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POLICY BRIEF

The perfect blend

Getting flexible GP funding right

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1 The best of both worlds

Around the world, blended funding has become a common way to fund general practice. It combines a flexible budget for each patient with a fee for each service.

Grattan Institute has recommended blended funding for Australia.[1] So have three recent independent, government-commissioned reviews.[2] Blended funding would reward prevention and continuity of care, support multidisciplinary care, and make funding fairer (Box 1).

Today, the federal government funds general practice almost entirely through fee-for-service payments. The Medicare Benefits Schedule pays for each individual service delivered, and mostly only for care delivered by GPs. This rewards short, one-off consultations and limits team-based care.

The opposite funding model is called capitation: the GP clinic gets a fixed budget for each patient, adjusted up or down depending on the patient's predicted healthcare needs. That budget doesn't change if they get a lot of care, a little, or none at all. This means that under capitation, practices have a financial incentive to provide too little care, since each additional service is a cost and not a source of revenue.

As discussed in Chapter 3, each way of funding care has benefits and drawbacks. Blended models are designed to balance them to get the best result.[3]

Many other countries use blended funding, and they have chosen a wide range of designs.[4] Making it work requires the right design, and one choice matters more than any other: how much funding is flexible, and how much remains fee-for-service. But there is little research on how to strike the right balance.[5] That is the topic of this Grattan policy brief.

The next chapter shows that there is a measurable floor below which flexible funding is too low, making it financially unattractive for GP clinics to delegate care. The final chapter shows how different policy goals require higher and lower levels of flexible funding, making the final policy choice a trade-off between those goals.

1. Breadon et al (2022).
2. Strengthening Medicare Taskforce (2023), Cormack (2024), and Expert Advisory Panel on the Review of General Practice Incentives (2024).
3. This idea has a long pedigree in health economics. Ellis and McGuire (1986) showed formally that pure prospective payment can lead to too few services and pure cost-based reimbursement to too many, while a blended model can improve the incentive to deliver an efficient level of care.
4. OECD (2016) and Commonwealth Fund (n.d.). For example, among systems implementing new models in recent years, one in Belgium has roughly 50:50 capitated and fee-for-service funding, while a model in Alberta, Canada, has 85 per cent capitation: Van de Voorde et al (2024) and Alberta Health (2026).
5. There is research comparing blended and fee-for-service models, for example Kralj and Kantarevic (2013) and Glazier et al (2009), but that research compares funding models and provides little guidance on how to strike the right balance within one.

Box 1: Why general practice funding needs reform

In our 2022 report *A new Medicare*, we proposed a range of reforms to strengthen general practice.[a] A key goal is to make general practice a team sport, with nurses, pharmacists, allied health professionals, and other clinicians working under GP leadership to share the load.

That will free GPs to spend more time on complex patients, and give all patients faster access to care and more support. Team-based care is already business as usual in many other countries, and in Aboriginal Community Controlled Health Organisations here.

But Australia's GP funding model stands in the way. Government funding is more than 90 per cent fee-for-service. This rewards episodic, high-turnover care, and does little to reward prevention, continuity of care, or the multidisciplinary care that complex patients need.[b] It also does little to steer money towards the patients and communities that need it most: Australia's funding does less to adjust for needs than any comparable country.[c]

Almost all fee-for-service funding pays GPs for each service they personally deliver, so delegating care means giving up income. That is why it will take fixing the funding model — and setting the right blend — to unlock team-based care.

We proposed that blended funding be opt-in: no clinic would be forced to switch. That avoids imposing change on clinics that don't want it, and means government can offer focused and intensive support to help clinics change.

a. Breadon et al (2022).
b. Cormack (2024).
c. Breadon and Chapman (2026).

2 A profitable cocktail

While they are mostly government-funded, the vast majority of Australia's general practices are small or large businesses.[6] For them to participate in a new funding model, they will need to see an opportunity to at least maintain, and ideally increase, their profitability.

Non-profit providers, such as the Aboriginal community-controlled sector, will also need a good reason to switch. Their motivation might not be profit, but they will want to create a surplus to reinvest in improving and expanding care.

