May 2026

POLICY BRIEF

GRATTAN Institute

A better Medicare

How to reform GP funding

Peter Breadon, Molly Chapman

Founding Members (2009)

Australian Government

Victoria State Government

BHP

The University of Melbourne

Endowment Supporters

McKinnon

Summer Foundation

thirdlink

nab

The Myer Foundation

origin foundation

scanlon foundation

Affiliate Partners

Commonwealth Bank

cotality

UTS

Senior Affiliates

medibank

Wesfarmers

Affiliates

Allens

Ashurst

Maddocks

Westpac

Patrons

Carol Austin

Be BlueRock Foundation – Antipodean Family Endowment Fund

Carla Zampatti Foundation

The Cuthbertson Family Fund

Bronwyn Ann Davies Estate

Denbigh Foundation

Finkel Foundation

Lambert Bridge Foundation

Rob Keldoulis

Frank Macindoe

Lindsay Maxsted

Parncutt Family Foundation

The Reed Family Foundation

Michael Traill and Jenny Gage Traill

Frederick Woollard

Yarranabbe Foundation

Anonymous x 1

A more extensive list of Grattan's supporters and donors is on our website and in our Annual Report.

1 A big bulk-billing boost

Australia has just poured billions of extra dollars into general practice. In many ways, that's good news. The share of health funding going to primary care has been falling, and more investment could improve health and take pressure of hospitals. The government's goal was to increase bulk-billing, which had been falling sharply (Figure 1.2), and the policy worked.

But the new spending has also deepened fundamental problems with how we fund GPs. It has strengthened incentives for GPs to have quick consultations with their patients, sent money to parts of Australia that didn't need it, and left behind areas that need more funding the most.

It's time to start fixing the funding model, not just pouring more into it.

1.1 What changed

The bulk-billing incentive is a bonus GPs get when they don't charge patients a fee. It has been supercharged twice in recent years.

In 2023, it was tripled for all but the shortest general face-to-face consultations.[1] From November 2025, all patients became eligible, not just children and concession card holders. In addition, clinics that bulk-bill all their patients now get an extra 12.5 per cent on top of their Medicare funding.[2]

The changes have caused a massive increase in spending. The incentive now costs the equivalent of $2.8 billion a year (Figure 1.2).[3]

1. Incentives for some telehealth consultations were also tripled. See Department of Health and Aged Care (2023a).
2. Department of Health and Aged Care (2025).
3. In November and December 2025 – the two months following the expansion – about $470 million was spent on the GP bulk-billing incentive. When annualised, this gives $2.8 billion. See Australian Institute of Health and Welfare (2026a).

New spending from the tripling is equivalent to about 15 per cent of total government funding for GP services.[4]

The latest spending surge seems to have achieved the government's goal of boosting bulk-billing. Early signs suggest the national rate rose by 4.3 percentage points, with increases in most parts of Australia.[5]

Bulk-billing in regional centres and towns increased the most. In 2022, they had the lowest bulk-billing rates, but now regional centres have caught up with cities, and towns are closing in on remote areas, which have the highest bulk-billing rate of all.

But before these changes, fee-for-service payments already made up about 90 per cent of government funding for general practice, well above the level in comparable countries.[6] Every dollar of new spending has been tipped into that fee-for-service model, pushing the share even higher. This has made three big problems worse, with:

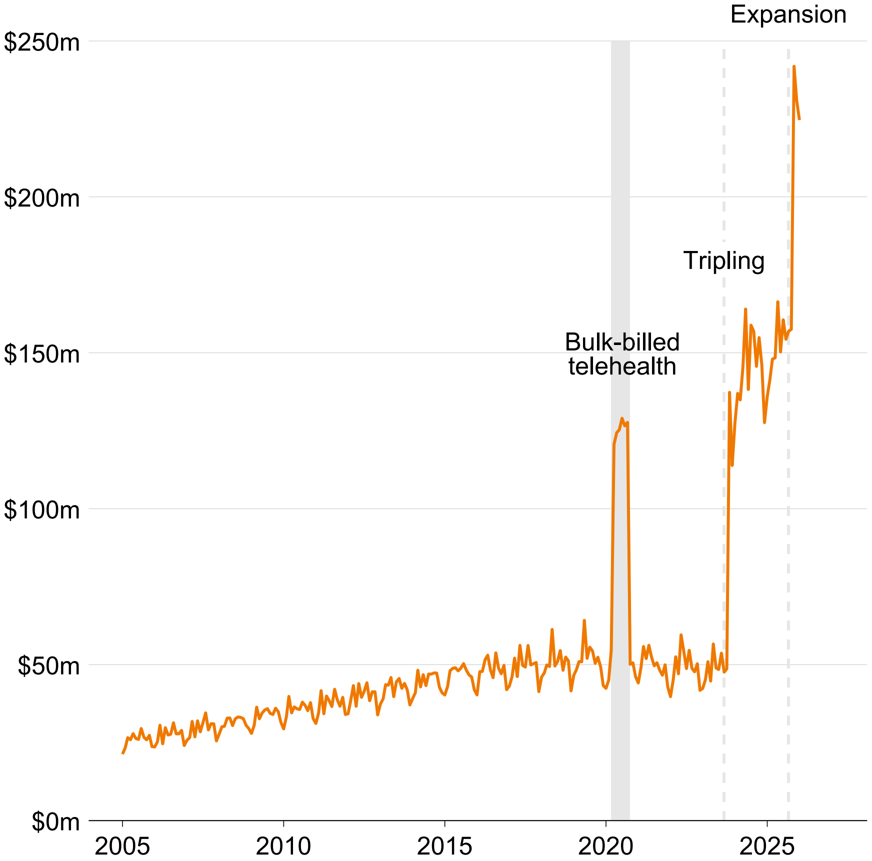
- even more focus on speed
- even less focus on need
- more spending on poorly-targeted rural subsidies.

