BBPIP 2025: Is Full Bulk Billing Right for Your Practice?

From November 1, 2025, Australian general practice enters a new era with the introduction of the Bulk Billing Practice Incentive Program (BBPIP). As healthcare professionals across the country weigh their options, understanding what these changes mean for practices, GPs, and patients has never been more critical.

What Is the Bulk Billing Practice Incentive Program?
The Australian Government's bulk billing reform represents the most significant shift in general practice funding in recent years. BBPIP introduces two major changes to Medicare bulk billing incentives:
First, bulk billing incentives (BBI), previously limited to children under 16 and concession card holders, will now extend to all Medicare-eligible patients attending any general practice across Australia, for eligible MBS services that are bulk-billed.
Second, BBPIP participating practices (which have voluntarily registered to join BBPIP) receive an additional 12.5% incentive payment on eligible MBS benefits, split evenly between the GP and the practice1. BBPIP Participating Practices must commit to all their GPs bulk billing every eligible MBS service for every Medicare-eligible patient. This all-or-nothing approach is generating considerable debate within the general practice sector.

BBPIP Eligibility and Requirements
To participate in the Bulk Billing Practice Incentive Program, practices must:

- Voluntarily Register with MyMedicare to join the BBPIP (non-NGPA accredited practices exempt from accreditation requirements)
- Ensure that all their GP participate
- Bulk-bill all eligible MBS services for every Medicare-eligible patient
- Advertise participation on Healthdirect Australia's National Health Services Directory
- Display Medicare Bulk Billing Practice signage on-site
- Register through Services Australia's Organisation Register from November 1, 2025[1]

Financial Impact: What GPs and Practices Can Expect
Health Minister Mark Butler projects that nine out of ten GP visits will be bulk billed by 2030 under BBPIP.[2] The government estimates approximately 4,800 practices will be financially better off adopting full bulk billing compared to their current mixed billing models.[1]
However, recent Royal Australian College of GPs (RACGP) survey data reveals current challenges:

- Only 12% of GPs can afford to bulk bill all patients
- Average gap fee is $39 for standard consultations
- 50% of GPs charge $90 or more for short appointments[3]

Many practice managers question whether the 12.5% bulk billing incentive (which is split evenly between GPs and the practice and is not CPI indexed) covers rising operational costs including staff wages, rent, equipment, and compliance expenses.

Mental Health Medicare Item Changes
The 1st November 2025 changes also eliminate specific MHTP review and mental health consultation items, requiring GPs to use standard time-based Medicare item numbers instead.[2] This affects

practices that previously used "co-billing" strategies, charging privately for one condition while bulk billing mental health items.
For patients with complex mental health needs, this change may result in higher out-of-pocket costs or reduced consultation times.
Additionally, referrals for treatment will be linked to a patient's MyMedicare practice or usual GP, strengthening the patient-provider relationship and continuity of care.

GP Perspectives: Bulk Billing vs Mixed Billing in 2025
The RACGP survey shows GPs increasingly manage conditions typically handled by specialists, with longer appointment times becoming standard, particularly for mental health consultations.[3]
Dr Owen Harris, a Melbourne GP specialising in complex care, highlights the challenge: "There is simply no way to sustain empathy, compassion and concentration seeing that many patients in a day. Burnout or more superficial care is almost guaranteed."[2]
Current Medicare rebate structures incentivise "six-minute medicine" rather than comprehensive care, creating tension between financial viability and quality patient outcomes.[2]

Practice Manager Decisions: To Join BBPIP or Not?
The general response from Practice Managers from many practices operating under mixed billing models remain hesitant to transition back to full bulk billing. Key concerns include:
Business Risk: Since bulk billing incentives exist as separate Medicare item numbers rather than base consultation fee increases, they can be removed at any time
Operational Challenges: Full bulk billing creates rapidly filling appointment books with limited capacity for urgent presentations or complex cases requiring longer consultations
Investment in Change: Practices that educated patients about private fees are reluctant to reverse course, citing concern if government policies change again

Regional and Demographic Variations
Practice responses to BBPIP vary significantly based on:

- **Location**: Lower socioeconomic areas view BBPIP as welcome financial support for accessible care
- **Patient demographics**: Practices serving disadvantaged communities align naturally with full bulk billing models
- **Service offerings**: Specialised practices express greater scepticism about BBPIP viability
- **Existing billing models**: Always-bulk-billing practices welcome additional support; mixed billing practices remain cautious

BBPIP Calculator and Resources
The Australian Government provides a Bulk Billing Incentives Calculator to help practices estimate potential payments, though early users report results don't always align with practice-specific circumstances.
Practice teams should review:

- Detailed factsheets on the Department of Health website
- Eligible service item numbers requiring bulk billing
- BBPIP frequently asked questions for practices and providers[1]

What This Means for Australian General Practice
The Bulk Billing Practice Incentive Program represents a significant Medicare policy shift with far-reaching implications. For practices already bulk billing or serving financially disadvantaged communities, BBPIP offers genuine support. For others, the incentives may not justify operational challenges and business risks.
As the November 1 start date approaches, practice teams must conduct thorough financial analyses specific to their circumstances, consult with their GPs and colleagues, and carefully evaluate whether BBPIP aligns with their practice's culture, sustainability goals and patient care standards.
The coming months will reveal whether BBPIP achieves its goal of improving access to affordable GP care and the financial sustainability of general practices across Australia

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Paracetamol in pregnancy: separating fact from misinformation

The message is: listen to your GP, not an unqualified politician. Almost everything stated at the widely publicised press conference held by US President Donald Trump a few weeks ago regarding paracetamol advice for pregnant women, was incorrect.

