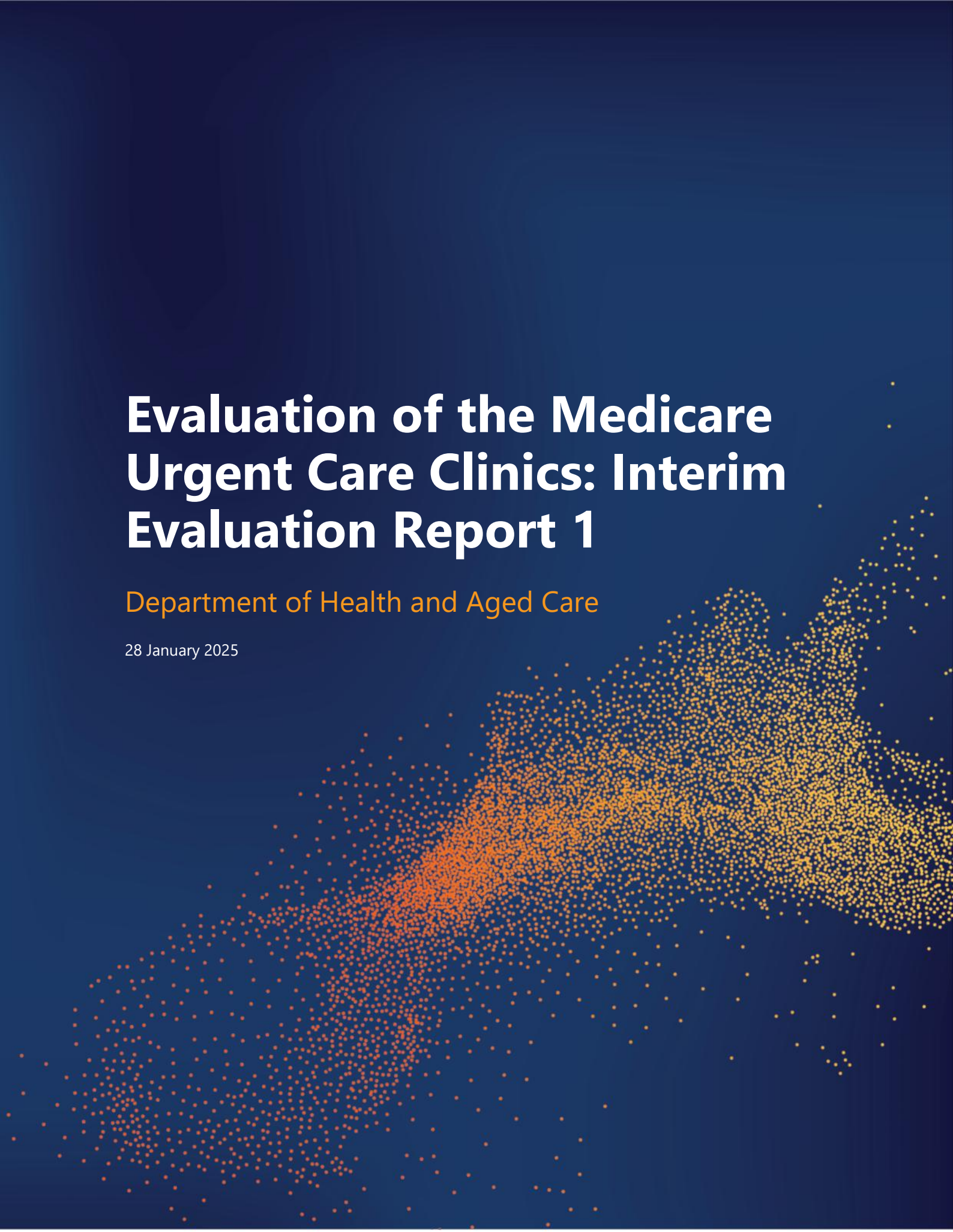
Evaluation of the Medicare Urgent Care Clinics: Interim Evaluation Report 1

Department of Health and Aged Care

28 January 2025



nous

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

Note on limitations of this Interim Report

This report of the Interim Evaluation of the Medicare Urgent Care Clinics (UCCs) program has been developed by the Nous Group (Nous) as the first of three reports that will progressively evaluate this program through to 2026. Interim Evaluation Report 2 is due in late 2025 and the Final Evaluation Report in 2026. This report is based on information available from the establishment of the first clinics on 30 June 2023 through to 30 September 2024, at which time 75 of the proposed 87 clinics had been established. Given the program is still in implementation stage, the report does not contain any final evaluation findings.

The interim findings outlined in this report should be read in light of limitations in the evidence base for this initial phase of the evaluation. These are:

- The data available for assessing the impact of Medicare UCCs on Emergency Department (ED) presentations was largely limited to data reported by the Medicare UCCs on where patients would have sought treatment if the Medicare UCC was not available. This data has limitations and needs to be triangulated with analyses of ED presentations. The ED data that was publicly available for this report does not have sufficient observations post-implementation of the Medicare UCCs to validly assess their impact on ED activity and waiting times. Additionally, due to granularity of the available data it was not feasible to isolate the impact on urgent care-equivalent presentations among triage category four and five ED presentations – which requires consideration of the arrival mode and episode end status – nor to assess the impact specifically for the catchment populations of the Medicare UCCs which are usually different to the broader catchments of partner hospitals These gaps will be addressed in the next two Evaluation Reports.
- Stakeholder engagement was limited to commissioners of all Medicare UCCs, the executive of the Consumers Health Forum (CHF), staff representatives from three Medicare UCCs and a meeting of the Medicare UCC Operational Advisory Group. The evaluation team was not able to directly engage with patients or other consumers, staff of the Medicare UCCs beyond those mentioned, staff of partner hospital EDs, or local GPs in the areas where the Medicare UCCs are located. As outlined in the report, the next phase of the evaluation will include more extensive stakeholder engagement. Planned activities include surveys of Medicare UCC patients and staff, as well as consultations with other GPs and GP representatives, ED staff and stakeholders in the local health ecosystem.
- Many of the Medicare UCCs had been operating for less than 12 months at the cut-off date for analysis for this report (30 September 2024) and 12 Medicare UCCs were yet to implement arrangements to supply data to the Department of Health and Aged Care (the Department) for the evaluation.

Data issues are discussed more fully in the body of the report.

Nous Group, January 2025.

Contents

Abbreviations

Abbreviation	Meaning
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Services
ACT	Australian Capital Territory
AECC	Australian Emergency Care Classification
AIHW	Australian Institute of Health and Welfare
AMI	Acute myocardial infarction
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATS	Australasian Triage Scale
CALD	Culturally and linguistically diverse
CHF	Consumers Health Forum
CHS	Canberra Health Services
CoP	Community of practice
DiD	Difference-in-differences
DMO	District Medical Officer
ED	Emergency department
FTE	Full time equivalent
GP	General practitioner
HPA	Health Policy Analysis
IHACPA	Independent Health and Aged Care Pricing Authority
IRSD	Index of relative socio-economic disadvantage
ITS	Interrupted time series
LHN	Local Hospital Network
UCC	Urgent Care Clinic
MBS	Medicare Benefits Schedule

Abbreviation	Meaning
MMM	Modified Monash Model
MyHR	My Health Record
NEP	National Efficient Price
NSW	New South Wales
NT	Northern Territory
NWAU	National Weighted Activity Unit
NZ	New Zealand
PCP	Primary Care Pilot
PHN	Primary Health Network
PREM	Patient reported experience measure
RAN	Remote Area Nurse
QLD	Queensland
QPA	Quality Practice Accreditation
SA	South Australia
TAS	Tasmania
TIS	Translation and Interpreting Service
UK	United Kingdom
VIC	Victoria
WA	Western Australia
WAPHA	WA Primary Health Alliance

Executive summary

This report provides the first interim evaluation of the Medicare UCC pilot program, based on program implementation from 30 June 2023 to 30 September 2024 (the cut-off date for analysis for this report). The evaluation, being undertaken by Nous, will provide two further reports – at the end of 2025 and in 2026.

The Medicare UCC Program – what was intended

The Australian Government is investing $759.9 million over five years from 2022-23 for the implementation and operations of 87 Medicare UCCs across Australia. Of these, 58 clinics were implemented by 31 December 2023, with a further 29 clinics being implemented progressively from 1 July 2024. By 30 September 2024 (the cut-off date for analysis of clinic data for this evaluation report), 75 Medicare UCCs had opened.

The program was launched by the Australian Government in 2023 with the aim of alleviating pressure on hospital emergency departments (EDs), by offering short-term, episodic care for *urgent but non-life-threatening conditions*. The program was part of the Australian Government's broader response to recommendations of the Strengthening Medicare Taskforce and was launched as a pilot through to 2026.

The Medicare UCC Operational Guidance was developed by the Department, in consultation with state and territory governments. The Operational Guidance outlines the minimum standards and expectations in relation to scope, accessibility, referrals, activity, infrastructure and staffing at the Medicare UCCs.