This Grattan policy brief explains how each problem is getting worse, and how to solve them.

4. Pre-reform expenditure is calculated from November 2022 to October 2023 – the 12 months before the tripling – then adjusted for inflation. Post-reform expenditure is calculated from February 2025 to January 2026 – the most recent 12 months of available data. The difference is then divided by total Medicare GP benefits from January to December 2025. See Australian Institute of Health and Welfare (2026a) and Australian Institute of Health and Welfare (2026b).
5. Department of Health, Disability, and Ageing (2026a).
6. Department of Health and Aged Care (2024).

Figure 1.1: Bulk-billing spending has surged

Monthly spending on the bulk-billing incentive

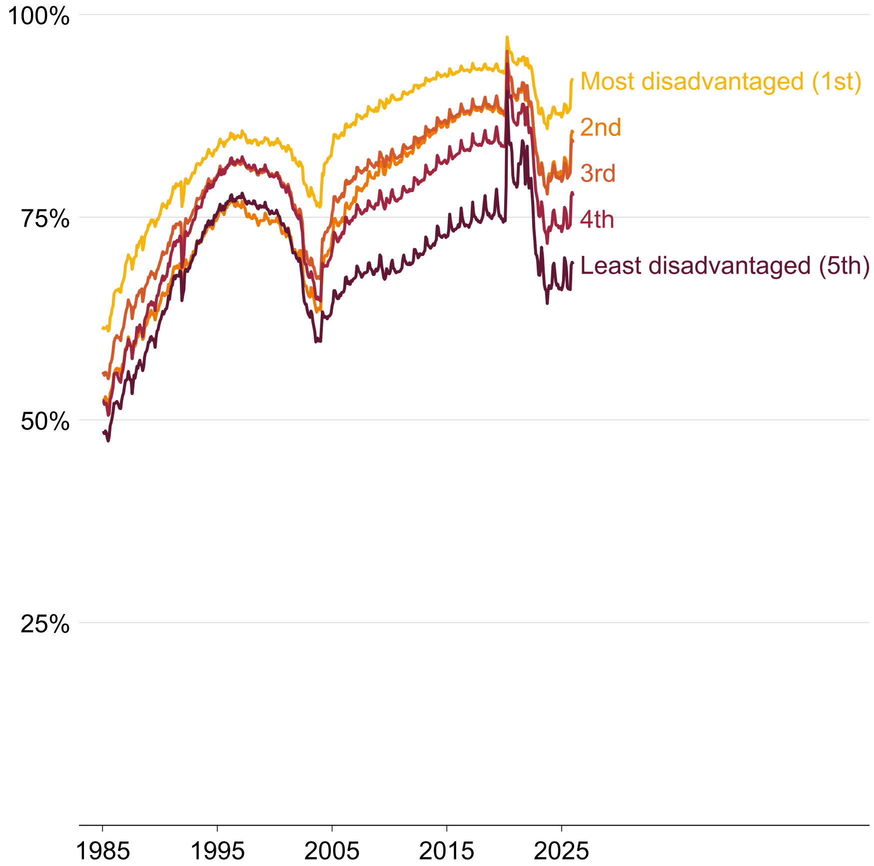


Notes: This data only includes bulk-billing incentive payments funded through Medicare, not the additional 12.5 per cent incentive payment. From 13 March 2020 to 1 October 2020 (during the COVID pandemic), GPs were required to bulk-bill all telehealth appointments: Department of Health (2020).

Source: Australian Institute of Health and Welfare (2026a).

Figure 1.2: Bulk-billing has increased across all levels of disadvantage

GP bulk-billing rate by disadvantage



Note: Disadvantage is measured using the Index of Relative Socio-economic Disadvantage (IRSD).

Source: Australian Institute of Health and Welfare (ibid).

2 Even more focus on speed

The tripled incentive has further increased the financial reward to GPs for quicker consultations, a well-known drawback of Australia's fee-for-service funding model.[7]

A standard Level B consultation covers visits from 6-to-20 minutes. A GP who wraps up at 6 minutes earns far more per minute than one who takes the full 20. The tripling of the incentive has widened that gap. Before the change it was about $6 a minute, and now it is $7.70 (see Figure 2.1).

