

BUYER'S GUIDE

What to look for when buying a general practice

A due diligence framework for GP practice acquisition
in Australia

What to look for when buying a general practice

A due diligence framework for GP practice acquisition in Australia

AUTHOR

Mark Donato

PUBLISHER

Medius Global, a trading name of iaso health Pty Ltd

ABN 35 621 345 695

Sydney, Australia

www.mediushglobal.com.au

Contact: admin@mediushglobal.com.au

First published May 2026

LEGAL DISCLAIMER

This publication provides general information only and does not constitute professional medical, legal, financial or business advice. Readers should consult qualified professionals before making decisions about practice acquisition. The information is specific to the Australian healthcare system and current at the time of publication. Laws, regulations and market conditions may change and vary by state and territory. Every practice is unique. The author and publisher make no guarantees about results and disclaim liability for any loss or damage arising from use of this information.

COPYRIGHT

© 2026 iaso health Pty Ltd. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.

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 guide, at notebooklm.google.com.

ABOUT THE AUTHOR

Mark Donato

Mark Donato is a healthcare executive with over 30 years' experience in general practice sustainability, strategy and change management. His career includes CEO of RACGP Oxygen, General Manager of Membership and Marketing at the RACGP and leadership roles at Better Medical and Precedence Health Care. Mark specialises in primary healthcare solutions, practice growth strategies and innovation in general practice business models.

Introduction

GP practice acquisition in Australia is not a standard business purchase. The asset is not the building, the equipment or the patient list. It is the capacity of a group of doctors, working inside a particular structure, to generate billings consistently over time. Everything that affects that capacity, the workforce pipeline, the billing model, the governance arrangements, the practice manager, the owner's role, affects what the business is worth and whether it will hold its value after settlement.

This guide covers the areas I assess on every acquisition. It is not a financial modelling exercise. It is the work that should happen before you open the spreadsheet: understanding what holds the revenue together, what could take it apart and what the practice needs to look like three years after you buy it.

The regulatory environment has shifted materially since 2023. The Bulk Billing Practice Incentive Program has restructured the billing model question. Payroll tax positions have moved state by state. GP training has transferred to a college-led model. Each of these changes affects acquisition risk and post-acquisition economics. The guide reflects the position as at May 2026.

What this guide covers

Nine areas, in the order I work through them. Sections 1 through 5 deal with the structural questions that determine whether the earnings are durable: who generates the revenue, what systems hold the practice together, whether the practice manager will stay and is the right person, how governance and compliance are structured, and whether the practice can

replace doctors when it loses them. Section 6 covers the billing model, patient base and cost structure. Section 7 addresses owner dependency and transition risk. Section 8 identifies where post-acquisition upside typically sits. Section 9 is the test I apply to every deal: whether the earnings survive if nothing changes for three years.

Each section includes a 'Verify before offer' checklist where applicable. These are the specific items I would want answered before making an offer on any practice.

Contents

1. Doctor risk and revenue concentration	6
2. Clinical and practice management systems	8
3. The practice manager	9
4. Structure, governance and payroll tax	11
5. Workforce pipeline and GP recruitment	13
6. Billing model, patient base and cost structure	15
7. Owner dependency and transition	17
8. Growth levers and post-acquisition upside	18
9. Earnings durability	19

SECTION 1

Doctor risk and revenue concentration

Most people start with EBITDA. That is the wrong place to start.

EBITDA tells you what the practice earned last year. It does not tell you whether those earnings will repeat next year, or the year after that. The question for any buyer is whether the business can reliably generate earnings over the next three to five years, because that is what you are paying for. Historical profit is a data point. Future maintainable earnings are the asset.

Before you open the financials, you need to understand what holds the revenue together and what could take it apart.

Who generates the billings

A GP practice produces revenue from its doctors. That statement is obvious enough to be ignored, but it is the single most important variable in any acquisition.

I want to know who is generating the billings, what percentage of total revenue each doctor represents, how long they have been at the practice, whether they are contracted or informal, and what their age profile looks like. If two doctors generate 60% of the revenue and both are over 60 with no written service agreements, you do not have a business with a retention problem. You have a business where the majority of the asset can walk out the door with 30 days' notice or less.

