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The Australian general practice landscape

Trends, challenges
and opportunities

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Trends, challenges and opportunities

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CONTRIBUTING EDITORS

The publisher and contributing editors developed the initial draft of this report, drawing together publicly available research, sector data, and strategic insights to identify key themes affecting Australian general practice. Expert contributors and reviewers provided input, critique, guidance and feedback at different stages of development. Their involvement has helped strengthen the report's relevance but does not imply endorsement of every statement, data point or recommendation in the final document.

SOURCES AND REFERENCES

References for all cited sources are maintained in Humphrey, Medius Global's curated online reference library for general practice. This keeps the report readable while giving readers a single live source list to interrogate by topic. Visit humphrey.fyi.

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This report was produced by Medius Global with input from a panel of contributing editors. They provided input, critique and review across drafts. Their involvement strengthens the report's relevance but does not imply endorsement of every statement or recommendation in the final document.

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METHOD

How this report was produced

The source material for this report spans legislation, MBS item documentation, Commonwealth departmental publications, ACCC and AHPRA decisions, peer-reviewed health economics literature, corporate filing data and trade press. Managing that volume across a single research project requires a structured approach.

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 material needing verification. Sources cited in the report are available through Humphrey, Medius Global's curated knowledge base for general practice (humphrey.fyi).

AI assistance does not change the verification requirement. Citation errors from AI research tools are common: wrong authors, invented references, conflated sources. Every factual claim, statutory reference and quantitative assertion in this report was checked against a named primary or authoritative secondary source before publication. Unverified claims were removed or qualified.

The practical reality is that a report of this scope, across this many policy and regulatory domains, would not be feasible as a small-practice project without AI agent assistance. The research architecture it enables does not lower the standard; it makes the standard achievable at a scale that would otherwise require a large research team.

Sources

The report draws on published data from the Australian Bureau of Statistics, Australian Institute of Health and Welfare, Department of Health, Disability and Ageing (including Medicare statistics, workforce data and the GP Supply and Demand Study), Medicare Benefits Schedule documentation, RACGP Health of the Nation reports and technology surveys, and BEACH program reports.

Industry benchmarking data comes from the Prosperity Health GP Industry Benchmark Reports, Cubiko's Touchstone General Practice Industry Report, the CommBank GP Insights Report 2024, the CommBank Patient Experience Insights Report 2024, the NAB Health Insights Reports (2024-25 and 2025-26) and the ANZ-Melbourne Institute Health Sector Report.

Additional sources include the General Practitioner Workforce Report (Cornerstone Health and Deloitte), HotDoc surveys, MABEL (Medicine in Australia: Balancing Employment and Life) longitudinal research, Medical Deans Australia and New Zealand data, the Medical Journal of Australia, Cleanbill data (as quoted in key publications) and various government services reports.

This report does not use traditional footnotes or a bibliography. References for all cited data points are extracted into Ask Humphrey ([humphrey.fyi](https://www.humphrey.fyi)), Medius Global's curated knowledge base for general practice. Each source is decomposed into discrete factual claims, tagged by domain and date, and linked to the original publication. Readers can interrogate the underlying evidence by topic rather than scanning a flat reference list. The knowledge base is maintained as sources are updated or superseded, so the reference layer stays current after the report itself is published. The trade-off is that readers accustomed to numbered endnotes will need to use the knowledge base to trace a specific claim. We consider that a reasonable exchange for a reference system that remains live and searchable.

Corporate and group operator dataset

This report includes original research on corporate and group ownership of general practice in Australia. No public dataset tracks group operator activity at this level of detail. Government data counts practices and GPs but does not map ownership structures, operator footprints or site-level affiliation.

The dataset is compiled and maintained by Medius Global, current to 19 May 2026. It covers 234 operators managing 1,706 practice sites.

An operator is included if it manages two or more general practice sites under a common ownership or management structure. The dataset covers ASX-listed health companies, private-equity-backed and insurer-owned groups, franchised models and privately held multi-site groups. It does not include independent solo practices, urgent care centres, Aboriginal Community Controlled Health Organisations or state-operated community health centres.

Construction followed a three-stage process. First, AI research tools (Claude Cowork) were used to identify operators from corporate filings, ACCC decisions, trade press, operator websites and booking platforms (HotDoc, HealthEngine, AutoMed Systems). This produced the initial long list of operators and site counts. Second, each operator record was manually verified against public sources: website listings, AHPRA provider directories, regulator filings and, where available, direct confirmation. GP counts reflect unique individuals identified per operator after de-duplication of multi-site practitioners within each group. Third, disputed or ambiguous entries were flagged and either resolved against a second source or marked as estimates.

AI tools were used for collection and cross-referencing at scale. They were not used to generate figures. Every operator count, site count and GP headcount traces to a named public source. The dataset has not been independently audited. Corrections and updated figures from operators are welcome at admin@mediusglobal.com.au.

National benchmarks for comparison (7,135 to 7,500 practice sites, approximately 40,375 GPs) are from the Australian Institute of Health and Welfare and the Department of Health and Aged Care.

The Australian general practice landscape

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Sector snapshot

Market size: Total health expenditure reached \$270.5 billion in 2023–24, representing 10.1% of GDP. Unreferred medical services (primarily general practice) accounted for \$14.6 billion, with Australian Government funding of \$11.5 billion. Primary health care accounted for \$89.1 billion, or 33% of total health spending.

\$270.5bn total health expenditure 2023–24, 10.1% of GDP

\$89.1bn primary health care, 33% of total health spending

Revenue structure: Most general practice revenue is derived from Medicare rebates, paid either directly to the practice (bulk billing) or to the patient as a rebate against a higher fee (mixed or private billing). Practices do not receive direct government funding beyond several small incentive programs (PIP, WIP). The introduction of the BBPIP in November 2025, with a 12.5% loading on MBS fees for practices meeting a 100% bulk billing threshold for eligible items, has sharpened the structural choice between full bulk billing and mixed billing models.

Patient utilisation: Over 81.4% of consultations were bulk billed in the period November 2025 to January 2026 (NRA), up 4.3 percentage points year-on-year following the introduction of the Bulk Billing Practice Incentive Program (BBPIP) on 1 November 2025.

81.4% bulk billed Nov 2025 – Jan 2026, up 4.3pp year-on-year

Workforce: The GP workforce comprises 40,375 practitioners, of whom 80.7% are vocationally registered, 4.0% are non-vocationally registered, and 15.4% are in training. One in three practising GPs intends to stop practising within five years, with the impact concentrated in regional and remote areas where replacement pipelines are weakest.

Practice ownership: Corporate and group operators now control approximately 23% of general practice sites nationally, across 234 identified operators managing 1,706 sites. Consolidation continues, driven by practice owners exiting at or near retirement, rising compliance burden and the capital requirements of modern practice infrastructure. Average practice size has grown as smaller practices merge or are acquired. See Section 13.2 'Who owns the practice is changing' in this report for more information.

~23% of practice sites under corporate/group ownership

Key trends and challenges

Workforce shortages: Workforce shortages affect urban and rural settings differently. In rural and remote areas, smaller practices dominate, economies of scale are harder to achieve, and the higher bulk billing rates constrain revenue. Covering leave is a persistent operational risk where a practice has one or two GPs. Urban areas face rising demand from complex, time-intensive consultations, particularly in residential aged care and among socio-economically disadvantaged populations. Multimorbidity is increasing across the GP caseload as the population ages, compressing consultation times and reducing throughput.

Growth in niche markets: Cosmetic procedures, skin cancer medicine, women's health and wellness-focused services have expanded as discrete revenue lines. These markets benefit from patient willingness to pay out of pocket, lower regulatory burden relative to core general practice, and growing consumer demand. They also illustrate that practices can diversify beyond Medicare fee-for-service where the clinical capability and catchment demographics support it.

Defining and delivering quality care: Rising operational costs (rent, labour, compliance) create pressure to prioritise throughput over complexity. This can divert clinical time away from chronic disease management and mental health, where patient needs are most resource intensive. Wellness clinics operate with lower overheads and narrower scope, making them more financially sustainable, but they do not substitute for the GP's role in managing multimorbidity, medication review and coordinated care. Reducing non-clinical operational costs and redirecting resources toward high-acuity work remains the structural challenge.

Adapting to technological and regulatory change: Telehealth accounted for approximately 20% of Medicare-funded GP services in 2022-23. Broader digital health integration faces uneven access to infrastructure, outdated regulatory frameworks and the cost of implementation for practices already operating on constrained margins. Practice management system upgrades, clinical decision support tools and interoperability with My Health Record all require capital and training that many practices cannot fund from current revenue sources.

Managing the increasing complexity of care: An ageing population, rising multimorbidity and growing mental health demand are increasing the clinical complexity of general practice caseloads. General practices bridge gaps when acute care and specialist services reach capacity or are unavailable. Voluntary assisted dying (VAD) accounted for approximately 1.8% of all deaths nationally in 2024-25 (3,329 deaths across all jurisdictions), with the rate varying from under 1% in Victoria to over 1.5% in South Australia. Closure of palliative care facilities in some areas has shifted additional end-of-life workload onto GPs. Mental health and preventive care are areas of growing GP involvement, presenting both clinical demand and potential revenue diversification where funding models support it.

Opportunities for stakeholders

Telehealth and digital solutions: Telehealth infrastructure is established but underutilised beyond telephone consultations. Video consultation uptake remains low (under 5% of telehealth services). Scaling virtual care has the most immediate impact in areas with GP shortages, where it extends the reach of existing practitioners rather than replacing face-to-face care. The investment case is strongest for practices that can integrate telehealth with existing practice management systems and chronic disease monitoring.

Value-based care models: Integrated, multidisciplinary models are a structural response to rising multimorbidity. Patients with multiple chronic conditions require coordinated input from GPs, allied health, nursing and specialist services. Practices that co-locate or formally coordinate these services capture more of the care episode and reduce leakage to hospital outpatient departments. Funding remains the constraint: Medicare fee-for-service does not reward coordination time, and the Practice Incentives Program payments are too small to underwrite genuine team-based care.

Allied health integration and networked models: Co-located GP and allied health practices are well established in larger group practices and health precincts. Networked models, where independently owned practices share referral platforms and coordinated care plans without merging ownership, exist in pilot form (including PHN-funded shared care planning platforms in Western NSW and Adelaide) but are not yet widespread. The constraint is interoperability: most practice management systems do not communicate across disciplines without middleware, and Medicare billing rules do not incentivise coordination between providers beyond the limited Team Care Arrangement framework (replaced by GPCCMP items from 1 July 2025).

Corporate investment: Consolidation continues to concentrate ownership among fewer, larger operators. The acquisition case rests on economies of scale in procurement, compliance, workforce recruitment and back-office functions. For investors, the risks lie in GP retention post-acquisition and in the regulatory

environment around contractor versus employee classification. Practices that are acquired for scale efficiencies can lose revenue if experienced GPs leave and are replaced by less established practitioners with smaller patient followings.

Workforce development: Training pipeline expansion, bonded rural placements and improved remuneration structures for regional and remote practice are the levers available. One in three GPs intending to stop practising within five years makes retention as important as recruitment. Retention interventions that reduce administrative burden, improve locum access for leave cover and support flexible working arrangements have more immediate impact than training pipeline measures, which can take up to 10-12 years to produce a practising GP.

Investment parameters: The areas with the clearest return on investment are practice management technology (operational efficiency), workforce retention programs (protecting revenue-generating capacity), chronic disease management capability (growing patient demand) and revenue diversification beyond Medicare (subscription models, employer contracts, medico-legal work). Each requires different capital profiles and operating capabilities.

Funding model and structural trajectory

Medicare fee-for-service rewards consultation volume, not complexity. This misalignment is structural and has been for over a decade. Blended payment models (capitation combined with pay-for-performance, fee-for-service, and outcome payments) are under active policy discussion, but no legislation or funding commitment exists as of June 2026. If implemented, blended models may reduce revenue for high-throughput, short-consultation practices and increase it for practices managing chronic disease, mental health and multimorbidity over longer appointments.

Medicare fee-for-service rewards consultation volume, not complexity. This misalignment is structural and has been for over a decade.

The BBPIP has sharpened the bulk billing decision for practice owners but has not resolved the underlying funding gap. Practices that converted to full bulk billing to capture the 12.5% loading have potentially locked in lower per-consultation revenue in exchange for volume certainty. Practices that retain mixed billing forgo the loading but preserve fee flexibility. Neither model addresses the cost of delivering comprehensive primary care to an ageing population with a rising chronic disease burden.

Three areas will determine the sector's trajectory over the next five years: workforce supply (whether the one in three planning to exit do leave, and whether training pipeline expansion can offset losses) funding model reform (whether blended payments move beyond discussion into implementation), and ownership structure (whether consolidation improves operational efficiency or transfers margin from GPs to corporate operators without improving access or clinical outcomes).

Three areas will determine the sector's trajectory over the next five years: workforce supply, funding model reform, and ownership structure.

Practices that have diversified revenue beyond Medicare, invested in allied health integration, and built operational systems that reduce the administrative burden on clinicians are better positioned, regardless of which policy direction prevails. Practices that remain dependent on higher-volume, shorter consultations funded entirely through MBS rebates face the greatest exposure to structural reform and fee indexation risks.

SECTION 1

Introduction

Australian general practice delivers over 172 million consultations per year and is the primary point of entry for most patients into the health system. The sector accounts for approximately \$14.6 billion in unreferred medical services expenditure and employs a workforce of 40,375 practitioners across approximately 7,135 accredited practices.

The operating environment has shifted materially since the previous edition of this report. The BBPIP, introduced in November 2025, has reversed a multi-year decline in bulk billing rates and forced practice owners to choose between full bulk billing and mixed billing models.

Corporate and group operators now control approximately 22% of practice sites nationally.

32% of practising GPs plan to cease practice within five years, with the impact concentrated in regional and remote areas. The GP workforce is increasingly part-time, female and reliant on international medical graduates, all of which affect workforce capacity calculations that were built around a full-time, predominantly male workforce model.

This report covers market structure and ownership, workforce profile and demographics, financial performance, regulatory environment, technology, patient access, emerging business models and revenue diversification, barriers to entry, future projections and international comparisons. Data is current to June 2026 unless otherwise noted. Sources, methodology and verification status are documented in the relevant sections.

SECTION 2

Market overview and practice structure

2.1 Scoping market size

Definition of the primary healthcare industry in Australia

Primary healthcare in Australia encompasses services that are typically the first point of contact for patients. These include general practice clinics, community health centres, allied health services (physiotherapy, dietetics, psychology), pharmacies, dental services, Aboriginal community-controlled health services, nurse-led clinics, urgent care centres and after-hours GP services.

This report focuses specifically on general practice: accredited practices delivering non-referred medical services billed through the MBS, including both traditional and corporate-owned models. Allied health, pharmacy, dental and community health are excluded except where they intersect with general practice ownership, co-location or revenue structures.

Defining the general practice landscape

The general practice landscape covers primary care services delivered by GPs across the following practice settings:

- **Solo GP practices:** practices with a single GP.
- **Group GP practices:** practices owned and operated by GPs or other independent owners, not affiliated with major investment groups or publicly listed companies.
- **Corporate-owned medical centres:** practices owned by corporate entities, investment groups or publicly listed companies.
- **Aboriginal Community Controlled Health Services:** incorporated Aboriginal organisations initiated by and based in a local Aboriginal community, delivering holistic and culturally appropriate health services.
- **GP services in specialised settings:** services delivered within community health centres, schools, correctional facilities, residential aged care facilities and specialised environments such as the Australian Defence Forces.

Scope of the general practice landscape

GP workforce: Approximately 7,135 accredited general practices and 40,375 GPs. 29,976 full-time equivalent GPs. 80.7% vocationally registered, 4% non-vocationally registered, 15.4% in training. 48.1% female. 41.4% trained overseas. These are distinct registration categories with different MBS access and provider number arrangements.

Patient consultations: Over 22 million Australians visited a GP in 2023, receiving an average of 7.6 services per patient per year and generating over 172 million services nationally. By 2023–24, 84% of Australians had at least one Medicare-subsidised GP attendance, down from higher levels during the COVID-19 period.