Medicare UCCs are intended to be GP-led (unless specifically exempted) and are staffed and equipped to provide treatment for urgent non-life-threatening conditions, including access to diagnostic services. They are expected to be open for extended hours, offer walk-in services without the need for appointments and provide care with no out-of-pocket costs for patients.

The clinics can be co-located with existing general practices, Aboriginal Community Controlled Health Services (ACCHS) and other community health services. Each Medicare UCC must have a local partner public hospital ED and is expected to integrate with local health services.

Medicare UCCs are expected to refer patients to their usual primary care provider for follow up care and where presentations are out of scope of the Medicare UCC and can be safely and more appropriately managed by the usual primary care provider. If a patient's condition is assessed as an emergency, they are to be transferred to an ED for appropriate care.

Patients attending Medicare UCCs can access the clinics directly or be referred from various services, including EDs, GPs, ambulances, the Healthdirect telephone health advice line, or other providers.

The evaluation

This evaluation addresses the nine Measures of Success that were agreed by the Australian, and state and territory governments. These measures have informed the key questions to be considered for this evaluation. The Measures of Success were designed to assess the quality of care, accessibility of services and cost-efficiency in Medicare UCCs, as well as their impact on consumer behaviour and the alleviation of demand pressures on partner hospital EDs. The measures acknowledge the necessity for Medicare UCCs to be effectively integrated into the broader health ecosystem. This includes seamless connections with local GPs and other primary care services, and partner EDs, ensuring a comprehensive and coordinated approach to patient care. This Interim Evaluation Report 1 focuses on initial insights into the nine Measures of Success for the period 30 June 2023 to 30 September 2024, to inform program improvement.

Interim Evaluation Report 1 will be followed by an Interim Evaluation Report 2 in late 2025 and a Final Evaluation Report in 2026. Across its three phases, the evaluation is using a mixed-methods approach drawing on a range of data sources, which are discussed in depth in the report.

As noted elsewhere, very limited stakeholder engagement was conducted for this evaluation report, given the early implementation phase of the program. This included all Medicare UCC commissioners (including some jurisdictions and some Primary Health Networks (PHNs)), the executive of the CHF and three Medicare UCCs. The remaining two phases of the evaluation will be based on more comprehensive engagement, including surveys of Medicare UCC staff and patients, and greater engagement with non-UCC GPs and EDs.

There were also several limitations with the Medicare UCC data, for example, data was only available in aggregate counts for some clinics and some variables collected through the Medicare UCC Module were poorly completed or missing. Opportunities for data improvement are detailed in the body of the report.

Implementation progress

The first Medicare UCC opened on 30 June 2023 and many have been operational for less than 12 months. Of the 75 Medicare UCCs that were operational by 30 September 2024, there are 20 in New South Wales (NSW), 17 in Victoria (VIC), 12 in Queensland (QLD), seven in Western Australia (WA), five in South Australia (SA), five in the Australian Capital Territory (ACT), five in the Northern Territory (NT) and four in Tasmania (TAS).

As of 30 September 2024, Medicare UCCs operated for an average of 12 hours per day, with slightly lower average operating hours outside of metropolitan areas, especially on weekends. Onsite or affiliated diagnostic services are widely available during business hours, but availability is more limited after 5:00 pm and on weekends.

Between 30 June 2023 and 30 September 2024, there were 784,071 presentations to Medicare UCCs. Children under the age of 15 account for 28 per cent of all Medicare UCC presentations.

Medicare UCCs have been implemented flexibly according to local need and context.

Interim evaluation against the nine Measures of Success

Interim findings have been provided for each of the nine Measures of Success. Further information about the approach to assessing each Measure of Success for this Interim Evaluation Report 1, opportunities for improvement, and further investigation proposed for each Measure in the future phases of the evaluation is included in the main body of the report. The opportunities for improvement are summarised in the final section.

Measure of Success 1: Timely treatment

This Measure of Success seeks to understand whether patients receive timely treatment for urgent non-life-threatening conditions in Medicare UCCs. There is no agreed clinical definition of timely treatment. It can differ based on clinical context, urgency of the condition and factors such as resource availability, geographic location and patient circumstances. This Interim Evaluation Report 1 considered timely care through a quantitative lens in the statistical analysis of patient waiting times at Medicare UCCs and comparison with public hospital EDs for patients in triage categories four (semi-urgent) and five (non-urgent care).

While a comparison with ED waiting times is of interest, there are significant differences between the two settings, such as differences in case acuity, patient volumes and operational factors, that impact the analysis. These factors will be further considered in future reports.

Interim findings

- In the period to 30 September 2024, median waiting times at Medicare UCCs were estimated at 14.5 minutes. This was shorter than the median waiting times at EDs for triage category four which is 31 minutes and category five which is 24 minutes, noting that these waiting times are not directly comparable.

- A small proportion of Medicare UCC patients (12 per cent) waited longer than 60 minutes to be seen. In EDs, 32 per cent of patients in triage category four are seen outside of the 60-minute benchmark and 12 per cent of category five patients are seen outside the 120-minute benchmark.

Measure of Success 2: Safe and quality treatment

This Measure of Success seeks to understand whether Medicare UCCs provide safe and quality treatment to patients. There are multiple dimensions to safety and quality, many of which are considered across other Measures of Success in this report (including Measures 1, 4 and 9 which cover timeliness of care, patient-centred care and efficiency). This Measure considers the Department's approach to assessing Medicare UCCs' safety, the appropriateness of presentations and equitable access for priority populations.

Patient perceptions of safety and quality will be collected for future reports, together with information from a range of stakeholders about appropriateness of care and redirections from Medicare UCCs. The Medicare UCCs Operational Guidance will also be reviewed.

Interim findings

- The Medicare UCC Program implements a robust clinical assessment process prior to opening to ensure clinics meet safety standards and are ready to operate in accordance with the Medicare UCC Operational Guidance.
- Medicare UCCs are primarily treating patients with conditions that fall within the scope of the Medicare UCC Operational Guidance, with most patients presenting with acute illnesses (63 per cent) and acute injuries (26 per cent). The majority of patients (84 per cent) return home after receiving care and a small proportion are referred to an ED (5 per cent) or redirected to their usual GP (10 per cent) when necessary, suggesting Medicare UCCs are utilising diversion and escalation protocols to redirect patients to other settings where appropriate.
- As of 30 September 2024, 6 per cent of those Medicare UCC patients with recorded status identified as Aboriginal and/or Torres Strait Islander, which is slightly lower than for EDs (8 per cent). There is limited data available on utilisation of Medicare UCCs by other priority populations.

Measure of Success 3: Coordinated care

This Measure of Success seeks to understand whether Medicare UCCs deliver coordinated care for Medicare UCC patients. There are multiple dimensions to coordinating a patient's healthcare services across multiple providers and settings. For this Interim Evaluation Report, the evaluation assesses channels of clinical handover and Medicare UCCs' use of referral pathways using the Medicare UCC data, as well as through engagement with commissioners. In future phases of the evaluation, Medicare UCCs will be asked about their care coordination processes, barriers and enablers to effective coordination, including use of My Health Record (MyHR) and how they support patients without a regular GP to identify and connect with one. Patient experience of care coordination will also be sought through patient feedback mechanisms.

Interim findings

- In the period to 30 September 2024, 89 per cent of presentations had a clinical handover provided by at least one method outlined in the Operational Guidance (provided directly to usual GP, uploaded to MyHR or paper copy given to the patient). A small proportion (11 per cent) had a clinical handover provided by 'other' means.
- Approximately 68 per cent of presentations had a handover directly back to the patient's usual GP/practice in the period to 30 September 2024. A further 10 per cent of presentations had information uploaded to MyHR (but not provided directly to the patient's usual GP). Approximately 11 per cent of presentations received a hard copy of a discharge summary only, which is consistent with the proportion of patients (11 per cent) that did not identify a usual GP/practice. Commissioners reported receiving feedback from local GPs that electronic provision of a discharge summary was their

preferred method of receiving clinical handovers.

Measure of Success 4: Experience for patients and carers

This Measure of Success seeks to understand whether Medicare UCCs provide a positive experience for patients and carers. Limited insights on patient experience were gained for this Interim Evaluation Report 1 through interviews with commissioning organisations and the CHF executive. The Department also provided a selection of written patient stories and a high-level summary of the complaints it received.

Given the limitations, the report outlines key themes regarding aspects of the Medicare UCC services that patients are reported to value and identifies early opportunities to improve patient experience. For subsequent evaluation phases, the evaluators will work closely with the CHF and seek to conduct a patient survey to obtain patient feedback on their experience at the Medicare UCCs and an understanding of how experience differs across Medicare UCC models.

Interim findings

- Based on available evidence, it is too early to provide a balanced assessment of how satisfied patients are with Medicare UCCs and the extent to which Medicare UCCs are providing a positive experience for patients and carers. The feedback received from commissioners indicated their consistent view that patients appreciated avoiding extended waits in ED and having access to bulk-billed care.
- Early opportunities to improve patient experience in some clinics include better management of demand during peak periods, improved communication about local Medicare UCC service offerings and upgrades to physical infrastructure to support accessibility.

