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Royal Australian College of General Practitioners

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28 August 2026

Ms. Peta Lane
Group Executive Director
Performance Audit Services Group
Australian National Audit Office

Via email: medicare.urgent.care.clinics.audit@anao.gov.au

Dear Ms Lane,

RE: Australian National Audit Office (ANAO) Performance audit: Award of funding for Medicare Urgent Care Clinics (UCCs)

The Royal Australian College of General Practitioners (RACGP) thanks the ANAO for the opportunity to provide a submission in response to the ANAO Performance Audit: *Award of Funding for Medicare UCCs*.

The RACGP is the voice of specialist general practitioners (GPs) representing more than 50,000 members in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians. Our core commitment is to support specialist GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population. The College now trains more than 90% of Australia's GPs, including those in rural and remote areas and in Aboriginal and Torres Strait Islander communities.

As the audit progresses, it is essential to evaluate the planning, implementation and governance of Medicare UCCs to determine their effectiveness, equity, continuity of care and address unintended impacts across the health system.

The RACGP surmises that:

- Concerns remain that oversights during the establishment of UCCs may contribute to fragmentation of care and UCCs not being well integrated with existing primary care services.
- Specialist GPs argue that services provided by UCCs could be more efficiently delivered through local general practices if adequate funding and support were available.
- While UCCs now have a role within the health system, their integration with broader care pathways and long-term cost-effectiveness require ongoing evaluation.
- Government pressure to establish services at pace has not been matched by adequate governance arrangements, creating risks to patient safety and placing unsustainable demands on the workforce.

It will be critical to introduce measures that will strengthen future similar programs, including any further expansion of UCCs, and address the concerns outlined above. Specifically, we endorse greater transparency around future arrangements and a greater focus on integration of care and services throughout the award of funding (as detailed in Appendix A). Ensuring culturally safe care in UCCs also remains an important consideration, services need to be accessible, responsive and culturally safe for all communities.

We look forward to continuing to work with the ANAO to strengthen the delivery of the UCC program, while supporting Australia's primary healthcare system.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade, East Melbourne VIC 3002
Tel **1800 4RACGP** | 1800 472 247 Fax (03) 8699 0400 Email racgp@racgp.org.au
racgp.org.au ACN 000 223 807 ABN 34 000 223 807

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We would welcome the opportunity to discuss this further and provide any additional information that may assist. If you would like to arrange a meeting to discuss the above, please contact Ms Shayne Sutton, Chief Advocacy Officer, on 0410 508 541 or via shayne.sutton@racgp.org.au.

Yours sincerely

Dr Michael Wright
President

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade, East Melbourne VIC 3002
Tel **1800 4RACGP** | 1800 472 247 Fax (03) 8699 0400 Email racgp@racgp.org.au
racgp.org.au ACN 000 223 807 ABN 34 000 223 807

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Australian National Audit Office (ANAO) Performance audit: Award of funding for Medicare Urgent Care Clinics (UCCs)

Royal Australian College of General Practitioners (RACGP) submission – August 2026

RACGP recommendations

The RACGP recommends the Federal Government:

- Embed greater consistency, accountability and quality across the program prioritise the application and implementation of nationally consistent, profession-led Standards currently under development by the RACGP to all Medicare UCCs.
- Strengthen integration between UCCs, general practice and hospital services through improved clinical handover, referral pathways and information sharing.
- Undertake ongoing independent evaluation of UCC effectiveness, viability, equity, coordination and continuity of care, plus health system-wide impacts, including on existing general practices already present in the community.
- Ensure future UCC expansion is guided by community need, workforce capacity and the sustainability of existing primary healthcare services.
- Strengthen transparency, accountability and oversight of Primary Health Network (PHN) commissioning and grant administration.
- Prioritise commissioning approaches that recognise and support established local providers with demonstrated community connections and service delivery capability.
- Require commissioning decisions to assess impacts on continuity of care, workforce sustainability and local primary care viability.
- Ensure culturally safe care is embedded in the design, governance and delivery of UCC services, with appropriate measures in place to monitor and support this.
- Undertake an independent review of commissioning outcomes, provider selection processes and community-level impact.
- Strengthen federation funding arrangements to support shared accountability and integrated patient care across Commonwealth and state-funded services.
- Increase transparency of funding arrangements.
- Ensure any new service models complement, rather than duplicate, existing general practice services and support a sustainable primary care system.
- Ensure the program is supported with appropriate education and clear guidelines for patients and healthcare professionals on when to attend a UCC.
- Providing flexible funding arrangements for rural and remote communities without access to a UCC to ensure equitable access to urgent care for all Australians, where and when they need it.
- The RACGP recommends the ANAO audit the chosen locations and independently assess these locations against locally determined need. All communities deserve equitable access to high-quality urgent care.

RACGP response

1. Did the Department of Health, Disability and Ageing (DoHDA) appropriately establish the Medicare Urgent Care Clinic program?