While the tripling doesn't apply to the shortest visits of five minutes or less, they make up only 4 per cent of standard, time-tiered consultations.[8]

For clinics that bulk-bill all their patients, the 12.5 per cent bonus further compounds the incentive for speed, and that bonus applies to the shortest visits too.

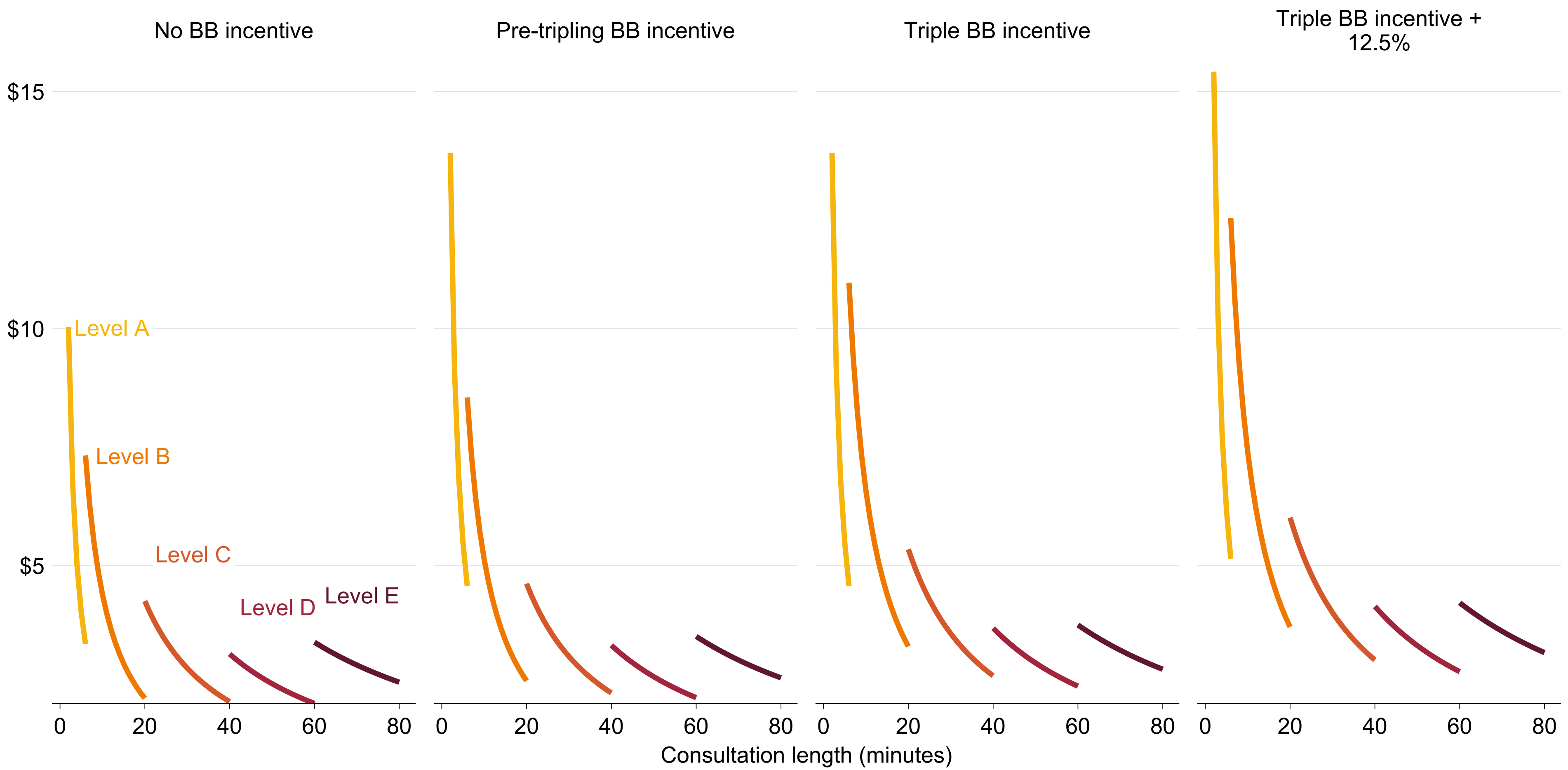
Increasing the incentive for speed is a poor fit for the growing number of patients with complex chronic disease. Those patients often need longer consultations, team-based care, and work between visits to plan and coordinate their treatment.[9]

Australia's fee-for-service funding promotes the opposite. It rewards short visits, blocks multi-disciplinary care, and only directly funds consultation face-time, not crucial behind-the-scenes work to plan, join up, and improve care.[10]

Intensifying incentives for speed also disadvantages female GPs, who spend longer with patients.[11]

7. Department of Health and Aged Care (2023b).
8. Services Australia (2026).
9. Breadon and Romanes (2022).
10. Department of Health and Aged Care (2023b), Department of Health and Aged Care (2024), and Breadon and Romanes (2022).
11. Royal College of General Practitioners (2024).