Measure of Success 5: Experience for providers at Medicare UCCs, partner hospital EDs and local GP practices

This Measure of Success seeks to understand whether Medicare UCCs provide a positive experience for providers at Medicare UCCs, in partner hospital EDs and in local GP practices. For this Interim Evaluation Report 1, insights into provider experience were limited. Interviews were conducted with all the commissioning organisations and one NSW Medicare UCC. In addition, consultations were undertaken with one remote NT Medicare UCC and the ACT Medicare UCCs to support a greater understanding of the unique models of care operating within the program. Preliminary analysis of workforce availability was also undertaken. For subsequent evaluation phases, stakeholders will be engaged more widely about their experiences of services provided by Medicare UCCs and the impact of Medicare UCCs on local GP practices and workforce availability. Medicare UCCs will be surveyed to provide further insights on provider experience as well as barriers and enablers to adopting flexible workforce models.

Interim findings

- Although direct consultations with Medicare UCC staff were very limited, feedback from commissioners reported a consistent view that Medicare UCC staff appreciated the variety and style of work at Medicare UCCs, though high workloads at some clinics were noted to impact staff experiences.
- At this early stage, the evaluation cannot draw conclusions about the concerns expressed from some GPs that Medicare UCCs will interfere with established relationships between GPs and their patients and attract patients who do not have urgent care needs. The evaluation notes that commissioners are aware of these concerns and are working to improve communications and build stronger relationships locally.
- Recruitment of vocationally registered GPs to achieve the minimum workforce requirements outlined in the Medicare UCC Operational Guidance across extended hours is a significant and ongoing challenge for Medicare UCC providers, particularly in regional and rural areas.
- Medicare UCCs face ongoing challenges with offering access to X-ray services across all hours of operation and ultrasound/CT services across the majority of hours of operation (as per the Medicare

UCC Operational Guidance) due to radiology workforce shortages and after-hours service availability.

Measure of Success 6: ED presentations at partner hospitals

This Measure of Success seeks to understand whether Medicare UCCs reduce pressure on hospital ED presentations at partner hospitals. Data availability to assess this Measure of Success will increase over the period of the evaluation. At this early stage, insights are based on Medicare UCC Module data and publicly available partner hospital data (where available) from six jurisdictions. Future analytical approaches for assessing this Measure of Success include an interrupted time series (ITS) analysis to be undertaken with more comprehensive and granular data collected, over longer timeframes (Interim Evaluation Report 2) and a difference-in-differences (DiD) analysis to be undertaken for the Final Evaluation Report, where outcomes are compared between an intervention group – residents in regions with Medicare UCCs – and a control group – residents in other regions.

Interim findings

- In the period to 30 September 2024, it was reported that 46 per cent of patients (183,507 of 400,564 presentations for which there was data) would have sought care at an ED if the Medicare UCC was unavailable. This increased to 49 per cent after hours, presumably due to limited service availability. These proportions should be considered with caution as there are many limitations associated with reporting against the Medicare UCC Module question "where would the patient have gone otherwise?" These include incomplete data, no alternative data source for verification, variable respondents, variable interpretations by the respondent and the acknowledgment that some patients might still attend ED or be referred to one, regardless of their reported intentions at the start of their Medicare UCC visit. Noting these limitations, the evaluation estimates that 334,000 presentations to partner hospital EDs would have been avoided across a year due to the Medicare UCCs.
- In the period to 30 September 2024, based on available data, the proportion of patients who would have attended an ED if the Medicare UCC was not available was higher in:
    - Areas of median socio-economic disadvantage (ABS IRSD Quintile 3) (51 per cent) and high socio-economic disadvantage (Quintiles 1 and 2) (45 per cent) compared with areas of low socio-economic disadvantage (Quintiles 4 and 5) (40 per cent).
    - Rural and remote areas (51 per cent), compared with regional centres (48 per cent) and metropolitan areas (44 per cent).
- At this early stage, the evaluation cannot draw conclusions about the impact of the program on triage categories four and five presentations and waiting times at partner hospital EDs, based on the publicly available hospital data.

Measure of Success 7: Consumer behaviour

This Measure of Success seeks to understand whether there is a change in consumer behaviour over time to use Medicare UCCs where available instead of EDs for urgent non-life-threatening conditions. For this Interim Evaluation Report 1, insights presented are based on analysis of Medicare UCC data, interviews with commissioners, the CHF executive and the previously identified Medicare UCCs. The analysis also draws on Department-commissioned research assessing performance and the impact of a national communications campaign on patient awareness. In future phases of the evaluation, insights will be broadened through a survey of Medicare UCC patients and additional stakeholder engagement to understand reasons for changing behaviour over time to use Medicare UCC services, and barriers and enablers to using Medicare UCCs services for consumers. Differences by state and territory will also be considered.

Interim findings

- Medicare UCCs that were newly established experienced a rapid growth in activity, which stabilised within four months. There is also some evidence that Medicare UCCs that transitioned from a previous

state-based urgent care arrangement increased their level of activity after commencing as a Medicare UCC.

- Stakeholders report that understanding what urgent care is and navigating the variety of local service options continues to be a challenge for consumers, despite comprehensive national and local communications campaigns.

Measure of Success 8: Coordinated care within the health ecosytem

This Measure of Success seeks to understand whether Medicare UCCs, PHNs, Healthdirect, jurisdictions and the health ecosystem have established an effective coordinated care option for people with urgent non-life-threatening conditions. Care coordination within the health ecosystem improves integration and efficiency for urgent non-life-threatening conditions. While Measure of Success 3 focusses on Medicare UCCs' role in facilitating care coordination through effective clinical handover and referrals, this Measure of Success focusses on collaboration between the various groups involved in the health ecosystem – including Medicare UCCs, PHNs, state and territory-run health services and Healthdirect – to provide effective care options for people with urgent non-life-threatening conditions. At this system level, care coordination involves establishing clear roles and pathways, fostering communication and aligning efforts across providers within the ecosystem, enabling a consistent and connected health care experience.

For this Interim Evaluation Report 1, insights for this Measure of Success were gathered from interviews with commissioners. In later evaluation phases, a broader range of stakeholders will be engaged and Medicare UCCs will be surveyed to provide additional insights on this Measure. Staff and other healthcare providers' perspectives on referrals to other services and ways for Medicare UCCs to understand referral pathways and relationships will be explored.

Interim findings

- Activities focused on relationship building and fostering trust and familiarity between Medicare UCCs and key local health stakeholders are in place in some regions and are helping to foster an integrated local health care system.
- Communities of practice have helped Medicare UCC staff share experiences and learn from each other and local health system stakeholders. They are helping to build local health ecosystem relationships and integration.
- Commissioning organisations (PHNs and state and territory governments) are playing a beneficial role in building relationships with local GPs and health services, and navigating workforce challenges.

Measure of Success 9: Cost effectiveness

This Measure of Success seeks to understand whether Medicare UCCs are cost effective. At this early stage of the evaluation, estimates have been produced by calculating unit costs per Medicare UCC presentation and associated avoided ED attendances.

The analyses used data on the grants provided to Medicare UCCs, aggregate counts of presentations from Medicare UCCs and the Medicare UCC Module data. The Module data included information on Medicare Benefits Schedule (MBS) items claimed, which was analysed to estimate MBS payments. A separate analysis of MBS data was conducted to estimate MBS payments for diagnostic services delivered by non-Medicare UCC providers on the same day a patient attended a Medicare UCC. The reason for visit reported in the Module data and other variables were used to allocate presentations that were likely to represent avoided ED attendances to an Australian Emergency Care Classification (AECC) class, the classification used for funding ED presentations in Australia. This was used to estimate funding that would apply to these presentations under national activity-based funding arrangements.

Interim findings

- The annualised Australian Government funding support for Medicare UCCs is estimated to be $246.50 per presentation, excluding the five ACT Medicare UCCs, where MBS claims cannot be made, and the

seven Medicare UCCs in which Module data, including MBS items, was not yet reported at the time of undertaking the analysis. Across all Medicare UCCs, the annualised Australian Government's funding is $216 per presentation. These preliminary results do not include contributions to the operation of Medicare UCCs by state and territory governments.