The serviced office model that dominates Australian general practice makes this worse, not better. Under the standard facilities and services arrangement, doctors bill under their own provider numbers. Patients are

linked to their treating GP, not to the practice. If the doctor leaves, a proportion of those patients leave with them. The practice does not 'own' the patient base in any enforceable sense.

VERIFY BEFORE OFFER

- Number of billing GPs and revenue split by provider
- Current, signed facilities and services agreements for all GPs
- Notice periods and restraint clauses
- Age profile and stated intentions of key billers
- GP turnover history over the last three years

If the answer to any of those questions produces material uncertainty about future billings, the EBITDA figure in the information memorandum is not the number you should be modelling against. You should be modelling the earnings that survive if the risk materialises.

SECTION 2

Clinical and practice management systems

The clinical side of a practice is scrutinised: credentials, accreditation, patient outcomes. The systems that hold everything together rarely get the same level of rigour, and when they are inadequate, it shows up everywhere: billing errors, compliance gaps, staff frustration and eventually patient experience.

Practice management software, secure data storage, functional telehealth capability and reporting tools that produce usable billing and performance data are not optional items. They are the infrastructure that clinical and operational decisions depend on.

IT also carries regulatory weight. Privacy compliance, accreditation requirements and data sovereignty obligations do not go away because a practice is busy or under-resourced. The systems either support compliance or they create risk, and in a healthcare environment, that risk is both clinical and legal.

From a business standpoint, the practices that can scale (add a site, bring on a new doctor, take on a corporate contract without the wheels falling off) are the ones with solid underlying systems. IT problems left unaddressed compound, and they are almost always more expensive to fix later than they were to get right in the first place.

SECTION 3

The practice manager

Most buyers focus on the doctors. The practice or business manager deserves equal attention.

In a well-run clinic, the practice manager is often the person who keeps things moving: managing staff, handling operational details, maintaining supplier and referral relationships and dealing with the daily friction that does not show up in a financial report. They frequently carry institutional knowledge that exists nowhere else: why certain processes work the way they do, which staff dynamics need careful handling and where the problems sit. That knowledge does not transfer automatically when ownership changes.

Retention and transition risk

The first question is clear: will they stay? If the answer is no, you need to understand why and have a plan before settlement, not after. A departing practice manager in the first 90 days of ownership is a significant operational risk, particularly if the incoming owner is not yet embedded in the business.

If they are staying, assess whether they are the right person for the future, not just the present. A manager effective in the existing setup may not thrive in a more structured environment or under new ownership. Resistance to change or poor alignment with the incoming culture can be as disruptive as turnover.

Informal management arrangements

In many clinics, the previous owner and manager have developed an informal working arrangement over the years: undocumented, highly personalised and difficult to replicate. When that dynamic disappears,

gaps appear quickly. Governance, financial oversight, staff performance management and supplier relationships may all need to be formalised in ways they never were before.

The best outcome is a manager who understands the business deeply, is open to a new direction and sees the transition as an opportunity. That person is worth retaining at almost any reasonable cost. The alternative, recruiting into a business mid-transition while simultaneously trying to understand and stabilise operations, is a costly exercise that most buyers underestimate.

Assess the manager as carefully as you assess the doctors. In many practices, they carry just as much weight. The existence of a business plan, or at minimum a set of KPIs, should give the buyer some comfort and a foundation to work from.

Structure, governance and payroll tax

Decision-making and financial oversight

Governance is underrated in GP acquisitions. Most buyers focus on the numbers and the doctors. The structure underneath both determines whether you can actually operate the business once you own it.

You want to know how decisions are made. Is there a board, a partnership deed, a sole owner with clear authority, or an informal arrangement where nobody is sure who decides what? Is there meaningful financial reporting: monthly P&L, BAS reconciliation, billing reports by provider? Or does the owner check the bank balance and hope for the best? Are roles defined? If it is a multi-owner practice, what does the partnership deed or shareholders' agreement say about deadlock, exit and valuation on departure?

A practice with weak governance will absorb your first 12 months. You will spend that time building systems rather than running the business. That is not necessarily a deal-breaker if the price reflects it, but you need to know what you are buying: a business or a project.

Payroll tax exposure

The other governance risk that buyers consistently underestimate is payroll tax. Under the ATO's Practical Compliance Guideline PCG 2023/2, the classification of GPs as contractors or employees depends on the actual working relationship, not the label in the contract. Practices that exercise control over hours, bookings and service delivery may have payroll tax exposure they have never quantified.