Whether it pays to switch comes down to the level of flexible funding. In Appendix A we set out a derivation of the minimum level. It essentially boils down to a simple rule: the share of flexible funding must be at least the ratio of multidisciplinary team (MDT) cost to GP cost.

To understand why, it helps to think about a single instance of delegated care. When a clinic shifts care to a lower-cost team member, it earns the flexible payment but gives up the fee-for-service payment the GP would have billed.

As a general guide, if the flexible funding is high enough to cover the new cost of care, switching pays. Otherwise, the clinic loses money. That is what the break-even ratio captures: flexible funding must exceed the team's cost relative to the GP's. That holds when the clinic refills freed-up GP time with new patients. If the GP doesn't see new patients and simply works less, the bar is higher still.[7]

Here is an example to show how crucial the level of flexible funding is for profitability. Take a clinic with a single, fully bulk-billing GP. The clinic earns $600,000 a year from Medicare for the GP's services, and pays the GP $400,000 in wages. What is left after on-costs is profit.

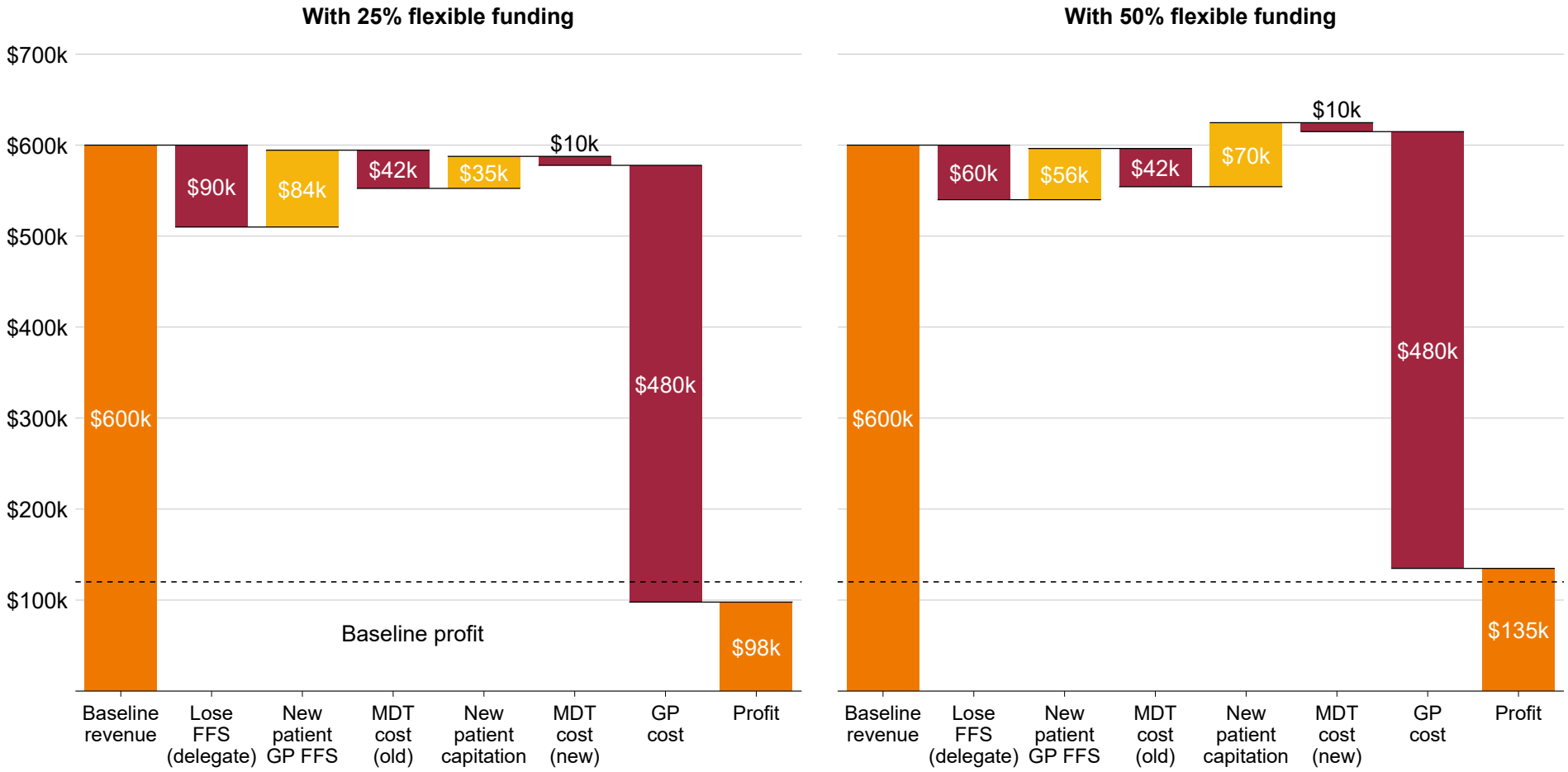
The clinic adopts the new, blended funding model. Every patient brings in flexible funding that adds up to the cost of their predicted care: the typical cost of treating a similar patient.[8] In this example, we assume the switch itself leaves the clinic's total funding unchanged: the original patients bring the same total budget, and only the blend changes.[9] Total funding is not frozen at the clinic's original level, so if new patients are enrolled, they bring in new funding.