The RACGP remains concerned that aspects of Medicare UCC establishment and expansion may contribute to fragmentation of care and limit effective integration with existing primary care services. Many specialist general practitioners (GPs) have expressed that a significant proportion of services currently delivered through UCCs could be provided through local general practices if adequate funding and support were available. While UCCs have an important role within the health system, their integration with broader care pathways, contribution to continuity of care and long-term cost-effectiveness require ongoing evaluation.

Reports indicate that political pressure to establish services quickly has created risks to patient safety, placed additional strain on the healthcare workforce and limited opportunities to ensure effective integration with existing services from the outset.

Standards and clinical governance

The rapid establishment of UCCs has not always been matched by sufficiently robust governance arrangements and is fragmenting care. The absence of nationally consistent, profession-led standards in the establishment of Medicare UCC's has been a key concern of the RACGP. Proxy readiness assessments have contributed to variability in service delivery, care coordination and governance across jurisdictions. As such, the RACGP has recently announced plans to develop profession-led Standards for nationally consistent UCCs in collaboration with the Department of Health, Disability and Ageing (DoHDA), representing an important opportunity to strengthen program consistency and accountability.

Ensuring culturally safe care in UCCs also remains an important consideration, services need to be accessible, responsive and culturally safe for all communities.

We recommend the development and implementation of nationally consistent, profession-led Standards should also be prioritised to support greater consistency, accountability and quality across the program.

Culturally safe care

Culturally safe care is an essential component of high-quality primary care and is particularly important in ensuring UCCs are responsive to the diverse needs and experiences of the communities they serve.

We recommend that culturally safe care be embedded in the design, governance and delivery of UCC services, with appropriate measures in place to monitor and support this.

Integration, care coordination and continuity of care

Concerns have also been raised regarding the extent to which UCCs have been integrated with broader health system pathways. To date, there has been insufficient collaboration with state and territory governments, Aboriginal Community Controlled Health Organisations (ACCHOs) and the RACGP to strengthen clinical handover arrangements, referral pathways and interoperability between emergency departments, urgent care services and general practice.

These concerns are reinforced by evidence in the Second Interim Evaluation Report (released February 2026), showing a decline in continuity of care through direct handover to a patient's usual GP, which fell to 65%, a 3% decrease from the First Interim Evaluation Report (released March 2025). More broadly, concerns remain regarding the absence of minimum requirements to ensure that UCCs support integration with local health services and complement, rather than compete with, general practice. Without clear expectations regarding integration, continuity of care and collaboration, there is a risk that urgent care services may contribute to further fragmentation across the primary healthcare system.

We recommend strengthening integration between UCCs and existing primary healthcare services, including improved clinical handover, referral pathways and interoperability of patient information.

Location and service planning

Questions have also been raised regarding whether UCC locations have been selected solely on the basis of community need and existing service availability. In rural and remote areas, barriers to accessing urgent and after-hours care remain

significant, highlighting the need to strengthen support for existing GP-led services to ensure the program does not inadvertently widen existing health inequities.[1]

The geographic distribution and location of services should be a key consideration in the design and implementation of the reform. The rollout highlights the potential for unintended consequences where service availability does not align with population need, including for the approximately one in five people who do not have access to a UCC. These issues are particularly pronounced in rural, regional and remote communities, where distance, workforce shortages and limited-service availability can create additional barriers to timely care. A more explicit focus on equitable access and geographic need is required to ensure that the benefits of the reform are realised across all communities, including those that may otherwise be at risk of being underserved. Equitable access to urgent care depends on flexible funding arrangements, especially for rural and remote communities without access to a UCC.[2]

Members have raised concerns regarding political influence during the rollout of Medicare UCCs. It appears a disproportionate number of UCCs have been established in Labor-held electorates (approximately two thirds of UCCs). Similar questions have been asked regarding the number of UCCs established in marginal seats. Given the lack of transparency regarding commissioning decisions, it is difficult to view the chosen locations objectively. The RACGP recommends the ANAO audit the chosen locations and independently assess these locations against locally determined need. All communities deserve equitable access to high-quality urgent care.

We recommend ensuring future expansion is aligned with demonstrated community need and workforce capacity, while supporting existing GP-led urgent care and after-hours services as a core component of the broader primary healthcare system.

Workforce sustainability

The sustainability of the UCC model is also closely linked to workforce availability. Expansion of the program at a rate greater than workforce availability has reportedly increased the reliance on expensive locums and casual workforce, increasing costs and creating service instability for the program, as per DoHDA's Second Interim Evaluation Report, released in February 2026. These workforce pressures risk undermining both the effectiveness of UCCs and the sustainability of existing general practice services (see recommendation above).

