – well below the population coverage of most practices.

1.5 Direct-to-consumer and platform telehealth

Platform telehealth has developed as a distinct revenue model operating largely outside Medicare fee-for-service. Three specific telehealth revenue streams warrant attention from practice owners.

Sexual and reproductive health telehealth

Twenty-four MBS items covering blood-borne virus, sexual and reproductive health services are permanently exempt from the existing clinical relationship (ECR) requirement. A GP can consult and treat a new patient via video or phone without a prior in-person relationship for these items. This creates a targeted telehealth stream that is not constrained by the ECR rules that limit most telehealth billing.

Condition-specific consumer platforms

Platforms including Mosh, Moshy and Pilot operate subscription-based models across weight loss, hair loss, skin and men's health. These platforms contract GPs to provide telehealth consultations, with the platform handling patient acquisition and administration. Revenue per consultation varies by platform and condition category. GP participation is as a contracted provider; the platform carries patient relationship and compliance obligations.

Medicinal cannabis. The Australian medicinal cannabis sector reached \$445.6 million in revenue in 2024–25, with 979,000 prescription applications approved by the TGA (up from 668,000 in 2023–24). The regulatory environment has tightened. AHPRA reported eight practitioners issuing more than 10,000 cannabis scripts in a single year, prompting formal investigation. Prescribing in this space requires current attention to AHPRA guidance on prescribing standards and advertising restrictions.

1.6 Employer and corporate wellness contracts

Employer-contracted GP services sit outside the Medicare rebate structure. Employers in construction, manufacturing, mining and retail pay above-MBS rates for on-site or reserved-access GP time. Contracts typically cover pre-employment medicals, occupational health assessments and dedicated access for staff.

GP locum rates in clinic settings run \$1,600 to \$3,000 per day; any corporate contract needs to price GP time against this benchmark. The employer case is straightforward: 60% of Australians delayed a GP visit in 2024 due to cost or unavailability. Employers understand this and some are willing to pay for access. The corporate wellness services industry generates approximately \$333 million in annual revenue.

For independent practice owners, competing against a corporate operator with 200 locations and a dedicated employer contracts team is a realistic constraint. Corporate contracting works for practices with a specific sectoral advantage – proximity to a major employer, established occupational health credentials, or existing WorkCover panel relationships.

1.7 Medico-legal and insurance examination work

Independent medical examination (IME) work sits outside Medicare billing and generates revenue not subject to rebate caps. Victoria, NSW and Queensland set GP IME fees through gazetted fee schedules updated annually (WorkSafe Victoria, SIRA NSW, WorkCover Queensland). Reported fee ranges run \$800 to \$4,400 per report depending on complexity and jurisdiction.

Volume depends on subspecialty credibility (occupational medicine, musculoskeletal, psychiatry) and on established relationships with plaintiff and defendant legal firms, insurers and workers compensation agencies. Without an established referral network, entry is slow. With one, volume can be significant and is not subject to the patient throughput constraints of standard GP work.

1.8 Subspecialty revenue layers

Subspecialty layers sit alongside core general practice as discrete revenue streams. Each has its own credentialing pathway, capital and operating profile, regulatory envelope and commercial logic. The summary table below covers all eight subspecialties; individual sections follow.

Subspecialty	Income range	Credential and time	Setup cost	Primary demand driver
Skin cancer	\$250k–\$400k/yr (full subspecialty)	RACGP Certificate in Primary Care Dermatology; several months to 1 year	Dermatoscope, biopsy room, histopathology. High	Highest melanoma incidence globally
Women's health	No published GP-specific figure	RANZCOG credential from \$1,810; 12 months part-time	Procedure room, nurse support. Moderate	Women 15–64 roughly half most patient bases
Aesthetic medicine	No published GP figure. Injector roles \$180k–\$250k+	ACAM Educational Pathway; 2 years	Existing treatment rooms, consumables. Low	Aesthetics market \$396M (2025), projected \$785M by 2034
GLP-1 / weight management	No published GP figure	No mandatory credential; CPD sufficient	Longer slots, pathology, bariatric scales. Low	Wegovy and Mounjaro demand running ahead of supply
Sports and MSK	No published GP figure. POCUS practices earn significantly more	No mandatory credential. ACSEP Diploma ~2 years	POCUS \$30k–\$150k. Highest capital outlay	High-volume primary care category; WorkCover
Travel medicine	No published GP figure. Privately billed	YF provider status required; ISTM Certificate	Vaccine fridge, cold-chain, inventory. Moderate	Travel volumes past pre-pandemic levels 2024–25
Occupational medicine	Pre-employment medicals \$150–\$400 each	No mandatory credential; HealthCert Certificate	Drug/alcohol testing, spirometry. Moderate	Mining, transport, construction, aged care sectors
Mental health	No published GP figure. Group billing can scale	FPS skills training ~40 hours; 3–6 months	Standard consult room, longer slots. Low	Most commonly managed problem in Australian GP

1.8.1 Skin cancer medicine

Australia has the highest melanoma incidence in the world, with Queensland the highest age-standardised rate globally. More than 1.1 million GP encounters relate to skin conditions annually.