The clinic delegates 20 per cent of the GP's care to a multidisciplinary team, and the GP uses the freed-up time to see new patients. The new patients bring in new funding – both flexible and fee-for-service – and add to the multidisciplinary team's workload.

If the level of flexible funding is 25 per cent, and 75 per cent is still fee-for-service, the clinic loses about $22,000 a year. If the level of flexible funding is raised to 50 per cent, with 50 per cent remaining fee-for-service, profit increases by about $15,000 a year. Figure 2.1 shows how clinic revenue and costs play out in each scenario.

6. Breadon et al (2022). This chapter treats the clinic as a single decision-maker. In practice, most GPs are independent contractors paid a share of the fees they personally bill, so delegation that adds to clinic profit can still cut an individual GP's income. Clinics that switch will need to update their internal payment arrangements – for example, sharing flexible funding with GPs and paying for oversight time – so that what is good for the clinic is also good for each GP.
7. The GP working less is substitution; refilling freed-up time with new patients is augmentation. How each shifts profitability is discussed below.
8. Scaled down to take the fee-for-service share of blended funding into account. Additional loadings may be added for traditionally under-served groups, such as First Nations patients.
9. Predicted funding will not be perfectly accurate in practice. Policy responses are discussed in Chapter 3.

Figure 2.1: The level of flexible funding can make the difference between profit and loss



Notes: FFS = fee for service. MDT = multidisciplinary team. Illustrative worked example. Assumptions: GP uses all the time freed up by delegation to see new patients (full augmentation); practice revenue baseline is $600,000 a year; GP wage cost is $400,000 a year (gross); GP and MDT on-costs are 20 per cent of wage; 20 per cent of GP care is delegated to the multidisciplinary team; MDT wage is 33 per cent of the GP's marginal cost; MDT throughput time is 1.25 times GP's; GP and MDT coordination time are both 5 per cent of delegated care; bulk-billing clinic, with total funding held constant at the point of switching, and no change in the number of services (low-value care reduction is discussed below). Figures are rounded.

Source: Grattan Institute analysis.

But while the break-even level of flexible funding is mostly about covering the multidisciplinary team's cost, several factors move it away from that anchor. Two things push the level of flexible funding needed higher:

- **Coordination costs** — delegating does not fully free up the GP, who still spends time overseeing each delegated case, and the MDT needs coordination time too.
- **Slower throughput** — evidence suggests that MDTs can take longer than a GP to provide the same care,[10] increasing their relative cost.

One factor pushes the break-even level down:

- **Augmentation** — if freed-up GP time is used to see new, fee-generating patients, the forgone billings are recovered and the break-even level falls.[11]

And the effect of a final factor depends on the level of augmentation:

- **Status-quo profit margins** — where a clinic refills most of its freed-up time (high augmentation), being more profitable lowers the break-even level.[12] By contrast, if freed-up GP time is mostly lost (low augmentation), a higher margin raises the break-even level of flexible funding, because more billing is given up.