- Based on reports of where patients attending a Medicare UCC would have sought care if the clinic was not available, it is estimated that around 334,000 ED presentations would be avoided annually if Medicare UCCs were operating at their stabilised activity levels post-opening. This estimate is based on the 63 clinics in which there is sufficient information available. It excludes 11 Medicare UCCs where only aggregate presentation volumes were available, including five from the ACT and three located in very remote regions in the NT. As discussed under Measure of Success 6, this is an interim estimate which relies on the accuracy of the reporting against the Medicare UCC Module question "where would the patient have gone otherwise?" This may under or over-estimate the level of ED attendances avoided due to the data limitations described previously. Future evaluation reports will have access to data across a full year of operation for Medicare UCCs and be able to triangulate these estimates with additional causal analysis using ED data. Additionally, the analysis will be extended to include an assessment of the cost impact for presentations in which it is indicated the patient would have taken actions other than attending an ED or calling an ambulance.
- The average funding that would be paid by the Australian and state and territory governments for these avoided ED attendances is estimated by the evaluation team to be $616 per presentation. This estimate is based on analysis of the reasons for attending the Medicare UCC and applying the classification and prices currently applied for ED funding. The estimate reflects government funding (Commonwealth, state and territory) based on the National Efficient Price (NEP) recommended by IHACPA. However, the marginal cost reductions for EDs are likely to be lower due to relatively high fixed costs associated with providing ED services. These savings are offset by the cost of the subset of Medicare UCC attendances related to avoided ED presentations, estimated to be $248 per presentation – which is slightly higher than the average for all Medicare UCC attendances. This yields a net saving to governments of around $368 per presentation.

These results will be revisited and refined through additional analyses in subsequent phases of the evaluation, including inclusion of data for all jurisdictions, costs associated with presentations to a Medicare UCC where the patient would have taken an alternative action other than attending an ED, time savings for patients accessing urgent care through a Medicare UCC compared to an ED and costs incurred by patients (for example, travel expenses) to access a Medicare UCC, ED or alternative. The analyses will also examine the sensitivity of the results to various assumptions and inputs, including estimates of the level of ED presentations avoided.

1 Interim Evaluation Report 1

1.1 Introduction

This report provides the first interim evaluation of the Medicare UCC pilot program, based on program implementation and operations up to 30 September 2024. Through the Medicare UCC Program, the Australian Government is investing $759.9 million over five years from 2022-23 for a total of 87 Medicare UCCs across Australia, with 58 clinics implemented before 31 December 2023 and 29 clinics being implemented progressively from 1 July 2024. By 30 September 2024 (the cut-off date for analysis of clinic data for this evaluation report), 75 Medicare UCCs had been implemented.

Medicare UCCs are staffed and equipped to provide treatment *for urgent non-life-threatening conditions*, including access to diagnostic services. They are open for extended hours, offer walk-in services without the need for appointments and provide care with no out-of-pocket costs for patients.

The clinics are operated by existing general practices, ACCHS and other community health services. Each Medicare UCC has a local partner public hospital ED and is expected to integrate with local health services.

Medicare UCCs refer patients to their usual primary care provider for follow up care and/or where presentations are out of scope of the Medicare UCC and can be safely and more appropriately managed by the usual primary care provider.

The Department engaged Health Policy Analysis (HPA) to undertake the evaluation of the Medicare UCCs. HPA was subsequently acquired (in August 2024) by Nous and the evaluation team was integrated into Nous. Nous is an independent Australian-owned consulting firm with extensive experience evaluating complex government initiatives across Australia, Canada and the United Kingdom (UK).

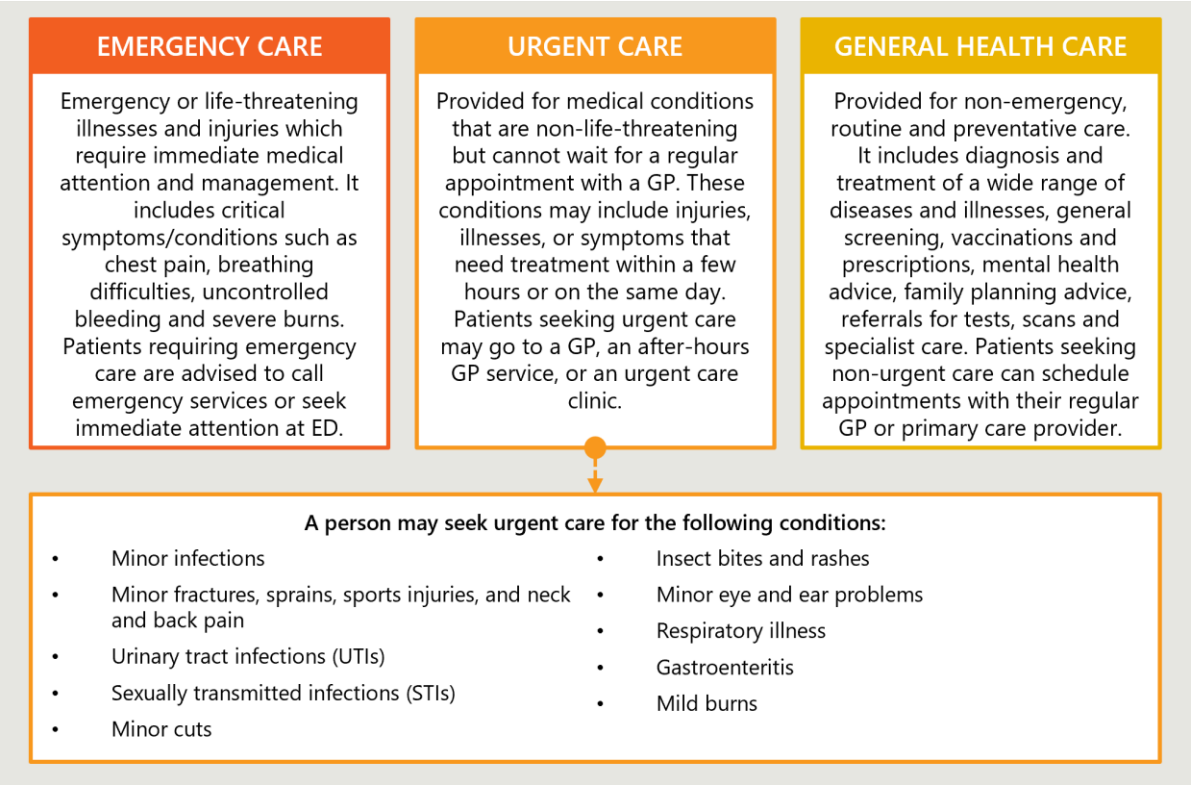
The Medicare UCC evaluation will assess the program against the nine Measures of Success agreed by the Australian, and state and territory governments (Figure 1). The evaluation will provide evidence-based recommendations to inform future health policy decisions. This first Interim Evaluation Report will be followed by a second Interim Evaluation Report in late 2025 and a Final Evaluation Report in 2026.

Figure 1 | Nationally agreed Measures of Success for the Medicare UCC Program

1.2 What is urgent care?

Figure 2 describes what urgent care is and the different levels of urgency and severity of patients' medical conditions.

Figure 2 | Categorisation of medical conditions[1]



Nous is using the National Healthcare Agreement indicator[2] definition of *urgent care equivalent activity in ED* for the analysis in this evaluation. The National Healthcare Agreement indicator defines this as potentially avoidable general practice type presentations to public hospital EDs where the patient:

- was allocated a triage category of four of five on the Australasian Triage Scale (ATS)
- did not arrive by ambulance, police, or correctional vehicle
- was not admitted to the hospital, not referred to another hospital, or did not die.[3,4]

The indicator is included in the suite of performance measures reported under the current National Healthcare Agreement and used in reports published by the Australian Institute of Health and Welfare (AIHW). Several other methods for defining urgent care equivalent activity in EDs have been referred to in the literature and these generally apply a more restrictive definition.[5] The sensitivity of the estimated effects will be tested by examining other definitions, where data is available to do this.

[1] Based on Australian Government Department of Health and Aged Care. (2024c). *When to visit a Medicare Urgent Care Clinic*. https://www.health.gov.au/find-a-medicare-ucc/when-to-visit

[2] Australian Institute of Health and Welfare. (2023c). *National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022*. https://meteor.aihw.gov.au/content/740847

[3] Note that this definition is applicable only in cases where NAPEDC data are available for analysis. Publicly accessible ED data do not include information on arrival mode or discharge disposition (that is, whether the patient was admitted to the hospital, discharged home, or died).

[4] Only triage category has been available in the ED data used for this Interim Evaluation Report 1. Other variables will be used when they become available in future evaluation phases.

[5] O'Loughlin, M., Mills, J., McDermott, R., & Harriss, L. R. (2021). Exploring the measure of potentially avoidable general practitioner-type presentations to the emergency department in regional Queensland using linked, patient-perspective data. *Aust Health Rev*, *45*(1), 90-96. https://doi.org/10.1071/AH19210

1.3 The policy context

The Medicare UCC Program was implemented to provide a coordinated, system-level response to improving access to urgent care while maintaining efficient use of ED resources. It forms part of the Australian Government's broader response to recommendations of the Strengthening Medicare Taskforce.

The Program establishes Medicare UCCs across Australia that aim to alleviate pressure on hospital EDs by offering short-term, episodic care for *urgent but non-life-threatening conditions*. Specifically, it seeks to divert triage categories four (semi-urgent) and five (non-urgent) urgent care equivalent presentations away from ED settings. This cohort accounted for 32 per cent of total presentations to EDs in public hospitals in 2022-23,[6] based on the National Healthcare Agreement indicator definition above.