UPSIDE

- Direct private billing above MBS rates. Skin cancer checks and procedures are privately billable at rates substantially above standard MBS rebates.
- Documented earnings. Reported salary ranges for GPs with skin cancer subspecialty work reach \$250,000 to \$400,000 per year at full subspecialty commitment.
- Accessible credential. The RACGP Certificate of Primary Care Dermatology can be completed in several months to a year.
- Demand concentration. High-SES metropolitan practices with older cohorts, outdoor occupational populations and Queensland locations have naturally higher demand.

DOWNSIDE

- Geography does most of the selection. Practices without an ageing, outdoor-exposed or higher-SES patient base face weaker demand for a premium skin cancer service.
- Training while billing. GPs struggle to find time for structured training while maintaining clinical workload.
- Indemnity loading. Procedural and skin cancer activity attracts higher professional indemnity premiums than non-procedural GP scope.

Income

\$250,000 to \$400,000 per year for GPs with skin cancer subspecialty work at full subspecialty commitment. Reported rates for 4 days per week dedicated skin cancer work approximately \$100,000 per year at lower commitment.

Credential and time

RACGP Certificate of Primary Care Dermatology: 25 online courses plus skin cancer procedural training. Completion in several months to a year depending on pace. No mandatory formal recertification cycle but ongoing CPD required.

Setup

Dermatoscopes, biopsy room and histopathology relationships. Higher capital requirement than most non-procedural subspecialties. Procedure room fit-out if not already available.

Demand signal

Australia has the highest melanoma incidence globally; skin conditions are a top-10 GP-managed condition. Demand is geographically concentrated in Queensland and coastal NSW.

1.8.2 Women's health and contraception

Women aged 15 to 64 make up roughly half of the patient base in most Australian general practices, and clinical demand for women's health procedural skills has grown consistently since 2020.

UPSIDE

- Multiple procedural billing lanes. Implanon NXT insertions and removals, IUD (Mirena, Kyleena) insertions and medical termination of pregnancy via MS-2 Step each carry specific MBS item numbers billable at standard or private rates.
- Structured and accessible credentialing. The RANZCOG Certificate of Women's Health and the Procedural and Advanced Procedural training pathways are available through a range of providers.
- Growing menopause demand. Clinical demand for menopause-literate GPs has risen since 2023. Australasian Menopause Society data indicates significant unmet patient demand for GP-level menopause management.
- Lower barrier to MS-2 Step. Since the July 2023 TGA change, GPs can prescribe MS-2 Step without specific certification, removing the main credential barrier to medical termination of pregnancy.

DOWNSIDE

- Procedural indemnity loading. Professional indemnity premiums increase for GPs performing insertion and termination procedures.
- Equipment and room requirements. LARC insertion needs a procedure room and supporting nurse. Menopause management does not require equipment but demands longer consultation slots.
- Medico-legal exposure. Uterine perforation, IUD expulsion and failed termination are low frequency but material complaints when they occur.
- State and regulatory variation. Scope of practice for MS-2 Step and broader reproductive care still varies by state.

Income	No publicly available GP-specific income figure for procedural women's health. LARC insertion, IUD management and MS-2 Step each have specific MBS items. Menopause management is typically privately billed.
Credential and time	RANZCOG one-time training fees: Certificate of Women's Health from \$1,810. Implanon NXT insertion training approximately \$300-\$500. MS-2 Step prescribing requires no specific credential since July 2023.
Setup	Procedure room, procedure couch, supporting nurse for LARC insertion. Minor procedure pack, speculum stock, ultrasound access for IUD confirmation. Moderate setup cost.
Demand signal	Women aged 15 to 64 are roughly half of most practice patient bases. Menopause demand accelerating since 2023. MS-2 Step prescribing demand consistent with TGA approval growth.

1.8.3 Aesthetic medicine

The Australian medical aesthetics market was valued at \$396.4 million in 2025 and is projected to reach \$784.8 million by 2034.

<p>UPSIDE</p> <ul style="list-style-type: none"> • Sustained sector demand. The Australian medical aesthetics market is projected to nearly double by 2034. Patient demand runs ahead of credentialed provider supply in most markets. • High per-session revenue. Cosmetic injectables and combined treatment plans support private fees well above standard GP consultation rates. • Established credentialing pathway. The ACAM Educational Pathway is designed for doctors with limited aesthetic medicine experience. • Limited capital outlay for injectables. A cosmetic injectable practice can operate from existing treatment rooms with supplier accounts for product. 	<p>DOWNSIDE</p> <ul style="list-style-type: none"> • New AHPRA prescription rules. In-person or video consultation is now required for each cosmetic injectable prescription under the 2023 AHPRA changes. • Advertising restrictions. Influencer testimonials are banned. Advertising cosmetic procedures to individuals under 18 is prohibited. • Patient assessment burden. Verbal consent discussion and written plain-language information are both required, and patient suitability screening carries medico-legal weight. • Regulatory and indemnity exposure. The sector sits on AHPRA's active enforcement radar. Non-compliance with advertising and prescribing rules carries registration risk.
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Income	No published GP-specific figure. Cosmetic injector roles advertised at \$180,000–\$250,000+ per year.
Credential and time	ACAM Educational Pathway: 2 years. Fees not publicly listed. Alternative providers include RACGP aesthetic medicine courses.
Setup	Existing treatment rooms, supplier accounts, consumables. No major equipment outlay for injectables alone. Laser and other device investment is additional.
Demand signal	Australian medical aesthetics market \$396.4 million (2025), projected \$784.8 million by 2034. Demand broad-based across age groups.