Figure 2.2 shows how profitability and the level of augmentation together shift the break-even level of flexible funding.

Putting it all together, you get the formula shown in Box 2, and derived in Appendix A.

10. A 2018 Cochrane review of 18 studies found that, compared with doctors, nurses delivering primary care probably have longer consultations while achieving similar or better health outcomes and higher patient satisfaction (Laurant et al 2018). Earlier systematic review evidence reached the same conclusion (Horrocks et al 2002).
11. Except at zero or negative status-quo profit, when there is no margin to recover, so augmentation has no effect (at zero) or a negative one (at below zero). Recovered billings are reduced by GP coordination time.
12. That is because each extra patient is worth more.

Figure 2.2: Prior profits and ability to grow the patient pool shift the break-even level of flexible funding
Cells show the break-even share of flexible funding for given levels of profit and augmentation

Profit	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%
18%	58.0%	56.3%	54.6%	52.8%	51.1%	49.4%	47.7%	46.0%	44.3%	42.6%
16%	57.0%	55.4%	53.9%	52.4%	50.9%	49.4%	47.8%	46.3%	44.8%	43.3%
14%	55.9%	54.6%	53.3%	51.9%	50.6%	49.3%	47.9%	46.6%	45.3%	44.0%
12%	54.9%	53.8%	52.6%	51.5%	50.3%	49.2%	48.1%	46.9%	45.8%	44.6%
10%	53.9%	52.9%	52.0%	51.0%	50.1%	49.1%	48.2%	47.2%	46.3%	45.3%
8%	52.9%	52.1%	51.3%	50.6%	49.8%	49.1%	48.3%	47.5%	46.8%	46.0%
6%	51.8%	51.3%	50.7%	50.1%	49.5%	49.0%	48.4%	47.8%	47.3%	46.7%
4%	50.8%	50.4%	50.0%	49.7%	49.3%	48.9%	48.5%	48.1%	47.8%	47.4%
2%	49.8%	49.6%	49.4%	49.2%	49.0%	48.8%	48.6%	48.4%	48.3%	48.1%
0%	48.8%	48.8%	48.8%	48.8%	48.8%	48.8%	48.8%	48.8%	48.8%	48.8%

Augmentation

Note: Assumptions: multidisciplinary team wage = 1/3 GP wage; MDT time taken = 1.25 GP time taken; on-costs = 20 per cent of wages; coordination time for delegated care is 5 per cent of delegated time (for both GP and MDT).

Source: Grattan Institute analysis.

Box 2: Break-even flexible funding is based on the ratio of GP cost and multidisciplinary team cost

The core break-even level for switching to be profitable is:

$$\frac{\text{Capitation}}{\text{Revenue}} > \frac{\text{MDT cost}}{\text{GP cost}}$$

But existing profits and ability to grow the patient pool make a difference, so the flexible share of funding must be greater than the sum of:

Multidisciplinary team cost: $\tau M(1+c_m)(1+o_m)\frac{C}{R}$

Cost of the team doing the delegated work: ratio of MDT wage to GP wage (M) with MDT coordination time (c_m) and on-costs (o_m) added, multiplied by patient throughput (τ) relative to GP.

GP oversight: $c_g(1+o_g)\frac{C}{R}$

Delegating doesn't fully free the GP due to coordination time (c_g) for all delegated care.

Lost fee-for-service: $\left[1-\frac{C}{R}(1+o_g)\right][1-A(1-c_g)]$

Margin given up by not billing the visit can only be partly clawed back by using freed-up time to see new patients. The more time is refilled – augmentation A, 0 (none) to 1 (all) – the more revenue is recovered.

Note: See Appendix A for full derivation and notation.

Source: Grattan Institute analysis.

3 Policy goals and trade-offs

The break-even point for a given clinic can be calculated using the formula in Box 2 on the preceding page. But knowing the break-even point doesn't tell you the right level of flexible funding.