Economic value: Australian Government funding for unreferral medical services (primarily general practice) was \$11.5 billion in 2023–24. Patient out-of-pocket costs for GP services more than doubled from \$780 million in 2021–22 to \$1.66 billion in

2023–24, reflecting the shift from bulk billing to mixed and private billing over that period. The BBPIP, introduced November 2025, has since reversed some of this trend.

\$780m to \$1.66bn patient out-of-pocket costs doubled between 2022–2024

2.2 Industry size and growth

Total health expenditure reached \$270.5 billion in 2023–24, representing 10.1% of GDP. Australian Government funding for unreferral medical services (primarily general practice) was \$11.5 billion. Patient out-of-pocket costs for GP services reached \$1.66 billion in 2023–24, more than double the \$780 million recorded in 2021–22, before the BBPIP reversed some of the shift away from bulk billing from November 2025. General practice accounts for a relatively small share of total health expenditure, despite delivering over 172 million services per year and being the first point of clinical contact for most patients.

— Drivers of growth

Ageing population: 17.7% of Australians are now aged 65 and over (ABS 2024), projected to reach 20.7% by 2066. Older patients account for a disproportionate share of GP consultations and are more likely to present with multimorbidity requiring longer appointments, chronic disease management plans and coordination across multiple providers. Diabetes, cardiovascular disease, arthritis and dementia are the primary drivers of rising consultation complexity.

Government initiatives: The BBPIP (November 2025) is the most significant recent intervention, creating a 12.5% MBS loading for practices meeting universal bulk billing requirements. Earlier measures include expanding permanent telehealth MBS items and the Workforce Incentive Program, targeting rural and regional GP recruitment. The GP Chronic Condition Management Plan (GPCCMP), which replaced GPMPs and TCAs from 1 July 2025, restructures chronic disease billing and focuses on comprehensive care management plans.

Technological change: Practice management systems, clinical decision support, AI-assisted clinical documentation and telehealth infrastructure are becoming operational requirements rather than optional investments. The constraint is the

cost of adoption for practices already operating on tight margins, particularly smaller independent practices without access to group purchasing or shared IT infrastructure.

— Challenges

Uneven GP distribution: Regional centres (MM2-MM3) have GP density closer to metropolitan levels but compete with metropolitan areas for graduating GPs. Remote and very remote areas (MM5-MM7) face absolute shortages, with GP densities below 82 per 100,000 population, heavy reliance on IMGs, locum cover and state-funded positions. The distinction matters for workforce policy: regional recruitment is a competition problem, remote recruitment is a supply problem.

Reliance on overseas-trained doctors: 41.4% of the GP workforce is trained overseas (AIHW 2024). IMGs are concentrated in rural, remote and outer-metropolitan areas where locally trained graduates are least likely to settle. Accreditation pathways, visa conditions and supervision requirements create a lag between an IMG arriving in Australia and practising independently. Any disruption to IMG supply (visa policy changes, competing demand from other countries) would have an immediate impact on service delivery in areas with the highest dependence on IMGs.

Funding model transition: The BBPIP has reversed the multi-year decline in bulk billing rates, with the national rate rising to 81.4% by January 2026. However, the structural tension remains: practices that fully bulk bill receive the 12.5% loading but forgo private fee revenue, while mixed-billing practices retain fee flexibility but lose the loading entirely. Average patient out-of-pocket contributions rose 9.6% year-on-year to \$50.77 in the six months to December 2025 (DoHAC), up from \$46.31 in the prior corresponding period.

2.3 Group ownership

The 234 operators in the dataset manage a combined 1,706 practice sites and approximately 11,900 unique GPs.

Against national benchmarks of 7,135–7,500 general practice locations and approximately 40,375 GPs, the corporate segment accounts for 22.7–23.9% of practice sites and 29% of the GP workforce.

These figures are approximate. The national practice count varies by source and definition; the GP workforce figure reflects headcount rather than full-time equivalent. But the order of magnitude is clear: roughly one in four practice sites and approaching three in ten GPs sit within a corporate or group structure.

The order of magnitude is clear: roughly one in four practice sites and approaching three in ten GPs sit within a corporate or group structure.

The average operator manages 7.3 sites. The median is 3. The average practice site within a corporate group employs 7 GPs.

2.4 Operator size distribution

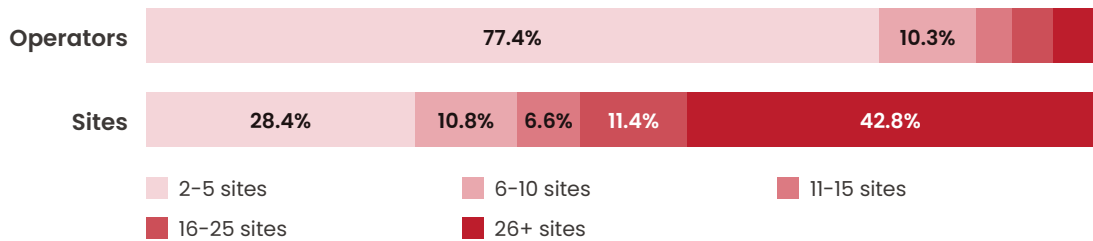
The 234 operators are distributed unevenly across size bands. The bulk of operators are small; a handful are large.

Operator size distribution by band

Size band	Operators	Sites	GPs	Share of operators	Share of sites
2-5 sites	181	484	2,966	77.4%	28.4%
6-10 sites	24	184	1,111	10.3%	10.8%
11-15 sites	9	113	724	3.8%	6.6%
16-25 sites	10	195	1,113	4.3%	11.4%
26+ sites	10	730	5,986	4.3%	42.8%

The 2-5 site band accounts for 181 of 234 operators (77.4%) but only 28.4% of total sites. At the other end, 10 operators with 26 or more sites hold 730 sites, which is 42.8% of the corporate footprint. Three operators exceed 100 sites.

Operator size bands: composition of operators vs composition of sites



Source: Medius Global analysis of operator disclosures, June 2026

The distribution is consistent with a market where entry at small scale is straightforward (a GP principal incorporating a second or third practice) but scaling beyond 25 sites requires capital, management infrastructure and workforce access that most operators lack.

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2.5 Largest operators

Rankings differ depending on whether the measure is site count or GP headcount. Both views are useful: site count reflects management footprint, while GP count reflects workforce reach and billing capacity.

— By site count

Top operators by site count

Rank	Operator	Sites	GPs	Avg GPs/site	Lead state
1	IPN (Sonic Healthcare)	143	1,402	9.8	NSW
2	Amplar Health - Myhealth	112	910	8.1	NSW
3	Family Doctor	109	728	6.7	VIC
4	ForHealth - Medical Centres	84	1,074	12.8	NSW
5	Ochre Health	66	208	3.2	NSW
6	Amplar Health - Better Medical	58	441	7.6	QLD
7	Partnered Health	57	481	8.4	VIC
8	Qualitas Health	40	300	7.5	VIC
9	Jupiter Health	35	196	5.6	WA
10	Brecken Health	26	246	9.5	WA

Amplar Health, a subsidiary of Medibank Private, operates two practice brands: Myhealth (112 sites) and Better Medical (58 sites). On a parent-company basis, Amplar manages 170 sites and 1,351 GPs, making it the largest single entity in Australian corporate general practice. IPN, owned by Sonic Healthcare, operates 143 sites under a consolidated national brand.

Family Doctor (109 sites) and ForHealth - Medical Centres (84 sites) round out the top four. Ochre Health ranks fifth by sites (66) but tenth by GP count (208), reflecting its focus on smaller regional and rural practices with an average of 3.2

GPs per site.

— **By GP count**

The GP count ranking diverges from the site ranking in several places. ForHealth - Medical Centres, fourth by sites (84), ranks second by GPs (1,074), with an average of 12.8 GPs per site, the highest among the top 10. This reflects a portfolio weighted toward large, high-throughput metropolitan practices.

Partnered Health (57 sites, 481 GPs) outranks Ochre Health (66 sites, 208 GPs) on GP count despite having fewer sites. Similarly, Brecken Health (26 sites, 246 GPs, 9.5 average) has more GPs than Jupiter Health (35 sites, 196 GPs, 5.6 average).

The divergence is notable. An operator with fewer sites but more GPs per site generates higher aggregate Medicare billings and has a different operational profile: more complex rostering, greater revenue exposure to individual practitioner retention, and typically stronger mixed-billing revenue.

2.6 Geographic distribution

Corporate practice sites are distributed across all states and territories. The Northern Territory has the smallest footprint, with 8 sites across 2 operators.

Geographic distribution of corporate sites

State	Sites	Share	Operators	Top operator	Top operator sites
NSW	444	26.0%	78	Amplar Health - Myhealth	57
VIC	432	25.3%	86	Family Doctor	52
QLD	418	24.5%	70	Family Doctor	32
WA	224	13.1%	23	Jupiter Health	35
SA	98	5.7%	28	Amplar Health - Better Medical	15
TAS	52	3.0%	11	Ochre Health	19
ACT	30	1.8%	10	Ochre Health	7
NT	8	0.5%	2	Radiant Doctors Group	6

New South Wales, Victoria and Queensland each host roughly a quarter of corporate sites. Western Australia accounts for 13.1% of sites across 23 operators, giving it the highest relative density at 9.7 sites per operator. This reflects the dominance of a few mid-to-large WA-based groups: Jupiter Health (35 sites), Spectrum Health (25 sites) and Brecken Health (26 sites) account for around 38% of WA's corporate sites between them.

The ACT has 30 corporate sites across 10 operators (3.0 sites per operator). South Australia has 98 sites across 28 operators, with Amplar Health - Better Medical (15 sites) and Pro Health Care (13 sites) the largest.

Tasmania's corporate footprint is small (52 sites, 11 operators), but is dominated by large multi-state groups: Ochre Health (19 sites), IPN (6 sites), and Amplar Health - Better Medical (6 sites) together account for nearly 60% of the state's corporate

practice sites.

— **Multi-state and single-state operators**

Thirty-five of the 234 operators run sites in more than one state or territory. These multi-state operators average 26 sites each. The remaining 199 single-state operators average 4 sites each.

All operators in the top 10 by site count are multi-state, except for Jupiter Health (WA only). Spectrum Health (WA only) ranks 11th. Multi-state reach is a function of scale: it requires management systems, compliance infrastructure and recruitment pipelines that work across jurisdictions.

2.7 Group footprint concentration

Concentration in the corporate segment is moderate at operator level and slightly higher when parent-company structures are considered.

Site concentration ratios

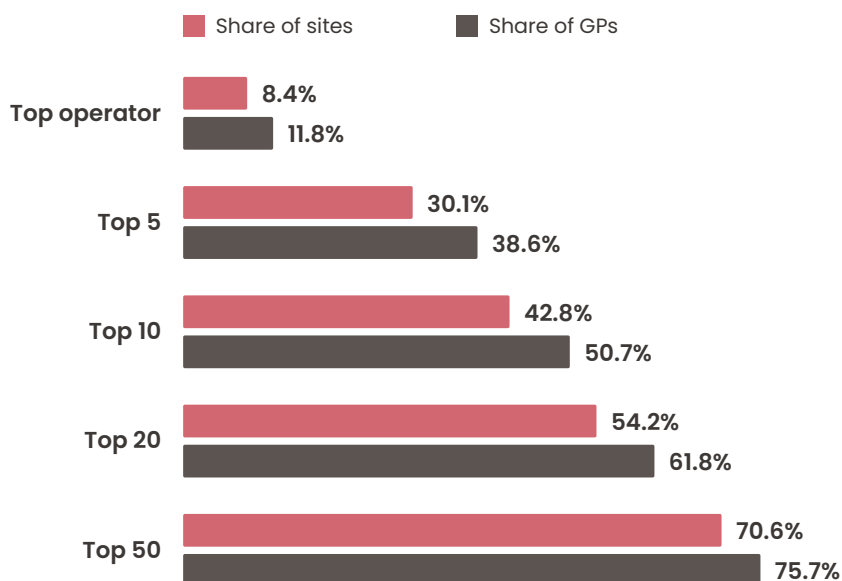
Measure	Share of sites
Top operator	8.4%
Top 5 operators	30.1%
Top 10 operators	42.8%
Top 20 operators	54.2%
Top 50 operators	70.6%

GP concentration ratios

Measure	Share of GPs
Top operator	11.8%
Top 5 operators	38.6%
Top 10 operators	50.7%
Top 20 operators	61.8%
Top 50 operators	75.7%

GP concentration is higher than site concentration at every tier because the largest operators tend to run larger, GP-dense practices.

Operator market concentration: share of sites and GPs



Source: Medius Global analysis of corporate operator disclosures, 2025

No single entity controls more than 10.0% of corporate sites (Ampliar Health at 170 of 1,706). Even combining the top two parent companies (Ampliar and Sonic Healthcare), the figure is 18.3% of the corporate segment, or roughly 4.2% of all national practice sites.

For context, concentration in the corporate GP segment is substantially lower than in comparable health sectors. In pathology, three operators hold over 85% of the market. In diagnostic imaging, two operators account for approximately 50%. General practice remains fragmented, a product of its history as a profession of small independent practices.

In pathology, three operators hold over 85% of the market. In diagnostic imaging, two operators account for approximately 50%. General practice remains fragmented.

2.8 Expansion and consolidation dynamics

Acquisition activity in the corporate general practice sector is ongoing but has changed character since 2022. The period from 2018 to 2022 saw aggressive site accumulation by several operators, some backed by private equity or insurer

capital. Since 2023, the emphasis has shifted toward operational consolidation, improving margins, retention and clinical systems within existing portfolios, rather than continued expansion at pace.

— Where acquisition targets sit

The dataset identifies 199 single-state operators, the majority of which fall in the 2–5 site band. These operators are the natural acquisition pool for larger groups seeking to grow. They are typically owner-managed, often by a GP principal approaching retirement, and lack the administrative scale to manage increasing compliance and workforce demands independently.

New South Wales has 54 small-group operators (2–5 sites) holding 145 sites with 811 GPs. Victoria has 57 small groups with 156 sites and 1,063 GPs. Queensland has 45 small groups with 131 sites and 768 GPs.

Western Australia presents a different profile: 9 small-group operators alongside 5 WA-based larger operators (Jupiter Health, Brecken Health, Spectrum Health, GP West and Livingston Medical), reflecting earlier consolidation by WA-based groups. South Australia has 20 small groups but no mid-size (6–9 site) operators, leaving a gap between the small independents and the large multi-state groups that dominate the state.

— Drivers of continued acquisitions

GP principal retirement remains the primary driver. The average age of a practice-owning GP is over 55, and many are approaching the point where selling is preferable to managing succession. Regulatory and compliance burdens favour operators with dedicated administrative capacity. Workforce access in Distribution Priority Areas (DPA), where corporate operators can recruit international medical graduates more readily than solo practitioners, adds a structural advantage. The 2026 budget may impact these decisions.

— Structural constraints on consolidation

Several features of the Australian market limit the pace and extent of consolidation:

GP contractor model. Most GPs contract the practice to provide premises, staff and administrative infrastructure in return for a service fee on billings. The GP generates the revenue; the practice provides the platform. A GP can move to another

practice with limited notice, taking their patient relationships and Medicare billings with them. This makes practice goodwill less durable than in other professional services.

Medicare fee schedule. The universal fee schedule limits revenue upside. Margin improvement depends on volume, mixed billing and non-MBS revenue streams rather than pricing power.

Workforce shortage. The national GP shortage means acquired practices can lose doctors to competitors, making retention the primary operational challenge after an acquisition.

Professional sentiment. The AMA, RACGP and sections of the medical profession remain sceptical of corporate ownership. This constrains expansion strategies that depend on GP goodwill for recruitment.

— Outlook

The corporate share of general practice is likely to continue growing incrementally as GP retirements create forced succession events and smaller operators seek acquisition. The rate of growth depends on workforce availability, Medicare indexation and whether government policy creates new incentives or constraints for corporate operators.

The current structure, where there are 234 operators, heavily fragmented, with no single entity controlling more than 10% of corporate sites, suggests the sector will remain pluralistic for the foreseeable future. Whether any operator can build a national platform at scale, or whether the sector settles into a pattern of regional consolidation around a handful of mid-size groups, remains an open question.