1.8.4 GLP-1 and weight management

GLP-1 receptor agonist prescribing has reset the commercial landscape for GP weight management since 2023. Wegovy (semaglutide) and Mounjaro (tirzepatide) are TGA-approved for chronic weight management; neither is PBS-listed for obesity, meaning patients carry the full private script cost. Patient demand has run ahead of GP-side capacity to assess, prescribe and follow up.

UPSIDE

- Sustained patient demand. GLP-1 demand is broad-based and runs ahead of credentialed GP supply for assessment and follow-up. Saxenda discontinuation by end of 2025 has redirected prescribing to Wegovy and Mounjaro.
- Multiple consultation lanes. Initial assessment, prescription review, side-effect management and combined metabolic and lifestyle consultations each generate separate billing.
- No mandatory specialist credential. GPs can begin prescribing within scope after structured CPD; the entry barrier is clinical knowledge, not a formal qualification.
- Practice differentiation. A weight and metabolic clinic differentiates a practice in markets with high patient demand and low credentialed GP supply.

DOWNSIDE

- Out-of-pocket cost barrier. With no PBS listing for obesity, patients carry the full private script cost (approximately \$395/month for Mounjaro). Price sensitivity limits the addressable patient population.
- Compounding and prescribing scrutiny. The October 2024 removal of GLP-1 RAs from pharmacy compounding allowance increased regulatory attention on prescribing patterns.
- Long-term outcome data limited. Long-term safety, weight regain on cessation and combination-with-lifestyle outcomes are not yet fully established.

Income	No published GP-specific figure for weight management revenue. Tracks private prescription consultation volume and follow-up frequency.
Credential and time	No mandatory credential beyond GP scope. HealthCert Professional and Advanced Certificate options available. CPD pathways through RACGP and NPS MedicineWise.
Setup	Consultation rooms; scales rated to bariatric weight; longer appointment slots; pathology access; patient monitoring protocol.
Demand signal	Saxenda discontinued by end 2025. Demand redirected to Wegovy and Mounjaro. Prescriptions growing quarter-on-quarter since 2023.

1.8.5 Sports and musculoskeletal medicine

Sports and musculoskeletal work combines private fees, MBS consultation and procedure items, and WorkCover and TAC scheduled fees across several conditions in a high-volume primary care category.

<p>UPSIDE</p> <ul style="list-style-type: none"> • Multiple revenue streams. Private fees, MBS items, WorkCover and TAC scheduled fees can combine into a higher-yield consultation pattern than standard GP work. • Equipment investment pays back at scale. POCUS and procedure setup is a one-time capital cost that supports ultrasound-guided injections and imaging at private rates. • Diploma pathway. ACSEP Diploma is accessible part-time over approximately 2 years and is well recognised in the workers compensation and sports medicine referral chain. • Demand resilience. Musculoskeletal demand is structurally embedded in the population and tracks workforce participation rates rather than discretionary spending. 	<p>DOWNSIDE</p> <ul style="list-style-type: none"> • Capital outlay. POCUS equipment is the largest single setup cost across the subspecialties covered here: entry-level clinical grade from \$30,000; advanced from \$80,000–\$150,000. • Two-year credential timeline. ACSEP Diploma is longer than several alternative subspecialty pathways. • Procedural indemnity loading. Injection work attracts higher professional indemnity premiums than non-procedural GP scope. • Workers compensation administrative load. WorkCover and TAC interactions carry documentation and reporting obligations that add time to each case.
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Income	No published GP-specific figure. POCUS-equipped practices with WorkCover and TAC panels generate materially more per consultation than non-procedural GP work.
Credential and time	No mandatory credential beyond GP scope for musculoskeletal management. ACSEP Diploma accessible part-time over approximately 2 years. HealthCert Certificate/Diploma in Musculoskeletal Medicine as an alternative.
Setup	Procedure room with examination couch and ultrasound. Entry POCUS approximately \$30,000; clinical grade \$80,000–\$150,000. Highest capital requirement across subspecialties.
Demand signal	Musculoskeletal presentations are a top-5 GP-managed condition category. Workers compensation and motor accident claim volumes sustained.