Figure 2.1: Supercharging the bulk-billing incentive has increased the payment GPs get per minute for short consultations length
Medicare Benefits Schedule (MBS) payment per minute under recent bulk-billing incentive reforms



Notes: BB = bulk-billing. Standard GP attendances are split into levels based on duration: Level A (<6 minutes), Level B (6-to-20 minutes), Level C (20+ minutes), Level D (40+ minutes), and Level E (60+ minutes).

Source: Grattan analysis of MBS data.

3 Even less focus on need

Before November 2025, restricting the bulk-billing incentive to children and concession card holders was the closest thing mainstream GP funding had to a needs-based adjustment. It wasn't much, but it did direct more money to clinics with more disadvantaged patients. Expanding the incentive to all patients removed that.

It is no surprise that immediately after the change, the share of incentive spending going to wealthier areas increased, at the expense of the poorest (Figure 3.1). Without the right policies, healthcare always flows uphill to the wealthiest,[12] and Australia removed one of the few ways policy shifted GP funding towards need.

We now have the crudest funding model that our research could uncover in any comparable system (Table 3.1 on the following page).[13] Australia's only remaining adjustment to mainstream GP funding is remoteness (bulk-billing incentives increase as remoteness increases, as discussed in the next chapter).

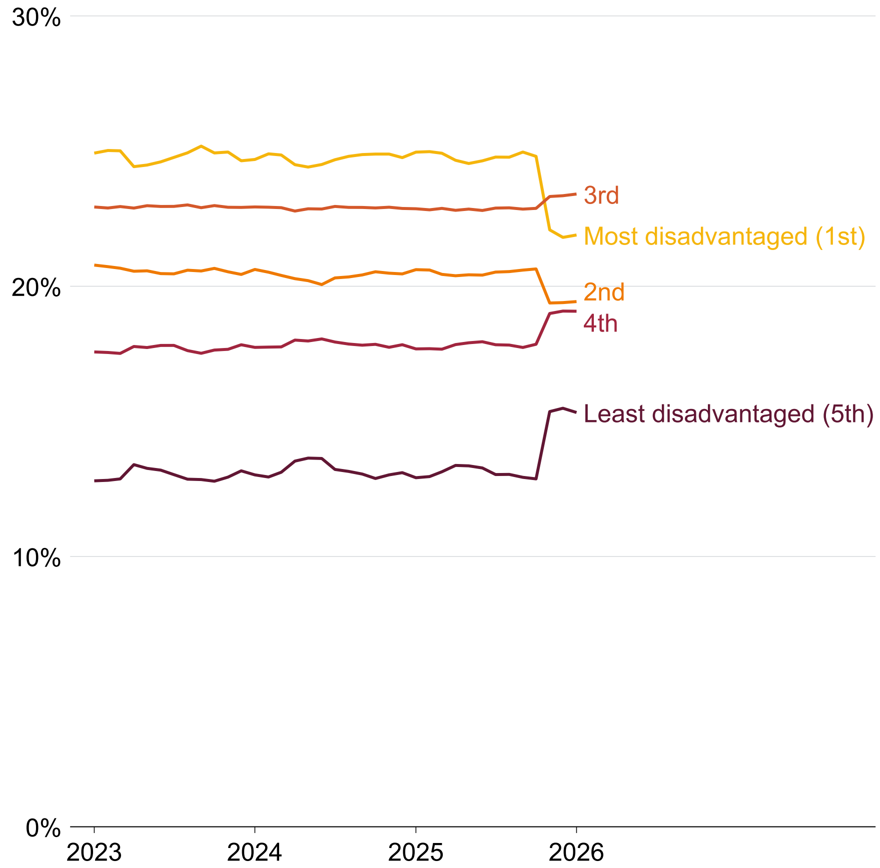
By contrast, England adjusts for age, sex, disease, and remoteness, and even that is being criticised as doing too little. After calls from think tanks and doctors' groups to add disadvantage to the formula, the UK government recently committed to a review.[14]

New Zealand's funding will change this year to adjust for age, sex, disease, deprivation, rurality, and ethnicity.[15] Scotland, Denmark, Sweden, the Netherlands, Catalonia, Portugal, and parts of Canada are among the many places that do more than Australia to make GP funding fair.

12. Hart (1971).
13. Some social insurance systems use fee-for-service schedules without needs adjustment, but apply sophisticated risk adjustment at the insurer level.
14. Breadon and Chapman (2026a).
15. New Zealand Ministry of Health (2025).

Figure 3.1: A bigger share of bulk-billing incentives now go to wealthy areas

Share of bulk-billing incentives by disadvantage



Note: Disadvantage is measured using the Index of Relative Socio-economic Disadvantage (IRSD).

Source: Australian Institute of Health and Welfare (2026a).