Setting it requires a series of judgments:

- How much financial incentive do clinics need to switch?
- Which clinics should be encouraged to switch?
- Which of the benefits and risks of each funding type matter most?

3.1 How much financial incentive is needed?

How much higher, or lower, than the break-even point should the level of flexible funding be?

Switching funding models is not free. Clinics must change how they roster and pay staff, redesign workflows, enrol patients, and learn a new billing system. But most of these costs are one-off, and a permanently higher level of flexible funding is the wrong tool for a temporary problem. Time-limited transition support is a better way to cover switching costs.[13]

But there is a still a good reason to set the ongoing level of flexible funding above break-even. A clinic offered a deal that merely breaks even has little reason to take it. Switching is risky and hard to reverse, so a clinic will need to expect a real gain – not just no loss – before they choose to move.

On the other hand, part of the reason for a new funding model is to blunt fee-for-service incentives to provide 'low-value care': visits that aren't really needed. A level of flexible funding below the break-even level might still generate new profits if clinics reduced low-value care. Despite this, there are two reasons that going below the break-even level is probably the wrong choice.

First, clinics will be more confident about switching if they don't have to cut low-value care just to break even. At or above the break-even level of flexible funding, the incentive to reduce low-value care is stronger,[14] and it becomes a way to increase profit, not just maintain it.

Second, setting the level of flexible funding below the break-even point essentially forces clinics to cut a specific amount of low-value care. But the amount of existing low-value care is hard to measure. It is even harder to know how much new care – such as preventive services – is needed, which would offset those reductions. Without reliable estimates for either, it is difficult to calculate a fair deduction below the break-even point.

This all suggests that the break-even level should probably be the minimum level of flexible funding. But as the next section shows, the break-even level varies for different clinics, so setting it at the average level will leave some clinics out.

3.2 Which clinics should have a financial incentive to participate?

A single level of flexible funding will not be right for every clinic, because the break-even point varies. Two features of a clinic matter most.

13. We have recommended this, as did the Strengthening Medicare Taskforce: Breadon et al (2022) and Strengthening Medicare Taskforce (2023).

14. The financial incentive to reduce low-value care increases with the share of flexible funding.

The first is augmentation: whether a clinic uses the GP time freed up by delegation to see new patients, or simply provides less GP care. A clinic that refills freed time with new patients recovers some of the fee-for-service revenue it gave up, so its break-even point is lower. A clinic that does not or cannot – perhaps because there are no more patients to see – has a higher break-even point.

The second is profitability. Rather than pointing in one direction, it magnifies the effect of augmentation. Where a clinic refills most of its freed-up time, a higher status-quo margin makes switching even more attractive, because each new patient is worth more. Where freed-up time is mostly lost, a higher margin makes switching even less attractive, because the clinic gives up more profit each time.

Finally, clinics with patients whose health needs are overestimated by the flexible funding formula will profit more, and be more likely to opt-in to blended funding. Risk adjustment using patient illness and disadvantage, as proposed for Australia, should close most of the gap.[15] But no formula knows patients as well as their clinic does, so flexible funding accuracy should be monitored and adjusted as the model matures.

All this means the funding model design determines not just how many clinics switch, but also which ones. For example, the government might want clinics that cannot increase the size of their patient pool much to switch, such as those in well-served rural areas. In that case, it would need to set the share of flexible funding above the level that works for the average clinic.

15. In Ontario, Canada, clinics with healthier patients opted in disproportionately, but only age and sex were used for risk-adjustment: Glazier et al (2009) and Kantarevic and Kralj (2016). We have proposed more extensive risk-adjustment, which Ontario later adopted, and which many systems use.

3.3 What are we aiming for?

Beyond the financial incentive to switch and which clinics take it up, there is a more fundamental choice when setting the funding blend: choosing which policy goals to prioritise.

Flexible and fee-for-service funding each have different benefits for efficiency today, efficiency in the future, and for the financial viability of clinics and the health system.

Australia's starting point is unusual, and it could lead us to overlook the benefits of keeping some fee-for-service funding in the mix. Our fee-for-service-dominated system is a global outlier, and the problems that come with it are well documented.