The Australian Government has made a significant investment to design and implement the Medicare UCCs

The Australian Government is investing $759.9 million over five years from 2022-23 to pilot the Program and support the establishment and operations of 87 Medicare UCCs across the country. This includes:

- An initial investment of $493.5 million over five years from 2022-23 to support the establishment of 58 Medicare UCCs, all of which were opened as planned by 31 December 2023.
- An additional $227 million as part of the 2024-25 Budget for a further 29 Medicare UCCs opening progressively from 1 July 2024 and to support existing Medicare UCCs in regional, rural and remote areas extend operating hours and service higher workforce costs.

Medicare UCCs can access specific MBS rebates for provision of urgent care services through section 19(2) exemptions to the *Health Insurance Act 1973*.[7] Anticipated MBS expenditure is included in the overall investment of $759.9 million.

Medicare UCCs exist amongst a complex landscape of urgent care services

The Program operates amongst a variety of urgent care services delivered through GPs, hospitals, after-hours services and other state, territory and PHN programs. Some Medicare UCCs transitioned from pre-existing programs, including NSW Urgent Care Services, Victorian Priority Primary Care Centres, SA Priority Care Centres, ACT Walk-in Centres and NT Primary Care Pilots (PCPs). Other Medicare UCCs were newly established to address the needs of communities across Australia. Urgent care services operating separate to the Program have different jurisdictional funding arrangements, operational requirements and in some instances, different eligibility criteria. There is not currently a universal approach to delivering urgent care (outside of the ED) across Australia.

This review forms one component of the government's broader efforts to understand the current state and impact of primary care policies and programs across Australia. Other reviews are being undertaken concurrently as part of the response to the Strengthening Medicare Taskforce, including the After-Hours Program Review,[8] which was completed in August 2024.

[6] Steering Committee for the Review of Government Service Provision 2024, Report on Government Services 2024, Productivity Commission, Canberra. https://www.pc.gov.au/ongoing/report-on-government-services/2024/health/Rogs-2024-parte-overview-and-sections.pdf

[7] An example is the Health Insurance (Medicare Benefits Payable in Respect of Professional Services - Services Rendered under the Commonwealth Medicare Urgent Care Clinic Program) Direction (No.4) 2024, (2024a). https://www.legislation.gov.au/F2024N01065/asmade/text

[8] https://www.health.gov.au/sites/default/files/2024-10/a-better-after-hours-system-review-of-after-hours-primary-care-programs-and-policy_0.pdf

International models for urgent care services

Similar urgent care service models have been implemented internationally, including in New Zealand (NZ)[9] and the UK.[10] Medicare UCCs were adapted for the Australian context from international models, with modifications to account for differences between the Australian and international contexts. The model in NZ closely mirrors the Medicare UCCs in Australia, offering an alternative for urgent, non-life-threatening conditions to help ease pressure on hospital EDs.[11] NZ's UCCs also typically operate on a walk-in basis and are staffed by a combination of GPs, nurse practitioners, registered nurses and nursing assistants.[12] They also commonly provide access to diagnostics, aligning with best practices seen internationally,[13] and offer services such as basic fracture care, IV cannulation, and minor wound and burn management.

In the UK, a variety of urgent care models have been developed to reduce ED demand by treating urgent but non-life-threatening conditions.[14,15,16] UCCs in the UK are either GP-led or nurse-led, supported by multidisciplinary teams that may include GPs, nurse practitioners, registered nurses and physiotherapy practitioners.[17] The UK UCCs can operate as standalone facilities, co-locate with EDs, or integrate within EDs, sharing the same triage functions.[18] They commonly have access to diagnostics, though this varies by location. Other services typically offered include basic fracture care, minor wound and burn management, and IV fluids.[19] Beyond UCCs, the UK also employs walk-in clinics and minor injury units, staffed primarily by GPs, emergency doctors and registered nurses.[20] These units aim to offer alternatives to ED for non-urgent conditions.

The evidence on the effectiveness of these clinics is mixed. Two recent reviews identified studies of models similar to UCCs. The first study was part of an evidence review of minor injury units, urgent care centres and walk-in centres, conducted for the UK National Institute for Health and Care Excellence.[21] The review identified five observational studies with before and after designs, three of which included comparators. The quality of evidence for these was assessed to be low to very low due to high risks of bias and imprecision in estimated effects. Within this review, three studies of walk-in centres suggested that stand-alone walk-in centres may provide benefits in terms of ED avoidance, although this evidence was inconsistent due to the different methods used by the studies.

[9] Royal New Zealand College of Urgent Care. (2015). *Urgent Care Standard 2015*. https://rnzcuc.org.nz/clinics-and-training-facilities/accredited-urgent-care-clinics/ucs/

[10] National Institute for Health and Care Excellence. (2018). *Minor injury unit, urgent care centre or walk-in centre in Emergency and acute medical care in over 16s: service delivery and organisation*. https://www.nice.org.uk/guidance/ng94/evidence/18minor-injury-unit-urgent-care-centre-or-walkin-centre-pdf-172397464605

[11] Royal New Zealand College of Urgent Care. (2015). *Urgent Care Standard 2015*. https://rnzcuc.org.nz/clinics-and-training-facilities/accredited-urgent-care-clinics/ucs/.

[12] Ibid.

[13] Ibid.

[14] Ablard, S., O'Keeffe, C., Ramlakhan, S., & Mason, S. M. (2017). Primary care services co-located with Emergency Departments across a UK region: early views on their development. *Emerg Med J*, *34*(10), 672-676. https://doi.org/10.1136/emermed-2016-206539

[15] Cowling, T. E., Ramzan, F., Ladbrooke, T., Millington, H., Majeed, A., & Gnani, S. (2016). Referral outcomes of attendances at general practitioner led urgent care centres in London, England: retrospective analysis of hospital administrative data. *Emergency Medicine Journal*, *33*(3), 200-207. https://emj.bmj.com/content/33/3/200.long

[16] UK National Guideline Centre. (2018). Minor injury unit, urgent care centre or walk-in centre. In *Emergency and acute medical care in over 16s: service delivery and organisation*. National Institute for Health and Care Excellence (NICE).

[17] McDonough, A., Lennox, A., Angus, M., & Coumbarides, A. (2022). An analysis of the utility, effectiveness and scope of advanced physiotherapy practitioners in an urgent treatment centre pilot. *Physiotherapy*, *115*, 61-65. https://doi.org/10.1016/j.physio.2021.12.005

[18] Cowling, T. E., Ramzan, F., Ladbrooke, T., Millington, H., Majeed, A., & Gnani, S. (2016). Referral outcomes of attendances at general practitioner led urgent care centres in London, England: retrospective analysis of hospital administrative data. *Emergency Medicine Journal*, *33*(3), 200-207. https://emj.bmj.com/content/33/3/200.long

[19] Benjamin, P., Bryce, R., Oyedokun, T., & Stempien, J. (2023). Strength in the gap: A rapid review of principles and practices for urgent care centres. *Healthc Manage Forum*, *36*(2), 101-106. https://doi.org/10.1177/08404704221143300

[20] Tammes, P., Morris, R. W., Brangan, E., Checkland, K., England, H., Huntley, A., Lasserson, D., MacKichan, F., Salisbury, C., Wye, L., & Purdy, S. (2017). Exploring the relationship between general practice characteristics and attendance at Walk-in Centres, Minor Injuries Units and Emergency Departments in England 2009/10-2012/2013: a longitudinal study. *BMC Health Serv Res*, *17*(1), 546. https://doi.org/10.1186/s12913-017-2483-x

[21] UK National Guideline Centre. (2018). Minor injury unit, urgent care centre or walk-in centre. In *Emergency and acute medical care in over 16s: service delivery and organisation*. National Institute for Health and Care Excellence (NICE).

The second study reviewed evidence of the impact of walk-in centres and GP cooperatives on ED avoidance.[22] The review identified 11 studies across five countries. The review concluded walk-in clinics "have the potential to reduce non-urgent ED presentations, however, the evidence of this effect is low."[23]

[22] Crawford, J., Cooper, S., Cant, R., & DeSouza, R. (2017). The impact of walk-in centres and GP co-operatives on emergency department presentations: A systematic review of the literature. *Int Emerg Nurs*, *34*, 36-42. https://doi.org/10.1016/j.ienj.2017.04.002
[23] Ibid.

2 Brief overview of the Program

This section of the report provides an overview of what was intended through the design of the Program.

2.1 What is a Medicare UCC?

Medicare UCCs are intended to be co-located with general practices, ACCHS and other community health centres. Each clinic is partnered with a local public hospital ED to encourage seamless coordination and integration with broader healthcare services.

The clinics are designed to be accessible and convenient, offering extended hours, walk-in services without appointments and access to diagnostic services such as pathology and radiology. Importantly, they operate with no out-of-pocket costs for patients. The clinics are intended to be welcoming, accessible and safe for all, particularly for priority populations.