Table 3.1: Other countries do more to make funding fair
Adjustements to general practice funding by country

	Denmark	**Sweden**	**England**	**Scotland**	**Nether-lands**	**France** (GP)	**France** (team)	**Catalonia** (Spain)	**Portugal**	**British Columbia** (Canada)	**Ontario** (Canada)	**NZ**	**Australia**
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Sex	✓	✓	✓	✓			✓		✓	✓	✓	✓	
Disadvantage	✓	✓		✓	✓	✓	✓	✓	✓			✓	
Disease	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Remoteness		✓	✓	✓			✓		✓	✓		✓	✓

Notes: For disadvantage in Denmark and France (GP), and for remoteness in France (team), loadings are additional adjustments outside core risk adjustment. Several countries have multiple funding models, but in all cases the model shown is a standard or dominant payment model, with the exception of France (team), which refers to the PEPS (Paiement en Équipe de Professionnels de Santé en ville), an experimental collective payment model for multidisciplinary primary care teams. New Zealand ratings reflect the capitation reweighting being introduced in July 2026 (the current formula adjusts only for age and sex).

Sources: Adapted from Van De Voorde et al (2024), Technical Advisory Group on Resource Allocation (n.d.), Government of British Columbia (2026), Government of Ontario (2025), New Zealand Ministry of Health (2025), and Department of Health and Aged Care (2024).

4 Poorly targeted rural subsidies

The bulk-billing incentive rises as clinics get more remote, so a clinic in a very remote area gets almost double what a clinic in the city does (Table 4.1). Tripling the payments magnified those gaps. Before the incentives were tripled, a clinic in a very remote area got $7.10 more than one in a city. Afterwards, the difference almost tripled to $20.20 (Table 4.1).

More money for rural clinics is a good thing, because rural Australians are sicker and die younger than people in cities, and clinics in some rural areas face additional financial pressures.[16] But when you look at the communities within each remoteness category, and the level of the incentive payments, it's clear that the rural incentives are crudely targeted and essentially arbitrary.

The levels of remoteness – such as 'regional centre' and 'small town' – lump together areas with vastly different levels of wealth, health, and access to care (Figure 4.1). For example, almost one in five regional centres are in the top quarter of the country for GP services per person. Some small towns have excellent access, while others are in crisis.

As well as being poorly targeted, the rural loadings seem arbitrary. Since 2022, the incentive has been split into six tiers. But the funding levels don't seem to be based on a robust analysis of what rural clinics actually need, meaning the subsidies may be too low or too high. Tripling them has only multiplied the problem.

Meanwhile, the areas with the least care – 'GP deserts' in the bottom 5 per cent for services per person – actually had service levels fall after both boosts to the incentive (Figure 4.2). They also had the smallest increases in bulk-billing (Figure 4.3).

16. Breadon and Chapman (2026b).

After so much new funding, and with GP deserts falling further and further behind, the case to get care where it's needed most is stronger than ever.[17]

17. More evidence on GP deserts is in our submission to the Senate inquiry into rural healthcare: Breadon and Chapman (ibid).

Table 4.1: Rural loadings have surged

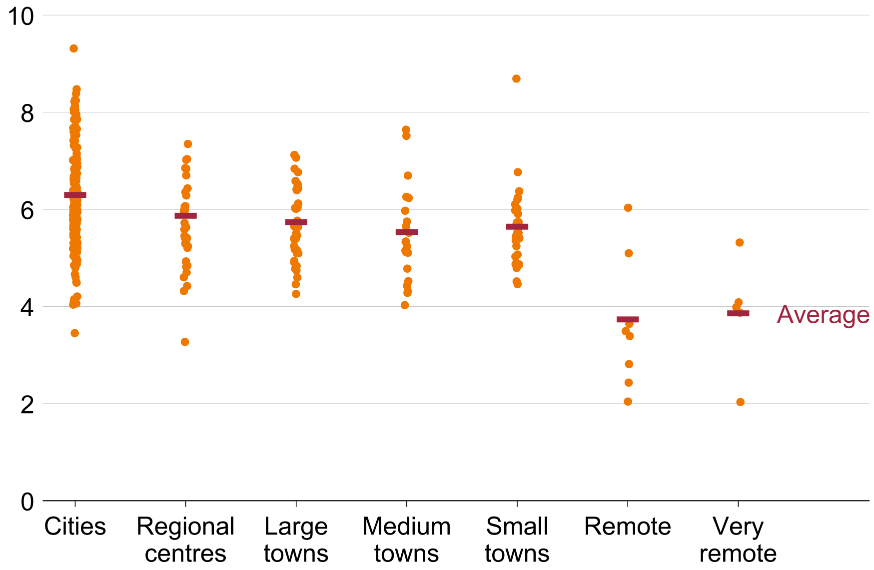
Location	2004 Incentives introduced	2022 Increases with remoteness	2023 Incentives tripled
Major city	$9.10	$7.80	$21.90
Regional centre	$13.60	$11.80	$33.30
Large/Medium town	$13.60	$12.50	$35.40
Small town	$13.60	$13.30	$37.60
Remote	$13.60	$14.10	$39.70
Very remote	$13.60	$14.90	$42.10
Range	$4.50	$7.10	$20.20

Note: Nominal prices have been inflated to December 2025 prices using the all groups consumer price index.

Sources: Parliament of Australia (2005), Department of Health, Disability, and Ageing (2026b), and Australian Bureau of Statistics (2026).