1.8.7 Travel medicine

Travel medicine is private-fee dominant with limited MBS dependency: consultation, vaccines and destination-specific advice are all privately billable. Demand tracks international travel volumes, which rebuilt past pre-pandemic levels in 2024–25.

<p>UPSIDE</p> <ul style="list-style-type: none"> • High per-consult private fee. Travel consults are routinely privately billed with limited rebate dependency. • Inventory turnover. Vaccine inventory generates margin where managed actively; corporate travel client contracts add steady volume. • Low-complexity expansion. Existing GPs with structured travel-medicine training can offer the service from existing practice rooms. • Discrete clinic format. Travel medicine sessions can be ring-fenced from core practice, maintaining throughput elsewhere. 	<p>DOWNSIDE</p> <ul style="list-style-type: none"> • Cold-chain and inventory exposure. Vaccine spoilage and stock financing carry real cost; small clinics carry the full risk without the volume to absorb it. • Demand seasonality. Travel patterns concentrate around school holidays and pre-departure windows; revenue is uneven across the year. • Competitive density. Dedicated travel clinic chains compete on price and convenience in metropolitan markets.
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Income	No published GP-specific figure. Revenue is largely private fee-for-consultation plus vaccine margin. Some MBS rebate applies to pre-travel health assessments.
Credential and time	No mandatory credential beyond GP scope but Yellow Fever vaccine provider status required for YF immunisation. ISTM Certificate of Knowledge in Travel Health available. Specific training pathways through RACGP.
Setup	Vaccine fridge, secure cold-chain, vaccine inventory financing. YF-approved clinic registration with the Commonwealth.
Demand signal	Domestic and international travel volumes rebuilt past pre-pandemic levels in 2024–25. Corporate travel segment generates contracted volume.

1.8.8 Occupational medicine

Occupational medicine generates contracted revenue from corporate accounts and workers compensation panels, providing volume predictability that core GP practice does not.

<p>UPSIDE</p> <ul style="list-style-type: none"> • Contracted revenue stream. Corporate accounts and workers compensation panels provide volume predictability. • Modular credential pathway. HealthCert and similar providers offer Certificate-level entry within 6 months. • Equipment-light entry. Pre-employment medicals can run from existing GP rooms with spirometry and basic equipment. • Sector-defined demand. Mining and resources, transport, construction and aged care sectors generate sustained corporate demand. 	<p>DOWNSIDE</p> <ul style="list-style-type: none"> • Procurement-driven pricing. Corporate accounts and workers compensation schedules cap fees; margins depend on throughput rather than per-item revenue. • Reporting and documentation load. Occupational assessments carry stricter documentation obligations than core GP consultations. • Sector concentration risk. Practices relying heavily on a single corporate account carry concentration risk if the contract is not renewed.
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Income	No published GP-specific figure. Pre-employment medicals \$150–\$400 each depending on complexity and jurisdiction.
Credential and time	No mandatory credential beyond GP scope. HealthCert Certificate/ Diploma. AFOM (Fellowship of the Australasian Faculty of Occupational and Environmental Medicine) for advanced practice.
Setup	Drug and alcohol testing equipment, spirometry, audiometry for full occupational health service. Some practices begin with pre-employment medicals only using standard consultation rooms.
Demand signal	Workplace health and safety regulation, workers compensation and pre-employment screening requirements drive consistent sector demand.

1.8.9 Mental health care

Focused Psychological Strategies (FPS) skills training enables GPs to bill higher-rebate Mental Health Treatment Plan (MHTP) items. Mental health is consistently the most commonly managed problem in Australian general practice.

<p>UPSIDE</p> <ul style="list-style-type: none"> • Higher-rebate items. MHTP and FPS items pay materially more than standard consultation rebates, lifting per-hour revenue without patient throughput changes. • Modest course load. FPS training at 40 hours is one of the shorter credentialing requirements across the subspecialties. • No equipment outlay. The credential converts existing consult time into higher-value billing. • Group-session leverage. Approved group items can scale per-session revenue beyond one-on-one consults. 	<p>DOWNSIDE</p> <ul style="list-style-type: none"> • Time per consult. MHTP and FPS consults are longer; throughput economics differ from standard GP work. • Documentation load. MHTP and FPS items carry detailed documentation requirements. • Policy exposure. Better Access session caps and item rebate levels have been reviewed periodically; revenue mix is more policy-dependent than other subspecialties.
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Income	No published GP-specific figure. Revenue combines higher-rebate MHTP items with standard consultation billings. Group billing can scale per-session revenue.
Credential and time	FPS skills training typically 40 hours via RACGP or General Practice Mental Health Standards Collaboration (GPMHSC). 3–6 months at standard pace.
Setup	Consultation rooms with private layout; longer appointment slots; no specialist equipment required.
Demand signal	Mental health is consistently the most commonly managed problem in Australian general practice. Demand substantially exceeds credentialed GP supply.