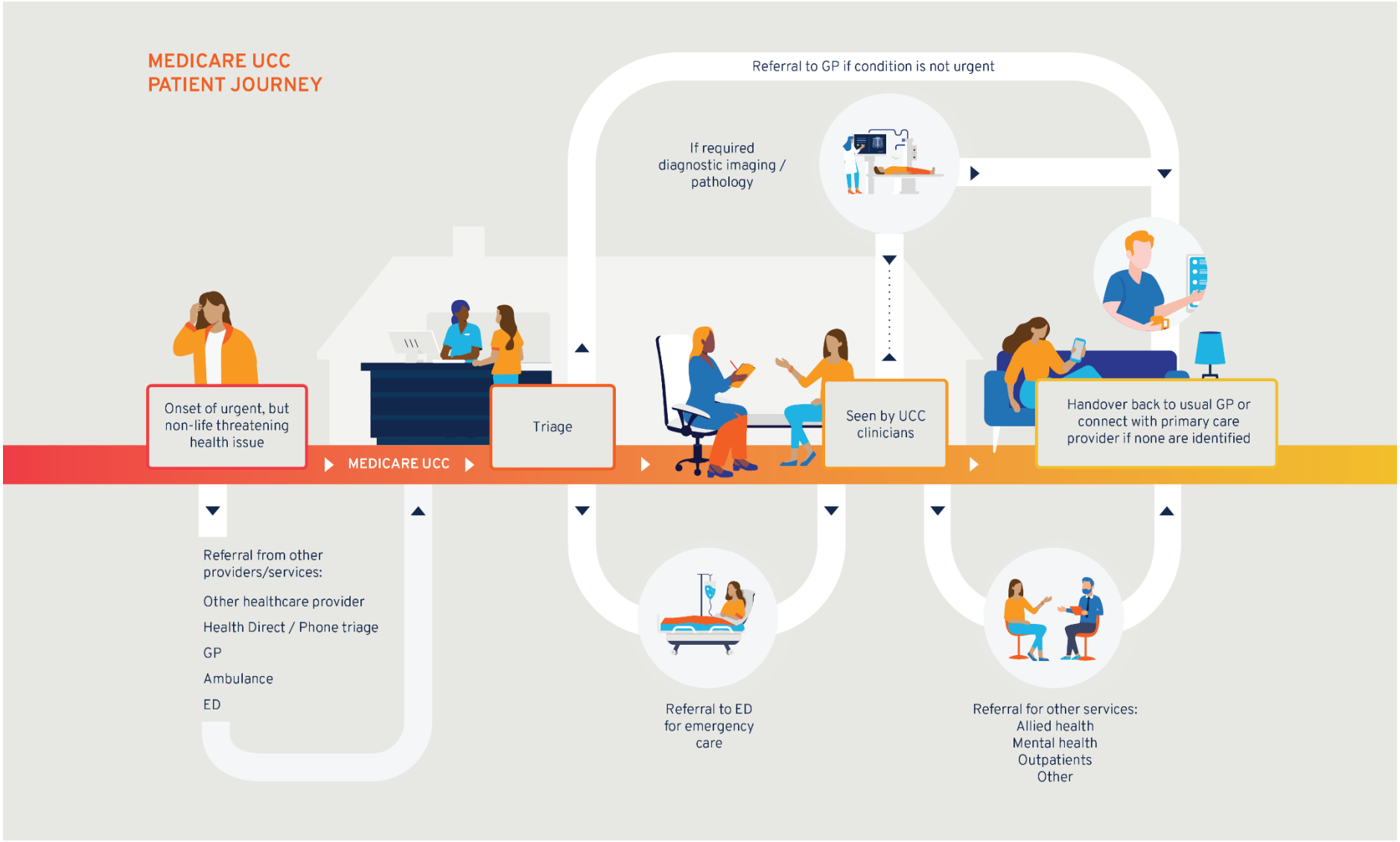
Patients can access Medicare UCCs directly or be referred by other services, including GPs, EDs, after-hours services, ambulance, Healthdirect and other primary healthcare services, such as allied health and community-based nursing services.

The Medicare UCCs are expected to establish clear escalation and referral pathways. This includes pathways to the local partner ED for emergency cases and a range of other services such as mental health, community health programs and hospital outpatient clinics. Medicare UCCs are not intended to provide follow-up care or to be the primary coordinator of care. Instead, they are expected to include the usual primary care provider in referrals for diagnostic tests and other services (relevant to the urgent care presentation), facilitate follow-up appointments with patients' usual primary care providers and ensure that every patient receives a discharge summary, which is communicated back to their primary care provider.

Some of the clinics transitioned from state and territory-managed urgent care services into the Medicare UCC Program.

Figure 3 depicts the intended Medicare UCC patient journey.

Figure 3 | The intended Medicare UCC patient journey



2.2 Where were they to be located?

Locations of the initial 50 Medicare UCCs established as part of the 2022 election commitment were announced progressively throughout the 2022 election campaign. The remaining eight Medicare UCCs established as part of the 2022 election commitment were determined in partnership with state and territory governments.

The Department advised that locations of the additional 29 clinics being established through the program funding expansion announced by the Australian Government in the 2024-25 Budget were informed by a range of factors including:

- equitable distribution of clinics around the country
- analysis of need and likely demand including triage categories four and five presentations to partner hospital EDs
- suitability of existing urgent care services to be funded by the Australian Government under the Medicare UCC Program
- advice from commissioners on the local operating context and likelihood of establishing a successful service, for example, workforce capacity and capability.

2.3 What governance arrangements were put in place?

Medicare UCCs were commissioned by state and territory governments in VIC, TAS, the ACT and the NT, and by PHNs in NSW, QLD, WA and SA. Commissioners undertook independent processes to identify suitable providers, manage the contracts and support the providers to establish and integrate the service within the local health ecosystem.

The Department developed Medicare UCC Operational Guidance[24] (the Guidance) in consultation with state and territory governments, which outlines the minimum standards and expectations in relation to scope, accessibility, referrals, activity, infrastructure and staffing at the Medicare UCCs among other things. The Medicare UCC Operational Guidance is based on the Urgent Care Standard developed by the Royal New Zealand College of Urgent Care and further informed by the Western Sydney Care Collective Urgent Care Service Standards and the Australian College of Rural and Remote Medicine Recommended Minimum Standards for small rural hospital EDs. The Guidance aims to support flexibility based on local need and context, including by outlining processes for seeking exemptions to the Guidance in certain circumstances.

The Guidance focuses on specific aspects of urgent care, rather than broader clinical governance and quality and safety in patient care. As such, Medicare UCCs are also required to be accredited to other recognised and relevant standards, such as the Royal Australian College of General Practitioners' (RACGP) *Standards for general practice*.

[24] Department of Health and Aged Care. (2022). Operational Guidance for Urgent Care Clinics.

3 Evaluation design and methodology

The evaluation is being conducted from 2024 through to 2026. A second Interim Evaluation Report will be delivered at the end of 2025 and a Final Evaluation Report in 2026.

The evaluation is guided by an Evaluation Plan, which includes the theory of change and logic model developed to guide the evaluation.

The theory of change for the Medicare UCC Program is based on the hypothesis that patients with urgent but non-life-threatening conditions attend or are referred to EDs due to a lack of accessible, affordable and trusted service alternatives. By providing this alternative, Medicare UCCs may result in more effective management of patients with these conditions, potentially reducing waiting times, alleviating pressure on EDs and improving the overall efficiency of the healthcare system. The theory of change is summarised in Figure 4.

Figure 4 | Theory of change for the Medicare UCC Program

The logic model (provided at Appendix A) complements this theory by mapping the inputs, activities, outputs and outcomes of the Medicare UCC Program. It includes key program components such as staffing, resources, operational activities and the strategic deployment of services that contribute to the desired change. All relevant aspects of the program are considered, from initial service design to outcomes, including the enhancement of patient pathways and the integration of services within local healthcare ecosystems.

3.1 Nationally agreed Measures of Success for the Medicare UCC Program

The key evaluation questions for this evaluation are based on the nine Measures of Success that were agreed by the Australian, and state and territory governments (Figure 1). This Interim Evaluation Report 1 focuses on initial insights into the nine Measures of Success to inform program improvement.

The Measures of Success were designed to assess the quality of care, accessibility of services and cost-efficiency in Medicare UCCs, as well as their impact on consumer behaviour and the extent to which they alleviate demand pressures on hospital EDs. The measures acknowledge the necessity for Medicare UCCs to be integrated effectively into the broader health ecosystem. This includes seamless connections with local GPs and other primary care services, and partner EDs, ensuring a comprehensive and coordinated approach to patient care.

3.2 Evaluation phases

Each phase of the evaluation is described in Figure 5. This Interim Evaluation Report 1 provides early insights into the nine Measures of Success, to inform future program improvement.

Figure 5 | Evaluation phases

3.3 Data sources

Across all phases, the evaluation uses a mixed-methods approach with a convergent parallel design, enabling the simultaneous collection and comparison of quantitative and qualitative data to provide a comprehensive analysis of the findings.

The data sources used for this Interim Evaluation Report 1 are listed below. Subsequent evaluation phases will expand on the sources listed here.