Figure 4.1: Access to GP services can vary significantly within location categories

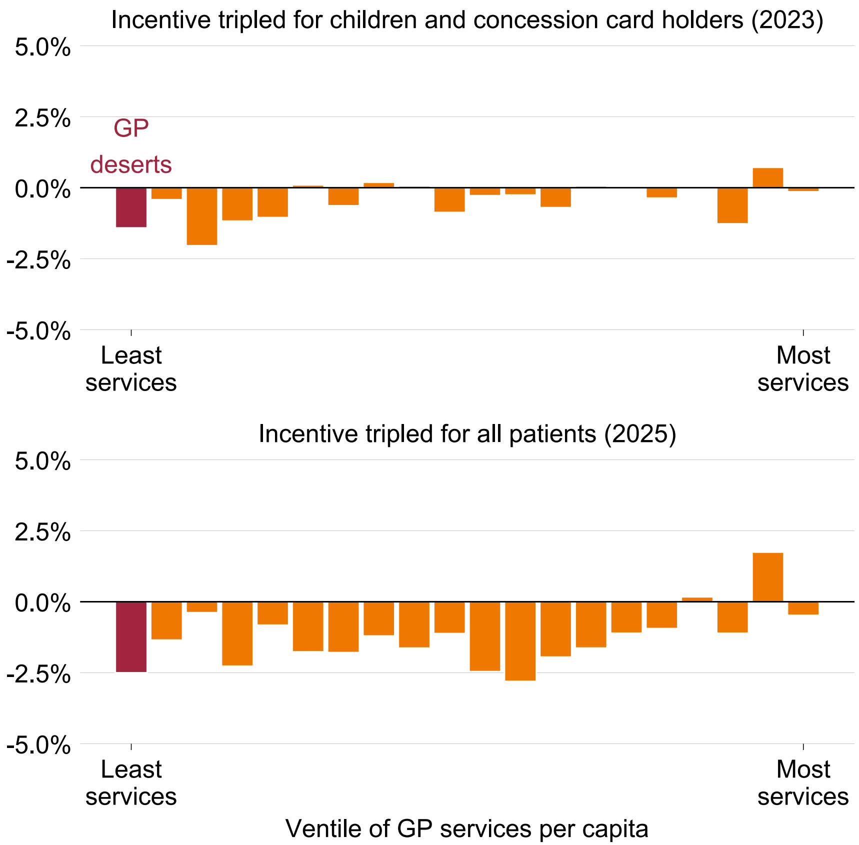
Age-adjusted GP services per person in each SA3 by location category (2023-24)



Notes: Location categories use the Modified Monash Model (MMM). SA3s are geographical areas typically covering a population of between 30,000 and 130,000 people: Australian Bureau of Statistics (2021). Each SA3 has been assigned to the MMM category in which the majority of its population live. The overall average for each MMM category is calculated as the average of the SA3s within that category, weighted by SA3 population. Some SA3s with small populations have been combined with nearby SA3s to allow for reporting of GP services per capita.

Sources: Australian Institute of Health and Welfare (2026c), Australian Government (2025), and Australian Bureau of Statistics (2025).

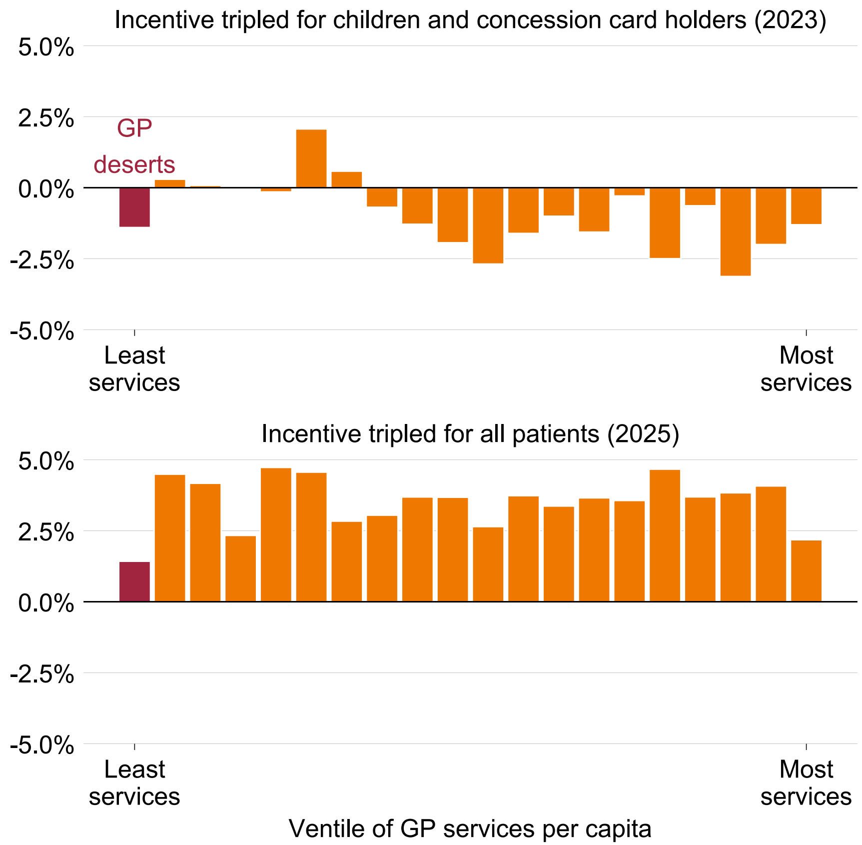
Figure 4.2: Service levels have been falling in GP deserts
Change in GP services per person by local age-adjusted service level



