

# Policy Meets Practice: Financial Modelling of Bulk-Billing and Practice Incentives Reform in Australian General Practice

Enoch Chi Ngai Lim 

Reddam House, Bondi, NSW, Australia  
Email: enochenochlim@gmail.com

**How to cite this paper:** Lim, E.C.N. (2025) Policy Meets Practice: Financial Modelling of Bulk-Billing and Practice Incentives Reform in Australian General Practice. *Open Journal of Applied Sciences*, 15, 3131-3145. <https://doi.org/10.4236/ojapps.2025.1510206>

**Received:** September 7, 2025

**Accepted:** October 18, 2025

**Published:** October 21, 2025

Copyright © 2025 by author(s) and Scientific Research Publishing Inc. This work is licensed under the Creative Commons Attribution-NonCommercial International License (CC BY-NC 4.0). <http://creativecommons.org/licenses/by-nc/4.0/>



Open Access

---

## Abstract

Bulk-billing incentives in Australian general practice are being significantly increased in an effort to boost universal bulk billing. The federal government has committed to tripling the Medicare bulk-billing incentive per consultation and introducing a new 12.5% practice incentive payment (PIP) for clinics that commit to bulk-billing all patients. This policy aims to make general practitioner (GP) visits free for more Australians and claims to improve GP revenues. This study analyses the financial and economic implications of this initiative against current GP billing models. This analysis reviews universal bulk billing, mixed billing, and private billing models and compares the new incentive-driven bulk-billing revenues to the Australian Medical Association (AMA) recommended fee benchmarks. Drawing on recent government data and independent financial modelling, this review indicates that while the incentives substantially increase Medicare payments, they still fall short of AMA-recommended fees for consultations. Mixed billing models often remain more lucrative for GPs unless current gap fees are very low. Business and economic perspectives are discussed, including potential impacts on practice viability, service quality, and healthcare access. Key challenges, such as clinic overhead costs, the 50:50 split of incentives between GPs and practices, and concerns about shorter consultation times, are highlighted. The findings suggest that despite the government's investment, many GPs may be hesitant to adopt universal bulk billing due to persistent gaps between Medicare reimbursement and the true cost of providing care.

## Keywords

Medicare, General Practitioners, Bulk Billing, Private Billing, Incentives, Australia

---

## 1. Introduction

Australia's universal healthcare system, Medicare, relies on a balance of government subsidies and provider pricing to ensure patient access to primary care. General practitioners (GPs) can either bulk bill (accept the Medicare rebate as full payment) or privately bill (charge a fee above the rebate, with patients paying the gap). In recent years, rising practice costs and stagnant Medicare rebates have driven more clinics to move from universal bulk billing to mixed or private billing models. The national GP bulk-billing rate has fallen from a peak of ~89% during the COVID-19 pandemic to around 77% in the past three years [1]. In parallel, patients' out-of-pocket costs more than doubled to \$1.66 billion annually [1]. These trends raise concerns about the affordability of care, as nearly 9% of people reported deferring GP visits due to cost [1]. In response, the Australian government announced a \$7.9 billion plan to strengthen Medicare by expanding bulk-billing incentives from 1 November 2025 [2]. This includes a tripling of the bulk-billing incentive payments and the introduction of a Bulk Billing Practice Incentive Program (BBPIP) to encourage entire practices to offer universal bulk billing [3]. Policymakers claim this will make up to 90% of GP visits free and improve GPs' financial viability [4] [5]. However, the efficacy of these incentives must be examined from business, financial, and health economics perspectives. This article provides an analytical overview of current GP billing models and evaluates the new incentive scheme's potential impact on GP earnings and practice sustainability.

## 2. Current Business Models in Primary Care

Australian general practices typically operate under one of three billing models: universal bulk billing, mixed billing, or private billing. Each model represents a different balance between patient affordability and practice revenue.

### 2.1. Universal Bulk Billing Model

In this model, the GP does not charge patients any out-of-pocket fees – every eligible consultation is bulk-billed to Medicare. The practice income for consultations comes solely from the government-set Medicare Benefits Schedule (MBS) rebate (and any incentive payments) for each visit. This model maximises patient access and eliminates cost barriers, aligning with Medicare's equity goals. Indeed, throughout the 2000s and 2010s, bulk billing became widespread; by 2019, over 85% of GP services were bulk billed [1]. Bulk billing is especially prevalent in high-volume corporate clinics and in areas serving lower socio-economic populations. The upside of universal bulk billing is increased patient throughput and community satisfaction due to free-at-point-of-care access. The downside is that the Medicare rebates often do not cover the full cost of providing care, putting pressure on the GP and practice finances. GPs have historically accepted lower margins under this model, but as expenses rise, viability has become a concern. Notably, the Australian Medical Association's (AMA) recommended fees for GP services

far exceed current Medicare rebates – for example, in September 2025, the AMA suggests AUD \$108 for a standard Level B consult and \$198 for a longer Level C consult, whereas the standard Medicare rebate (prior to the incentive boost) is only at \$43.90 for a Level B consult [6]. This discrepancy has made pure bulk-billing practices increasingly difficult to sustain financially without cross-subsidies or very high patient volume.