1.9 Nurse and allied health integration

The Workforce Incentive Program (WIP) Practice Stream provides financial support for practices employing eligible health professionals including practice nurses, Aboriginal and Torres Strait Islander health practitioners, allied health professionals and mental health professionals. The maximum WIP payment is \$137,375 per year, subject to a blended formula based on practice location, hours and staff mix.

The revenue rationale extends beyond the WIP. Practices with chronic disease management plans generate referral-linked allied health revenue through coordinated care arrangements. Practices with nurse-led chronic disease management programmes bill more GPCCMP items, more health assessments and more review consultations than those relying on GP time alone.

No peer-reviewed Australian study on the per-patient revenue uplift from nurse-led integration in general practice is available. The operational case is strong; the financial quantification is practice-specific.

1.10 General Practice in Aged Care Incentive (GPACI)

GPACI pays \$430 per enrolled RACH patient per year, split between the GP (\$300) and the practice (\$130), delivered quarterly. Those payments are added to standard MBS billing for each visit. RACH patients are universally concession cardholders, attracting the full bulk-billing incentive uplift under BBPIP.

The minimum service requirement under GPACI (10 visits per patient per year, including two care planning items) is compatible with standard RACH GP service patterns. Rural loading increases the payment: 20% for MMM 3, 30% for MMM 4–5, 50% for MMM 6–7.

The constraint sits in the registration architecture. GPACI requires the practice, the GP and each enrolled patient to be registered with MyMedicare. Patient registration requires active enrolment by the resident or their representative. GPACI replaced the PIP GP Aged Care Access Incentive, which ceased 31 July 2024. Registration opened 1 July 2024.

1.11 Private health insurer entry into general practice

Section 126 of the *Health Insurance Act 1973* (Cth) prohibits insurance contracts that cover medical expenses for a service where a Medicare benefit is payable. Section 121-10 of the *Private Health Insurance Act 2007* (Cth) separately prevents insurers from paying benefits for services attracting a Medicare benefit. Private health insurers cannot cover standard GP consultations.

The practical effect: private health insurers cannot cover standard GP consultations. They can fund services not on the MBS schedule, including allied health where no Medicare benefit applies, and preventive health programs outside rebate scope. Both major insurers are now operating GP clinic networks at scale. Medibank's subsidiary Amplar Health received ACCC approval to acquire Myhealth Medical Group in 2024, adding 50 clinics. Bupa operates Bupa Dental and Medical in major cities. The ACCC's mandatory merger regime, effective 1 January 2026, applies to further acquisitions above threshold.

No peer-reviewed financial analysis of insurer-owned clinic effects on competition between independent and corporate practices is available. The competitive dynamic is observable in metropolitan markets where insurer clinics operate.

SECTION 2

Structural barriers and go-to-market constraints

2.1 Structural barriers at a glance

Barrier	Regulatory basis	Practical effect
Marketing consent	Spam Act 2003, Privacy Act 1988 APP 7	Express consent required. Most practices have not collected marketing consent at registration, limiting electronic outreach to existing patients.
AHPRA advertising	Health Practitioner Regulation National Law s133(1)(c)	No testimonials, no unsubstantiated outcome claims. Advertising for cosmetic procedures to under-18s prohibited.
Non-contractual relationship	No formal service agreement with patients	Cannot impose fee model changes; patients can leave without notice or penalty.
Patient price sensitivity	BBPIP-driven bulk billing expectations	Subscription and mixed billing face resistance where bulk billing has become the local norm.
GP workforce shortage	3,010–3,620 FTE shortfall	Revenue models requiring extra GP time constrained by supply, not demand.
Accreditation overhead	RACGP Standards, PIP requirements	Each new service adds compliance layers to existing obligations.
Corporate competition	39% of group practices corporate-operated	Scale advantages in contracting, analytics and technology investment favour large operators.

2.2 Marketing consent requirements

Australian GP practices do not have a ready-made, legally clean channel for mass electronic marketing to their patient base. The Spam Act 2003 (Cth) requires express consent for commercial electronic messages. The Privacy Act 1988 (Cth) and APP 7 impose an additional layer: direct marketing using health information requires consent, and health information is sensitive information under the Act.

A practice wishing to communicate a new service model to existing patients must have obtained marketing consent at registration or through a subsequent explicit consent process. Most practices have not. The practical options are: obtain consent prospectively through a registration update process; use opt-in mechanisms in waiting rooms or patient portals; or limit electronic outreach to patients who have provided consent through a specific channel.

2.3 AHPRA advertising restrictions

The Health Practitioner Regulation National Law prohibits advertising that uses testimonials or purported testimonials about a regulated health service. This constrains patient review platforms, social media marketing and any content featuring patient outcomes or satisfaction statements.

The rules also prohibit unsubstantiated health outcome claims and claims creating unrealistic expectations. Advertising cosmetic procedures to individuals under 18 is prohibited. AHPRA's enforcement activity in aesthetic medicine has increased since 2023, with formal investigations of practitioners advertising prohibited content.