Notes: Crude GP services per capita are compared from the September quarter 2023 to the September quarter 2024 (2023 reform), and the December quarter 2024 to the December quarter 2025 (2025 reform). GP services per capita from 2024-25 are age-adjusted at the SA3 level using indirect standardisation and grouped into ventiles (5% bins). Includes Medicare-funded care only.

Sources: Department of Health, Disability, and Ageing (2026c), Australian Institute of Health and Welfare (2026c), Australian Government (2025), and Australian Bureau of Statistics (2025).

Figure 4.3: GP deserts have seen slower progress on bulk-billing
Change in GP bulk-billing rate by local age-adjusted service level



Notes: The bulk-billing rate is compared from the September quarter 2023 to the September quarter 2024 (2023 reform), and the December quarter 2024 to the December quarter 2025 (2025 reform). GP services per capita from 2024-25 are age-adjusted at the SA3 level using indirect standardisation and grouped into ventiles (5% bins). Includes Medicare-funded care only.

Sources: Department of Health, Disability, and Ageing (2026c), Australian Institute of Health and Welfare (2026c), Australian Government (2025), and Australian Bureau of Statistics (2025).

5 Two steps to fairer funding

Two reforms are needed.

First, the government should offer GP clinics an alternative to pure fee-for-service funding. Clinics should be able to opt in to blended funding: a combination of fees for each visit and a flexible budget for each enrolled patient.

Those budgets should be adjusted for age, sex, health conditions, disadvantage, Aboriginal status, and rurality. No clinic would be forced into the new model, but it should be financially attractive and come with the support practices need to make it work.

This would level the playing field for clinics caring for sicker, poorer, and older patients. It would get better value for taxpayers by targeting funding where it is most needed. And it would give clinics the flexibility to invest in team-based care and longer consultations – the things fee-for-service funding blocks.

It's an approach that has been adopted in many countries, and been recommended by the Strengthening Medicare Taskforce, the Review of General Practice Incentives, and in our 2022 report on primary care.[18]

Second, for the small number of communities where the market has failed, the federal government should fund Primary Health Networks to close gaps in care, with block funding, salaries, hub-and-spoke networks, or whatever each community needs.

The new National Health Reform Agreement lays the groundwork, with governments committing to develop options for thin markets, including pooled funding, new payment models, and flexible employment arrangements.[19] Now they need to follow through with dedicated, long-term funding, targeted at the areas with the most unmet need.

The federal government has focused on bulk-billing, and bulk-billing is going up. But the cost has been doubling down on a funding model that isn't fair, and that is a worse fit for our healthcare needs with every passing year.

After so many reviews and recommendations, and after being left behind by most of the world, it's time for Australia to catch up. The 2026 federal Budget is a chance to start building a GP funding system that sends money where it is needed most.

18. Department of Health and Aged Care (2023b), Department of Health and Aged Care (2024), and Breadon and Romanes (2022).

19. Department of Health, Disability, and Ageing (2026d).

Acknowledgements

This policy brief was written by Peter Breadon and Molly Chapman. Mia Jessurun also made a substantial contribution. It was edited by Paul Austin.

The opinions in this brief are those of the authors and do not necessarily represent the views of Grattan Institute's founding members, affiliates, individual board members, reference group members, or reviewers. The authors are responsible for any errors or omissions.

Grattan Institute is an independent think tank focused on Australian public policy. Our work is independent, practical, and rigorous. We aim to improve policy by engaging with decision makers and the broader community.

We acknowledge and celebrate the First Nations people on whose traditional lands we meet and work, and whose cultures are among the oldest in human history.

For further information on Grattan's programs, or to join our mailing list, please go to: www.grattan.edu.au. You can donate to support future Grattan reports here: www.grattan.edu.au/donate.

Grattan Institute Policy Brief May 2026

This policy brief may be cited as: Breadon, B and Chapman, M. (2026). *A better Medicare: How to reform GP funding*. Grattan Institute.

Bibliography

Australian Bureau of Statistics (2021). *Statistical Area Level 3*. https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/main-structure-and-greater-capital-city-statistical-areas/statistical-area-level-3.

——— (2025). *Data by region methodology, 2011-25*. https://www.abs.gov.au/methodologies/data-region-methodology/2011-25.

——— (2026). *Consumer Price Index, Australia*. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release.

Australian Government (2025). *ASGS SA3 2021 - Modified Monash Model 2023*. https://www.data.gov.au/data/dataset/asgs-sa3-2021-modified-monash-model-2023.