## 2.2. Mixed Billing Model

The mixed model is now the dominant approach in Australian general practice. In a mixed billing practice, GPs may choose to bulk bill certain patient groups (typically children, pensioners, healthcare card holders, and other concession patients), while privately charging other patients who can afford to pay a gap fee. For instance, a GP might elect to bulk bill all children under 16 and individuals with concession status, but charge a private fee for adults without concession cards. Those privately billed patients pay the GP's consultation fee (often \$20 - \$60 above the Medicare rebate), and they can claim the standard Medicare rebate back, effectively reducing their out-of-pocket cost by the rebate amount. Mixed billing allows GPs to receive additional income beyond the Medicare rebate for a subset of patients, helping cover rising operating costs while still providing gap-free services to vulnerable groups. From a business perspective, this model balances financial sustainability with equitable access. It has become prevalent as Medicare rebate indexation failed to keep pace with inflation over the past decade. Surveys indicate that the majority of GPs have adopted mixed billing; for example, an ABC News poll in 2025 found that over 92% of GP respondents did not plan to switch to full bulk billing under the new incentives [4]. This suggests that most GPs currently charge at least some patients a gap and intend to continue doing so. Mixed billing revenue strategies vary, but many practices set private fees close to or at the AMA-recommended rates to reflect the true cost of care [5]. Such fees can be around \$90 - \$110 for a standard consult, which significantly bolsters practice income compared to relying on the ~\$44 rebate alone for a routine standard consultation. The trade-off is that some patients face out-of-pocket costs, which may deter those who cannot afford the gap from seeking care.

## 2.3. Private Billing Model

In a fully private billing model, the GPs charge all patients for consultations regardless of their concession status, and usually, no routine services are bulk billed. Every patient pays the GP's full fee, and then claims the fixed Medicare rebate later (if eligible) to offset part of that cost. This model is relatively rare for general practice in some parts of Australia, as it means every visit has a cost to the patient; however, some boutique or specialised GP clinics and those in affluent areas operate this way. The appeal of private billing is maximised revenue per consult – GPs can set fees to match the workload and overheads. For instance, a private billing GP might charge \$80 - \$110 for a short consult and significantly more for

long consultations, aligning with AMA fee guidance. Patients bear higher upfront costs in exchange for potentially longer or more individualised consultations. From a health economics standpoint, pure private billing can reduce demand (since price is a barrier), which may lead to underutilization of preventive care in the community. Thus, few general practices are entirely private; most that attempted it have shifted to mixed models to retain patients. The financial viability of private billing is strong for GPs (since revenue per service is high), but the accessibility for patients is lowest in this model, conflicting with the equity principles of Medicare.

It is essential to note that many GPs have flexible approaches – for example, temporarily bulk billing more patients during specific periods (e.g., the 2020 pandemic telehealth period) and reverting to mixed billing as circumstances change [1]. Overall, as of early 2025, purely bulk-billing practices have dwindled, and mixed billing has become the norm as a pragmatic response to insufficient Medicare rebates. This context set the stage for the government’s new incentive scheme, which is explicitly designed to reverse the decline in bulk billing by making it more financially attractive for GPs to bulk bill every patient.

### **3. Government’s New Bulk Billing Incentive Scheme**

The Australian government’s 2025 incentive package for general practice has two main components: 1) Tripled Medicare bulk-billing incentives for GP consultations, and 2) a Bulk Billing Practice Incentive Program (BBPIP) that adds a 12.5% bonus on all billings for fully bulk-billing practices [2] [3]. As illustrated in **Table 1**, these measures, effective 1 November 2025, represent a substantial injection of funds into general practice with the aim of encouraging universal bulk billing.

#### **3.1. Tripled Bulk-Billing Incentive (Per Consultation)**

Medicare has long paid a small “bulk-billing incentive” for certain patients (children under 16, pensioners, and concession card holders) to compensate GPs for offering free care to those groups [2]. This incentive in major cities (Modified Monash 1 areas) was around \$6 - \$7 per eligible consult. The government’s new policy expands this incentive to all patients (no longer limited by age or concession status) and roughly triples the amount for GP attendances in most locations [2]. For a standard consult in a metropolitan area, the incentive will be approximately \$21.85 per visit. This is added on top of the base MBS rebate (which is \$43.90 for a Level B consultation [6]). Thus, a bulk-billed standard consult that previously earned a GP \$43.90 will now yield \$65.75 under the new rates, representing a ~50% increase in reimbursement for that service. Longer consultations similarly get the flat incentive added: e.g. a Level C consult (20 - 40 min, rebate ~\$83) would increase to roughly \$105 if bulk billed (rebate ~\$83 + \$21.85 incentive). These incentives are even higher in rural and remote areas due to scaling by the Modified Monash Model – rural GPs will receive 150% - 190% of the base incentive, translating into payments of approximately \$30 to \$41 per consultation