Whether any operator can build a national platform at scale, or whether the sector settles into a pattern of regional clusters with no single dominant national player, is the open question.

2.9 Sell-side positioning

The dataset includes a sell-side positioning analysis for all 234 operators, assessing each operator's percentile rank by sites and GPs, the number of larger operators in the same geography, and the count of potential acquirers.

The operators most likely to attract acquisition interest are mid-size single-state groups: large enough to offer a meaningful site portfolio but small enough that a larger operator can absorb them without antitrust concern. Groups in the 6-25 site range, concentrated in a single state, with above-average GP density, fit this profile.

— State-level patterns

Western Australia has the most concentrated sell-side dynamic. Spectrum Health (25 sites), GP West (17 sites) and Livingston Medical (17 sites) are single-state operators in a market dominated by Jupiter Health and Brecken Health. Any of these groups, if brought to market, would attract interest from both existing WA operators and multi-state groups seeking a WA footprint.

In Victoria, TLC Healthcare (11 sites), SIA Medical (9 sites, 109 GPs, 12.1 average) and Medical Hub Group (7 sites, 83 GPs, 11.9 average) are single-state operators with high GP density. Southern Cross GP (19 sites) offers a different profile: a larger site count but lower GP density (2.1 average), suggesting a portfolio of smaller practices.

New South Wales sell-side candidates include Nuvo Health (19 sites, 158 GPs), TeamMed (13 sites, 89 GPs) and Providence Medical (9 sites, 75 GPs). Queensland has Medicross (19 sites), Ausdocs Group (17 sites) and Top Health Doctors (9 sites).

South Australia's sell-side pool is limited. Pro Health Care (13 sites, 114 GPs) is the standout single-state operator, but few others in the state have more than 5 sites.

— Buyer depth

The number of potential acquirers varies by state. Operators in the eastern seaboard states (NSW, VIC, QLD) face a larger pool of potential buyers. The sell-side analysis identifies 20 to 50+ larger operators in the same geography for most

mid-size groups. Western Australian operators face a shallower pool of potential buyers (7-14), but fewer alternatives may support stronger pricing for sellers.

SECTION 3

Workforce profile

IN BRIEF

- GP workforce of 40,375 grew 2.3% in 2024 but FTE capacity is rising more slowly than headcount.
- Nearly half the workforce is now aged 55 or older; the 65+ group has grown from 14% to 18% in six years.
- Female GPs outnumber male GPs by headcount but male GPs deliver more FTE clinical hours on average.
- One in three GPs intends to stop practising within five years; replacement pipelines are weakest in rural and remote areas.

In 2024, Australia's primary care workforce comprised 40,375 GPs, up from 39,449 in 2023. Of these, 32,557 were vocationally registered (VR), 1,618 were non-vocationally registered, and 6,200 were in training. The total number of full-time equivalent GPs rose to 29,976, reversing a downward trend in FTEs that had been in place since 2022. National GP density increased to 113 FTE GPs per 100,000 population, up from 110 in 2023.

The headline numbers obscure a structural problem. Headcount grows each year, but FTE capacity has not kept pace. In 2023, FTEs accounted for 74% of total headcount, down from 77% in 2018. More GPs work part-time, more hold portfolio careers across clinical, teaching and administrative roles, and more female GPs entering the workforce work fewer clinical hours than the cohort they replace. For practice owners, headcount tells you how many GPs are on your books. FTE tells you how many patients you can see.

Headcount grows each year but FTE capacity has not kept pace.

3.1 Workforce composition

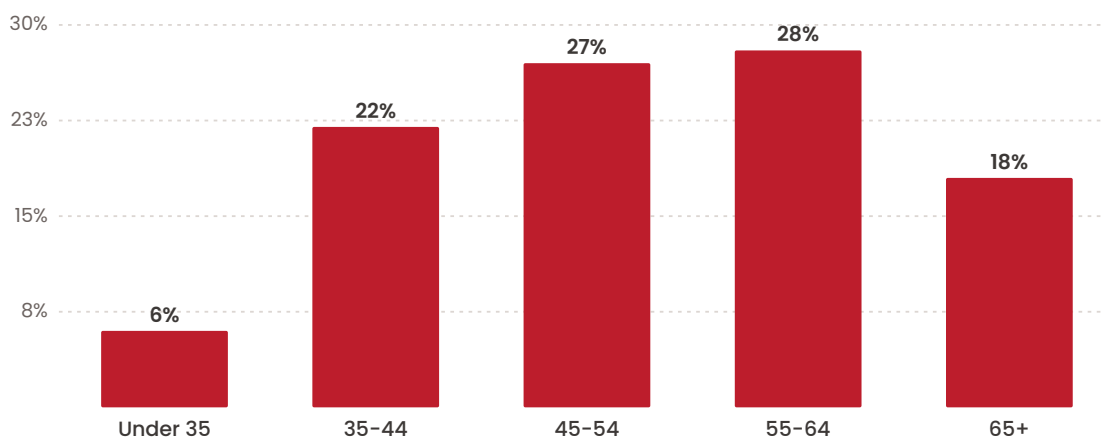
Registration and training status:

- Vocationally registered GPs (VR): 32,557
- Non-vocationally registered GPs (non-VR): 1,618
- GPs in training: 6,200

Gender: Female GPs now outnumber male GPs by headcount. Growth among female GPs has consistently outpaced that of male GPs over the past five years. However, male GPs constitute a larger share of the workforce by FTE, reflecting higher average clinical hours among male practitioners.

Age: The workforce is ageing. The 55-64 age group is now the largest single cohort at 28%, followed by 45-54 (27%), 35-44 (22%), 65 and over (18%) and under 35 (6%). Nearly half the workforce is aged 55 or older. The 65-plus group has grown from 14% in 2018 to 18% in 2024.

GP workforce by age band



Source: AIHW Medical workforce 2024

Qualifications: 58% of GPs earned their initial medical degree in Australia. The remainder are international medical graduates (IMGs), concentrated in rural and regional areas where they fill workforce gaps that domestic graduates do not.

Workload: GPs work an average of 36 hours per week across clinical and non-clinical duties.

3.2 GP shortfall projections

The Department of Health and Aged Care's supply and demand modelling projects a shortfall of approximately 5,560 FTE GPs by 2033 (7,700 by headcount). If current trends hold, that gap widens to 8,908 FTE by 2048 (12,400 by headcount). Demand growth outpaces FTE supply under most scenarios modelled to 2040. Absolute shortfalls are projected to emerge in major metropolitan areas by 2040, but access remains worst in rural and remote regions where retention post-fellowship is the binding constraint.

5,560 FTE GP shortfall by 2033 (7,700 by headcount)

3.3 Geographic distribution

Around 74% of GPs are based in metropolitan areas (MM1). Rural and remote locations have seen minimal growth.

The modified Monash model (MMM) classifies regions from MM1 (metropolitan) to MM7 (very remote). GP density by MMM classification:

Metropolitan areas (MM1): 116 GPs per 100,000 population. Highest GP density, highest concentration of infrastructure and the highest concentration of specialist referral options.

Regional centres (MM2): 115 per 100,000.

Large rural towns (MM3): 106 per 100,000.

Medium rural towns (MM4): 127 per 100,000. The elevated figure likely reflects targeted incentive programs and service clustering.

Small rural towns (MM5): 106 per 100,000. Retention drops in smaller, less populated areas.

Remote communities (MM6): 68 per 100,000.

Very remote communities (MM7): 82 per 100,000. Just 147 GPs nationally operated in MM7 areas in 2023.

The gap between MM1 and MM6/MM7 is the most visible disparity, but the MM3-MM5 band warrants attention as well. These towns have enough population to support multi-doctor practices, but many struggle to recruit beyond one or two GPs, leaving practices unable to provide leave cover or reduce reliance on locums.

Residents in remote and very remote areas face longer travel times, fewer service options and limited after-hours coverage.

State and territory distribution: NSW has the largest GP workforce (9,485), followed by Victoria (7,709) and Queensland (6,125). The Northern Territory has the lowest GP density at 82 per 100,000. Western Australia sits at 99 per 100,000.

3.4 Gender, pay and workload

Female GPs now outnumber male GPs by headcount. Growth in female GP numbers has consistently outpaced male GP growth, rising from 17,066 in 2018 to 20,274 in 2024, while male GP numbers rose from 19,776 in 2020 to 20,094 over the same period. However, a larger proportion of female GPs work part-time, and male GPs contribute more FTE hours on average.

Female GPs spend longer with patients (average 20 minutes per consultation versus 16.8 minutes for male GPs) and manage a higher proportion of complex, time-intensive presentations: mental health, women's health, psychosocial issues, family planning and domestic violence.

Female GPs also carry a heavier non-billable workload. An estimated 14.2% of their working hours goes to care coordination and administrative tasks, a higher proportion than male GPs. Under a fee-for-service model, longer consultations and

higher non-billable hours translate directly to lower gross billings per hour.

The gender pay gap in general practice is persistent. Female GPs earn approximately \$24 less per consulting hour than male GPs. Male GPs recorded average gross billings of \$372.68 per hour; female GPs, \$348.54. Based on an average 33-hour consulting week across 48 weeks, this equates to approximately \$38,000 less in annual gross billings for the same hours worked. The gap is driven primarily by consult volume: male GPs complete around 11% more consultations per hour, as female GPs spend longer with each patient. Female GPs are billing almost \$40,000 less per year on average for the same amount of consultation time.

~\$24 Female GPs earn approximately \$24 less on average per consulting hour

Female GPs also report higher rates of workplace stress and burnout, driven by systemic undervaluation of complex and time-intensive work, insufficient support structures for administrative demands and the compounding effects of part-time patterns on career progression.

3.5 Job satisfaction and burnout

Job satisfaction among GPs rose to 73% in 2024, up from 67% in 2023. This is an improvement, but it runs alongside persistent structural problems.

68% of GPs identified increasing complexity of patient presentations as the greatest challenge facing the profession. 84% want to provide more preventive care, but only one in three has the time to do so. Work-life balance remains uneven: 53% of GPs describe their balance as 'about right', with female and Generation X GPs more likely to report adequate balance than male and baby boomer GPs.

Burnout remains widespread. In 2023, 71% of GPs reported experiencing burnout. The principal drivers are rising patient complexity and longer consultations, administrative and regulatory burden (including real-time prescription monitoring, Medicare compliance requirements and CPD obligations), financial pressure from inadequate remuneration relative to workload, moral injury from systemic

constraints on care delivery, and cumulative emotional load from managing complex mental health and chronic disease presentations without adequate specialist referral pathways.

71% of GPs reported burnout in 2023

47% of GPs would now recommend general practice as a career, up from 38% in 2023. The proportion who would not recommend the profession dropped from 39% to 34% over the same period. These numbers suggest some stabilisation in professional sentiment, but sentiment and structural conditions are not the same thing.

3.6 Retirement intentions

32% of GPs plan to cease practising within five years. Half of these intend to retire earlier than they had originally planned when entering general practice. The proportion of GPs exiting the workforce in 2022 was 1.3% overall, rising to 2.5% for those aged 60 and over and 5.1% in the Northern Territory.

The primary reasons given for early retirement are regulatory and compliance burden (60%), CPD requirements (47%) and increasing complexity of general practice (40%). Retirement and lifestyle changes account for the remainder.

The retirement pipeline interacts directly with the training pipeline. If 32% of the current workforce exits within five years, replacement depends on GP registrars completing training and entering sustained clinical practice. The registrar cohort grew from 4,217 in 2018 to 6,200 in 2024 (a 47% increase), but completion rates and retention in clinical practice post-fellowship remain the determinants of whether that growth translates to workforce replacement.

3.7 Medical student preferences

9.4% of medical students nominated general practice as their first-choice specialty in 2024, down from 16% in 2011. 32.9% of medical school graduates enter general practice training: 20% in urban areas, 12.4% in periurban, rural and remote areas (MJA InSight Plus, 2025).

9.4% of medical students chose GP in 2024, down from 16% in 2011

In 2026, a record 1,772 doctors began the Australian General Practice Training (AGPT) Program with the RACGP. Rural pathway enrolments grew 47% nationally. The Federal Government awarded the RACGP a \$751.3 million five-year AGPT Grant agreement, the largest and longest training agreement awarded to a medical college.

The GP registrar cohort grew from 4,217 in 2018 to 6,200 in 2024.

Demand for training places exceeds funded capacity. In 2026, more than 340 eligible applicants were turned away in Queensland, 28 in Tasmania and 10 in the Northern Territory.

Several medical schools are extending rural clinical placements from eight to twelve weeks to full-year or whole-of-degree models. The University of the Sunshine Coast is designing a medical program structured around general practice rather than hospital-based specialisation.

Health systems perform best when at least 40% of physicians work in primary care. Australia is below that threshold.

SECTION 4

Financial performance of general practices

IN BRIEF

- Medicare rebate indexation has averaged 1.1% pa since 1995, against CPI of 2.4% and wage growth of 3.5%.
- BBPIP (Nov 2025) reversed a 20-year decline in bulk billing; national rate now 81.4% with state range 72.1% (ACT) to 88.3% (NT).
- For practice owners, BBPIP creates a binary structural choice: full bulk billing for the 12.5% loading, or mixed billing for fee flexibility.
- Patient out-of-pocket spend on GPs rose from \$780m (2021-22) to \$1.66bn (2023-24), partly reversed by BBPIP.

4.1 Medicare funding model

Australia's Medicare system, established under the Health Insurance Act 1973, operates as a government-funded health insurance program. GPs claim a rebate from the Medicare Benefits Schedule for each consultation. Bulk billing means the GP accepts the rebate as full payment, with no out-of-pocket cost to the patient. Where the GP charges above the rebate, the patient pays the difference (the gap fee).

The rebate was originally set at 85% of a scheduled fee. Operational costs, principally staff wages, rent, indemnity and equipment, have risen faster than rebate indexation for over two decades. Between 1995 and 2022, the average annual indexation of Medicare rebates was 1.1%, against CPI of 2.4% and Average

Weekly Earnings growth of 3.5%. From 1 July 2025, a 2.4% indexation factor was applied to most MBS general medical services items. The current schedule fee for a standard Level B consultation (item 23, 6 to 20 minutes) is \$43.90.

Between 1995 and 2022, the average annual indexation of Medicare rebates was 1.1%, against CPI of 2.4% and health-specific inflation regularly exceeding 4%.

Medicare covers GP consultations, specialist referrals and diagnostic services, but rebates frequently fall short of actual service costs. Dental care, most allied health services and some mental health treatments sit largely outside Medicare coverage. Public hospital treatment is free but rationed by clinical urgency. The system provides universal eligibility, not universal access.

4.2 Bulk billing and the BBPIP

In 2023, 76.5% of non-referred GP services were bulk billed, an all-time low. The proportion of GPs bulk billing all their patients halved from 24% in 2022 to 12% in 2023. The RACGP Health of the Nation 2025, published September 2025, reported that 12% of GPs still bulk billed all patients, 36% bulk billed most patients, and 40% bulk billed a minority or none.

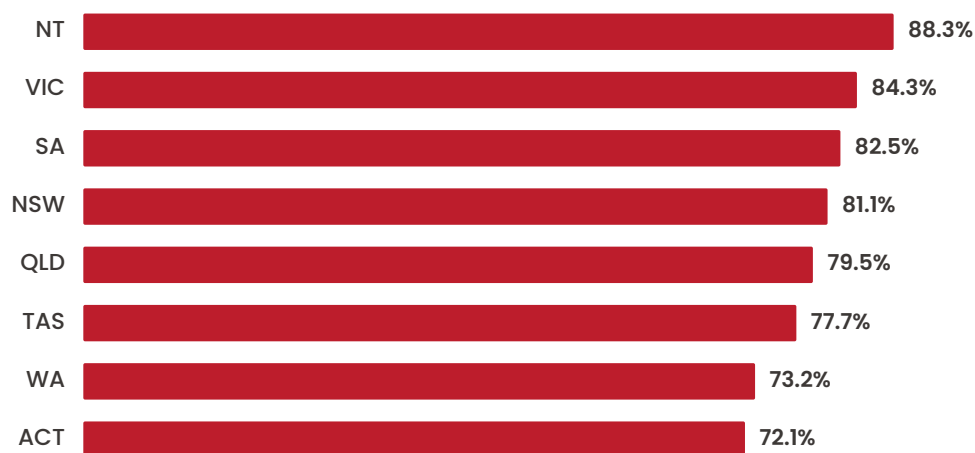
On 1 November 2025, the Commonwealth expanded the Bulk Billing Incentives and added a Practice Incentive Program (BBPIP). There is expanded eligibility for MBS bulk billing incentives to all Medicare cardholders, including children and concession cardholders, and a 12.5% loading on MBS fees for practices that register as a Medicare Bulk Billing Practice and bulk-bill 100% of eligible consultations. The 12.5% payment is split evenly between the GP and the practice. The expansion also made 45.5 million services per year for non-concessional patients aged 16 and over eligible for the bulk billing incentive for the first time. The triple bulk billing incentive ranges from \$25.70 per service in major cities (MMM1) to \$42.05 in very remote areas (MM7), with the standard incentive at \$7.35 and \$14.05, respectively.