Australian Institute of Health and Welfare (2026a). *Medicare bulk billing of GP attendances: Monthly data*. https://www.aihw.gov.au/reports/medicare/medicare-bulk-billing-gp-attendances-monthly-data/related-material.

——— (2026b). *Medicare Benefits Scheme funded services: Monthly data*. https://www.aihw.gov.au/reports/medicare/mbs-funded-services-data/contents/summary.

——— (2026c). *Medicare-subsidised GP, allied health and specialist health care across local areas*. https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist/data.

Breadon, P. and Romanes, D. (2022). *A new Medicare: Strengthening general practice*. Grattan Institute. https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/.

Breadon, P. and Chapman, M. (2026a). 'Bulk-billing rates are up. But there's more to delivering the best possible care'. *The Conversation*. DOI: 10.64628/AA.u74ehhm69. http://theconversation.com/bulk-billing-rates-are-up-but-theres-more-to-delivering-the-best-possible-care-275669.

——— (2026b). *Getting care into 'GP deserts'*. https://grattan.edu.au/news/getting-care-into-gp-deserts/.

Department of Health (2020). *COVID-19 Telehealth Services*. https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/%24File/Factsheet-COVID-19-Obs-19.03.2021.pdf.

Department of Health and Aged Care (2023a). *Supporting Bulk Billing in General Practice*. https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/D204B38ED29B5FC8CA258A3E000EE282/$File/PDF%20vers%20-%20Supporting%20Bulk%20Billing%20in%20General%20Practice%20Factsheet.pdf.

——— (2023b). *Strengthening Medicare taskforce report*. https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en.

——— (2024). *Review of general practice incentives*. https://www.health.gov.au/sites/default/files/2024-10/review-of-general-practice-incentives-expert-advisory-panel-report-to-the-australian-government_0.pdf.

——— (2025). *Strengthening Medicare: More bulk billing*. https://www.health.gov.au/sites/default/files/2025-03/budget-2025-26-strengthening-medicare-more-bulk-billing.pdf.

Department of Health, Disability, and Ageing (2026a). *National GP Bulk Billing Snapshot - 1 November 2025 to 31 January 2026*. https://www.health.gov.au/sites/default/files/2026-02/national-gp-bulk-billing-snapshot-1-november-2025-to-31-january-2026.pdf.

——— (2026b). *Downloads*. http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads.

——— (2026c). *Medicare quarterly statistics – bulk billing by primary health network (December quarter 2025–26)*. https://www.health.gov.au/resources/publications/medicare-quarterly-statistics-bulk-billing-by-primary-health-network-december-quarter-2025-26?language=en.

——— (2026d). *Addendum to the National Health Reform Agreement 2026–2031*. https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2026-03/nhra-2026-31-addendum-consolidated.pdf.

Government of British Columbia (2026). *MSC Longitudinal Family Physician (LFP) Payment Schedule Summary of Changes – February 23, 2026*. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/longitudinal-family-physician/web-lfp_payment_schedule-feb_23_2026.pdf.

Government of Ontario (2025). *Bulletin 250901 — Capitation acuity modifier for FHN and FHO*. http://www.ontario.ca/document/ohip-infobulletins-2025/bulletin-250901-capitation-acuity-modifier-fhn-and-fho.

Hart, J. T. (1971). 'The inverse care law'. English. *The Lancet* 297.7696, pp. 405–412. ISSN: 0140-6736, 1474-547X. DOI: 10.1016/S0140-6736(71)92410-X. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/fulltext.

New Zealand Ministry of Health (2025). *Briefing for decision: Capitation reweighting*.

Parliament of Australia (2005). *Examination of Budget Estimates 2004-2005*. https://www.aph.gov.au/~/media/Committees/clac_ctte/estimates/bud_0405/vol4_doha_feb05.pdf.

Royal College of General Practitioners (2024). *Patient experiences of general practice care*. https://www.racgp.org.au/health-of-the-nation/chapter-1-patient-interactions-and-health-trends/patient-experiences-of-general-practice-care.

Services Australia (2026). *Requested Medicare items processed from January 2025 to January 2026*. https://medicarestatistics.humanservices.gov.au/SASStoredProcess/guest?_PROGRAM=SBIP%3A%2F%2FMETASERVER%2FShared+Data%2Fsasdata%2Fprod%2FVEA0032%2FSAS.StoredProcess%2Fstatistics%2Fmbs_item_standard_report&DRILL=ag&group=3%2C23%2C36%2C44%2C123&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=calyear&START_DT=202501&END_DT=202601.

Technical Advisory Group on Resource Allocation (n.d.). *Frequently asked questions*. https://www.tagra.scot.nhs.uk/frequently-asked-questions/.

Van De Voorde et al (2024). Van De Voorde, C., Lefèvre, M., Detollenaere, J., Brouckaert, N., and Jonckheer, P. 'Data requirements for risk-adjusted capitation payments for community health centres in Belgium'. en. KCE Reports. Edition: 1. DOI: 10.57598/R385C. https://kce.fgov.be/sites/default/files/2024-06/KCE_385_Risk-Adjusted_Capitation_Payments_Report.pdf.