2.4 Non-contractual patient relationship

The standard GP-patient relationship is not contractual. A patient does not sign a service agreement. Transitioning a patient panel to a subscription or mixed-billing model requires each patient to consent to the new arrangement individually – and patients can choose not to. For MyMedicare-enrolled patients, enrolment is voluntary and can be changed. Patient loyalty data suggests 68% prefer to stay with their regular GP when a choice is available, but this figure reflects preference, not contractual obligation.

2.5 Patient price sensitivity and bulk billing expectations

The 2025 bulk billing expansion has materially altered patient expectations in metropolitan areas. RSM noted in February 2026 that government messaging has created patient expectations of bulk billing as a norm in areas where it was previously uncommon. Lower-SES areas, concession cardholders and children under 16 now attract full bulk billing uplift, making private billing economically unjustifiable for those patient cohorts.

2.6 GP workforce shortage as a constraint

The GP shortfall constrains every revenue model requiring additional GP time, training or patient capacity (see section 5 for workforce economics in full). With 69% of GPs reporting burnout in 2025 and 32% planning to retire within five years, the ability to recruit additional GP capacity for new service lines cannot be assumed. Revenue models that require additional GP FTE to generate incremental income are constrained at source.

2.7 Accreditation and compliance overhead

RACGP accreditation under the Standards for General Practices involves ongoing documentation, audit and compliance obligations. Each new service stream adds documentation requirements, risk management obligations and potentially additional accreditation standards. For small practices without administrative support, compliance overhead is a genuine constraint on service expansion.

2.8 Corporate ownership and independent practice competitiveness

The top eight corporate and group operators control approximately 39% of group-operated practices and related facilities. For an independent owner seeking to enter employer contracting, the competitive constraint is real: a corporate operator can offer an employer guaranteed coverage across multiple locations, dedicated account management and integrated billing, none of which an independent practice can match. Independent practices competing in this space need a specific sector advantage – proximity, established relationships or subspecialty credentials.

SECTION 3

International models with Australian applicability

3.1 US direct primary care

As of early 2026, approximately 2,827 DPC offices operate across the United States, up from approximately 1,200 in 2020. DPC Frontier reports practices maintaining panels of approximately 600 patients achieve 66% fewer ED visits and a 20% reduction in specialist referrals compared to fee-for-service equivalents.

Structural transferability to Australia is limited: US DPC practices opt out of all insurance billing. In Australia, even subscription-model practices bulk-bill through Medicare for eligible services. The compliant Australian equivalent is a hybrid: subscription fee plus Medicare billing. True opt-out is not a viable mass-market model under current legislation.

3.2 UK primary care networks

Primary care networks (PCNs) are groups of GP practices covering populations of approximately 30,000–50,000 patients. Over 99% of English GP practices have joined one; approximately 1,250 PCNs operate across England. PCN funding enables practices to employ multidisciplinary roles (pharmacists, physiotherapists, social prescribers, mental health workers) through additional PCN payments, reducing the individual practice's cost of allied health integration.

The comparison with Australia: PCNs are a geographically organised collaboration model funded through a capitation-adjacent mechanism tied to enrolled patient populations. MyMedicare introduces a similar logic at the patient level, but without the practice collaboration or dedicated multidisciplinary workforce funding that PCNs provide. The WIP Practice Stream is the closest Australian equivalent, but operates at a fraction of PCN funding levels.

3.3 New Zealand capitation model

New Zealand's Primary Health Organisations (PHOs) are paid based on enrolled patients, not consultations. A 2019 BMJ Open study found higher per-patient costs and similar or better health outcomes compared to fee-for-service models for chronic disease management.

The feature most relevant to Australia: MyMedicare introduces a partial capitation logic, with practices receiving additional payments per enrolled patient (GPACI, enhanced telehealth, GPCCMP lock-in). The constraint is scale. In NZ, PHO enrolment is the primary funding mechanism. In Australia, MyMedicare is a voluntary supplement to a fee-for-service base. The incentive architecture points toward capitation without the funding volume that makes it the dominant model.

SECTION 4

Practice acquisition, consolidation and group operating models

4.1 Practice acquisition and consolidation

Australian general practice is in an accelerating phase of consolidation. Of approximately 7,135 accredited practices, the top eight corporate and group operators control approximately 39% of group-operated practices and related facilities. Private equity investment in Australian health care reached \$4.5 billion in acquisitions during 2022, with general practice a primary target.

The RACGP's Health of the Nation 2024 report found nearly one in four practice owners (24%) intended to sell within 12 months of the survey. That supply pipeline, combined with corporate and PE buyer demand, sustained high transaction volume through 2023–25.

4.2 GP practice valuation

GP practices are typically valued using an EBITDA multiple. Clinch Group's September 2025 analysis found average EBIT at 14.4% of revenue, lower than the broader healthcare sector. The prevailing benchmark: 3x to 5x EBITDA for standard practices sold to individual buyers or smaller groups. At the corporate end, 5x to 8x EBITDA for practices with strong billings, good location, and low owner-dependence.