in the most remote regions [3]. By significantly raising the payment for each bulk-billed visit, the government expects GPs to find bulk billing more financially palatable and to reduce their reliance on charging gap fees [7]. Importantly, GPs can claim this incentive for any patient they bulk bill, regardless of whether their practice joins the full program [7]. In other words, even a mixed-billing GP will receive approximately \$21 more for each consultation they bulk-bill. This change alone (without the PIP) is projected to increase GP earnings for those who currently privately charge some patients, because now “those 1 in 4 services” (the approximate share of non-concessional visits that were privately billed) will attract an incentive as well [8]. The Department of Health estimated that simply extending incentives to all patients could raise the average bulk-billing rate by around 10 percentage points (e.g. from ~77% to ~87% of services) as some GPs choose to bulk bill more often [7] [9].

### 3.2. Bulk Billing Practice Incentive Program (BBPIP)

The second component is a practice-level incentive designed to encourage entire clinics to move to a universal bulk billing model. Under BBPIP, if *all* GPs in a practice agree to bulk bill every eligible general practice service for every patient, the practice receives an additional 12.5% loading on all Medicare billings for those services [2] [3]. This 12.5% bonus is calculated on the total MBS benefits paid for GP attendances (e.g. consultations, chronic disease plan items, health assessments, etc.) in a quarter, and paid quarterly in arrears [3]. The payment is split 50:50 between the practice and the GPs – effectively a 6.25% boost to doctor revenue and 6.25% to clinic income for all bulk-billed services [2]. **Table 1** summarises key features of the two incentives.

**Table 1.** Comparison of the new triple incentive vs practice incentive payment.

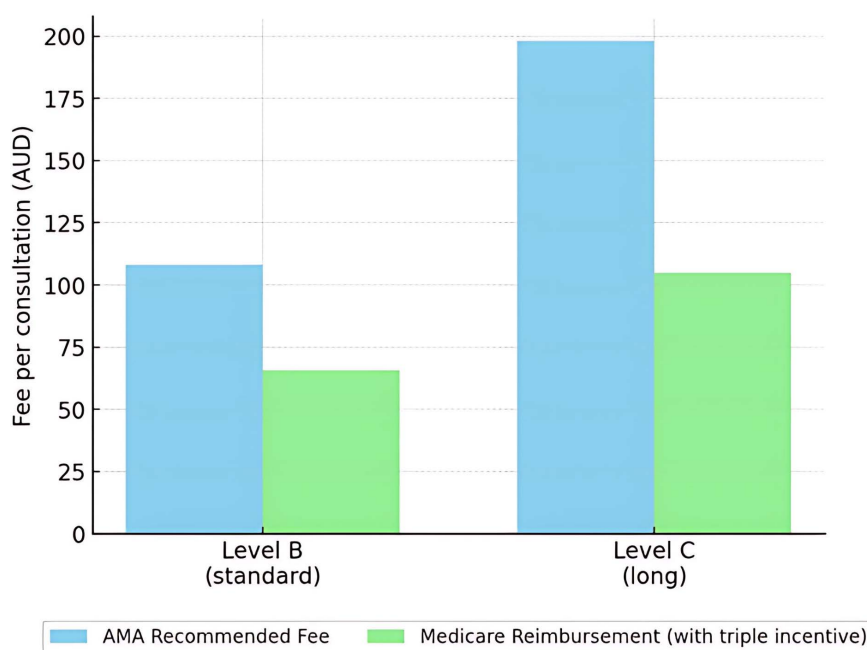
Feature	Tripled Bulk-Billing Incentive (per consult)	Bulk Billing Practice Incentive (BBPIP, quarterly)
<i>Payment trigger</i>	Each bulk-billed consultation (item added to Medicare claim)	Quarterly bonus on total Medicare billings for GP services
<i>Value (metro area)</i>	≈\$21.85 per eligible consult (MMM1 rate, triple the previous incentive)	12.5% of Medicare benefits paid for GP services, split evenly between GP and practice
<i>Eligibility</i>	Bulk billing any Medicare-eligible patient for an eligible GP service (expanded to <i>all patients</i> from Nov 2025)	<i>All</i> GPs in the practice must bulk-bill <i>all</i> eligible GP services (e.g. standard consults, chronic condition care plans) for <i>all</i> patients. Non-eligible services (e.g. certain procedures) can still be privately billed.
<i>Who receives it</i>	GP (paid with the Medicare rebate for that consult)	Paid to the practice (then split 50/50 between practice and doctors)
<i>Frequency</i>	Immediate per consultation payment via Medicare	Paid quarterly (retrospective for the quarter's billings)

To join the BBPIP, practices must register and commit to advertising themselves as a “Medicare Bulk Billing Practice” to patients [7]. Compliance will be monitored (practices that charge any gaps for included services become ineligible) [7]. The government has set a goal of roughly tripling the number of fully bulk-billing practices nationwide from the current ~1600 to about 4800 clinics with this program [5] [8]. Major corporate clinic chains have already indicated plans to opt in; for example, ForHealth (one of the largest bulk-billing providers) announced that most of its 70+ clinics will transition to 100% bulk billing by November, 2025 [5].