Community and stakeholder education

Another key issue has been education for patients and all health care stakeholders, including general practice teams, on what constitutes an urgent presentation and when to attend a usual GP, UCC or hospital emergency department. Education and communication should also target general practice reception, administrative and nursing staff, who are often the first point of contact for patients and play an important role in directing them to appropriate care. This would support a clearer understanding of where UCCs fit within the broader primary care system.

We recommend the program be supported with education and clear guidelines for patients and healthcare professionals on when to attend a UCC.

Evaluation

These concerns highlight the need for a more deliberate and evidence-based approach to the ongoing development of the UCC program. We recommend further evaluation is required to assess the value, equity, sustainability and long-term system impacts of UCCs, including their effect on continuity of care, workforce distribution and access to services for priority populations.

The evaluation of UCCs should consider their impact within the broader primary care system, including the cumulative impact of government-funded service models on the viability of established general practices, workforce distribution, continuity of care and long-term sustainability. This should include consideration of the value and opportunity cost of public investment, including whether equivalent investment in established community-based general practices could achieve comparable or improved access outcomes.

2. Has DoHDA effectively developed, implemented and managed grant agreements with Primary Health Networks for Medicare Urgent Care Clinics?

While Primary Health Networks (PHNs) have demonstrated the ability to commission and deliver UCCs, significant concerns remain regarding the transparency, consistency and accountability of commissioning decisions across regions.

The limited availability of detailed information on provider selection, performance and community outcomes makes it difficult to assess whether public investment is consistently delivering the intended benefits or whether grant agreements are being managed effectively.

Evidence presented throughout the implementation of the program indicates substantial variation in commissioning approaches and outcomes between regions. In particular, concerns have been raised that some procurement processes have favoured large corporate healthcare providers over established local general practices with genuine community connections, proven service delivery capability and existing relationships with patients. This raises questions about whether current procurement frameworks adequately value local healthcare expertise and improved patient outcomes, or whether they place disproportionate weight on an organisation's capacity to prepare competitive tender applications.

There are also concerns that commissioning decisions may not be sufficiently considering the broader impacts on local health systems. Reports of fragmented care suggest that UCCs operating outside existing general practice settings can undermine continuity of care, particularly where communication and information-sharing arrangements with patients' regular GPs are inconsistent or inadequate. In many communities, these risks are compounded by concerns that UCCs may be competing with, rather than complementing, existing primary healthcare services.

PHNs found themselves in a position that highlights broader governance challenges that can arise where responsibilities, accountabilities and decision-making authority are distributed across multiple stakeholders. While these challenges may not be directly attributable to PHNs, they are worth being mindful of more generally when considering the design and implementation of future policy arrangements.

Workforce impacts are of particular concern in regional and rural areas, where workforce shortages are already a longstanding challenge. The establishment of UCCs has the potential to draw clinicians, nurses and administrative staff away from existing general practices, placing additional pressure on services that communities already rely upon. Where this occurs, the broader objective of improving access to care may be offset by unintended consequences elsewhere in the local healthcare system.

The effectiveness of grant implementation is ultimately dependent on the capability of commissioned providers, including their local decision-making capacity, leadership, governance arrangements and ability to work collaboratively with other health services.[3] Given the concentration of contracts among larger corporate providers, ongoing concerns regarding continuity of care, and reported workforce pressures on existing practices, there remains insufficient evidence to conclude that the current commissioning approach is consistently achieving its intended outcomes across all regions.

We recommend stronger oversight, greater transparency and more robust evaluation of commissioning decisions and outcomes. Greater emphasis should be placed on supporting established local providers, ensuring commissioned services are integrated with existing primary healthcare infrastructure, and assessing the broader impacts of commissioning decisions on community health outcomes, workforce sustainability and the long-term viability of local general practice services.

3. Has DoHDA effectively developed, implemented and managed federation funding agreements with states and territories for Medicare Urgent Care Clinics?

While funding agreements have facilitated the establishment of UCCs, there is limited evidence that they have effectively addressed the longstanding structural challenges associated with coordination and integration between Commonwealth and state-funded components of the health system. Addressing these challenges should be a central objective of federation funding arrangements.

Effective federation funding agreements should establish shared accountability for health outcomes and support seamless patient pathways across primary care, community care and hospital services. However, ongoing evidence of fragmented care and integration challenges suggests that these arrangements are not yet consistently delivering on these objectives.

Evidence also indicates that fragmented pathways between primary care, specialist services and hospitals continue to adversely affect patient experience, quality of care and system efficiency.[4] Without stronger mechanisms to support coordination across jurisdictions and service settings, there is a risk that investments in new service models may add complexity to an already fragmented system rather than improve integration.

Greater transparency, accountability and evaluation of federation funding agreements are therefore required to determine whether they are achieving their intended objectives and delivering improved coordination between Commonwealth and state-funded health services.

We recommend future funding arrangements should place stronger emphasis on shared responsibility for patient outcomes, service integration and continuity of care across the healthcare system.

References

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