The distinction between personal goodwill and commercial goodwill matters. Practices where the principal generates a large proportion of billings and has deep personal relationships with patients trade at lower multiples than those with distributed billing across multiple GPs and a transferable patient base. Subcontracting GPs now typically receive 65–75% of billings (up from 60–65%), meaning only 25–35% flows to practice revenue. This compression affects EBITDA and therefore sale multiples.

4.3 Due diligence beyond financials

Dimensions buyers commonly under-weigh:

- Revenue sustainability: whether billing patterns and CDM volumes would survive audit scrutiny.
- Payroll tax position: settled differently by state (see section 5.5).
- Lease security: 5+5 year option lease is a baseline for premium multiples.
- GP service agreements: written, compliant contractor agreements required for payroll tax exemption.
- Owner-dependence: proportion of billings attributable to the selling principal.
- Accreditation: RACGP Standards status affects PIP eligibility.

4.4 ACCC mandatory merger regime

From 1 January 2026, Australia moved to a mandatory and suspensory merger control regime. Acquisitions meeting thresholds must be notified to the ACCC before completion. Two thresholds apply. First: combined Australian revenue of \$200 million or more and target revenue of \$50 million or more. Second: a cumulative acquisition threshold where the acquirer has made three or more acquisitions in the same or a similar sector over three years.

For major operators including Amplar Health and PE platforms above \$500 million, the three-year cumulative threshold means most individual practice acquisitions now require notification. Mid-tier operators below \$500 million face more limited impact: most individual practice acquisitions at typical valuations do not clear the first threshold. The regime adds time and cost to transactions at scale.

4.5 Corporate ownership and quality of care

A 2021 MJA Perspective identified four potential effects of corporatisation: reduced access where small practices consolidate; reduced quality where profit pressure alters clinical decisions; reduced choice where local market concentration increases; and reduced GP autonomy. The evidence base for these effects in the Australian context remains limited. The RACGP has called for regulatory oversight of GP corporate concentration; no specific legislative response has followed to date.

Workforce attraction and retention as a revenue lever

5.1 GP shortage and revenue constraints

A practice that cannot attract or retain GPs cannot bill. High turnover loses continuity-linked revenue: CDM plan reviews, MyMedicare-enrolled patient billings and GPACI payments are all attached to the patient-GP relationship. Australia's current GP shortfall is estimated at 3,010–3,620 FTE. The RACGP National Workforce Strategy 2025–30 projects a shortfall of 6,400 FTE by 2040 if current training and distribution patterns continue.

5.2 GP remuneration models

The standard structure: VR GPs receive approximately 65–70% of billings as subcontractors; non-VR GPs 60–65%. Competition for VR GPs in metropolitan markets has pushed rates above 70% in some practices. Mixed-billing and private-billing practices offer GPs higher gross billings per consultation. The average Level B fee has increased since the 2023 bulk billing expansion; the percentage split determines whether that increase reaches the GP.

Evercare's subscription model is partly a GP attraction mechanism: GPs retain 100% of consultation billings, with practice revenue coming entirely from subscriptions. The BBPIP 50:50 split between GPs and practices has drawn RACGP concern. In bulk billing practices, economics have typically seen GPs receive a higher percentage; the 50:50 split formalises a practice revenue share that some GPs view as unfavourable.

5.3 Government workforce recruitment incentives

The government has committed \$204.8 million for salary incentives for junior doctors to specialise in general practice, and \$110.7 million for scholarships and incentives to attract GPs to rural and remote areas. The WIP Doctor Stream provides payments to GPs in MM 3–7 areas based on hours, location and rurality loading.

The GP Training Incentive Payment provides \$30,000 for junior doctors commencing rural GP training rotations. Practices in eligible locations that take registrars can access this payment as part of the broader teaching and training ecosystem.

5.4 Practice design and GP retention

Financial remuneration is necessary but not sufficient. RACGP research found burnout common in GP supervisors and associated with administrative load, not clinical load. AI scribe adoption (40% of GPs by November 2025) recovers approximately 4 minutes of documentation per consultation, equivalent to approximately 2 clinical sessions per week for a full-time GP. Practices that have adopted scribes can present this as a measurable working condition improvement in recruitment conversations.

Doctor ownership is a documented recruitment differentiator: GPs cite clinical autonomy, governance participation and investment in the practice as factors in choosing a practice over a corporate employer. Mixed-ownership models and partnership tracks are retention mechanisms independent of remuneration percentage.

5.5 Payroll tax by state

The payroll tax position diverges materially across states following the 2023–24 relief and amnesty period.

Queensland: Blanket exemption covering all GP wages (contractor and employee) regardless of billing model, effective 1 December 2024. Estimated cost: \$538 million over five years.

Victoria: Proportional exemption from 1 July 2025, calculated by reference to the practice's bulk-billed revenue share. Practices with 75% or more bulk billing receive a full exemption; below that, a partial exemption applies.