#### 4. Government’s Financial Rationale

From a health economics perspective, the government’s investment is intended to realign GP incentives with public health objectives. By boosting the payment for bulk-billed services, the policy attempts to narrow the long-standing gap between what a GP earns from a privately billed consult versus a bulk-billed consult, as illustrated in **Figure 1**. According to the Department of Health’s modelling, prior to these changes, a typical GP in a metropolitan practice who bulk-billed all patients earned significantly less than a peer who mixed-billed. For example, one analysis of 2023-24 data found a \$45,757 annual earnings gap for a GP in a city practice who bulk billed every visit compared to a GP with “average” bulk-billing rates (*i.e.* partially charging fees) [8]. In rural areas, the gap was slightly smaller (around \$32k annually) but still sizeable [8]. The government asserts that the new incentives will close or even reverse these gaps. A March 2025 departmental fact sheet indicates that after November 2025, a GP who fully bulk bills in a typical metropolitan clinic could earn roughly the same or slightly more than if they continued mixed billing [8]. For instance, projected “annual GP billings” for an average metro GP vs a fully bulk-billing GP are \$569k vs \$576k, respectively, after the incentive, leaving a small net positive difference of about \$7.6k in billings ( $\approx$ \$2.3k in take-home earnings) for the fully bulk-billing GP [8]. In rural settings, the modelling suggests a larger benefit: a rural GP practice that switches to full bulk billing could be \$34k better off in gross billings per year, translating to around \$10k higher earnings for the GP after overheads [8]. These estimates align with public statements by the Health Minister that “*bulk-billing GPs will earn more than average mixed-billing GPs*” under the new scheme [5]. It is worth noting, however, that these figures depend on assumptions of “average” billing patterns and overhead splits. The government’s examples often describe GPs who already bulk bill a high proportion (e.g., ~80% - 90% of visits) and have relatively modest gap fees [7]. In such cases, the added incentives (plus the removal of patient billing) yield a clear net gain.

Despite the government’s optimistic projections, the AMA and RACGP have urged caution, noting that the incentives may not be sufficient to cover all practice costs, especially for longer consultations. The AMA emphasises that GPs remain free to set their own fees and are not obligated to bulk bill all patients [3]. Indeed,



**Figure 1.** Comparison of AMA-recommended fees vs Medicare reimbursement. Note: Medicare’s new bulk-billing incentives substantially raise the GP’s payment for each service, but the total remains well below the AMA’s recommended fee, especially for longer consultations (indicative of the cost gap).

the AMA’s position is that Medicare rebates (even after this boost) do not accurately reflect the true cost of providing high-quality care, which includes longer consultation times for complex issues [3] [5]. The RACGP has similarly stated that “*the new bulk-billing incentives are not going to be viable for everyone*” and pledged to continue advocating for higher rebates for longer consults [5]. In practice, the decision to shift to universal bulk billing will be a business decision for each practice, weighing the new incentive income against the loss of private fees and any changes in patient load.

## 5. Methods

The financial modelling presented in **Table 2** was based on the following assumptions:

- **Patient volume:** 30 patients per day, reflecting a typical full-time GP workload.
- **Consultation type mix:** The base model assumes predominantly Level B consultations (<20 minutes), as these represent the majority of GP services.
- **Private fee levels:** Scenarios modelled at \$95, \$105, \$115, and \$125 per consultation for privately billed patients.
- **Medicare rebate and incentive:** Level B rebate = \$43.90; bulk-billing incentive (MMM1) = \$21.85; total = \$65.75.
- **Practice Incentive Payment (PIP):** 12.5% loading on Medicare billings for fully bulk-billed practices, split equally (6.25% each) between GP and practice.
- **Overheads:** Estimated at 30% - 40% of gross billings, consistent with industry

benchmarks.

- **Data sources:** AMA fee schedules, Department of Health MBS Online [6], and recent government modelling reports [8].