As of April 2026, more than 3,700 practices are registered as Medicare Bulk Billing Practices under the BBPIP, up from approximately 1,600 fully bulk-billing practices before the program launched on 1 November 2025. By January 2026, 1,269 of those

were previously mixed-billing practices that had converted. The government's target of 3,600 registered practices by 2028 was exceeded within six months of launch.

The national GP NRA bulk billing rate rose to 81.4% for November 2025 to January 2026, up 4.3 percentage points year-on-year (DoHAC, National GP Bulk Billing Snapshot, published February 2026). For the full July to December 2025–26 half-year, which includes the four pre-BBPIP months, the GP NRA bulk billing rate was 78.8%, up from 77.5% in the prior corresponding period. The range across Primary Health Networks runs from 94.8% in South Western Sydney to 52.2% in the ACT. Bulk billing rates correlate with socioeconomic disadvantage: practices in the most disadvantaged areas (SEIFA quintile 1) bulk bill 89.1% of services, 10.3 percentage points above the national average. Over the first half of 2025–26, GP NRA service volumes fell to 82.1 million from 83.5 million the previous year (1.7% decline), while total benefits paid rose to \$5 billion from \$4.9 billion. Fewer services, more revenue per service.

Bulk-billing rates by state and territory



Source: Services Australia Medicare statistics, 12 months to Sep 2025

Two metrics must be distinguished. The proportion of GPs who bulk bill all patients (12% in 2023 and 2025) measures individual GP behaviour. The system-level NRA bulk billing rate (81.4%, DoHAC) measures the share of total GP services that attract no out-of-pocket cost. The gap between the two reflects the large number of GPs who bulk bill selectively: concession card holders and children are bulk-billed, and privately insured working-age adults are not. From the patient perspective, 56% report always being bulk-billed, unchanged from 2024. Prior to the BBPIP, bulk billing rates for children exceeded 90% following the tripling of the bulk billing incentive in November 2023. Rates for older Australians exceeded 87%. Working-

age adults had fallen below 70%. The projected fully implemented national rate is 87.8%, a 10.5 percentage-point increase from the December 2024 baseline of 77.3%, with 4,800 or more practices expected to register.

For practice owners, the BBPIP creates a binary structural choice. Fully bulk-billing practices receive the 12.5% loading on every eligible service but forgo private fee revenue. Mixed-billing practices retain fee flexibility but lose the loading entirely. The breakeven calculation depends on the practice's current gap fee, patient mix and location. In areas with high concession card density, the loading may exceed the average gap fee collected. In affluent metropolitan areas with low concession density, the gap fee revenue typically exceeds the loading.

For practice owners, the BBPIP creates a binary structural choice.

Assignment of Medicare benefits for bulk-billed consultations will create new cash flow and workflow issues for practices. From 1 July 2026, verbal consent to assign benefits will no longer be an option. Patients will need to assign a benefit either before a service (episodic pre-service assignment) or after a service, as set out in subsection 65C(4) of the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025. An electronic or physical signature will be required from the patient or a responsible person on an assignment of benefit agreement. A signature must be identifiable, auditable and compliant with the Electronic Transactions Act 1999. Practitioners will be required to keep a copy of the completed assignment of benefit agreements for two years and must provide a copy to the patient upon request. Bulk-billed enduring assignment of benefit, which would allow a single signature to cover future visits, will not commence until 2027, subject to final regulations. Until then, every bulk-billed consultation requires a fresh episodic agreement.

4.3 Financial performance benchmarks

Published benchmarks for general practice financial performance are limited, derived from relatively small samples and not always methodologically comparable. The figures in this section draw primarily on the Prosperity Health GP Industry Benchmark Report (April 2024, based on 2023 data) and Cubiko's Touchstone General Practice Industry Report, neither of which publishes post-BBPIP benchmark data as at June 2026.

In 2023, Prosperity Health reports average gross billings per GP hour of \$355, up from \$324 in 2022. Cubiko's Touchstone dataset, drawn from 1,048 practices nationwide, reports an average of \$308 per hour, reflecting differences in sample composition, practice mix and methodology between the two datasets.

In 2023, average annual billings per FTE GP were \$356,000, with the top 20% of GPs billing \$478,000 per year. Service fee arrangements typically allocate 25–35% of billings to the practice, with the balance paid to the GP as contractor income. On a 65% service fee split, a GP billing \$356,000 retains approximately \$231,000 in gross contractor income before superannuation, leave, insurance and other contractor-borne costs.

Net profit to the practice per FTE GP is estimated at \$41,000 on average, with the highest-performing practices achieving \$83,000 per FTE GP, again on 2023 data. These profit benchmarks predate both the Bulk Billing Practice Incentive Program (BBPIP) and the GP Chronic Condition Management Plan (GPCCMP) framework changes, so their post-reform trajectory is not yet observable in published benchmarking.

Chronic disease management items accounted for 10.49% of all billings in 2023, up from 9.32% in 2022, indicating a gradual shift in revenue mix towards structured chronic care. From 1 July 2025, the previous GP Management Plan and Team Care Arrangement items were replaced by GPCCMP items, with a \$156.55 fee for both the initial plan and each review for vocationally registered GPs, and a two-year transition period for existing plans. Reviews can be conducted every three months where clinically relevant. Allied Health items under GPCCMP (items 10950 to 10970) pay \$61.80 per session, with five sessions per year (10 for Aboriginal and Torres Strait Islander patients), unchanged from the prior scheme. The financial impact of this change on practice billing patterns is not yet reflected in benchmark reports.

Metro practices reported slightly higher gross billings per hour than rural practices in 2023, at \$358.83 versus \$352.62, respectively (pre-BBPIP data). Bulk billing rates are higher in rural practices (70.88%) than in metro practices (62.80%), while the average fee for a Level B consultation is highest in outer metropolitan areas (MM2) at \$86.74, compared with approximately \$82 in major cities and a broader use of procedural and other MBS items. Metro practices average 4.23 appointments per hour, compared with 4.04 in rural settings, reflecting subtle differences in throughput.

Practice operational costs for nurse and administration salaries have been estimated at around 20% of billings, noting that the practice typically retains only 30 to 40% of gross billings where GPs are contractors. Some higher-efficiency practices keep staffing costs at approximately 13.9% of billings, but this is at the lower end of the observed range.

4.4 Factors affecting financial performance

Medicare's fee-for-service structure disadvantages practitioners who manage complex cases requiring longer consultations, multimorbidity management, chronic disease care and mental health support. Longer consultations for complex presentations generally generate lower revenue per hour than shorter, transactional consultations, even when they are clinically appropriate.

Level B consultations (item 23, 6 to 20 minutes) account for approximately 66.9% of GP NRA services, while Level D consultations (item 36, 20 to 40 minutes) represent 2.8% of billings overall and 6.6% of billings in practices that deliberately focus on longer consultations. The MBS rebate per minute falls as consultation duration increases: at the July 2025 schedule fees, a Level B consultation at \$43.90 yields about \$7.32 per minute at 6 minutes and \$2.20 per minute at 20 minutes, while a Level D consultation at \$84.90 yields about \$4.25 per minute at 20 minutes and \$2.12 per minute at 40 minutes. This pricing structure structurally disadvantages practices providing longer, more complex care, particularly where the case mix is skewed toward chronic disease, mental health and multimorbidity. Half of all GPs now charge \$90 or more for a Level B consultation, the first time that threshold has been reached.

Population ageing and rising multimorbidity increase the prevalence of chronic conditions and the proportion of patients who present with multiple issues per consultation. Reduced outpatient capacity and shorter hospital stays have shifted more complex monitoring and follow-up work into general practice, while mental health presentations further increase time pressure per consult. Patients are more likely to present with multiple concerns in a single appointment, increasing complexity and extending average consultation time without a proportional increase in revenue per consult.

Experienced GPs generally attract patients with more complex conditions, including those with multiple chronic illnesses, extensive medication lists and psychosocial complexity. This case mix tends to reduce billings per hour relative to

GPs whose workload is weighted toward higher volumes of short, acute presentations. In metropolitan areas with high GP density, competition between practices can also suppress gap fees, limiting complex-care practices' ability to compensate for lower throughput through higher prices.

Urban practices typically face higher rent and fit-out costs but can access economies of scale in staffing, consumables and technology amortisation. Larger practices and corporate groups can spread overhead roles, such as practice management, HR, finance and marketing, across more FTE GPs, reducing the cost per GP. Rural practices often experience lower rent but higher relative costs for most other inputs, including equipment shared among fewer GPs, staff salaries with rural loadings, freight and travel costs, and continuing education, which can erode margins despite higher bulk billing rates and slightly higher private fees.

Average consultation time reported by GPs rose from 18.7 minutes to 19.7 minutes between 2022 and 2025, an 11% increase, according to RACGP Health of the Nation data. Under a fee-for-service model in which most billings are still generated from Level B and Level C items, longer average consultation times compress the number of consultations per hour and, unless offset by higher fees or a shift in the item mix, directly reduce hourly revenue.

SECTION 5

Contractual arrangements and remuneration models

IN BRIEF

- Most GPs are not employees: practices supply management services and retain a percentage of billings, typically 25-35%.
- GP revenue share rising: VR GPs now commonly receive 65-75% of billings, up from 60-65% as workforce shortage bids splits higher.
- Closing Loopholes No. 2 Act (Aug 2024) tests the substance of the working relationship, not the contract label; exposure can exceed \$500k per FTE GP.
- Single Employer Model trials run to Dec 2028; ~120 registrars enrolled, two-thirds via ACRRM pathways.

5.1 The contractor model and its variants

Most GPs working in general practice are not employees. They engage a practice to provide management services on their behalf, including premises, administrative staff, equipment and billing infrastructure. The GP retains clinical independence and typically receives a percentage of billings, with the balance retained by the practice as a management fee. The term 'contractor' is widely used but misleading. The GP is not contracted by the practice but contracts the practice to supply a service.

This structure has historically sat in a grey zone between independent contracting and employment. From 26 August 2024, the Closing Loopholes No. 2 Act 2024 introduced a new employee definition (section 15AA of the Fair Work Act) that assesses the practical reality of a working relationship, rather than the contractual

label. For medical practices, the risk is that GPs classified as contractors may be deemed employees, triggering retrospective obligations for superannuation (12% SG rate from 2025–26), annual and personal leave, notice and redundancy, PAYG withholding, and workers' compensation insurance. Estimated exposure has been as high as \$500,000 per FTE GP over a five-year clawback period, though this figure depends on the specific arrangement and jurisdiction.

\$500k per FTE GP: estimated five-year exposure if a contractor arrangement is reclassified as employment

The flow of funds has shifted in response. Previously, patient payments were deposited into the practice account, and the practice distributed the GP's share net of the service fee (including GST). Under arrangements now being adopted by an increasing number of practices, payments flow directly to the GP, who then pays the practice a service fee. This change is designed to reinforce the contractor characterisation but incurs GST on the service fee, requiring adjustments to contracts and financial arrangements.

Payroll tax remains a separate and overlapping risk. The state-by-state position is addressed in section 8. The contractor/employment classification and the payroll tax question are legally distinct but practically entangled: a service agreement structured to reduce payroll tax exposure may strengthen the contractor characterisation, or it may not, depending on the totality of the arrangement. Practices must now manage both risks simultaneously.

5.2 Remuneration models

— Percentage of billings

The dominant model. Vocationally registered GPs typically receive 65 to 75% of billings, up from 60 to 65% in preceding years (Clinch Group, September 2025). Non-vocationally registered GPs and international medical graduates subject to section 19AB restrictions typically receive 60–65%, reflecting their lower Medicare rebate entitlements and, for IMGs, restricted provider number conditions. The practice retains 25–35% and pays all overheads from that share.

The upward pressure on GP percentages reflects a workforce shortage. Practices competing for GPs in the same catchment have bid the percentage higher, compressing practice margins. A GP billing \$82 for a Level B consultation at a 70% split generates \$57.40 per consultation versus \$43.90 at pure bulk billing with no split (BBPIP-registered practice where the GP retains the full rebate). Across 25 to 30 patients per day, the difference is material.

The BBPIP 12.5% loading is split 50:50 between the GP and the practice. In universal bulk billing practices, this is additional income to both parties. The RACGP has raised concerns that the economics of bulk billing have historically compensated GPs through higher throughput rather than higher per-consultation income, and the 50:50 split does not change that dynamic.

— **Fixed hourly rate**

Less common. Used primarily in Aboriginal Medical Services, Medicare Urgent Care Clinics and other settings funded outside standard fee-for-service. Rates typically range from \$150 to \$300 per hour, depending on the shifts worked, with after-hours and weekends attracting higher rates, particularly at Urgent Care Clinics, which often schedule 10-12 hour shifts. The model provides stable income to the GP and removes throughput pressure but is more expensive for the practice and may attract payroll tax depending on the arrangement.

— **Mixed models**

A combination of percentage billings and a base rate. A common structure: 50% of billings or \$150 per hour, whichever is greater. Provides income stability while maintaining a throughput incentive. Frequently used for GP Registrars, where the guaranteed floor supports the learning phase while the percentage component encourages efficiency. This model may be subject to payroll tax depending on how the base component is characterised.

— **Sessional rate**

A fixed amount per session, typically three to four hours. Used in some corporate practices, community health settings and hospital outpatient departments using the GP with Special Interest (GPwSI) model. Suits part-time arrangements. This model does not reflect actual workload or complexity within the session.

5.3 Teaching practices and registrar arrangements

Teaching practices receive payments for supervising medical students and training GP Registrars. As of 2024, practices receive \$500 per registrar, per semester, for supervisor professional development, capped at 4 registrars per semester. Supervisors in priority workforce areas (MMM 3-7) may also receive travel expense reimbursement for training workshops. Supervisors must complete 3 hours of professional development per semester for each registrar, proportional to their level of involvement. Payment is contingent on meeting these requirements. Some practices do not pass supervision payments through to the supervising GPs.

The Single Employer Model (SEM) restructures GP Registrar employment so a state health service, rather than the training practice, becomes the employer of record. Registrars receive a fixed salary under the state enterprise agreement and retain leave continuously across placements. The practice no longer pays registrar wages. In Tasmania, the practice retains 50% of registrar billings and remits the remainder to the health service. Practices retain 100% of PIP, WIP and teaching payments.

The SEM is not a national rollout. It is a phased trial across five states running until 31 December 2028 (no trials in WA, NT or ACT). Approximately 120 registrars were enrolled as of mid-2025, with roughly two-thirds enrolled in ACRRM pathways. Commonwealth commitment: \$6.4 million through 2027-28 for expansion and evaluation, plus \$7.97 million for Tasmania.

5.4 Other contractual considerations

Service fees: Some practices charge GPs a flat service fee instead of a percentage split. This is less common and is typically used when the GP has a large, established patient base and a strong negotiating position.

Non-compete clauses: Many GP contracts restrict the practitioner from operating within a specified radius of the practice for a period after leaving. Courts interpret these clauses narrowly, and enforcement is rare. The legal costs of pursuing enforcement through the Supreme Court start at approximately \$90,000, which functions as a practical deterrent. As consolidation increases and GP retention becomes more competitive, the enforceability and drafting of these clauses are receiving more attention.