New South Wales: Retrospective exemption for unpaid payroll tax on contractor GP wages before 4 September 2024 (no refunds). From that date, practices with bulk billing above 70% receive exemption. Below 70%, standard payroll tax rates apply to GP contractor payments.

South Australia: RevenueSA has issued post-*Thomas and Naaz* contractor guidance and provides a targeted bulk-billing-related relief. Independent advice recommended for mixed-billing practices.

Western Australia: WA has not adopted the contractor reassessment position taken in eastern states. RevenueWA continues to apply standard payroll tax principles.

Tasmania: State Revenue Office Tasmania has indicated that genuine independent contractor relationships in medical practice are outside payroll tax. The position is based on contractual substance, not a blanket GP exemption.

Australian Capital Territory: ACT Revenue Office provides a targeted exemption for bulk-billed GP consultations. Scope and threshold require independent verification.

Northern Territory: NT applies standard payroll tax principles without sector-specific GP rulings. Practices operate under standard contractor-versus-employee assessment.

For mixed-billing practices above threshold, exposure runs to approximately 4.85% of contractor GP payments in Victoria and NSW where exemptions do not fully apply. State-specific advice is required; the position in each jurisdiction has moved since 2023 and continues to evolve.

5.6 Single Employer Model for GP registrars

The Single Employer Model (SEM) restructures GP registrar employment so a state health service, rather than the training practice, becomes the employer of record. The SEM is a phased trial across five states running until 31 December 2028 (no trials in WA, NT or ACT). The cost change for practices is direct: the practice no longer pays registrar wages. In Tasmania, the practice retains a financial contribution obligation; in other SEM states, the health service bears the full employment cost.

Commonwealth commitment: \$6.4 million through 2027–28 for expansion and evaluation, plus \$7.97 million for Tasmania. The workforce rationale is to remove the financial barrier that prevents rural and regional practices from taking registrars. The commercial implication for training practices: reduced payroll and super obligations during the registrar's placement, offset by a reduction in the administrative control over the registrar's rostering.

Trends affecting revenue model viability

6.1 MBS indexation and the real value of GP fees

From 1995 to 2022, MBS items received average annual indexation of 1.1%, against CPI of 2.42% and Average Weekly Earnings growth of 3.5%. The 2023 Strengthening Medicare package committed to annual indexation aligned to wage growth; the first indexed increase applied in November 2023. Whether this commitment is maintained across budget cycles is the key variable for any revenue model that depends on MBS rebate levels.

6.2 Strengthening Medicare Taskforce implementation

The Taskforce reported February 2023 with four priority areas. The government committed \$750 million through the Strengthening Medicare Fund. Implemented measures include: expanded bulk billing incentive (November 2023, extended to all Australians from November 2025); Medicare Urgent Care Clinics (\$657.9 million committed for 137 UCCs); MyMedicare voluntary patient registration; and longer telehealth items for enrolled patients. Pending: Scope of Practice reforms, Multidisciplinary Team funding model.

6.3 GP workforce supply and distribution

113 FTE GPs per 100,000 population in 2024, up from 110 in 2023. Workforce headcount: 40,375 GPs (32,557 VR, 1,618 non-VR, 6,200 registrars in training). Distribution remains the constraint: supply is concentrated in major cities; rural and remote areas face structural shortfalls that incentives have not resolved.

6.4 Patient demand patterns

81.4% of Australians (approximately 20.7 million people) had at least one long-term health condition in 2022 (ABS). 9.7 million Australians had two or more. An older, more chronically ill population requires more GP time, more care coordination and more allied health integration. Chronic disease management is the structural growth category in GP revenue; the question for practice owners is whether their workforce and systems can service growing demand.

6.5 AI-assisted clinical tools

As of November 2025, approximately 40% of surveyed GPs were using AI scribes, up from 22% in August 2024. Avant data shows 75% of users reported improved work-life balance; 73% said clinical quality improved or stayed the same. From August 2025, the TGA began classifying AI scribes that provide diagnostic suggestions or clinical decision support as medical devices requiring registration. Scribes that only transcribe and summarise remain outside the medical device classification.

AI scribes can reduce documentation time by up to 40% (2025 AJGP). Saving 4 minutes per patient across 30 consultations equals 2 hours of recovered time daily. A small Australian survey found GPs often returned saved time to patients through longer consultations rather than increasing throughput. No published Australian study quantifies the billing revenue impact.

6.6 Medicare urgent care clinics

The government committed \$657.9 million to 137 UCCs. The 87 already operating delivered over 2.5 million visits since 2023. Each UCC presentation costs \$246.50, more than five times a standard GP consult at approximately \$44. Only 68% of UCC presentations included a face-to-face clinical assessment; 32% were nurse-led triage only.

UCCs create competitive pressure on nearby GP practices for walk-in, acute and after-hours presentations. Several contracts have been awarded to existing practices and GP corporate operators, creating a dual dynamic: some practices benefit from UCC contracts; others face diversion of their after-hours and acute patient base.