## 6. Financial Analysis: Incentives vs GP Revenue

A critical question is whether the new incentives truly make GPs “better off” financially by bulk billing all patients, compared to retaining a mixed billing model. This involves comparing the revenue under different scenarios of patient volume, fee levels, and bulk-billing rates. This study conducts an independent financial analysis of GP billing models to illustrate these comparisons in **Table 2**. The analysis modelled daily revenue for a GP under various bulk-billing proportions (50% up to 100%) and private fee levels, using a standard Level B consult as the baseline for calculations. Taking the new bulk-billing incentives and PIP proposed from 1 November 2025 into consideration, **Table 2** presents an excerpt focusing on a representative scenario of 30 patients per day, which is a reasonable daily workload for a full-time GP.

**Table 2.** Daily GP Revenue: Mixed Billing vs Universal Bulk Billing Models Comparison based on a 30 patients/day scenario.

Private Fee Charged (per consult)	Mixed Billing						Universal Bulk Billed
	(50% patients bulk billed, 50% privately billed)	(60% patients bulk billed, 40% privately billed)	(70% patients bulk billed, 30% privately billed)	(80% patients bulk billed, 20% privately billed)	(90% patients bulk billed, 10% privately billed)	(95% patients bulk billed, 5% privately billed)	(100% patients bulk billed, with triple incentive + PIP)
<b>\$95</b>	\$2411.25	2323.5	2235.75	2148	2060.25	2016.38	\$2063 per day
<b>\$105</b>	\$2561.25	2443.5	2325.75	2208	2090.25	2031.38	\$2063 per day
<b>\$115</b>	\$2711.25	2563.5	2415.75	2268	2120.25	2046.38	\$2063 per day
<b>\$125</b>	\$2861.25	2683.5	2505.75	2328	2150.25	2061.38	\$2063 per day

Note: Mixed billing scenario assumes a certain percentage of patients pay the stated private fee (plus they receive the Medicare rebate separately) and half are bulk billed (yielding \$65.75 each to the GP, *i.e.* routine rebate + triple bulk-billing incentive). The universal bulk-billed scenario assumes that every patient is bulk-billed, with the GP receiving \$65.75 + a 12.5% PIP loading (split)  $\approx$  \$68.75 per consultation. Figures represent gross billings before any operational overhead or rent is paid by the GPs to the practice. Scenarios highlighted in green indicate that the financial outcomes under the mixed billing model are more favourable than those observed with the universal bulk-billing model, whereas scenarios highlighted in purple denote circumstances in which the universal bulk-billing model demonstrates a relative financial advantage over the mixed billing model.

As shown in **Table 2**, at realistic private fee levels (\$95 - \$125 range), a mixed billing model would generate significantly higher daily revenue for a GP than full bulk billing would, given 30 patients a day. For example, at a \$105 fee, the GP’s gross billings are about \$2561/day under mixed billing vs \$2063/day under universal bulk billing, a difference of nearly \$500 per day in favour of mixed billing. Even at a relatively modest \$95 fee, mixed billing yields roughly \$350 more per day than the all-bulk scenario for 30 patients. The gap widens at higher fee levels

– charging \$125 per consult would bring in roughly \$800 more *per day* with a 50% mixed model compared to bulk billing everyone. These findings highlight that the new incentives, while substantial, do not fully offset the loss of private fee income for many clinics. In essence, the government is raising the Medicare payment for a standard consult to around \$65 - \$69, but if a GP can charge \$100+ in the market, there remains a shortfall. This aligns with the AMA's observation that the bulk-billing incentive boost "doesn't cover costs" for many practices and that GPs "need to be able to charge their worth" to run a viable business [5].

It is worth noting that the financial breakeven point varies depending on the current practice charges and the number of patients already bulk-billed. The modelling indicates that the higher the existing private fees and the lower the current bulk-billing proportion, the harder it is for the new incentives to match mixed-billing revenue. Conversely, for clinics that already bulk bill most patients or charge only small gap fees, the incentives could make full bulk billing more feasible. At very high bulk-billing rates (90% - 95% of patients are already bulk-billed), the difference between sticking with mixed billing and switching to all bulk billing becomes small. If the private fee is around \$90, a fully bulk-billed model with incentives can approximately break even with the mixed model. This explains why the government's case studies of benefiting clinics often involve those with ~80% bulk billing rates and modest \$10 - \$20 gap fees [7]. In such scenarios, the "loss" of private income is minimal, and the new incentive payments (on all visits) represent a net gain. However, for a practice currently bulk billing only 50% - 60% of patients and charging say \$40 gap fees to others, fully bulk billing everyone would still leave a substantial revenue gap of several hundred dollars per GP per day. In those cases, the mixed model remains substantially more profitable than universal bulk billing.

