

Urgent Care

Position statement – June 2026

1. Position

- The RACGP asserts urgent care is within the scope of specialist general practitioners (GPs) and that urgent care service models should remain GP-led.
- Notwithstanding this, the RACGP recognises that in Aboriginal Community Controlled Health Organisations (ACCHOs) and rural and remote settings, urgent care may be delivered at the point of care by nurses, nurse practitioners, Aboriginal Health Practitioners or other clinicians working within their scope of practice, supported by multidisciplinary teams operating under GP-inclusive clinical governance and escalation arrangements.
- The RACGP supports equitable access to GP-led and ACCHO-led Urgent Care Clinics (UCCs) and maintains that urgent care delivered through existing general practices and primary care services best supports continuity of care and reduces fragmentation.
- UCC models must be designed, funded and governed to deliver culturally safe, responsive care, free from racism.
- Further research and evaluation of UCCs is required to inform policy and assess value, equity, quality and impact.

1.1 The RACGP calls on Australian Governments to:

- support the development, implementation and use of nationally consistent, profession-led Standards for UCCs, led by the RACGP.
- ensure all UCCs are supported by clinical governance frameworks that include specialist GPs, with clear supervision, escalation and accountability arrangements.
- ensure urgent care policy and funding decisions align with the National Agreement on Closing the Gap, including implementation of the Priority Reform Areas.
- ensure urgent care models are designed, funded and governed to deliver culturally safe, responsive care, free from racism.
- fund flexible models to support the equitable provision of urgent care in all communities, particularly those without access to a Medicare UCC.
- improve incentives and increase funding to support general practices and ACCHOs to provide affordable, high-quality urgent care including through incentives to expand their hours, updating the definition of the after-hours period, increasing funding via the After Hours Practice Incentive Program (PIP) and appropriately funding accident-related and procedural care including for fracture management, imaging and consumables.
- work with state and territory governments, ACCHOs and the RACGP to strengthen integration between urgent care and general practice, including clinical handover, referral pathways and interoperability of health records.
- fund research and evaluation to assess the value, equity and sustainability of UCCs, including the impact on continuity of care.

2. Definition

Urgent care is short-term, episodic care provided for medical conditions that are non-life-threatening but need treatment within a few hours or on the same day.^{1, 2} Urgent care may be required within traditional business hours (in-hours), or after-hours. Patients seeking urgent care may go to their usual GP, after-hours GP service, emergency department or an UCC.

For the purposes of this position statement, an UCC refers to a health service that provides episodic, same-day care for acute conditions that are typically non-life-threatening but require timely assessment. Care is delivered by appropriately qualified clinicians with the capability to assess, treat, stabilise and, where required, safely transfer patients.

For the purposes of this position statement, GP-led urgent care refers to services operating within a clinical governance framework that includes specialist GPs, with clear systems for supervision, escalation, accountability and integration with broader primary care. Within this model:

- care may be delivered at the point of care by nurses, nurse practitioners, Aboriginal and Torres Strait Islander Health Practitioners and other clinicians working within their scope of practice
- GPs are an integral and ongoing presence in urgent care models through clinical governance, supervision and escalation arrangements, whether in person or enabled through these structures, particularly in ACCHO and rural and remote settings
- multidisciplinary teams operate with shared responsibility, communication and access to patient information.

These definitions are intended to support the scope of this position statement and do not pre-empt or replace formal definitions that may be developed through accreditation standards processes or those used by state and federal governments to name their service.

3. Background

3.1 The value of urgent care

Australian hospitals are under increasing strain from an ageing population, increased rates of chronic disease and health workforce shortages.^{3, 4} As a result, the cost of funding public hospitals is high and rising.^{4, 5} Over a ten-year period, spending on public hospitals increased by 50%.⁴ Increases on this scale are not sustainable, yet demand is only expected to grow.⁴ Governments are seeking to contain funding growth in the face of budgetary pressures and increased public scrutiny.⁴

With more than 22 million Australians seeking care from a specialist GP each year, general practice is the most accessed and cost-effective part of our healthcare system.^{5, 6} Community health outcomes and health equity are improved by access to GPs.⁷ Increased investment in GPs and general practices has been shown to reduce hospital demand and hospital re-admission rates, increase economic productivity and reduce healthcare expenditure for governments.⁶

Urgent care is routinely provided by GP-led multidisciplinary teams in general practice and increasingly, in UCCs. This care is valued for improving timely access in specific contexts. However, system complexity and fragmentation can lead to difficulties in accessing the most appropriate service. Patients in need of urgent care must navigate a range of public and private services, including hospital emergency departments, UCCs, satellite hospitals, after-hours GP services and 1800 Medicare. The Federal Government provides funding for urgent care through multiple programs including the Medicare Benefits Schedule (MBS), After Hours PIP, the Primary Health Network (PHN) After Hours Program and Medicare UCCs. Additional urgent care services are funded by state and territory governments.