Moving funding away from fee-for-service and toward flexible funding can reduce low-value care, promote multidisciplinary teams, reward prevention, and make funding fairer by following patient needs.

But more flexible isn't always better, since the two types of funding guard against different risks. Fee-for-service, for all its faults, keeps a direct incentive for GPs to see patients. Push flexible funding too high and that incentive weakens, and GPs might deliver too little care.[16]

The blend also determines where efficiencies go, and when. With more fee-for-service funding, government shares in clinic savings earlier, as soon as GPs delegate care.[17] That could quickly free-up much-needed funding for rising healthcare demand and costs, and wouldn't stop clinics earning higher profits than they do today.

16. Hanson et al (2022).
17. Assuming an adequate level of flexible funding, clinics will gain profits from delegation. Since fee-for-service billing declines when care is delegated, government shares in those savings (on a unit cost basis). Government can also gain second-round savings when flexible budgets are updated to reflect new patterns of care delivery, with more use of lower-cost multidisciplinary team members.

A higher flexible share also exposes clinics to more insurance risk. If the flexible funding formula underestimates how sick or costly a clinic's patients are, the clinic has to pay for care that wasn't predicted. A higher fee-for-service share avoids this, because there is more payment for the extra visits the funding model didn't predict.

Unlike setting a minimum level of flexible funding, choosing the precise level is about weighing a series of trade-offs, which are shown in Table 3.1

Table 3.1: The right level of flexible funding depends on policy goals

	More flexible funding	More fee-for-service
Allocative efficiency *Best use of resources*	• More funding linked to need • Care shifts to the most cost-effective clinician	• Avoids GP under-participation in direct care
Dynamic efficiency *Right trajectory*	• Stronger prevention incentive	—
Technical efficiency *Right price*	• More multidisciplinary-team care reduces unit cost	• Stronger incentive for GP to have high patient throughput
Provider viability *Sustainable clinics*	• More predictable revenue • More flexibility to adapt staffing and delivery	• Less insurance risk (less exposure to inaccurate loadings)
Fiscal sustainability *Affordable system*	• Less fiscal exposure from volume growth • Bigger savings if flexible funding is updated to reflect more delegation	• Bigger first-round savings (shared savings) • More incentive to grow patient pool, scaling efficiency gains

Source: Grattan Institute analysis.

4 The perfect blend

There is no single right level of flexible funding. But there is a reasonable range.

The floor is set by clinic participation. Flexible funding much below the break-even level will not cover switching costs, even taking into account profits from cutting low-value care, and too few clinics will move. And to bring in clinics with little room to increase the size of their patient pool, the level has to be set higher than the average clinic needs.

That floor can be measured. Three things determine it: the cost of different team configurations relative to GPs, the range of profitability across clinics, and how much different clinics can increase their patient pool. Analysing these would show the minimum level of flexible funding needed to attract the clinics government wants to participate.

The ceiling is set by risks. Close to full capitation, the incentive for GPs to provide direct care weakens, which could result in too little GP care. Immediate shared savings shrink, leaving government waiting for later budget adjustments. And clinics are more exposed to the inevitable errors in the funding formula. None of that argues against a high flexible share, just against pushing it to the extreme.

The ceiling is a matter of judgment, not data. It depends on how government weighs the goals it is pursuing against the risks it will accept. The important thing is to be clear about both, setting a level of flexible funding high enough to drive the shift to team-based, preventive, continuous care, while keeping it below the level where those gains could cost more than they are worth.

Appendix A: Deriving the break-even level of flexible funding

This appendix derives the break-even level of flexible funding: the level where a clinic is exactly indifferent between a GP continuing to deliver and bill care, and switching to blended funding and delegating that care to a lower-cost team member.

Above the break-even level, delegating raises clinic profit; below it, the clinic is worse off. The result is the condition presented in the main text and Box 2.

At its core, the condition is simple: the flexible payment must at least cover the cost of the multidisciplinary team doing the delegated work, measured against what the GP would have cost. That is, flexible funding/revenue $=$ MDT cost/GP cost.