Termination notice periods: Typically, 4 to 12 weeks. Longer notice periods can blur the distinction between contractors and employees. Practices must structure these provisions to avoid inadvertently triggering employment-related obligations.

Minimum billing requirements: Some agreements specify minimum billing requirements the GP must meet per session or per week. These provisions are more common in corporate practice and can also bear on the contractor/employment characterisation if they operate as directions to work rather than as commercial terms.

SECTION 6

Regulatory environment

IN BRIEF

- Multiple frameworks overlap: MBS rules, PSR, PIP/WIP, Health Insurance Act, employment law, ACCC merger control, privacy and TGA.
- From 1 Jan 2026 the ACCC operates a mandatory and suspensory merger regime; healthcare is a priority enforcement sector.
- Privacy Act penalties reach \$50m+ for body corporates; first civil penalty (\$5.8m, Australian Clinical Labs, 2025) signals active enforcement.
- TGA confirmed Aug 2025 that AI scribes generating diagnoses or recommendations may be classified as medical devices requiring ARTG inclusion.

General practice in Australia operates under multiple overlapping regulatory frameworks. The regulatory burden has increased materially in 2024–26 with new or amended legislation across employment law, merger control, Medicare compliance, AI device regulation, and state payroll tax. This section covers the key regulatory domains and their practical effect on practice operations and finances. Payroll tax is addressed separately in section 8.

6.1 Medicare Benefits Schedule

The MBS defines the services eligible for Commonwealth subsidy and the rebate payable for each. The rebate, combined with patients' willingness or ability to pay a gap fee, effectively caps GP pricing. Unlike other professional services where charge-out rates have tracked or exceeded inflation, GP fees have been

constrained by the rebate structure and public expectations around bulk billing. The result is that many other professions now exceed general practice in hourly charge-out rates.

Practices must comply with MBS billing rules to qualify for rebates. Item descriptors define minimum consultation times, service types and documentation requirements. The 1 July 2025 changes replaced chronic disease management items 721, 723 and 732 with the GPCCMP framework (addressed in section 5.4). The BBPIP (section 5.2) added a further layer of compliance tied to bulk billing thresholds and practice-level registration.

The bulk bill claims timeframe was reduced to one year from 5 September 2025, under the Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Act 2025.

6.2 Medicare Compliance and the Professional Services Review

The Professional Services Review (PSR) investigates suspected inappropriate practice under the Health Insurance Act 1973. Sanctions include repayment orders for Medicare benefits received and partial or full disqualification from Medicare for up to three years (five years in some circumstances).

The Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Act 2025, which passed Parliament in September 2025, strengthened compliance and enforcement powers in response to the Philip Review. The Act removed restrictions on the admission of information obtained under PSR notice-to-produce powers as evidence in broader proceedings, including those before AHPRA and National Boards. Documents produced to the PSR can now be passed to AHPRA without restriction.

The DoHAC Health Provider Compliance Strategy 2025–30 applies a risk-based approach. In March 2025, awareness letters were sent to GPs at risk of exceeding the prescribed pattern of services rule (the 80/20 rule). Research published in the Australian Journal of General Practice found that GPs undercharged 11.8% of consultations and overcharged only 1.6%, resulting in a net saving to Medicare of over \$351 million in 2021–22.

6.3 Practice Incentives Program and Workforce Incentive Program

The Practice Incentives Program (PIP) provides financial incentives to accredited practices for quality improvement and comprehensive patient management. PIP payments are not indexed and are subject to caps. The Quality Improvement Incentive is capped at \$12,500 per quarter (\$5.00 per SWPE). The Teaching Incentive is also capped at \$12,500 per quarter (\$6.50 per SWPE). Larger practices typically reach a maximum of \$45,000 to \$60,000 per quarter, limiting the scalability of PIP revenue. Compliance costs for maintaining PIP eligibility (infrastructure, reporting, accreditation) have risen while the payments have not, and some practices are re-evaluating whether participation remains cost-effective.

The Workforce Incentive Program (WIP) has two streams. The Practice Stream provides up to \$137,375 annually (from 1 July 2025, with indexation) for practices employing eligible health professionals, including practice nurses, nurse practitioners, midwives, allied health professionals and Aboriginal and Torres Strait Islander health workers. Rural loading of 30-60% applies to MMM practices 3-7. Payments are calculated quarterly based on hours worked by eligible professionals and SWPE values. The Doctor Stream provides up to \$60,000 annually to GPs practising in MMM 3 to 7 areas, depending on location, quarters worked, vocational registration status and duration of participation. Rural loadings apply. Non-vocationally registered GPs on approved training pathways may qualify at lower rates.

6.4 Health Insurance Act 1973

The Health Insurance Act 1973 governs Medicare and the provision of health insurance in Australia. Section 126 prohibits health insurance funds from covering out-of-hospital medical services that attract a Medicare rebate, including GP consultations and specialist consultations. Section 121-10 of the Private Health Insurance Act 2007 specifically prevents insurers from paying benefits for services that attract a Medicare benefit.

The practical effect: private health insurers cannot insure standard GP consultations. They can fund services not on the MBS, services in private hospitals, and administrative or coordination functions that are not professional services. Medibank (through Ampliar Health, 170 practice sites (Myhealth 112, Better Medical 58)) and Bupa (targeting 130 clinics by 2028) now operate GP clinic networks that bill under Medicare like any other practice. The prohibition on insurance coverage of MBS services remains, but insurers fund clinic establishment with premium revenue, creating cross-subsidy capacity and patient-acquisition advantages that independent practices cannot replicate.

6.5 Employment law and contractor classification

From 26 August 2024, the Closing Loopholes No. 2 Act 2024 introduced a new employee definition (section 15AA of the Fair Work Act) that assesses the practical reality of a working relationship, rather than the contractual label. For medical practices where GPs operate as contractors, a finding that the arrangement is in substance one of employment triggers obligations for superannuation (Superannuation Guarantee at 12% from 2025–26), annual and personal leave, notice and redundancy, PAYG withholding, and workers' compensation insurance. This overlaps with, but is legally distinct from, the payroll tax question addressed in section 8.

6.6 ACCC mandatory merger regime

From 1 January 2026, Australia moved to a mandatory and suspensory merger control regime. Acquisitions meeting size thresholds cannot complete without ACCC approval; non-compliant acquisitions are void and attract penalties.

Two thresholds apply. First: combined Australian revenue of \$200 million or more and target revenue of \$50 million or more (or global transaction value exceeding \$250 million). Second, targeting serial acquisitions: acquirer group revenue of \$500 million or more and target revenue of \$10 million or more, or cumulative revenue from similar acquisitions over three years totalling \$10 million or more.

For major operators, including Ampliar Health and private equity platforms above \$500 million, the three-year cumulative threshold means individual practice acquisitions will require notification, even at small values. Healthcare has been identified alongside supermarkets and hardware as a priority industry for enforcement. Mid-tier operators below \$500 million face more limited impact: most individual practice acquisitions at typical valuations will not trigger notification.

6.7 Privacy, data protection and cybersecurity

The Privacy Act 1988 and the Australian Privacy Principles govern the management of personal information by healthcare providers. Practices must implement secure storage, access controls, breach notification procedures and data breach response plans. Penalties for breaches of the Australian Privacy Principles reach \$2.5 million for individuals and \$50 million or more for bodies corporate.

Data breach obligations apply under both the Privacy Act 1988 (Notifiable Data Breaches scheme) and the My Health Records Act 2012 (section 75, requiring notification where My Health Record information is compromised). Practices holding records for more than 3,000 patients typically fall above the small business exemption threshold and must comply with both regimes.

The Federal Court's decision in *Australian Information Commissioner v Australian Clinical Labs (No 2)* [2025] FCA 1224 imposed the first civil penalty under the Privacy Act: \$5.8 million for a 2022 data breach. The decision signals that the OAIC will pursue enforcement action against health sector organisations that fail to meet reasonable security standards.

The Commonwealth allocated \$6.4 million in January 2025 to launch the Health Cyber Sharing Network through CI-ISAC, intended to improve threat intelligence sharing across healthcare providers.

6.8 TGA regulation of AI clinical tools

From August 2025, the TGA clarified that AI scribes that analyse or interpret clinical conversations, including by generating a diagnosis, differential diagnosis or treatment recommendation not explicitly stated by the practitioner, are classified as medical devices requiring inclusion in the Australian Register of Therapeutic Goods. Pure transcription tools that do not provide clinical interpretation are not captured. The rapid evolution of AI scribe features means products currently classified as transcription tools may cross into medical device territory with future software updates. Practices using AI scribes must monitor product updates and ensure the tools they use remain compliant.

6.9 Accreditation

RACGP accreditation under the current Standards for General Practices is required for PIP eligibility and is a condition of most insurer and PHN contracts. Accreditation is granted for three years with a mid-cycle review at 18 months. Assessment is conducted by AGPAL or QPA through self-assessment, document review and on-site visit. The 5th edition focuses on outcomes rather than prescribed processes across five core areas: communication and patient participation, patients' rights and needs, practice governance, comprehensive care, and clinical safety. An interim amendment to Criterion GP1.3 (after-hours care) was introduced in 2025 in response to difficulties practices faced in securing formal agreements with local emergency departments.

SECTION 7

Payroll tax considerations

IN BRIEF

- Optical Superstore (Vic 2019) and Thomas and Naaz (NSW 2023) established that contractor GP payments can be wages for payroll tax.
- Every state has now responded but the relief diverges: QLD full exemption, VIC proportional (bulk-billing-linked), NSW rebate scheme, WA unchanged.
- WA is structurally different: it never adopted the relevant contract provisions, so genuine independent agreements fall outside the base.
- Multi-state operators carry the highest compliance overhead because thresholds, rates and exemption rules differ in every jurisdiction.

The payroll tax position for general practices has settled differently across states following the 2023-24 legal decisions and the subsequent relief measures. The foundational cases were the Optical Superstore Case (Victoria, 2019) and Thomas and Naaz (NSW, 2023), both of which found that payments to health professionals under service agreements could be classified as wages for payroll tax purposes. Every state has since responded, but the responses diverge.

7.1 State-by-state position

The table below summarises the position in each jurisdiction as at June 2026. Detailed notes follow.

Payroll tax position for GP practices by state and territory, June 2026

Jurisdiction	Threshold	Rate	Status for GP contractor payments
Queensland	\$1.3m	4.75%	Permanent exemption for all GP wages (contractor and employee) from 1 December 2024
Victoria	\$1.0m	4.85%	Proportional exemption from 1 July 2025, linked to bulk-billed revenue share
New South Wales	\$1.2m	5.45%	Full rebate where bulk billing thresholds met (80% metro Sydney, 70% elsewhere) from 4 September 2024
Western Australia	\$1.0m	5.5%	No change; common law contractor test applies. Most practices below threshold
South Australia	\$1.5m	4.95%+	Amnesty to 30 June 2024; payable from 1 July 2024 on arrangements meeting the relevant contract test
Australian Capital Territory	\$2.0m	6.85%	Bulk billing threshold for exemption waived in July 2025
Tasmania	\$1.25m	4.0%	Both major parties confirmed payroll tax will not apply to contracted GPs
Northern Territory	\$1.5m	5.5%	No specific rulings; standard provisions apply

— Queensland

Blanket exemption covering all GP wages (contractor and employee) regardless of billing model, effective 1 December 2024. The exemption was applied retrospectively by a public ruling before formal legislation. Queensland is the first state to permanently exempt GPs from payroll tax. Estimated cost to the state: \$538 million over five years.

\$538m

Queensland's estimated five-year cost of the permanent GP payroll tax exemption

— Victoria

Proportional exemption from 1 July 2025, calculated by reference to the practice's bulk-billed revenue share. A practice that derives 60% of GP revenue from bulk-billed services receives approximately 60% relief on GP wages. Fully private-billing practices receive no exemption. Payroll tax threshold: \$1,000,000 (increased from \$700,000 effective 1 July 2024). Payroll tax rate: 4.85%. For mixed-billing practices above the threshold, exposure runs to approximately 4.85% of contractor GP payments on the non-exempt proportion.

— New South Wales

Retrospective exemption for unpaid payroll tax on contractor GP wages before 4 September 2024 (no refunds for amounts already paid). The 12-month audit pause from August 2023 preceded this. From 4 September 2024, an ongoing Bulk Billing Support Initiative provides a full payroll tax rebate on contractor GP 'wages' where bulk billing thresholds are met: 80% of GP services billed through the centre in metropolitan Sydney, 70% elsewhere. Employee GP wages remain liable regardless of the billing model. Payroll tax threshold: \$1,200,000. Payroll tax rate: 5.45%.

— Western Australia

No change to existing payroll tax provisions. The state applies the common law test to determine the nature of the relationship between the contractor and the practice. With a tax-free threshold of \$1,000,000, the majority of general practices in Western Australia fall below the threshold. The state government has confirmed it does not intend to alter the current framework.

— South Australia

An amnesty covering the period 1 July 2018 to 30 June 2024. Practices have been advised that their arrangements with GPs are relevant contracts for payroll tax purposes. Payroll tax is payable from 1 July 2024 on arrangements that meet the relevant contract test. Payroll tax threshold: \$1,500,000. Payroll tax rate: 4.95% (rising with payroll size).

— Australian Capital Territory

Amnesty for GP practices that bulk bill 65% of their patients, initially running to 30 June 2025. In July 2025, the ACT Government waived the 65% bulk billing threshold for the payroll tax exemption.

— Tasmania

Both major parties confirmed during the most recent state election that payroll tax would not apply to contracted GPs. Payroll tax threshold: \$1,250,000.

— Northern Territory

No specific rulings or exemptions for medical practices. Standard payroll tax provisions apply. Payroll tax threshold: \$1,500,000. Payroll tax rate: 5.5%.

7.2 Financial exposure and interaction with employment law

The financial exposure for a practice that exceeds its state threshold and does not qualify for an exemption or rebate is the applicable payroll tax rate on GP contractor payments. On total GP billings of \$2.5 million with a 65% payout to GPs, the payroll tax liability at 4.85% (Victoria) is approximately \$78,800 per year, equivalent to roughly 3.2% of gross billings. At 5.45% (NSW), approximately \$88,600.

This sits alongside but is legally distinct from the employment classification risk under the Closing Loopholes No. 2 Act 2024 (section 6.1) and the superannuation guarantee obligation under section 12(3) of the Superannuation Guarantee (Administration) Act 1992. Where a contractor GP is reclassified as an employee, the practice faces retrospective exposure to unpaid superannuation (12% from 2025–26), annual and personal leave entitlements, payroll tax on the full remuneration, and potential Fair Work claims. The ATO has indicated it will pursue historical superannuation shortfalls where a contractor arrangement is found to be a sham.

The state-by-state divergence adds compliance overhead for multi-state operators. Practices operating across Queensland (full exemption) and Victoria (proportional exemption linked to the bulk billing share) face different compliance regimes, thresholds and documentation requirements.

SECTION 8

Technology in general practice

IN BRIEF

- Best Practice and MedicalDirector dominate clinical software; cloud-native alternatives (Helix, Cliniko, Genie, Cubiko) hold a growing minority share.
- AI scribe adoption jumped from 3% (2023) to 40% (Nov 2025); Heidi and Lyrebird lead the Australian market.
- Documented time savings of up to 40% per consult, but most GPs reinvested the time into longer consultations rather than higher throughput.
- Healthcare reported the most OAIC data breach notifications of any sector in H2 2024; ransomware success rate against healthcare is 95%.

8.1 Clinical software and digital infrastructure

Two patient management systems dominate Australian general practice. Best Practice holds the largest market share, followed by MedicalDirector. Both handle clinical records, prescribing, billing, pathology results and correspondence. A smaller number of practices use cloud-native alternatives, including Helix, Cliniko, Genie Solutions and Cubiko (analytics rather than PMS, but increasingly integrated with clinical workflows).

Electronic prescribing has moved from optional to near-default. Over 219 million electronic prescriptions have been issued since May 2020 across more than 85,958 prescribers. The Department of Health has confirmed that electronic prescribing

will be implemented by default in primary care, with a trial planned for early 2026 in selected settings. Allied health electronic prescribing software is on track for market launch by June 2026.