Research has demonstrated a role for UCCs in a modern healthcare system, however, challenges include a lack of continuity of care, system integration and standardised protocols.⁸ Patient satisfaction with UCCs is high but would be enhanced by improved coordination with existing healthcare services.^{8, 9} By design, UCCs provide episodic care and do not support the longitudinal patient-GP relationship that underpins safe, high-quality and efficient primary care. Without strong integration with a patient's usual general practice or ACCHO, UCCs may contribute to duplication of services, fragmented care and inefficiencies across the health system.

3.2 Medicare Urgent Care Clinics

Medicare UCCs are an evolving component of the Australian healthcare system that require ongoing evaluation to ensure alignment with high-value general practice care. They provide walk-in, bulk billed, urgent care and are intended to reduce pressure on emergency departments. Medicare UCCs are not for routine or preventive care, and are expected to refer out of scope presentations to a patient's usual GP.¹

Medicare UCCs must be staffed by a GP-led multidisciplinary team.¹⁰ Well-resourced, GP-led teams have the capability to coordinate care and improve health outcomes. GPs are experts in managing complexity. Healthcare professionals who do not have the same medical education and clinical experience as GPs may miss more serious underlying health issues in the urgent care environment.

A government evaluation found federal funding per Medicare UCC presentation is \$206 and the annual net savings per emergency department presentation avoided are estimated at \$36.2 million to \$99 million, dependent on methodology.⁹

Ongoing operational challenges have been identified by the Medicare UCC evaluation. These include the recruitment of appropriately qualified GPs and nurses to achieve the minimum workforce requirements and access to imaging and pathology services across all hours of operation.⁹ The evaluation also highlighted areas for improvement, such as improved data collection for culturally and linguistically diverse patients, improved service integration and improved coordination of care through the provision of a timely clinical handover.⁹

The evaluation found most patient presentations to Medicare UCCs are within scope, however, a small proportion of presentations required referral or education regarding more appropriate services.⁹ Ongoing education is needed to help patients better understand the role of UCCs and ensure continued accessibility of comprehensive care through a patient's usual GP.

Evaluation findings indicate variable relationships between UCCs and ACCHOs, with examples of both effective collaboration and gaps in coordination.^{2, 9} Continued liaison with ACCHOs will be important to understand opportunities to strengthen collaboration.^{2, 9}

3.3 Training opportunity in Urgent Care Clinics

The RACGP's training standards require that registrars engage in a broad scope of clinical practice during their general practice placements and limit the proportion of their general practice training time that can be allocated to a particular area of practice to 20%. This applies to UCC work. If their training practice is involved in a dedicated UCC, a GP registrar may contribute to the services provided by that UCC as part of their placement.

Australian General Practice Training (AGPT) registrars can choose to undertake a six-month extended skill placement in an UCC that is accredited for training. To be accredited for training, the UCC must provide a level of supervision that is commensurate with the registrar's demonstrated competency. Extended skills placements are not part of the Fellowship Support Program (FSP).

4. Key Issues

4.1 Role of GPs in urgent care

All specialist GPs are trained to provide urgent care. It is a core part of general practice and sits within a GPs' scope of practice. The RACGP Curriculum has a contextual unit on Emergency medicine.¹¹ The [RACGP progressive capability profile](#) includes competencies related to urgent care.¹² Assessment for Fellowship includes assessment of urgent care competencies. CPD courses offered by the RACGP cover topics such as practical emergency skills, acute and critical care skills, emergency chest x-ray, basic and advanced life support, paediatric emergencies, acute mental health, splinter and fracture management, emergency ultrasound, X-ray and CT, and suturing. In addition, GPs are required to complete an Advanced Life Support (ALS) course in the four years pre-fellowship and as a requirement of accreditation to the RACGP Standards.¹³ They are also required to maintain Basic Life Support competency.

In addition to these expert emergency skills, GPs have important, often under-recognised skills in safely diagnosing and managing symptoms that don't have a clear diagnosis, in being able to reassure people with viral illnesses (and so avoid

antibiotics), in being able to differentiate between a well child and a sick child, in consulting with anxious patients in a second language and in sensitively managing injuries that are a result of family violence. These skills ensure that people who are reluctant to visit health services for fear of being diminished are made to feel comfortable and leave feeling that they have been heard and taken seriously. These skills are a component of culturally safe care. The specialty of general practice has a long history of teaching and research into all these important urgent care skills.

Six-month extended skills placements are an opportunity for GPs in training to do further work in primary care in an area of specific interest or skill. They may choose to do this in an UCC. The use of the term extended does not infer that these skills are additional to those in the RACGP general practice curriculum. The RACGP rural generalist training program requires registrars to undertake six months training in emergency medicine. This is to prepare registrars to work in settings where backup non-GP specialist care is not quickly available.