Another consideration is the role of longer consultations and procedural items. The financial analysis above used Level B (standard < 20 minutes) consults for baseline; GPs who do a lot of Level C (between 20 - 40 minutes) or D (between 40 - 60 minutes) consults, or billable procedures (skin excisions, contraceptive device implants, etc.), derive significant revenue from those longer or higher-effort services. Medicare's new incentives add the same ~\$21 per service regardless of length, which proportionally benefits short visits much more than long visits. For example, an extra \$21 on a \$44 item (Level B) is nearly a 50% bump, but on a \$125 item (Level D), it's about 17%. Thus, GPs who provide lengthy consultations for complex cases may find the incentive insufficient to compensate for not charging a gap. The realistic mixes of Level C/D consultations and procedure fees would further increase the overall financial advantage of the mixed billing model compared to universal bulk billing. This is because in a mixed model, a GP could charge, say, \$150 for a Level C (with a patient rebate of approximately \$83), netting significantly more than the approximately \$105 they would receive from Medicare by bulk billing that Level C with incentives.

In summary, from a pure revenue standpoint, the new incentives greatly im-

prove bulk-billing income but do not universally surpass mixed billing income under typical conditions. Many GPs will indeed earn more per consult by bulk billing post-November 2025 than they did before (since previously non-concession patients had no incentive, now ~\$21 extra) [4] [8]. However, for GPs who were charging substantial gap fees, the trade-off remains: they will be paid less for those patients if they forego the gap, even after accounting for the government's incentives. Whether the difference is small enough to accept will vary from practice to practice. A brief sensitivity analysis indicates that the conclusions are robust across plausible workload variations. For example, at 20 patients per day, mixed billing still yields higher revenue than universal bulk billing unless private fees are set at or below \$90. At 40 patients per day, the revenue gap narrows, but mixed billing remains more profitable when private fees exceed \$100. Similarly, scenarios with a higher mix of Level C/D consultations further favour mixed billing, as the flat incentive represents a smaller proportional increase for longer services. The government's hope is that improved bulk-billing revenue, along with intangible benefits (e.g., increased patient volume or goodwill), will tip the balance in favour of universal bulk billing for many clinics. But as the next section discusses, there are challenges and considerations beyond just the raw revenue figures.

## **7. Challenges and Considerations**

Implementing the new bulk-billing incentive scheme in practice presents several business and policy challenges. These include financial sustainability concerns for GPs, variability across locations, potential effects on service delivery, and the complexity of practice-level adoption. This analysis primarily models a single representative scenario (30 patients/day, mostly Level B consultations). While this reflects a common practice profile, it does not capture the full diversity of general practice billing patterns, such as higher proportions of long consultations, procedures, or varying patient demographics. As such, the findings should be interpreted as illustrative rather than universally generalisable.

### **7.1. Viability of GP Practices and Overheads**

One major challenge is whether the incentive-driven bulk billing income is sufficient for GPs and practices to cover their operating costs. General practices incur overheads such as rent, staff salaries, medical equipment, clinical consumables, insurance, cybersecurity, stationery, technology, software, administration and communication costs. In Australia, these often consume at least 30% - 40% of their gross billings. In mixed or private models, this overhead is built into the gap fees charged. Under full bulk billing, however, the only revenue is the Medicare payment. If that payment remains below the cost-recovery level, clinics risk operating at a loss. As shown earlier, even with the triple incentive, a standard consult yields about \$65 - \$69 to the GP. Many clinics consider this inadequate – a practice manager in NSW noted that with the new incentives, their clinic would get \$87

per visit (likely a rural-loaded rate) for previously paying patients, which is still “a loss of \$21 on every private consultation patient” compared to the status quo fee of \$108 [4]. She flatly stated that “we can’t afford [it] if we bulk-billed everybody” [4]. Such sentiments are common; a national GP survey found 66% of GPs plan to “keep their current billing practices” (and 6% even intend to raise private fees) despite the new incentives [4]. This suggests that many GPs fear that full bulk billing would undermine their practice’s financial stability. The RACGP has warned that if incentives “don’t cover costs, then practices will keep... current billing practices”, highlighting that GPs need adequate compensation to run a viable business [5]. In high-overhead urban clinics, the \$65 - \$70 Medicare payment may barely break even per consult after costs. In contrast, large bulk-billing corporate clinics (which operate on high volume and perhaps lower cost per consult via economies of scale) may find the incentives more workable. The 50:50 split of the PIP between GPs and practices was intended to address overhead sharing [5]. However, many GPs felt the entire 12.5% should go to the doctor (who could then pay their usual percentage to the practice) to truly make bulk billing attractive [5]. The government’s refusal to budge on the split was criticised as not listening to GP feedback and possibly a deterrent for some clinics to participate [5].