My Health Record uptake has been accelerated by legislative change. The Health Legislation Amendment Act 2025 mandates sharing-by-default of key health information, expanding the scope and utility of the national record. The Regulatory Reform Omnibus Act 2025, passed on 27 November 2025, amends healthcare identifiers and My Health Record legislation to streamline data sharing.

8.2 Telehealth

Telehealth accounted for 20% of GP services in 2022–23, stabilising after the pandemic-era peak. Of GP telehealth consultations in 2022, 5.1% were by video, with telephone consultations making up the balance. In January 2022, 211 telehealth items were made permanent on the MBS.

From 1 July 2025, 18 new video consultation items and 5 new telephone consultation items were added under the GPCCMP framework. MyMedicare-registered patients can access telehealth for chronic condition management without a prior face-to-face consultation in some circumstances, expanding access for rural and remote populations.

The commercial effect of practices is mixed. Telehealth reduces no-show rates and allows GPs to see follow-up patients without a physical room, but rebates for telephone consultations remain lower than those for equivalent face-to-face consultations. The throughput gain is real but narrow. Telehealth reduces room occupancy and eliminates patient flow bottlenecks for straightforward consultations. The Productivity Commission estimated telehealth saves consumers approximately \$895 million per year in travel and waiting time; the practice-side equivalent is the capacity to schedule more consultations per hour for appropriate presentations. The gain is concentrated in short follow-up and results consultations, not in complex or new-patient consults.

8.3 AI clinical documentation

AI scribes have moved from early adoption to mainstream use faster than any previous clinical technology in Australian general practice. By November 2025, 40% of Australian GPs reported using an AI scribe, up from 22% in August 2024 and 3% in late 2023. Avant's member survey in February 2025 found 19% adoption, suggesting variation across the profession but a clear upward trajectory.

40% of GPs using AI scribes by Nov 2025, up from 3% in late 2023

Two Australian-founded providers lead the market. Heidi Health, priced at \$150 per month from early 2026, offers ambient documentation across 110 languages with real-time ICD-10-CM and SNOMED-CT code suggestions. In March 2026, Heidi announced a strategic partnership with R1 RCM to integrate clinical documentation directly into the revenue cycle, linking care delivery to reimbursement. While the R1 partnership is US-focused, the direction of travel is clear: AI scribes are moving from documentation tools to end-to-end billing and coding platforms.

Lyrebird Health has taken a different path into billing optimisation through the Australian clinical software stack. Lyrebird holds an exclusive read-write integration with Best Practice SP2, allowing notes, observations, plans and assessments to be written directly into the patient record without copy-paste. In June 2025, Lyrebird launched a Cubiko integration that feeds Cubiko's care prompts into Lyrebird via Best Practice. The integration identifies patients eligible for chronic disease care plans and recommends the most relevant MBS item numbers based on the consultation content. Practitioners need live subscriptions to Cubiko, Best Practice and Lyrebird to use the integration. Lyrebird also offers a free tier for all Best Practice Premier users.

The clinical time savings are documented. A 2025 study published in the Australian Journal of General Practice reported reductions in documentation time of up to 40%. However, most GPs reported returning saved time to patients through longer consultations rather than increasing throughput. No published Australian study has yet quantified the impact of AI scribe use on billing revenue.

Most GPs reported returning saved time to patients through longer consultations rather than increasing throughput.

The TGA issued guidance in August 2025 confirming that AI scribes providing diagnostic suggestions or clinical decision support may be classified as therapeutic goods and subject to regulatory oversight. This distinction matters: a tool that transcribes and formats a consultation note is not caught; a tool that suggests diagnoses, recommends investigations or flags clinical risks may be. Providers offering recommendations for MBS item numbers or care plan identification are operating close to this boundary. Section 7.8 of this report provides a detailed overview of the regulatory framework.

The global AI scribe market reached an estimated USD 1.94 billion in 2026, growing at an annual rate of 26.9%. Over 120 providers operate internationally, though the Australian GP market is effectively a two-provider contest between Heidi and Lyrebird for integrated clinical use, although new players such as Medow Health are continuing to enter the space.

8.4 Cybersecurity

Health service providers reported 121 data breach notifications to the OAIC in the July to December 2024 period, the highest of any sector.

121 OAIC data breach notifications from health service providers, Jul-Dec 2024, the highest of any sector

The OAIC received 532 notifications in the January to July 2025 period, of which 178 (33%) were due to cybersecurity incidents. Ransomware incidents experienced by healthcare organisations doubled in the 2024-25 financial year, with cybercriminals succeeding in 95% of healthcare attacks compared with approximately 52% across all industries.

For GP practices, the cybersecurity exposure sits in three areas: patient management system access (typically single-factor authentication in older installations), third-party integrations (pathology, prescribing and AI scribe providers all hold or process clinical data), and staff email compromise (the most common initial attack vector in small health organisations). The RACGP's computer

and information security standards, embedded in the current accreditation standards, require practices to maintain current security policies, but compliance auditing is inconsistent.

Cybersecurity costs for general practices, including insurance, monitoring, staff training and incident response planning, run to \$10,000 to \$30,000 per year for a small clinic. These costs cannot be passed to patients under the pricing constraints described in section 5.

SECTION 9

Patient access and service demand

IN BRIEF

- 172 million GP services were delivered in 2023, averaging 7.6 services per person and 18.7 minutes per consultation.
- GP visitation rose to 80% of Australians in 2025, up from 71% in 2022.
- 59% of patients have now had at least one telehealth GP consultation, up from 35% in 2020.
- Service use rises steeply with age: patients aged 80+ average 17.3 GP services per year.

9.1 Service volumes and consultation patterns

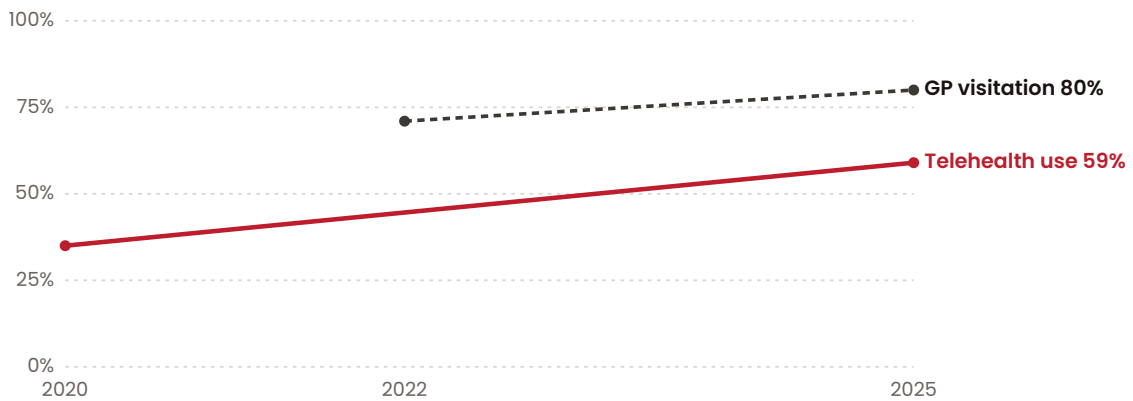
Over 172 million GP services were delivered in 2023, covering more than 22 million Australians at an average of 7.6 services per person per year. Average consultation time was 18.7 minutes.

Service use rises steeply with age. Medicare-subsidised GP services per person for those aged 80 and over reached 17.3 in 2022-23, up from 16.1 in 2018-19. Around 39% of Australians require ongoing treatment or medication for a medical condition, rising to 65% among those over 65.

Telehealth accounted for 20% of GP services in 2022-23, predominantly by telephone. Video consultations remain marginal at under 1% of total GP telehealth. The 1 July 2025 MBS changes added 18 video and 5 telephone items under the

GPCCMP framework, though it is too early to measure the effect on the telehealth mix. Separate industry survey data suggests 59% of patients have now had at least one telehealth consultation with a GP, up from 35% in 2020. GP visitation rose sharply to 80% in 2025 from 71% in 2022. Eight in 10 Australians visited a GP in the past 12 months.

Patient telehealth use and overall GP visitation



Source: Industry survey data and ABS Patient Experiences Survey

9.2 Mental health demand in primary care

Over 43% of Australians reported needing professional help for emotional, stress or mental health concerns in the past year, rising to 69% among 18 - 24 year olds. GPs are the first point of contact for most of these presentations.

The gap between demand and funded capacity in primary care mental health is structural. Medicare rebates for GP mental health consultations have not kept pace with the length or complexity of consultations. Practices that absorb this demand face a choice between longer unbilled consultation time, co-payments that deter patients most in need, or referral to already overstretched psychology and psychiatry services. The November 2024 federal government commitment to 50 Medicare-funded psychology sessions for severe mental illness addresses the acute end but does not change the primary care bottleneck.

The integration of mental health services into general practice depends on how they are funded. Additional MBS items, patient co-contributions and private health insurer entry into primary mental health are the most discussed options, each with different implications for practice economics and access equity.

9.3 After-hours care and the convenience gap

Patient demand for after-hours and weekend GP access has grown steadily, driven by workforce participation patterns and the availability of on-demand services in other sectors. Around 80% of patients report that online booking and appointment management improve their experience, but digital access does not solve the supply-side constraint.

The after-hours market has been through three phases. Changes to after-hours service provisions in 2012 expanded the number of services and attracted new entrants, including private equity-backed providers. Rebate reductions in 2018 compressed margins. The COVID-19 period forced several providers out of business, and telehealth has since absorbed a proportion of what would previously have been in-home after-hours visits.

Replicating the after-hours coverage that existed in the 1980s and 1990s would require investment that current MBS settings do not support. Staff penalty rates for weekend and evening work are not matched by the Medicare rebate, which remains flat regardless of the time of day, with limited exceptions. The GP workforce shortage compounds the problem: there are not enough GPs to staff extended hours, even where the economics could work.

Urgent Care Clinics, funded through Commonwealth grants, were intended to fill the gap. The program has favoured new entrants over established practices, which has drawn criticism from practice owners who argue that existing infrastructure could deliver after-hours services more efficiently with targeted support. The super clinic experience of the previous decade illustrates the difficulty of establishing new primary care sites when there is no GP workforce to staff them.

9.4 Complaints and consumer expectations

Health service complaints rose 14% over the five years to 2022. Communication-related complaints (inadequate information, poor provider-patient interaction) accounted for 16% of all issues in 2021-22. The Australian Consumer Survey 2023 found 30% of consumers are more likely to lodge complaints than in previous years.

For practice owners, the operational implications lie in systems rather than individual clinician behaviour: appointment communication, results follow-up, consent processes and complaints-handling procedures. Practices accredited under RACGP 5th edition standards are required to maintain a complaints register and demonstrate a resolution process, but the standard does not prescribe how complaints data should inform practice improvement.

SECTION 10

Business models and revenue diversification

IN BRIEF

- The fee-for-service consultation alone no longer covers cost in many catchments; revenue diversification has become a survival strategy, not a growth play.
- New revenue streams sit in GPCCMP chronic disease management, GPACI aged care (\$430 per enrolled RACF patient), AI-optimised MBS billing and subspecialty services.
- Non-MBS revenue (skin clinics, aesthetics, occupational health, employer health programs) is the main avenue for practices in higher-SES catchments.
- MyMedicare enrolment is the gateway to most new funding streams; 80% of practices have registered but only 10% of the population has enrolled.

10.1 Subscription and direct primary care

The subscription model charges patients a regular fee for a defined range of GP services, rather than the standard Medicare fee-for-service model. In its compliant form, the practice does not bill Medicare for services covered by the subscription.

Brisbane-based Evercare Health, operating in Clayfield since July 2023, has built the most documented, legally compliant version in Australia. Patients pay \$45 per month for unlimited consultations with their nominated GP plus a defined set of chronic disease management services. The practice does not bill Medicare for subscription-covered consultations. The legal basis: there is no prohibition on a

patient paying a doctor directly for medical services, provided the doctor does not also claim a Medicare rebate for the same service. Evercare announced plans to open additional clinics in late 2025.

The revenue arithmetic: at \$45 per patient per month, a panel of 600 patients generates \$27,000 per month (\$324,000 per annum) from subscriptions alone, before any non-subscription services. A GP working four days per week with a panel of 600 is operating within normal consultation capacity. GPs at Evercare retain 100% of consultation billings, with practice costs funded through subscription revenue.

Separately, Cleanbill data identifies at least 98 medical centres offering bulk billing to non-concession adult patients subject to a paid membership fee averaging \$77.94 annually. These arrangements raise compliance risk under the Health Insurance Act 1973. DoHAC has confirmed that practices charging annual administration or registration fees to guarantee bulk-billed services are in breach of the Act. The MBS requires that if a practitioner bulk bills, the Medicare benefit is accepted as full payment with no additional charge. The RACGP has warned that GPs working in practices with these fee structures may face compliance issues.

State-level membership fee averages: South Australia: \$60; Tasmania: \$67; Victoria: \$70.79 (40 clinics); Queensland: \$72.94 (18 clinics); New South Wales: \$86.31 (30 clinics).

In the United States, approximately 2,827 direct primary care offices operate as of early 2026 (up from 1,200 in 2020). Monthly fees for adult patients typically range from USD 65 to USD 85. DPC Frontier reports practices maintaining panels of approximately 600 patients achieve 66% fewer ED visits and a 20% reduction in specialist referrals, though these figures come from a self-selected, advocacy-adjacent data source. Structural transferability to Australia is limited: US DPC practices opt out of all insurance billing entirely. In Australia, even Evercare continues to use Medicare billing as its consultation revenue base.

10.2 Online and condition-specific platforms

Platforms including Mosh, Moshy and Pilot operate subscription-based models across weight loss, hair loss, skin and men's and women's health. GPs are employed or contracted to provide clinical assessment and prescribing. Revenue

to the GP is via employment or per-consultation contracting rather than independent billing.

The medicinal cannabis sector reached \$445.6 million in revenue in 2024-25, with 979,000 TGA prescription applications processed in 2024 alone. Telehealth is the dominant delivery model. Montu, operating the Alternaleaf patient platform, grew from \$103,000 in revenue in 2020 to \$263 million in 2024. AHPRA reported eight practitioners issuing more than 10,000 cannabis scripts in a six-month period and issued guidance in mid-2025 reminding prescribers that medicinal cannabis is mostly Schedule 8 and that prescribing must meet professional and safety obligations.

\$445.6m medicinal cannabis revenue 2024-25

These platforms draw GP labour out of traditional practice settings and into telehealth-first, condition-specific workflows. The competitive effect on GP practices is indirect but real: they absorb GP workforce capacity without adding to local practice supply.

10.3 Private health insurer entry into general practice

Section 126 of the Health Insurance Act 1973 (Cth) prohibits insurance contracts covering 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 rebate. The practical effect: private health insurers cannot cover standard GP consultations. They can fund services not on the MBS, services in private hospitals, and administrative or coordination functions that do not constitute a professional medical service.

Both major insurers are now operating GP clinic networks at scale. Medibank's subsidiary Ampliar Health received ACCC approval to acquire Better Medical's 61-practice network for approximately \$159 million, bringing Medibank's total to approximately 170 practice sites (Myhealth 112 and Better Medical 58) and making it the second-largest corporate operator behind IPN. Bupa has announced a target of 130 GP clinics, including new mental health-focused primary care sites.

No peer-reviewed financial analysis of insurer-owned clinics and the effects on competition between independent and corporate practice is yet available. The sector concern, articulated by the AMA and RACGP, is a managed-care dynamic where insurer ownership of GP clinics creates incentives to steer referral and prescribing patterns.

10.4 Corporate consolidation and acquisition

Australian general practice is in an accelerating phase of consolidation. Of approximately 7,135 accredited practices, the top eight operators control an estimated 42% of group-operated facilities by facility count. IPN operates approximately 143 practices; Ampliar Health approximately 170 across its Myhealth and Better Medical networks; Family Doctor 109; ForHealth 84.

The prevailing valuation benchmark is 3x to 5x EBITDA for standard practices sold to individual buyers or smaller groups. At the corporate and platform level, the Medibank/Myhealth transaction was reported at 9x EBITDA. The gap between independent-buyer and corporate-buyer multiples reflects the strategic premium corporate acquirers place on network scale, patient data assets and vertical integration opportunities.