1. There is no epidemic of autism spectrum disorder (ASD). The rates increased slightly to between 2-3% of births. What's changed are the **criteria for diagnosis**. Years ago, children on the spectrum were given a label called Asperger's syndrome, which was unhelpful and stigmatising. Additionally, the only children to receive an autism diagnosis were those with intellectual disability and severe repetitive behaviours. The recognition that issues with communication and repetition exist on a spectrum has allowed more people to access help.
2. ASD is largely genetic with only minor contributions from the environment, such as prematurity and perhaps maternal and paternal age.
3. The allegation that the MMR vaccine causes autism is based on fraudulent research, and exhaustive studies have shown the vaccine to be safe.
4. As for paracetamol in pregnancy - the evidence shows that it is safe. A large Swedish study followed 2.5 million children from birth to the age of 26 and found no link with autism.
5. Pregnant women should not "tough it out" when they have a fever. What we do know is that having a fever in pregnancy can be dangerous for the baby. That's why paracetamol is needed.

For a comprehensive overview of what's known about Autism Spectrum Disorder, listen to the recent ABC Health Report.

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Which is better for you: butter or margarine?

Margarine is an ultra-processed spread originally invented in the 19th century as a replacement for butter which didn't become rancid. The first recipe used beef tallow, so it definitely wasn't a healthier choice. Over the years, margarine has evolved, and these days it's mostly made with polyunsaturated fats or fortified with plant sterols.

Butter is made by churning large amounts of whole fat milk and contains about 80% saturated fat. Saturated fat has been consistently associated with blocked arteries, and increased risk of coronary heart disease, and stroke. By contrast, polyunsaturated fats and the plant sterols in margarines have been shown to lower LDL cholesterol levels and therefore reduce the risk of heart disease.

But it's a bit more complicated than that. While there's no doubt that saturated fat in meat contributes to arterial disease, there's little evidence that it's harmful in butter. Researchers believe this may be due to the bioactive compounds in butter, which counteract the effects of the saturated fat.

Both margarine and butter are very calorie dense – both spreads have approximately 700 calories per 100g, so overconsumption is not good for weight management and will likely lead to increased visceral fat around the belly.

But to answer the question, which is better for you? The polyunsaturated or plant sterol margarine wins. But if you prefer a smear of butter on your toast, it isn't going to kill you.

Can changing your diet help endometriosis?

Endometriosis occurs when the lining tissue from the uterus grows outside of the uterus, throughout the pelvis, and sometimes into the abdomen. Just like the lining of the uterus, endometriosis lesions are sensitive to menstrual hormones and bleed causing:

- painful periods
- pain with sex
- pelvic pain
- heavy menstrual bleeding
- reduced infertility.

Sometimes there are no symptoms, and the condition is discovered during fertility assessments. According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), one in seven Australians who were born as female will be diagnosed with endometriosis by the time they're 49- So it's common, but the cause is unknown.

RANZCOG has developed what they call a Living Evidence Guideline which aims to be practical, up to date and give women the knowledge and choices they need to minimise the impact of what can be a seriously debilitating condition.

Hormone therapy and pain relief are the bases for treatment, with surgery as a secondary option, but there's increasing evidence that non-drug treatments can help. However, there hasn't been many credible studies for a firm recommendation.

Pelvic physiotherapy has been reported to have some benefits, as well as mindfulness classes to help manage the pain. Dietary changes can help manage symptoms; fish oil has been suggested to help reduce the inflammation and vitamin D supplements have potential benefits. The other recommendation has been the FODMAP diet which was developed in Australia, and was originally designed for people with Irritable Bowel Syndrome (IBS). The diet is not a permanent change since it is not nutritionally complete, and a FODMAP diet is low in poorly absorbed fermentable carbohydrates.

A small randomised trial conducted by Monash University in Melbourne found that a low FODMAP diet improved gastrointestinal symptoms in women with endometriosis. Symptoms like bloating, abdominal pain and having poorly formed (or loose) stools. The diet was also associated with an improvement in quality of life. This trial doesn't prove that there is a reliable benefit, but for women desperate for some relief, the diet could be worth trying after discussion with your GP.

The Monash FODMAP group has various resources available including recipes. Low FODMAP Diet | IBS Research at Monash University - Monash Fodmap