## 7.2. Urban-Rural Disparities

The impact of the incentives will differ across locations. Rural GPs stand to gain more per consultation (with up to 190% incentive scaling) and typically had lower gap fees to begin with, making the transition to full bulk billing relatively more appealing [4]. Indeed, the government specifically noted that rural practices might feel the biggest difference [4], which could improve access in underserved areas. Urban GPs, on the other hand, face higher patient expectations and higher practice costs (e.g. city rents and staff wages). They also often charge higher fees. For them, the flat incentive may not be as persuasive. As Dr. John Deery of the GP Alliance pointed out, “there’s a disincentive for urban GPs to bulk-bill” despite many urban patients also struggling with costs [4]. This raises a policy concern: If mostly rural and corporate clinics adopt universal bulk billing, while many urban private clinics do not, an inequality in access could persist or worsen (a “postcode lottery” for free GP visits). The MMM-based scaling partly addresses this by paying rural GPs more, but there is no equivalent extra loading for high-cost metropolitan areas. Additionally, areas with doctor shortages (e.g. regional towns) might see an influx of patients if GP visits become free, potentially overwhelming clinics unless more workforce measures accompany the incentives.

## 7.3. Practice Behavioural Changes—Consultation Length and Throughput

A significant concern within the profession is that these incentives may inadvertently encourage shorter consultations. Since the new \$21.85 incentive is a flat amount per consult, GPs only get it by seeing more patients – there is no addi-

tional reward for spending extra time with one patient beyond the normal time-tiered rebate. Many doctors worry this could “*reward getting more patients through the door*” rather than providing comprehensive care [4]. For example, under full bulk billing, a GP might reason that two 15-minute consults (each attracting an incentive) are financially better than one 30-minute consult (which still only attracts one incentive). Female GPs and those managing complex chronic cases have voiced concern that they will be “*disadvantaged*” because they tend to have longer visits [4]. The RACGP has advocated for a structural fix – such as introducing longer consultation items with higher rebates (their proposed “seven-tier structure”) – to ensure quality is not compromised [3]. From a health economics view, incentivising quantity over quality could lead to efficiency gains in simple cases but risks poorer outcomes for complex patients if GPs feel pressure to shorten visits. It could also contribute to GP burnout by increasing the daily patient load. The government has claimed that the investments will allow practices to “*grow [their] team... and expand services*” [7], which might mitigate workload concerns if clinics reinvest extra revenue into hiring more GPs or nurses. Whether that happens will depend on if the incentives truly generate surplus funds after covering costs.

#### **7.4. Patient Expectations and Continuity**

There is also the challenge of managing patient expectations during this transition. The high-profile announcement of “free GP visits” for most has already led to some public misunderstanding. Many patients might expect that from November 2025, all clinics will offer free GP consultations. In reality, participation is voluntary and not all GPs will opt in. Frontline staff fear a “*whingeing*” backlash from patients if their clinic chooses to remain mixed billing [4]. Practice managers anticipate having to explain why some patients are still being charged despite the government program. This situation is evident in the Mudgee example, where staff expected to “*have to put armour on*” receptionists to deal with complaints [4]. Such friction could impact the doctor-patient relationship and tarnish the reputations of both the GP and the clinic. On the flip side, clinics that do switch to full bulk billing may attract new patients and increase loyalty of existing ones, which could benefit the business in the long run (through higher volume and possibly more chronic conditions management plans, etc.). Economically, if many patients migrate to the universal bulk-billing (*i.e.*, “free”) clinics, other clinics might be pressured to join the trend or risk losing clientele. We may see market competition playing a role: larger corporate practices making the shift (a number have announced plans to bulk bill millions of extra appointments [4]) could force smaller practices in the vicinity to reconsider their model. This dynamic will become clearer after implementation.

#### **7.5. Administrative and Compliance Burden**

Joining the BBPIP requires administrative steps (MyMedicare registration, adver-

tising status, etc.) [2] [7] and ongoing compliance (ensuring no ineligible billing). There may be concerns about inadvertent breaches – for example, if a GP charges a gap for a service that they did not realise was under the “eligible services” list, the whole practice could lose the PIP bonus for that quarter. The government plans automated monitoring via Services Australia [7]. Some practices could find these requirements onerous or risky, especially multi-doctor clinics where maintaining 100% adherence by all providers is challenging. This could dissuade a cautious practice owner from opting in unless they are confident all colleagues will comply.

### 7.6. Duration and Indexation of Incentives

Although not explicitly labelled “temporary” by the government, the funding for these incentives is part of a budget measure and will need to be maintained in future budgets to continue. If inflation erodes the value of rebates and incentives in the coming years (as has happened in the past with Medicare freezes), GPs might again face the squeeze, and the cycle of moving to mixed billing could recur. There is also a question of whether the “triple” incentive is a one-off boost or if further adjustments will follow. The 2023-24 Budget called it a “historic boost” to Medicare, but long-term sustainability will depend on regular indexation that keeps up with practice cost inflation [5]. From a financial planning perspective, practices might be wary if they suspect the incentives could be reduced by a future government; this uncertainty could impact willingness to overhaul billing models.