The ACCC mandatory merger notification regime, effective 1 January 2026, requires notification of acquisitions meeting prescribed thresholds. Healthcare has been identified as a priority sector. For major operators including Ampliar Health and PE platforms above \$500 million, the three-year cumulative threshold means individual practice acquisitions will require notification even at small individual values.

A 2021 MJA Perspective identified four potential effects of corporatisation: reduced access where small practices consolidate into larger facilities, loss of continuity, evidence suggesting corporatised practices may deliver less preventive care, and a shift in GP autonomy over clinical decisions where corporate protocols apply.

10.5 Employer and corporate wellness contracts

Employer-contracted GP services are not covered by the Medicare rebate structure. Employers in construction, manufacturing, mining and retail pay above-MBS rates for on-site or reserved-access GP time. Contract structures vary: fixed annual fee, per-session fee, or per-consultation fee, with the employer as the payer.

The corporate wellness services industry generates approximately \$333 million in annual revenue, growing at 0.3% through to 2025-26. The market is not exclusively GP-led: occupational health specialists and large corporate operators compete for the same contracts. GP locum rates in clinic settings run \$1,600 to \$3,000 per day; any corporate contract needs to price GP time against that benchmark.

Sixty per cent of Australians delayed a GP visit in 2024 due to cost or unavailability, a 246% increase in delayed care due to affordability from the prior year. 37% of emergency department visits are for conditions a GP could have managed. The employer case is that on-site or near-site GP access reduces presenteeism, sick leave and ED diversion costs.

The constraint for most practices is sales capability. Few GP practices have experience selling B2B contracted services or relationships with HR and occupational health procurement teams.

The constraint for most practices is sales capability. Few GP practices have experience selling B2B contracted services.

10.6 Medico-legal and insurance examination work

Independent medical examinations are not billed under Medicare. Fee schedules are jurisdiction-specific and updated annually. Victoria's WorkSafe fee schedule (effective 1 November 2025) sets the GP initial examination and report at \$1,150.16 plus GST, covering up to 200 pages of reading time and examination and report

writing. NSW's SIRA fee schedule (effective 1 February 2026) sets the GP standard examination and report at \$731.70 plus GST, rising to \$1,092.20 for complex reports. Subsequent examinations are lower in both jurisdictions. Queensland sets equivalent rates through WorkCover Queensland. Reported fee ranges across all jurisdictions range from \$800 to \$4,400 per report, depending on complexity, specialty and jurisdiction.

Volume depends on subspecialty credibility (occupational medicine, musculoskeletal, psychiatry) and on established relationships with insurers and law firms. The pathway is through Avant or MIGA's medicolegal divisions, or through specialist IME providers who maintain panels of examiners.

10.7 Subspecialty revenue layers

Subspecialty layers sit alongside core general practice as discrete revenue streams, each with its own credentialing pathway, capital requirements and regulatory envelope.

Skin cancer medicine: Australia has the highest melanoma incidence in the world. Reported remuneration for GPs with skin cancer subspecialty work reaches \$250,000 to \$400,000 (or more for some) per year. The RACGP Certificate of Primary Care Dermatology can be completed in several months to a year. Direct private billing above MBS rates. Demand is concentrated in high-SES metropolitan practices, among older cohorts, in outdoor occupational populations and in Queensland or regional locations.

Women's health and contraception: Women aged 15 to 64 make up roughly half of the patient base in most practices, and clinical demand for procedural contraception and menopause management currently exceeds credentialed GP supply. Implanon NXT, IUD insertions and medical termination under MS-2 Step each attract MBS item rebates alongside standard consultation billing.

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. GPs running cosmetic sessions operate entirely outside MBS at private rates. AHPRA's new guidelines for non-surgical cosmetic procedures took effect on 2 September 2025. The ACAM Educational Pathway spans 2 years for doctors with no prior aesthetic experience.

Travel medicine: Private-fee dominant with limited MBS dependency. Consultation, vaccines and destination-specific advice are billed directly to patients, with corporate travel accounts adding contracted volume. Operates from existing practice rooms with a vaccine fridge and Yellow Fever vaccination centre accreditation.

Occupational medicine: Contracted revenue from corporate accounts and workers' compensation panels. Pre-employment medicals are employer-funded at typically \$150 to \$400 per assessment. Demand is concentrated in mining, resources, transport, construction and aged care sectors.

10.8 Medicare urgent care clinics

The Commonwealth committed \$657.9 million to 137 Medicare Urgent Care Clinics. The 87, operating by early 2026, has delivered over 2.5 million visits since 2023. The second interim evaluation (February 2026) found UCCs reduced ED urgent-care presentations by up to 10% but found no evidence that hospital waiting times had improved.

\$657.9m Commonwealth commitment to 137 Medicare Urgent Care Clinics

Each UCC presentation costs \$246.50, more than five times the cost of a standard GP consultation at approximately \$44. 68% included a discharge summary for the patient's GP. Half of the clinic staff reported concerns about their workload.

The Evaluation of the Medicare Urgent Care Clinics: Interim Evaluation Report 2, published by the Department of Health, Disability and Ageing on 2 December 2025, estimates a net saving per avoided ED presentation of \$381 per patient.

UCCs create competitive pressure on nearby GP practices. Several contracts have been awarded to existing practices and group operators. The program has favoured new entrants over established practices, drawing criticism from practice owners who argue existing infrastructure could deliver after-hours services more efficiently with targeted support. Final evaluation expected later in 2026.

10.9 Aged care as a revenue stream

GPACI pays \$430 per enrolled residential aged care patient per year, split between the GP (\$300) and the practice (\$130), delivered quarterly. For a GP with 50 enrolled residents in a metropolitan RACF, the annual GPACI payment is \$15,000 in addition to standard MBS consultation billing.

\$430 per enrolled RACF patient per year under GPACI (\$300 GP, \$130 practice)

The minimum service requirement under GPACI is 10 visits per patient per year, including two care planning items, compatible with a fortnightly round structure. GPACI replaced the PIP GP Aged Care Access Incentive, which ceased on 31 July 2024. Registration opened on 1 July 2024.

The constraint is MyMedicare. GPACI requires MyMedicare registration for the practice, the GP and each enrolled patient. Residents who are not yet enrolled must register before the incentive applies.

SECTION 11

Barriers to entry and operating constraints

IN BRIEF

- Small practice setup runs \$200k-\$500k; multidisciplinary clinics \$1.5m-\$2m; fit-out costs have roughly doubled in five years.
- 72% of practices report staffing-related capacity and growth constraints; new sites outside major cities face the deepest workforce gaps.
- 81% of practice owners are concerned about their clinic's viability; 63% identify rising costs as a major challenge.
- Established practices hold sticky patient bases (68% prefer to stay with their regular GP), making acquisition a more reliable entry path than greenfield.

11.1 Capital requirements

Setting up a small general practice costs \$200,000 to \$500,000. Larger multidisciplinary clinics run \$1.5 million to \$2 million. Fit-out costs have roughly doubled in five years due to construction and materials inflation.

\$200k-\$500k setup costs small practice; \$1.5m-\$2m multidisciplinary

Working capital, until profitability is achieved, falls on the owning principal in non-corporate practices. Loan repayment timelines of up to seven years compress cash flow during the establishment phase. Technology upgrades and compliance account for an estimated 5 – 10% of annual revenue on an ongoing basis.

The capital barrier favours corporate entrants. Corporate groups absorb setup costs across a portfolio and access cheaper capital. Independent entrants carry personal financial risk that compounds with the workforce and rebate pressures described in earlier sections.

The capital barrier favours corporate entrants.

11.2 Workforce

The Department of Health and Aged Care projects a shortage of 5,560 full-time equivalent GPs by 2033 (7,700 by headcount), widening to 8,908 FTE by 2048. The shortfall is disproportionately concentrated in outer urban and rural areas. The proportion of GPs working in practices with six or more doctors increased from 47% in 2008 to 61% in 2015, reflecting a structural shift toward larger teams.

Smaller practices face competition for staff from corporate groups offering higher salaries and from public health systems. Administrative staff trained in general practice routinely leave for state health roles, often at up to 25% higher pay. Seventy-two per cent of practices reported capacity and growth constraints due to staffing shortages.

New practices outside major urban centres face the greatest difficulties. The GP workforce does not exist in sufficient numbers to staff new sites in many regional and outer-suburban areas, regardless of the commercial case.

11.3 Operating costs and margin pressure

63% of GPs identified increasing practice costs as a major challenge in 2022. Health inflation reached 6.1% in the 12 months to May 2024, against general CPI of 4.0%. Anecdotal estimates from health executives suggest a rule-of-thumb medical

inflation rate of 8 to 10% annually over the past decade, though no formal citation exists. Eighty-one per cent of practice owners are now concerned about their clinic's viability.

Medicare rebates have not kept pace with these cost increases. In Australia, GPs do not typically charge by the minute like a lawyer. Instead, they use a fee-for-service model governed by the Medicare Benefits Schedule (MBS). Clinics charge flat fees for specific time blocks and complexity levels. Where a standard consultation runs 18 minutes instead of 15, the practice absorbs the additional time unless it bills at a higher item level. This systemic underbilling erodes revenue across the day.

The margin constraint is most acute in high-GP-density urban areas where competitive pressure limits the ability to shift from bulk billing to mixed or private billing. Lower-SES areas, concession cardholders and children under 16 now attract full BBPIP uplift, making private billing economically irrational in those geographies.

11.4 Patient switching costs and continuity

68% of patients prefer to stay with their regular GP (2022 consumer survey). Over 87.8% of Australians visit a GP at least once annually. 80% of patients aged 65+ identify a regular GP or practice as their primary point of care.

These figures represent a real barrier for new entrants. Established practices hold embedded patient bases that do not move easily. AHPRA advertising restrictions limit how new practices can promote services: testimonials, financial incentives and claims creating unrealistic expectations are prohibited.

In rural and regional areas, patient switching is constrained further by limited alternatives. The practical effect is that practice acquisition (buying an existing patient base) is a more reliable entry path than greenfield establishment in most geographies.

11.5 Regulatory and compliance burden

Medicare compliance, privacy legislation, accreditation standards and payroll tax obligations create a cumulative administrative load. Frequent MBS updates, telehealth eligibility changes and the introduction of new item frameworks

(GPCCMP from 1 July 2025) require continuous operational adjustment.

Governance systems required under RACGP accreditation, including incident reporting and quality improvement programs, are largely unfunded. Practices absorb these costs without a corresponding MBS item or incentive payment. For new entrants, the compliance learning curve adds to establishment costs and time-to-profitability. For existing practices, the cumulative regulatory burden is a drag on capacity that compounds the workforce and margin pressures above.

SECTION 12

The GP and the medical centre in five years

IN BRIEF

- The funding model is shifting from pure fee-for-service to a blend that includes enrolled-patient capitation and pay-for-performance.
- Ownership is consolidating: PE acquired 256 GP clinics 2017-2022; Amplar 170 sites, Bupa targeting 130, IPN ~143; top 8 operators control ~42% of group-operated sites.
- The medical centre of 2030 is multidisciplinary by default: nurse practitioners, pharmacists, mental health clinicians and chronic disease nurses alongside GPs.
- AI moves from documentation to MBS optimisation to clinical decision support; practices using AI-assisted billing will capture revenue manual processes leave on the table.

12.1 The funding model is shifting under the practice

Australian general practice has operated on a fee-for-service basis since Medicare's introduction in 1984. That model is now being layered with population-based funding elements that change the economics of how practices operate and what they are paid for.

MyMedicare introduced voluntary patient enrolment in 2023. By April 2026, approximately 80% of practices had registered, but only around 10% of the population had enrolled. The financial uplift for most practices remains modest at

current enrolment levels. But the architecture is load-bearing: GPCCMP access, GPACI payments and proposed blended funding streams all require MyMedicare registration as a precondition. Practices that have not registered are progressively locked out of new funding lines.

The direction is toward blended payment. The Strengthening Medicare Taskforce recommended moving from pure fee-for-service to a model combining consultation payments with per-patient capitation-style funding and pay-for-performance. The GPCCMP reform from 1 July 2025, which replaced episodic care planning items with ongoing management items tied to enrolled patients, is an early expression of this. GPACI at \$430 per enrolled RACF patient per year is another.

If this trajectory continues and no policy signals suggest otherwise, the GP practice of 2030 will derive a material proportion of its income from enrolled-patient funding streams rather than from consultation volume alone. Practices with high enrolment rates and active chronic disease management programs will earn more per patient than those running high-throughput, low-continuity models. The financial incentive is shifting from seeing more patients to retaining them.

The New Zealand capitation model offers a reference point. PHOs receive funding based on the number of enrolled patients, not on consultations. A 2019 BMJ Open study found higher per-patient capitation associated with better quality-of-care scores. Australia is not adopting full capitation, but MyMedicare moves in that direction. The constraint is that at 10% enrolment, the financial signal is too weak to change practice behaviour at scale.

12.2 Who owns the practice is changing

Between 2017 and 2022, private equity firms acquired 256 GP clinics, the largest clinic category in PE healthcare acquisitions. Medibank's Ampliar Health now operates 170 practice sites across the Myhealth and Better Medical brands. Bupa has announced a target of 130. IPN operates approximately 143. The top eight corporate and group operators control an estimated 42% of group-operated facilities.

The independent owner-operator model is not dead, but it is under structural pressure from three directions: capital requirements that favour scaled entrants, a workforce that increasingly prefers employed positions over independent

contracting, and new funding streams (BBPIP, GPCCMP, GPACI) that reward administrative capacity most practices under four GPs struggle to maintain.

The independent owner-operator model is not dead, but it is under structural pressure from three directions.

The Single Employer Model trials, with \$6.4 million in additional Commonwealth funding and 86% registrar satisfaction, signal that salaried GP employment is becoming normalised for the training pipeline. 97% of registrars intend to be working as a GP in five years, but most will enter a workforce where employment, not ownership, is the default entry point. The pipeline employs GPs. Employed GPs do not buy practices.

The practice of 2030 is increasingly likely to be owned by a corporate group, a private equity platform, a health insurer or a non-GP investor rather than by the GP working in it. Independent practices will persist where the principal has strong local patient loyalty, low debt and a succession plan. Practices without those features are acquisition targets.

The ACCC's mandatory merger notification regime, introduced from 1 January 2026, introduces regulatory friction to this consolidation, but it does not reverse it. Healthcare is a priority sector. The regime requires notification of acquisitions that meet prescribed thresholds, which, for major operators, means that even small individual practice acquisitions may trigger review.

12.3 The workforce composition inside the practice is changing

Australia had 40,375 GPs in 2024: 32,557 vocationally registered, 1,618 non-VR and 6,200 in training. The ratio was 113 FTE GPs per 100,000 population, up from 110 in 2023. The Department of Health projects a shortage of 5,560 FTE GPs by 2033 (8,908 by 2048), concentrated in outer urban and rural areas.

The GP workforce is not going to grow fast enough to meet demand through GP numbers alone. The response is scope expansion for other practitioners.

Pharmacist prescribing for acute conditions has moved from a pilot to a permanent program in Queensland. Within the past year, the number of states permitting pharmacist prescribing for urinary tract infections increased from one to seven. Several states now allow hormonal contraceptive renewals by pharmacists. NSW and South Australia have expanded further in 2025–26. The RACGP has opposed these expansions on patient safety grounds; the Pharmacy Guild and Pharmaceutical Society of Australia support them.

The Cormack Review (Unleashing the Potential of our Health Workforce, final report delivered October 2024) made 18 recommendations across workforce design, development, education and planning. The review covers GPs, nurses, midwives, pharmacists, Aboriginal and Torres Strait Islander health practitioners, allied health professionals and paramedics. Implementation is underway at the state level: Tasmania has published a Nurse Practitioner Strategy 2025–2030 that incorporates Cormack recommendations.

Australia faces a projected national undersupply of 70,707 FTE nurses by 2035, with a nurse practitioner gap of 296 FTE. Nurse practitioners can practise independently in primary care with an extended scope, including prescribing, ordering diagnostics and referral. Their numbers remain small relative to GPs, but the policy direction is toward expansion.