The position varies by state and has moved significantly since the *Thomas and Naaz* decision in 2021.

State	Position (as at May 2026)
Queensland	Permanent exemption for GP contractor payments from 1 December 2024, with retrospective amnesty covering the previous five years (Revenue Legislation Amendment Bill 2024, passed 21 February 2025).
NSW	Practices where 80% or more of GP services are bulk billed are eligible for a payroll tax rebate on GP wages from 4 September 2024 (Revenue NSW, CPN 036v2). No amnesty for practices below threshold.
Victoria	Ex gratia exemption for contractor GPs ran to 30 June 2025. From 1 July 2025, exemption for wages on bulk-billed GP services proportional to practice bulk billing rate. Payroll tax threshold increased to \$1 million from 1 July 2025 (State Revenue Office Victoria).
South Australia	Amnesty for payments to contracted GPs to 30 June 2024. From 1 July 2024, bulk billing exemption proportional to practice bulk billing rate (RevenueSA, Payroll Tax Regulations 2025).

The pattern is clear: payroll tax relief is now linked to bulk billing in every mainland state except Queensland, where the exemption is unconditional. For a buyer, this creates a direct connection between the practice's billing model and its payroll tax exposure. A practice on BBPIP that bulk bills every patient will have minimal or no payroll tax liability on GP contractor payments in any state. A mixed-billing practice outside Queensland may carry significant exposure, depending on its bulk billing percentage and the state in which it operates.

VERIFY BEFORE OFFER

- Clear analysis of payroll tax position by state
- GP agreements that reflect actual working arrangements
- Bulk billing percentage (determines relief eligibility outside Queensland)

SECTION 5

Workforce pipeline and GP recruitment

Can the practice replace doctors when it loses them?

This is a question about the workforce pipeline. GP training transferred from the old Regional Training Organisations to a college-led model under the RACGP and ACRRM in February 2023. A practice that is accredited for training and takes registrars has a built-in renewal mechanism. A practice that fills gaps with locums or relies on recruitment agencies is a depreciating asset, regardless of what it earns today.

VERIFY BEFORE OFFER

- Training accreditation status (RACGP or ACRRM programs)
- Pathway doctors on s19AB or DPA restrictions
- Locum and recruitment spend over the last two years, and what triggered it
- Time taken to fill the last vacancy
- What the practice offers a GP considering where to work: location, facilities, billing model, patient mix, admin support, culture

The GP workforce shortage is structural. Full-time equivalent GPs per 100,000 population declined from 117 in 2019 to 113 in 2024, even as headcount grew (DoHAC Supply and Demand Study, August 2024). More GPs are working fewer hours. The government's own modelling projects a national shortage approaching 9,000 FTE GPs by 2048. Training positions were up 20% in 2025, with 1,504 junior doctors accepting places, but the pipeline takes years to produce a practising GP. International medical graduates still make up 32% of the workforce.

If the practice cannot articulate how it attracts and retains doctors, the buyer is inheriting that structural problem with no short-term fix.

SECTION 6

Billing model, patient base and cost structure

BBPIP and the billing model question

Once you have established that the doctors are likely to stay and the structure is workable, then look at the money.

The billing model is now the most consequential structural question in any GP acquisition. The federal government's Bulk Billing Practice Incentive Program (BBPIP), which started on 1 November 2025, pays participating practices an additional 12.5% on every dollar of MBS benefit for eligible services, split evenly between the GP and the practice.

The catch: participating practices must bulk bill every patient for every eligible service. No gap fees. The Cleanbill 2026 Blue Report found that 40.2% of clinics now fully bulk bill standard weekday adult consultations, up from 20.7% a year earlier. The government's stated target is for 90% of GP visits to be bulk billed by 2030, backed by \$7.9 billion in funding.

Two acquisition scenarios

A practice that has joined BBPIP is locked into universal bulk billing. Revenue depends on patient throughput and the 12.5% loading, split between the practice and the billing GP. There is no capacity to introduce gap fees without leaving the program. The upside is income certainty and reduced billing administration. The risk is volume-dependent: if patient numbers drop or GP hours contract, revenue falls with no pricing lever to offset the decline.