In light of these challenges, the transition to more bulk billing will likely be gradual. The incentives clearly improve the financial equation for bulk billing, but adoption will vary. GPs who practice with lower consultation fees, higher existing bulk-billing rates, or corporate support are likely to benefit and may therefore opt in quickly. Others will likely take a “wait and see” approach, doing their own calculations as recommended by the AMA [3]. It is a significant change in the business model for GPs, and not without risk. Policymakers will need to monitor uptake and be prepared to adjust settings (for example, boosting rebates for longer consults or increasing the incentive further) if the goal of 90% bulk billing by 2030 is to be achieved.

## 8. Conclusion

The Australian government’s bold push to revive bulk billing through a temporary triple incentive and practice-level bonus is a landmark investment in primary care. From a business and financial perspective, the policy substantially increases Medicare payments to GPs for each visit, partially bridging the long-standing gap between government rebates and the real costs of care. Our analysis indicates that while many GPs will find their income bolstered for bulk-billed services, the new rates still fall short of the AMA’s recommended fee levels. Mixed billing is likely to remain more financially viable for practices that currently charge moderate to high gap fees, unless they significantly alter their service volume or cost structure.

Health economics considerations suggest that improved access (via more free services) must be balanced against maintaining quality and sustainable practice operations. The incentives may succeed in lifting bulk-billing rates in the short term, especially in rural areas and high-volume clinics, but their universal uptake remains uncertain. In the academic and policy context, this case illustrates the challenges of using financial incentives to steer provider behaviour in healthcare. A limitation of this study is its reliance on government projections and modelling. Independent validation using real-world data, such as GP billing practices, patient demographics, and practice cost structures, would strengthen the robustness of the findings. Future research should incorporate primary data from practices to test the assumptions underpinning the financial scenarios presented here. Ongoing evaluation will be needed to see if the policy delivers the intended outcomes of increased access without compromising the financial viability of Australia's GP sector.

### Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

### References

- [1] Department of Health and Aged Care, Australian Government (2025) Bulk Billing for All Australians. Impact Analysis—February 2025. Office of Impact Analysis. [https://oia.pmc.gov.au/sites/default/files/posts/2025/02/Impact%20Analysis\\_0.pdf#:~:text=to%20bulk%20bill%20certain%20services%20aged%20people](https://oia.pmc.gov.au/sites/default/files/posts/2025/02/Impact%20Analysis_0.pdf#:~:text=to%20bulk%20bill%20certain%20services%20aged%20people)
- [2] Department of Health, Disability and Ageing, Australian Government (2025) Upcoming Changes to Bulk Billing Incentives in General Practice. Department of Health. <https://www.health.gov.au/our-work/upcoming-changes-to-bulk-billing-incentives-in-general-practice#:~:text=Upcoming%20changes%20to%20bulk%20billing,incentives%20in%20general%20practice>
- [3] Australian Medical Association (2025) Changes to Bulk Billing Incentives in General Practice. AMA. <https://www.ama.com.au/resources/changes-bulk-billing-incentives-general-practice#:~:text=The%20federal%20government's%20decision%20to,effect%20on%201%20November%202025>
- [4] Worthington, E., Cockburn, P. and Edmonds, C. (2025) Most GPs Won't Exclusively Bulk-Bill Even with Record Medicare Promise, New Surveys Suggest. ABC News. <https://www.abc.net.au/news/2025-04-24/election-2025-bulk-billing-incentives-surveys/105188924>
- [5] Burge, K. (2025) "Disappointing": Bulk-Billing Loading Allocation Revealed. newsGP. <https://www1.racgp.org.au/newsgp/professional/disappointing-bulk-billing-loading-allocation-reve#:~:text=know%20this%20is%20an%20area,of%20rapid%20growth%2C'%20share%20said>
- [6] Department of Health, Disability and Ageing, Australian Government. MBS Online. Department of Health. <https://www9.health.gov.au/mbs/search.cfm?q=23&Submit=&sopt=I>
- [7] Burge, K. (2025) Government Continues Bulk Billing Push. newsGP.

<https://www1.racgp.org.au/newsgp/professional/government-continues-bulk-billing-push#:~:text=The%20Federal%20Government%20continues%20to,arrangements%20for%20GPs%20and%20practices>

- [8] Department of Health and Aged Care, Australian Government (2025) The Impact of Bulk Billing Investments on GP Earnings and Billings. Department of Health. <https://www.health.gov.au/sites/default/files/2025-03/the-impact-of-bulk-billing-investments-on-gp-earnings-and-billings.pdf#:~:text=incentive,receive%20have%20higher%20billings%20and>
- [9] Attwooll, J. (2025) Government Rejects Bulk Billing Incentive Analysis. newsGP. <https://www1.racgp.org.au/newsgp/professional/government-rejects-bulk-billing-incentive-analysis#:~:text=Government%20rejects%20bulk%20billing%20incentive,by%202030%20under%20new%20reforms>