- **Stakeholder engagement.** Stakeholder engagement was limited due to the focus on program implementation and establishing initial operations of the Medicare UCCs. For this Interim Evaluation Report 1, stakeholder engagement included:
    - consultations with all the commissioners across Australia, including 19 PHNs and the four state and territory health departments
    - interviews with staff from selected Medicare UCCs to understand operations in various local contexts, including one remote NT Medicare UCC, the ACT Medicare UCCs and one NSW Medicare UCC
    - an interview with executive from the CHF
    - a meeting with the Medicare UCC Operational Advisory Group, which advises the Department on program operations and policy.

- **Program information** provided by the Department, including:
    - characteristics of Medicare UCCs, their location, opening hours, workforce details, radiology and pathology arrangements
    - grants provided to Medicare UCC commissioners
    - the approach to clinical assessment of Medicare UCCs against Operational Guidance
    - research data on the performance and impact of the national communications campaign on community awareness and use of Medicare UCCs
    - de-identified patient stories
    - federation funding agreement Medicare UCC performance reports
    - Medicare UCC policies to support priority populations.
- **Medicare UCC aggregate presentation counts**. Each Medicare UCC reported an aggregate count of presentations for each day from the date it opened, up to 30 June 2024. From 1 July 2024 the Medicare UCC Module is the only form of data reporting for most Medicare UCCs, including newly onboarded Medicare UCCs. At 30 September 2024, ACT Medicare UCCs, three remote NT Medicare UCCs and four other Medicare UCCs continued to report aggregate data rather than through the Medicare UCC Module.
- **Medicare UCC Module data and data extracts implemented prior to the Module being implemented**. Unit record data is available for 63 Medicare UCCs, whereas for another 12 clinics, only aggregate counts of presentations are available. These 12 include the ACT Medicare UCCs, the remote NT Medicare UCCs and four other Medicare UCCs.
- **MBS data.** For claims related to provider numbers associated with the Medicare UCCs.
- **Publicly available ED data.** ED data reported by the AIHW and state and territory health departments.
- **Other publicly available data.** A range of external data sources are used for comparisons, designed to provide a deeper understanding of the Medicare UCCs. They are used for example to compare demographic characteristics of patients attending Medicare UCCs with the general population and the geographic distribution of the Medicare UCCs compared with the distribution of the Australian population.

Appendix B provides a comprehensive overview of the data sources and Appendix C provides the list of stakeholders who were engaged for Interim Evaluation Report 1.

3.4 Data limitations

The data analysed for this interim evaluation is limited in several areas, including:

- **Recency of program implementation.** The first Medicare UCCs commenced operation on 30 June 2023, with the first 58 opening before 31 December 2023 and a further 17 opening between July and September 2024. Consequently, many clinics had not yet completed 12 months of operation at the time data was gathered and analysed for this report. As a result, the available data is insufficient to fully assess the clinics' performance or comprehensively measure their impact.
- **Data only available as aggregate counts.** The remote NT and the ACT Medicare UCCs are not providing unit record data for program monitoring and evaluation. The three small remote NT clinics do not currently use compatible software and are therefore manually collecting counts of presentation data and providing these to the Department. The five ACT Medicare UCCs have been impacted by a territory-wide implementation of the Digital Health Record in the ACT in November 2022, which has changed source data for health service activity in the territory. For four additional Medicare UCCs that opened after 1 September 2024, the Medicare UCC Module data was not yet fully implemented by 30 September 2024 (the cut-off date for data analysis). Prior to the implementation of the Medicare UCC Module data, some clinics only provided aggregate counts of activity. Additionally, aggregate counts are provided where the patient has specifically requested that data not be released through the Medicare UCC Module. For a small number of data items, an interim data extract was implemented

prior to the availability of the Medicare UCC Module, which provided unit record data on a limited number of data items. In the tables throughout this report 'Aggregate and other unit records counts' have been used as appropriate. See Appendix B for further information.

- **Non-mandatory data items specified for the Medicare UCC Module data.** Several data variables in the Module data that are directly relevant to the Measures of Success are not mandatory for data collection. This partly reflects the variability across source primary care patient management systems in the way data items are defined and collected. For many Medicare UCC Module data items, the data is populated from these source systems.
- **Missing data.** Some variables collected through the Medicare UCC Module are poorly completed or missing. For example, Aboriginal and Torres Strait Islander status was not recorded or reported as unknown for about 20 per cent of presentations in the Medicare UCC Module data and about 26 per cent in the full set of unit record data reported (the Module data plus the interim data extract reported prior to the Module being implemented). This is higher than for EDs, where this information was not recorded for about 0.8 per cent of patients in the 2022-23 national data. A reason for visit was not recorded for 20 per cent of Medicare UCC presentations reported through the Module data.
- **Variation in the interpretation of data items identified for the Module data.** Several mandatory and non-mandatory data items may be interpreted and reported differently by Medicare UCC clinicians and other staff. Analyses based on these items should be treated with caution. Examples of these include:
    - Where patient would have gone otherwise. Although this variable is intended to be collected by asking patients where they would have gone or sought advice from if a Medicare UCC was not available, some commissioners reported that clinic staff sometimes make this assessment on behalf of the patient. Other issues with this variable are detailed in Measure of Success 6 (section 5.6).
    - Reason for visit. Understanding the reasons patients attend Medicare UCCs is critical for analysing visit patterns and how these may change over time. Currently, the reason for visit is recorded as a text variable by the clinics, leading to numerous variations in how the same condition or symptom is described (for example, "abdo pain", "abdominal pain", "abdo pain for investigation", "abdo ache"). Implementing a classification system with a short list of reasons would standardise these representations, improving data consistency and facilitating more meaningful analysis. For example, EDs across Australia use the ED International Classification of Diseases-10th Revision – Australian Modification (ICD-10-AM) Diagnosis Short List maintained by the Independent Health and Aged Care Pricing Authority (IHACPA). Additionally, providing education on accurately assigning the reason for visit would be beneficial. Instances were observed where the patient's medical history (for example, premature birth), or a hospital-based procedure (for example, hip replacement) were incorrectly recorded as the reason for the visit, pointing to a potential data extraction issue or the need for better training and guidance on collecting these data.
- **Data availability for key program measures.** Medicare UCCs are intended to be accessible for priority populations. The data available to measure clinic usage by these groups is limited. For instance, there is no definitive metric for cultural and linguistic diversity. Through the Module data, information on country of birth, language spoken at home and interpreter usage are defined and reported. However, these variables appear to be relatively poorly reported. Additionally, these items, individually or together, provide only a partial insight into accessibility for culturally and linguistically diverse (CALD) populations. Another issue is the inability to separate out time of triage from clinical commencement time, which is important for accurately measuring waiting times for treatment.
- **Limitations of data for measuring impact on partner hospital EDs.** At this stage of the evaluation, the report draws on two primary data sources to assess the impact of Medicare UCCs on partner hospital EDs. The first is data from Medicare UCCs, where patients are asked where they would have gone or sought advice if the Medicare UCC was not available. This data is subject to potential bias, as some commissioners reported responses may vary depending on how the question is phrased, how patients interpret it, or how clinic staff assess the patient's condition. The second source is publicly available ED data, which tracks trends in triage categories four and five presentations before and after the

establishment of Medicare UCCs. While this data provides valuable insights, it has limitations, including the inability to apply robust methods for assessing causal relationships. Limitations inherent in observational data will be addressed in subsequent analyses through:

- Applying a DiD method to strengthen causal inferences through use of a comparison group.
- Narrowing the focus to ED presentations that are more likely to have been impacted by the presence of a Medicare UCC, specifically through estimating the effect for populations within the catchments of the Medicare UCCs and focusing on the subset of triage categories four and five ED presentations that better align with the definition of urgent care.
- Exploring the potential use of linked MBS and ED data to assess the extent to which patients who have attended a Medicare UCC subsequently attend an ED and comparing populations for whom a Medicare UCC is available with others where it is not available.

The Department reported it is working with commissioners to uplift the quality of data captured, for example, through development of the data manual and support with onboarding clinics to the Medicare UCC Module.

DATA IMPROVEMENT OPPORTUNITIES

There are opportunities to improve the quality of data reported through the Medicare UCC Module, through the following steps:

- Explore with Medicare UCCs and clinicians the data items within the Module data that are the most challenging to capture, seeking their views on improvements that could be made.
- Review and refine definitions of key data items and add guidance for interpreting areas identified as problematic within the Medicare UCC data dictionary. This would be particularly useful on "Reason for visit" and "Where patient would have gone otherwise".
- Develop a short list of "Reasons for visit" that could be implemented in the Module data. A starting point for this could be the ED ICD-10-AM Diagnosis Short List, but this will need to be modified to be more suitable for urgent care settings. This could be provided as a pick list for clinicians to select the appropriate reason(s) for visit.
- Associated with the short list, implement an approach to flag reasons for visit that relate to a prior condition or medical events that may be relevant to the current presentation, but are not the reason for the current presentation.
- Identify Medicare UCCs with low reporting of Indigenous status, country of birth, language spoken at home and interpreter use and request that commissioners troubleshoot with these Medicare UCCs the reasons for low reporting and identify steps to improve reporting.