GP leadership in urgent care encompasses clinical governance, risk management, escalation and stewardship of whole-person care, rather than sole responsibility for all urgent care consultations. Due to their extensive training, clinical governance expertise and broad scope of practice, GPs are ideally placed to lead clinical and corporate governance for whole person care.

In rural and remote areas, GPs are the backbone of urgent, and after-hours, care, supported by partnerships between local general practices and hospitals. UCCs are often located in metropolitan areas and rely on infrastructure, workforce availability and service access that are not present in rural and remote settings. GPs and ACCHOs must be supported to deliver urgent care in these settings.

4.2 Urgent care standards

There are currently no standards for UCCs in Australia. Profession-led standards are needed to provide a nationally consistent framework that defines safe, high-quality urgent care, helps translate policy intent into assessable expectations, and supports consistent accreditation across Medicare-funded, private and hybrid models.

The existing [Medicare UCC Program Operational Guidance](#) establishes operational expectations for Medicare UCCs but does not function as a nationally consistent, assessable safety and quality standard. Existing general practice accreditation provides important safety and quality assurance for GP-based UCCs but it was not designed to assess the specific clinical risks, workflows and service interfaces that characterise urgent, episodic care.

UCCs operate in a high-risk, time-critical clinical environment and patients reasonably assume that core safeguards are in place. However, in the absence of clear standards, there is no consistent mechanism to assure UCC safety and quality. This creates system risk in a care setting where timely decision-making, effective escalation and reliable communication are critical to patient safety.

Dedicated standards will establish clear, assessable expectations regarding workforce capability, timely access to radiology services, required equipment, on-site services, referral pathways into and out of the service, triage, and surge capacity as well as staffing models and clinical leadership, recognising that inadequate resourcing or unclear skill mix can result in avoidable escalation. Standards will help ensure clear, agreed pathways between UCCs, general practice and hospital emergency departments. In the absence of standards, variability in local arrangements can contribute to fragmented decision-making and unnecessary transfers to emergency departments.

Evidence from the Medicare UCC evaluation highlights continuity and handover as key risk areas, with only 65–68% of presentations including direct handover to the patient's usual GP.^{2,9} Best practice clinical handover involves one health practitioner providing patient information to another.¹³ In urgent care settings, failures in clinical handover increase the risk of fragmented care, duplication, preventable deterioration and avoidable hospital admissions. Standards establish handover and integration as core safety requirements rather than discretionary practices.

In urgent care settings, access to shared health information, such as medication histories and immunisation records, is particularly important for safe clinical decision-making. Nationally consistent Standards can support appropriate use of shared digital health systems, to facilitate timely access to relevant information and reliable transfer of clinical summaries following urgent care encounters.

As the professional body responsible for developing standards for general practice for more than three decades, the RACGP is taking the lead in developing UCC standards. We advocate that, when published, these form the basis of future UCC accreditation.

A dedicated set of RACGP Standards for UCCs would:

- establish profession-led, nationally consistent expectations for safe, high-quality urgent care across different urgent care locations and models, including Medicare-funded, private and hybrid models
- help translate Federal Government policy intent and operational guidance into clear, assessable outcomes and criteria
- address safety-critical risks specific to urgent care, including triage, escalation, diagnostics and after-hours governance
- underpin a future accreditation regime and provide accreditation bodies with a coherent, fit-for-purpose framework to assess safety and quality
- enable safe coexistence and clear boundaries between UCCs and general practice, including in co-located settings.

4.3 Funding urgent care

Access to urgent care must be equitable. As a first principle, the RACGP expects funding decisions to align with the National Agreement on Closing the Gap, including the Priority Reform Areas, for provision of urgent care for Aboriginal and Torres Strait Islander people.

UCCs may be a viable model in large population centres but alternative funding models are required for smaller communities, including in rural and remote areas. Investment in UCCs should not occur at the expense of strengthening general practice and ACCHO services, which remain the most cost-effective and sustainable models of care. At present, patients needing urgent care in smaller or more remote communities have limited options and are likely to attend the nearest emergency department. If more GPs and general practices are supported to deliver urgent care, patients will be able to access care from their usual GP, improving continuity of care and reducing demand on hospitals.

Medicare UCCs receive block funding from the Federal Government, in addition to access to the MBS. This level of support is not provided to general practices without UCC contracts. Reform of urgent care funding, and after-hours funding, for general practice is vital, in addition to a sustainable approach to funding consumables used in the provision of urgent care. Any funding model must:

- incentivise participation through adequate payments
- provide flexibility for GPs and their practices, including the provision of multidisciplinary care as appropriate
- enable coordination with local health and social services
- be tailored to local communities and meet identified needs.