A practice that has not joined BBPIP may still charge gap fees. The Cleanbill 2026 data shows the average out-of-pocket cost at non-bulk-billing clinics has risen to \$49.23, up 13.5% from the previous year. These

practices can price to the market, but they and their doctors forgo the 12.5% loading and may face competitive pressure from nearby practices that bulk bill all patients.

Either model can work. Neither is inherently better. The question for a buyer is whether the billing model aligns with the practice's patient demographics, location, GP workforce and cost structure, and whether it is sustainable under current policy settings.

Patient base

How strong is patient demand? What are the wait times for new and existing patients? Is the patient base growing, stable or declining? Would patients stay if a doctor changed? In a serviced office model, continuity of care sits with the GP, not the practice. A practice with strong branding, good nursing support and efficient systems retains more patients through GP transitions than one where the doctor is the only reason people attend.

Cost structure

Staff wages as a percentage of billings are the single most telling metric. The benchmark is around 20% of total billings. Above 25% and you are carrying inefficiency. Below 15% and you are probably under-resourced.

Most practices carry margin improvement in admin and nursing utilisation, billing approaches (under-billing chronic disease management items, missed health assessments) and discretionary costs that accumulated under the previous owner. The question is whether the structure allows you to move those levers. An owner who has never measured these metrics and a team that has never been asked to change will not respond to a spreadsheet.

SECTION 7

Owner dependency and transition

If the seller is the highest biller, the sole decision-maker and the person every staff member and patient defers to, the business changes fundamentally when they leave, or even when they sell and stay. That is not automatically a deal-breaker. Sometimes it is a deal-maker: an overbearing owner whose departure allows the team to function is a genuine upside case. But it needs to be identified, priced and managed.

The best acquisitions I have seen involve an outgoing owner who stays for three years post-settlement, supports the clinical transition, gradually reduces their hours and has a financial interest tied to the practice's performance during the earn-out period. The worst involves an owner who wants a clean break within three months and has not told their staff or patients anything.

VERIFY BEFORE OFFER

- Percentage of total billings the owner generates personally
- Who makes operational decisions in the owner's absence
- Whether the practice manager has genuine authority or executes the owner's instructions
- New patient vs established patient ratios for owner vs non-owner GPs
- Proposed transition period, including whether the owner has financial interest post-settlement

If owner dependency is high and the transition period is short, discount accordingly. The stated EBITDA includes revenue that depends on a person who is leaving.

SECTION 8

Growth levers and post-acquisition upside

A practice that performs adequately today but has no clear growth pathway is not necessarily a good acquisition. You are buying risk without a return mechanism beyond the current margin.

In Australian general practice, upside typically sits in one or more of five areas:

- **Billing optimisation.** For BBPIP practices, this means maximising throughput and chronic disease management capture to drive volume through the 12.5% loading. For mixed-billing practices, it means reviewing fee schedules, improving health assessment capture and chronic disease management billing.
- **Utilisation.** Filling empty sessions, extending hours, adding weekend or after-hours capacity.
- **Diversified revenue.** Allied health tenancies, occupational health contracts, corporate health and pathology collection room income.
- **Workforce.** Adding registrars or pathway doctors who generate billings at a lower marginal cost than fully qualified GPs on high-percentage service fee arrangements.
- **Cost reduction.** Removing owner-specific costs, renegotiating vendor contracts, improving nursing utilisation.

If you cannot identify at least two concrete growth levers before you sign, you are paying for today's earnings and hoping nothing changes. In general practice, things always change.

SECTION 9

Earnings durability

The question I come back to on every acquisition: if nothing changed over the next three years (same doctors, same model, same structure, same costs) would this business still deliver the EBITDA it delivered last year?

If the answer is yes, you have a stable asset, and the multiple is defensible.

If the answer is no, because key doctors are ageing out, the billing model is under pressure, the lease is expiring, the workforce pipeline is empty, there is no history of recruiting new doctors, or the owner's departure will destabilise the team, then you are buying risk. The multiple should reflect that, and your post-acquisition plan needs to address it from day one.

Get clarity before negotiation starts

Encourage any practice you are looking at to complete the GP sale readiness assessment. It gives both parties a structured read of where the business sits: financial performance, operational risk, workforce stability and market positioning. Better to surface the gaps before negotiation than discover them during due diligence.

[Share the assessment](#)