The rest of this appendix derives that result in full, accounting for the real-world frictions that move the true break-even level away from this simple anchor: on-costs, coordination time, slower team throughput, and what the GP does with the time delegation frees up.

We then show how the full condition collapses back to the simple anchor when those frictions are stripped away.

A.1 Setup and notation

Consider a single instance of care that the GP currently delivers and bills under fee-for-service. The clinic is deciding whether to adopt blended funding and delegate that care to an multidisciplinary team member (for example a nurse, pharmacist, or allied-health professional).

We compare clinic profit per instance under the two options and solve for the level of flexible funding that equates them. The symbols are defined in Table A.1.

A.2 Profit if the clinic does not switch (status quo)

The GP delivers the care and bills the rebate R. In units of GP cost, the revenue is $1/\rho$ and the loaded cost of GP time is $(1 + o_g)$. Profit per instance under the status quo is therefore:

$$\pi_{\text{FFS}} = \frac{1}{\rho} - (1 + o_g) \tag{A.1}$$

A.3 Profit if the clinic switches and delegates care

When the clinic delegates, three things change relative to the status quo:

- It receives the flexible payment Cap (in units of GP cost, Cap/ρ) and gives up the fee-for-service rebate $1/\rho$ on this instance.
- It incurs the cost of the multidisciplinary team doing the work, plus residual GP oversight. The loaded MDT cost is $\tau M(1+c_m)(1+o_m)$ – the team's wage, scaled by how much longer it takes the MDT relative to the GP (τ) and grossed up for coordination and on-costs – and the loaded cost of the GP oversight that delegation does not remove is $c_g(1 + o_g)$.
- Freed-up GP time may be refilled. Delegation frees $(1 - c_g)$ of a case of GP time. A share A of it is used to see new fee-generating patients, each yielding the status-quo margin $\frac{1}{\rho} - (1 + o_g)$, so a fraction $A(1 - c_g)$ of the forgone billing is recovered.[18]

Collecting these, profit per instance after switching is:

$$\pi_{\text{SWITCH}} = \frac{Cap}{\rho} - \tau M(1+c_m)(1+o_m) - c_g(1+o_g) + A(1-c_g)\left[\tfrac{1}{\rho} - (1 + o_g)\right] \tag{A.2}$$

18. Assumes seeing new patients earns the same margin as seeing existing patients.

A.4 Solve for the break-even flexible payment

The clinic is indifferent when $\pi_{\text{SWITCH}} = \pi_{\text{FFS}}$. Setting the two equal:

$$\frac{Cap}{\rho} - \tau M(1+c_m)(1+o_m) - c_g(1+o_g) + A(1-c_g)\left[\tfrac{1}{\rho} - (1+o_g)\right] = \frac{1}{\rho} - (1+o_g) \tag{A.3}$$

Collect the flexible-payment term on the left and everything else on the right:

$$\frac{Cap}{\rho} = \tau M(1+c_m)(1+o_m) + c_g(1+o_g) + \underbrace{\left[\tfrac{1}{\rho} - (1+o_g)\right]}_{\text{margin kept if not delegated}} - A(1-c_g)\left[\tfrac{1}{\rho} - (1+o_g)\right] \tag{A.4}$$

The last two terms share the factor $\left[\frac{1}{\rho} - (1+o_g)\right]$, the status-quo per-instance margin. Grouping them:

$$\frac{Cap}{\rho} = \tau M(1+c_m)(1+o_m) + c_g(1+o_g) + \left[\tfrac{1}{\rho} - (1+o_g)\right][1 - A(1-c_g)] \tag{A.5}$$

Finally, multiply through by ρ to express the break-even payment Cap^* as a share of revenue. Note that $\rho\left[\frac{1}{\rho} - (1+o_g)\right] = 1 - \rho(1+o_g)$, so the $1/\rho$ inside the margin term cancels:

$$Cap^* = \tau\rho M(1+c_m)(1+o_m) + \rho\, c_g(1+o_g) + \left[1-\rho(1+o_g)\right]\left[1-A(1-c_g)\right] \tag{A.6}$$

Switching is profitable whenever $Cap > Cap^*$.