MBS funding reform is needed to ensure patient rebates for after-hours care, including urgent after-hours, cover the actual cost of providing high-quality care in general practice. This should occur in conjunction with reform of the After Hours PIP to support a sustainable workforce. The RACGP recommends updating the definition of the after-hours period to commence at 5pm on weekdays and include all of Saturday. This will support the provision of urgent care to patients both in-hours and after-hours, by the usual GP and general practice team.

Access to urgent care, including urgent after-hours care, must be improved in rural and remote areas. The underinvestment in rural health demonstrates the need to increase support to existing GP-led services to avoid widening inequalities.¹⁴ Urgent care reform should consider workforce constraints, as well as meaningful funding commitments. Alongside reform of relevant MBS items and the After Hours PIP, the RACGP recommends distributional equity in block funding to ensure rural services are not disadvantaged relative to urban models.

4.4 Cultural safety in Urgent Care Clinics

The RACGP considers culturally safe, responsive care to be a fundamental requirement of urgent care delivery across all models, including Medicare-funded, private and hybrid services. This expectation is reflected in the Medicare UCC Program Operational Guidance and includes care that recognises and responds to the impact of trauma, prior healthcare experiences and distress on how patients present, communicate and engage with care.¹⁰ Cultural safety is clinical safety. Where patients do not feel safe, they may delay care, disengage from services or experience poorer outcomes.

Medicare UCC evaluation findings highlight gaps in data quality and identification, limiting the ability to assess access, outcomes and equity.^{2, 9} Accurate identification of Aboriginal and Torres Strait Islander people is a critical first step in delivering culturally safe care and supporting continuity of care.

The [RACGP Aboriginal and Torres Strait Islander Cultural and Health Training Framework](#) is a key training reference that ensures registrars are trained to be culturally competent and that they have a commitment to support Aboriginal and Torres Strait Islander people in meeting their health needs.¹⁵

Cultural safety in urgent care settings requires more than training alone. It requires a systems approach, supported through service design and co-design, clinical and data governance, integration with existing primary care services and workforce strategies to recruit Aboriginal and Torres Strait Islander clinicians including Health Workers and Health Practitioners.¹⁶

Some ACCHOs host and manage UCCs. Many offer urgent care for Aboriginal and Torres Strait Islander people and non-Indigenous people (e.g. Mparntwe Urgent Care at Congress Alice Springs). ACCHO-led urgent care models, including Medicare UCCs, are an established approach to delivering urgent and after-hours care in remote and regional communities where alternative services are limited or inaccessible. These services commonly utilise nurse-, nurse practitioner- and Aboriginal Health Practitioner-led models of care at the point of service, supported by multidisciplinary teams and GP-inclusive clinical governance frameworks. The RACGP supports ACCHOs to be funded to provide urgent care to communities.

The development of nationally consistent, profession-led Standards for UCCs provides an opportunity to embed clear expectations for culturally safe, inclusive and responsive care within urgent care models. Where urgent care is delivered outside ACCHOs and Aboriginal Medical Services, strong coordination and communication with a patient's usual GP are essential to support culturally safe, continuous care.

4.5 Urgent care research

While the Medicare UCC Program Evaluation provided early insights, research into UCCs in Australia is limited and many questions remain around the impact and outcomes of UCCs.^{2, 9} It is essential to have quality evidence to inform policy on urgent care and UCCs to ensure that they are delivering value for money, equitable access, clinical quality and continuity of care, and that they are not diverting funds from higher-value services.

Research and evaluation must prioritise the needs of the communities involved, be culturally safe and incorporate knowledge translation and Indigenous data sovereignty principles. It is important for the research to be situated and look at UCCs as part of the broader fragmentation happening in general practice.

The RACGP is exploring the research gaps that need to be addressed which are likely to be in the following areas:

- the cost-effectiveness of using primary care funding for UCCs, compared with strengthening existing general practice and after-hours care
- the longer-term outcomes of UCCs, including impacts on overall healthcare utilisation and costs
- whether UCCs reduce or exacerbate access inequities for priority populations and underserved groups, including a consideration of cultural safety and antiracism, and how UCCs could better serve priority groups
- outcomes and attendance data of UCCs, including characteristics and behaviour of patients who attend UCCs, which presentations are commonly referred from UCCs to emergency departments, and which are referred to general practices
- the role of UCCs in identifying, responding to and safely managing domestic and family violence, including staff capability, referral pathways, information sharing and continuity of care
- the impact of UCCs on continuity of care for patients and ways in which UCCs could support or complement local general practices
- how the emergence and expansion of UCCs contributes to the fragmentation of general practice, including the redistribution of traditional GP functions to other service models and the system-level implications of this shift
- the effectiveness of registrar training in urgent care settings.

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