The medical centre of 2030 is a multidisciplinary site. 65% of GPs already want to participate in more multidisciplinary team care. The practice that employs or co-locates nurse practitioners, pharmacists, mental health clinicians and chronic disease nurses alongside GPs will be better positioned to capture blended funding, meet GPCCMP service requirements and absorb demand that the GP workforce alone cannot serve.

The question for practice owners is whether they lead this workforce redesign, or have it imposed by corporate operators who can afford to employ the broader team.

The question for practice owners is whether they lead this workforce redesign, or have it imposed by corporate operators who can afford to employ the broader team.

12.4 AI moves from documentation to clinical workflow

Section 9 covers the current state of AI scribes. The trajectory is more significant than the current adoption rate.

Heidi Health's March 2026 partnership with R1 RCM to integrate clinical documentation directly into revenue cycle management is the clearest signal of where AI is heading in general practice. The Lyrebird-Cubiko-Best Practice integration already recommends MBS item numbers based on consultation content and identifies patients eligible for chronic disease care plans.

The next layer is clinical decision support at the point of care. AI tools that analyse patient history, current presentation and MBS eligibility to suggest investigations, flag overdue screening and prompt care plan reviews are in development or early deployment. The TGA's August 2025 guidance confirmed that AI tools providing diagnostic suggestions or clinical decision support may be classified as therapeutic goods. The regulatory framework exists; the products are arriving.

A 2026 European Journal of General Practice systematic review found that AI diagnostic prediction tools in general practice show promise, but evidence of clinical effectiveness remains limited and inconsistent. Safety evaluation relies primarily on self-reported side effects, with little structured monitoring of AI-related risks. The Lancet Primary Care published two companion pieces in 2025, noting that rapid AI deployment before rigorous real-world evaluation raises concerns about unintended consequences for care quality.

For practice economics, there are many AI-based tools that optimise MBS item selection, identify missed billing opportunities and automate care plan documentation, and these potentially have a direct revenue effect. No published Australian study has yet quantified this. But the logical endpoint is clear: practices that adopt AI-assisted billing and care planning will capture revenue that practices relying on manual processes leave on the table.

12.5 What the medical centre of 2030 looks like

The forces described above converge on a practice model that looks materially different from the median Australian GP practice today.

Funding: A blend of fee-for-service consultation income, MyMedicare-linked capitation payments, Pay for Performance, GPCCMP chronic disease management income, GPACI aged care payments and potentially employer or subscription revenue. Pure bulk-billing-only or pure private-billing-only models will persist at the extremes, but the middle ground moves toward diversified revenue.

Ownership: Increasingly likely to be corporate, PE-backed or insurer-owned than owner-operator. Independent practices survive where the principal has built a defensible patient base, keeps debt low and has a clear succession path. The proportion of independent practices in the total mix declines.

Workforce: GPs supported and potentially competing (depending on government policy), nurse practitioners, practice nurses with expanded scope, pharmacists (employed or co-located), mental health clinicians, physician assistants and chronic disease coordinators. The GP's role shifts toward complex clinical work, care plan oversight and multidisciplinary team leadership. Routine acute presentations will most likely be increasingly handled by other practitioners within the practice.

Technology: AI scribe as standard. AI-assisted MBS item selection and billing optimisation are integrated into the clinical workflow. Electronic prescribing by default. Telehealth for follow-up and chronic disease monitoring as a standard appointment type, not a separate service line.

Physical space: Designed for multidisciplinary teams, not solo consulting rooms off a corridor. Treatment rooms for procedural work (skin, contraception, musculoskeletal). Spaces for allied health. The fit-out reflects a business generating revenue from multiple practitioner types, not a single GP billing model.

Patient relationship: Enrolled rather than episodic. MyMedicare registration as the default. Continuity of care is measured and incentivised. After-hours access via telehealth or urgent care, rather than in-home visits.

The practices that are already moving in this direction, enrolling patients, diversifying their workforce, adopting AI tools and building subspecialty revenue, are the ones that will hold or grow their value. The practices that are not will find themselves either acquired or progressively uncompetitive as the funding model rewards what they do not do.

SECTION 13

Current position

IN BRIEF

- Australian general practice is repricing on five fronts at once: funding, ownership, workforce, technology and regulation.
- Best-positioned practices: MyMedicare registered with active enrolment, BBPIP registered where economics support it, AI-assisted documentation and billing, multidisciplinary workforce, diversified revenue, succession plan in place.
- Most exposed: single-GP workforce, manual billing, no subspecialty revenue, no plan for what happens when the principal stops working.
- The question is not whether to change but what to change first.

Australian general practice is repricing. The funding model, ownership structure, workforce mix and technology stack are all shifting simultaneously. This is not a sector in gradual evolution. The changes between 2023 and 2026 have been more structurally significant than those of the preceding decade.

This is not a sector in gradual evolution. The changes between 2023 and 2026 have been more structurally significant than the preceding decade.

Key figures as at June 2026

The bulk billing rate reversed a 20-year decline, rising to 81.4% nationally by January 2026, driven by BBPIP. Over 3,700 practices registered within months. The financial logic of mixed billing has changed for any practice in a geography with a material concession card or under-16 population. Practices that switched to full bulk billing under BBPIP are collecting the 12.5% loading on every eligible consultation. Practices that did not are foregoing that income.

GPCCMP replaced the episodic care planning items from 1 July 2025, tying chronic disease management revenue to enrolled patients under MyMedicare. GPCCMP items can be billed without MyMedicare registration, provided the patient is not enrolled with another practice. GPACI added \$430 per enrolled RACF patient per year and requires MyMedicare registration. For practices without registration, access to both streams narrows as patient enrolment at other practices grows.

Corporate and insurer ownership is accelerating. Private equity acquired 256 GP clinics between 2017 and 2022. Medibank now operates approximately 170 clinics. Bupa has announced a target of 130. The top eight operators control an estimated 42% of group-operated facilities. The ACCC mandatory merger regime from 1 January 2026 introduces regulatory oversight but does not reverse the trend.

The GP workforce numbered 40,375 in 2024 against a current shortage of 2,460 FTE GPs, projected to reach 5,560 by 2033 and 8,908 by 2048. Pharmacist prescribing for UTIs has expanded from one state to seven in a single year. The Cormack Review's 18 recommendations on scope of practice are being implemented at the state level. The workforce inside the practice of 2030 will not be GP-only.

AI scribe adoption reached 40% of GPs by November 2025. Lyrebird's Cubiko integration already recommends MBS item numbers from consultation content. Heidi's R1 RCM partnership links documentation to the revenue cycle management process. The tools are moving from transcription to billing optimisation to clinical decision support. The TGA confirmed in August 2025 that AI tools providing diagnostic suggestions may be classified as therapeutic goods.

Payroll tax remains unresolved in most jurisdictions. Queensland offers a full exemption for GP practices. Victoria introduced a bulk billing exemption from 1 July 2025 with a \$1 million threshold. NSW operates a rebate scheme. WA stands apart: the state never adopted the 'relevant contract' provisions that deem independent contractor GPs to be employees for payroll tax purposes, so genuine independent

service agreements fall outside the payroll tax base without requiring an exemption. The WA tax-free threshold of \$1 million applies in the ordinary way. The contractor model that underpins most GP practice economics is under sustained pressure elsewhere from the Closing Loopholes Act's expanded employee definition and from state revenue offices testing existing arrangements.

For practice owners, the question this report raises is not whether to change but what to change first. The practices best positioned are those that have registered for MyMedicare and are actively enrolling patients, have adopted or are adopting AI-assisted documentation and billing tools, employ or co-locate nurse practitioners and allied health alongside GPs, have diversified revenue beyond pure consultation billing, and have a succession or exit plan that reflects current market valuations.

The practices most exposed in the short term are those with low MyMedicare enrolment and no BBPIP registration. This all depends on adequate indexation of rebates. For all practices, the most exposed are those with a single-GP workforce, manual billing processes, no subspecialty or non-MBS revenue, and no plan for what happens when the principal stops working.

This report is a reference document for practice owners, investors, advisors and policymakers working in or entering Australian general practice. The data, sources and analysis are current to June 2026. Figures that carry an expiry date, including BBPIP registration numbers, bulk billing rates, payroll tax thresholds and AI adoption data, are flagged in the relevant sections and should be verified before use in commercial decisions.

Glossary of terms

ACAM: Australasian College of Aesthetic Medicine. Professional body providing fellowship and education pathways for doctors practising aesthetic medicine.

ACCC: Australian Competition and Consumer Commission. The competition regulator. Administers the mandatory merger notification regime from 1 January 2026.

AHPRA: Australian Health Practitioner Regulation Agency. The national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia.

AJGP: Australian Journal of General Practice. The RACGP's peer-reviewed clinical journal.

Ampliar Health: Medibank's subsidiary operating its GP clinic network, including the Myhealth and Better Medical brands. 170 practice sites (Myhealth 112, Better Medical 58) as at June 2026.

Avant: A medical defence organisation providing professional indemnity insurance and medicolegal services to Australian doctors.

BBPIP: Bulk Billing Practice Incentive Program. Pays a 12.5% loading on MBS benefits for fully bulk-billing practices. Replaced the former bulk billing incentive from November 2025.

Best Practice: The largest patient management system used in Australian general practice. Best Practice SP2 supports read-write integration with third-party clinical tools.

Bulk billing: A billing arrangement where the doctor accepts the Medicare rebate as full payment, with no out-of-pocket cost to the patient.

Capitation: A payment model where providers receive a set amount per enrolled patient per period, regardless of whether the patient seeks care.

Cleanbill: An independent data platform tracking bulk billing rates, membership fees and billing practices across Australian GP clinics.

Closing Loopholes Act: Fair Work Legislation Amendment (Closing Loopholes No. 2) Act 2024. Inserted section 15AA into the Fair Work Act 2009, expanding the definition of 'employee' with implications for GP contractor arrangements.

Cormack Review: The independent Scope of Practice Review led by Professor Mark Cormack, delivered to the Commonwealth Government in October 2024. Made 18 recommendations on workforce design, development, education and planning across primary care professions.

Cubiko: A patient analytics platform for Australian general practice. Integrates with Best Practice to provide practice performance data, MBS billing analysis and care prompts.

DoHAC: Department of Health and Aged Care. The Australian Government department responsible for national health policy, Medicare and pharmaceutical benefits.

DPA: Distribution Priority Area. A classification system used to determine eligibility for various GP workforce incentive programs based on geographic need.

DPC: Direct primary care. A payment model where patients pay a subscription fee directly to a practice for a defined range of services, outside the Medicare fee-for-service structure.

EBITDA: Earnings before interest, taxes, depreciation and amortisation. The standard measure used in GP practice valuation, typically benchmarked at 13 to 17% of gross revenue for well-run practices.

EHR: Electronic health record. A digital version of a patient's medical history maintained by healthcare providers.

Fair Work Act: Fair Work Act 2009 (Cth). The principal federal legislation governing employment relationships, including the contractor/employee distinction relevant to GP arrangements.

Fee-for-service: A payment model where each service is billed and paid for separately. The dominant funding model for Australian general practice under Medicare.

FTE: Full-time equivalent. A standardised measure of workforce capacity.

GPACI: General Practice in Aged Care Incentive. Pays \$430 per enrolled residential aged care patient per year (\$300 to the GP, \$130 to the practice), delivered quarterly. Requires MyMedicare registration. Replaced the PIP GP Aged Care Access Incentive from 1 July 2024.

GPCCMP: GP Chronic Condition Management Plan. The MBS framework that replaced items 721, 723 and 732 from 1 July 2025. Key items 965, 393, 967 and 392. Ties chronic disease management billing to enrolled patients under MyMedicare.

GPMP: GP Management Plan. The former MBS item (721) for preparing a chronic disease management plan. Replaced by GPCCMP items from 1 July 2025.

Health Insurance Act: Health Insurance Act 1973 (Cth). The principal legislation governing Medicare, including section 126 (prohibition on insurance covering services attracting a Medicare rebate) and provisions on bulk billing compliance.

Heidi Health: An Australian-founded AI clinical documentation platform. Offers ambient scribe, ICD-10-CM and SNOMED-CT code suggestions. Partnered with R1 RCM for revenue cycle management integration in March 2026.

ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification. The standard coding system for diagnoses used in clinical and billing contexts.

IMG: International medical graduate. A doctor who obtained their primary medical qualification outside Australia. Subject to section 19AB restrictions on Medicare billing for a period after arrival.

IPN: Independent Practitioner Network. The largest corporate GP operator in Australia by site count, operating approximately 143 practices.

Lyrebird Health: An Australian AI scribe platform with exclusive read-write integration into Best Practice SP2. Cubiko integration recommends MBS item numbers based on consultation content.

MBS: Medicare Benefits Schedule. The listing of all services subsidised by Medicare, including item numbers, schedule fees and billing rules.

Medicare: Australia's universal health care system providing subsidised access to medical services, pharmaceuticals and hospital care.

Medicare Integrity Act: Medicare Integrity and Other Measures Act 2025. Passed September 2025. Strengthens compliance and enforcement provisions.

MedicalDirector: The second-largest patient management system used in Australian general practice.

MIGA: Medical Insurance Group Australia. A medical defence organisation providing professional indemnity insurance.

My Health Record: The national digital health record system. The Health Legislation Amendment Act 2025 mandates sharing-by-default of key health information.

MyMedicare: The voluntary patient enrolment system introduced in 2023, linking patients to a nominated GP and practice. Precondition for GPCCMP, GPACI and blended funding access.

Non-VR GP: A GP who is not vocationally registered with Medicare. Non-VR GPs attract a lower Medicare rebate for their services.

OAIC: Office of the Australian Information Commissioner. Administers the Notifiable Data Breaches scheme under the Privacy Act 1988 and oversees privacy regulation.

PIP: Practice Incentives Program. Provides financial incentives to general practices for quality improvement activities and specific service delivery targets.

PHN: Primary Health Network. Regional organisations funded by the Commonwealth to support primary care providers, commission services and improve health outcomes.

PHO: Primary Health Organisation. The New Zealand equivalent of capitation-funded primary care organisations. Referenced in international comparisons.

Privacy Act: Privacy Act 1988 (Cth). Governs the handling of personal information, including health information. Includes the Notifiable Data Breaches scheme and the Australian Privacy Principles.

PSR: Professional Services Review. The independent body that investigates potential inappropriate practice in relation to Medicare billing.

RACF: Residential aged care facility. The setting in which GPACI payments apply for enrolled residents.

RACGP: Royal Australian College of General Practitioners. The professional body for GPs in Australia. Sets training and accreditation standards.

Section 19AB: The provision of the Health Insurance Act 1973 restricting Medicare billing by IMGs and certain other doctors for a defined period. Commonly referred to as the '10-year moratorium'.

SEM: Single Employer Model. A trial arrangement allowing GP registrars to maintain employment with a single entity throughout hospital and community training rotations, with portable entitlements.

SNOMED-CT: Systematized Nomenclature of Medicine, Clinical Terms. A clinical terminology system used in electronic health records and increasingly in AI coding tools.

TCA: Team Care Arrangement. The former MBS item (723) for establishing a multidisciplinary care plan. Replaced by GPCCMP items from 1 July 2025.

Telehealth: The delivery of health care services via telecommunications technology, including telephone and video consultations billed under specific MBS items.

TGA: Therapeutic Goods Administration. The Australian regulator for therapeutic goods including medicines, medical devices and, from August 2025, potentially AI clinical decision support tools.

Value-based care: A payment model that rewards health outcomes rather than service volume. Not yet implemented at scale in Australian general practice but referenced in the Strengthening Medicare Taskforce recommendations.

VR GP: Vocationally registered GP. A GP who has completed RACGP or ACRRM fellowship and is eligible for the higher Medicare rebate (A1 rebate).

WIP: Workforce Incentive Program. Provides funding to practices employing nurses, Aboriginal and Torres Strait Islander health workers and allied health professionals. Practice Stream payments up to \$137,375 annually from 1 July 2025.

Medius Global advises GP practice owners, group operators and health sector investors on practice strategy, operational improvement, sale readiness and business expansion. If anything in this report bears on a decision you are weighing, we'd welcome the conversation.

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