The three terms of Equation A.6 are, in order: the loaded MDT cost of doing the work, scaled by throughput τ; the loaded cost of residual GP oversight; and the forgone fee-for-service margin, net of augmentation.

Table A.1: The symbols

Symbol	Definition
C	GP cost of delivering the instance of care (the numeraire – all monetary terms are expressed as a share of this).
R	Rebate: the fee-for-service payment the GP would have billed for the care.
ρ	Ratio of GP cost to the rebate, $\rho = C/R$. The status-quo per-visit profit margin, as a share, is $1 - \rho(1+o_g)$.
Cap	Flexible (capitation) payment received for the delegated care, as a share of revenue. The quantity to be solved for.
M	Wage of the multidisciplinary team (MDT) member who performs the delegated work, as a share of GP cost.
τ	Throughput factor: MDT time taken per case relative to the GP ($\tau = 1$ same speed; $\tau > 1$ slower). Scales the MDT cost of doing the delegated work.
c_m	Coordination-time loading on the MDT work (e.g. case conferences, handover).
o_m	On-cost loading on the MDT wage (superannuation, leave, overheads).
c_g	Residual GP oversight time per delegated case, as a fraction of a full GP-delivered case ($0 \leq c_g \leq 1$).
o_g	On-cost loading on GP time.
A	Augmentation: the share of freed-up GP time used to see new fee-generating patients ($A = 0$, full substitution – freed time lost; $A = 1$, full augmentation – all freed time refilled).

Notes: For simplicity and consistency with examples in the body, this appendix assumes the clinic is bulk-billing, but if R were defined as 'revenue', all formulae would hold for mixed-billing clinics too. All quantities are expressed as a share of GP cost, except Cap, which is a share of revenue.

Source: Grattan Institute analysis.

A.5 The simple anchor

The headline condition follows by stripping the formula back to its core, one assumption at a time. Start from Equation A.6 and set all the loadings to zero ($c_m = o_m = c_g = o_g = 0$):

$$Cap^* = \tau\rho M + (1-\rho)(1-A) \tag{A.7}$$

Assume the team works at the same speed as the GP ($\tau = 1$):

$$Cap^* = \rho M + (1-\rho)(1-A) \tag{A.8}$$

Assume full augmentation, so all freed time is refilled ($A = 1$); the second term vanishes:

$$Cap^* = \rho M \tag{A.9}$$

Finally, take the rebate to equal GP cost ($\rho = 1$):

$$Cap^* = M = \frac{\text{MDT cost}}{\text{GP cost}} \tag{A.10}$$

This is the simple anchor flagged at the start of this appendix: at break-even, the flexible payment must at least cover the team's cost of delivering the care, measured against the GP cost the clinic gives up. The loadings and the augmentation term in Equation A.6 are the adjustments that move the true break-even level away from this anchor.

A.6 Limiting cases

The condition behaves as expected at the boundaries:

- **No refill of freed time ($A = 0$).** The full forgone margin is lost, so the third term is at its maximum and the break-even level is highest.
- **Full augmentation, no oversight ($A = 1$, $c_g = 0$).** Every freed minute is refilled with new billings, the third term vanishes, and the break-even level falls to the loaded MDT cost alone.
- **Oversight consumes the whole case ($c_g = 1$).** No GP time is freed, so no billings can be recovered regardless of A, and the full margin is forgone.
- **Slower MDT throughput ($\tau > 1$).** The team takes longer than the GP for the same care, so the loaded MDT cost rises and the break-even level is higher. At $\tau = 1$ the team works at GP speed and this term is the MDT cost alone.
- **Different status-quo margins.** The effect depends on augmentation: where freed time is mostly refilled (high A) a larger margin lowers the break-even level, because each recovered visit is worth more; where freed time is mostly lost (low A) a larger margin raises it, because more billing is given up and not recovered. At zero margin the augmentation term vanishes entirely, so augmentation has no effect. At a negative margin, refilling freed time with loss-making visits raises the break-even level of flexible funding.

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