4 Implementation: what has been implemented so far?

This section provides a national overview of Medicare UCC locations, accessibility, workforce composition and patient presentations. It highlights variations in operating hours, workforce models, patient volumes and the conditions managed by Medicare UCCs, which are shaped by local contexts and community needs. As noted earlier, the Medicare UCC Operational Guidance aims to support flexibility based on local need and context, including by outlining processes for seeking exemptions to the guidance in certain circumstances.

4.1 Number of Medicare UCCs

By 30 September 2024, 75 Medicare UCCs had opened. Of these, 58 opened before 31 December 2023 and 17 opened between 1 July 2024 and 30 September 2024. A further 12 clinics will open progressively from 1 October 2024, making a total of 87 clinics to be funded through this program.

At the time of writing, one Medicare UCC is being recommissioned and a new provider is expected to be stood up in early 2025. This Medicare UCC was operational in the period up to 30 September 2024.

The first clinics opened on 30 June 2023 and many have yet to complete 12 months of operation. Initially, efforts have concentrated on establishing and operationalising these clinics. For those clinics that have been operating for longer, the focus has shifted to optimising their operations, including refining referral pathways and integrating them into local health ecosystems.

4.2 Locations of Medicare UCCs

Medicare UCC locations broadly follow the distribution of the Australian population

Medicare UCC locations and commissioning arrangements in place to 30 September 2024 are shown in Figure 6. The number of Medicare UCCs in each jurisdiction broadly follows the Australian population distribution, with a slightly higher proportion of clinics located in the smaller states and territories. This will be re-examined in the next evaluation phase once the remaining clinics are in place.

Figure 6 | Commissioning arrangements of operational Medicare UCCs on 30 September 2024

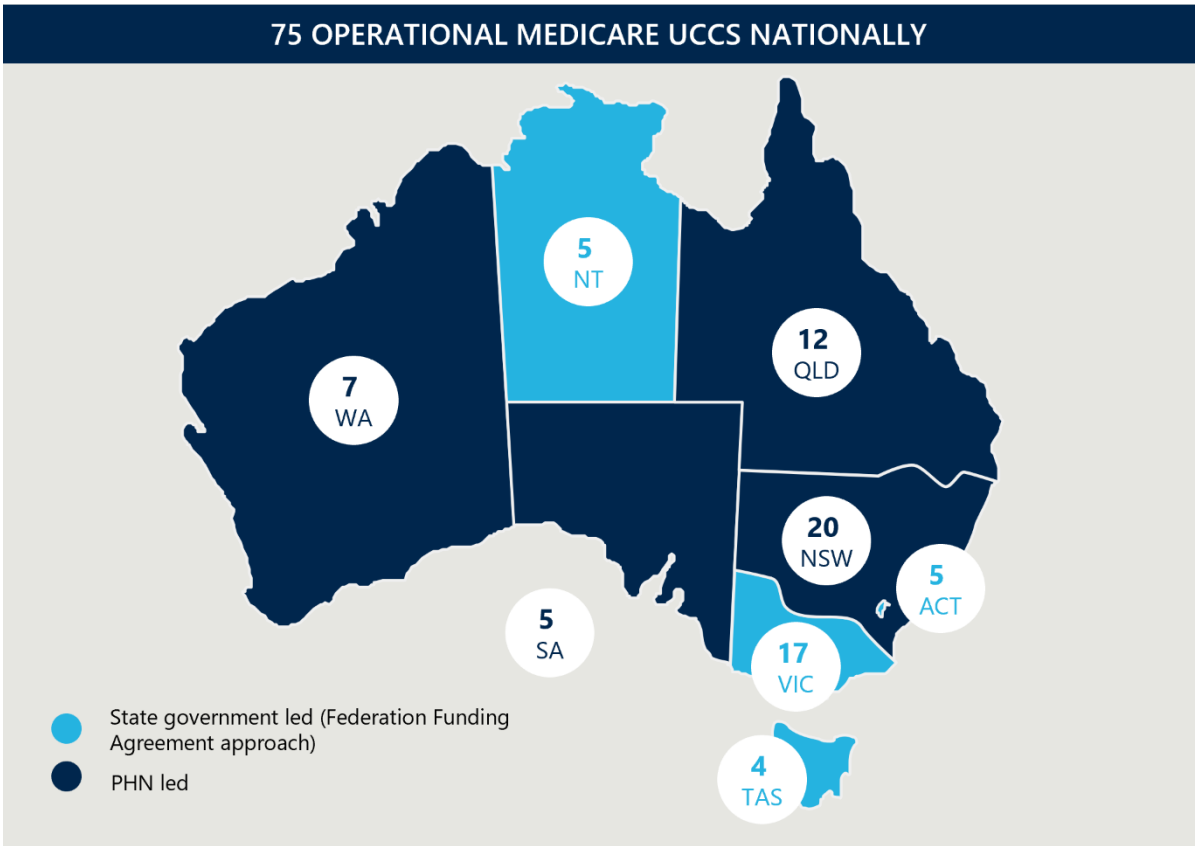


Table 1 shows the location of the Medicare UCCs operational by 30 September 2024 by Modified Monash Model (MMM) category, which classifies regions in Australia based on their remoteness and population size. Most clinics (65 per cent) are in MM1 (Metropolitan areas). About 72 per cent of the Australian population lived in these areas in 2021.[25]

Table 1 | Medicare UCC locations by MMM categories and comparison with Australian population usual residence, 2021

MMM category	Medicare UCCs operational 30 Sept 2024		Australian population 2021 (a)
	Number	Percentage	
MM1: Metropolitan areas	49	65%	72.0%
MM2: Regional centres	13	17%	8.7%
MM3: Large rural towns	7	9%	6.4%
MM4: Medium rural towns	1	1%	5.5%
MM6: Remote communities	2	3%	5.7%
MM7: Very remote communities	3	4%	1.0%
Total	**75**	**100%**	**100.0%**

Note: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. (a) Source: Australian Bureau of Statistics (ABS).[26]

[25] Based on analysis of Australian Bureau of Statistics. (2021). *Socio-Economic Indexes for Areas (SEIFA)* (https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release#data-downloads SA2s were mapped to MMM categories and Quintiles IRSD.
[26] Ibid.

Medicare UCCs are located in more socio-economically disadvantaged areas

Table 2 shows the location of existing Medicare UCCs by the ABS Index of Relative Socio-Economic Disadvantage (IRSD), based on Statistical Areas Level 2 (SA2).[27]

The index is divided into quintiles, with each quintile containing approximately 20 per cent of SA2 areas ranked by disadvantage level. As the quintiles are area-based, the population distributions across the quintiles may vary. However, each quintile contains approximately 20 per cent of the Australian population (ranging between 19 and 21 per cent based on the 2021 Usual Resident Population of each SA2). Medicare UCCs tend to be located in more disadvantaged SA2s, with 23 per cent located in the most disadvantaged quintile (Quintile 1) and 27 per cent in the next most disadvantaged quintile (Quintile 2).

Table 2 | Medicare UCC locations by ABS IRSD

SEIFA IRSD Quintile (a)	Medicare UCCs operational 30 September 2024 (75 clinics)		Australian population 2021
	Number	Percentage	Percentage
1 (most disadvantaged)	17	22.6%	16.9%
2	20	26.6%	17.2%
3	19	25.3%	21.9%
4	14	18.6%	21.8%
5 (least disadvantaged)	5	6.7%	22.1%

Note: Table reflects data from 30 June 2024 to 30 September 2024 and extracted on 6 November 2024. (a) Based on the quintile of the ABS IRSD of Medicare UCC location.

4.3 Accessibility of Medicare UCCs

Medicare UCCs operate for an average of 12 hours per day

Medicare UCC Operational Guidance stipulates that Medicare UCCs are to be open for extended hours seven days a week, with exact hours dependent on local conditions and needs.

Table 3 shows the days of the week Medicare UCCs are open and statistics on the hours open. All were open on weekdays for an average of 12.3 hours. On weekends, 73 clinics operated with a similar average of 12 hours on both Saturdays and Sundays. The two clinics that are not open on the weekend are based in remote areas of the NT and have GP on-call arrangements in place.

Table 3 | Medicare UCCs open by day of week and statistics on hours open[28]

Day of week	Hours open (a)			Number of clinics open
	Mean	Minimum	Maximum	
Weekdays	12.3	6.0	15.0	75
Saturday	12.0	4.0	14.5	73

[27] Ibid.

[28] Data captured regarding clinic opening hours, as well as pathology, X-ray, CT and ultrasound is point in time. This may continue to change as Medicare UCCs adjust their hours to meet demand and as part of existing efforts to improve the accessibility of clinics and/or ancillary services. This data represents the Department's best efforts to accurately capture opening hours information through a range of channels – when drawing on opening hours information.

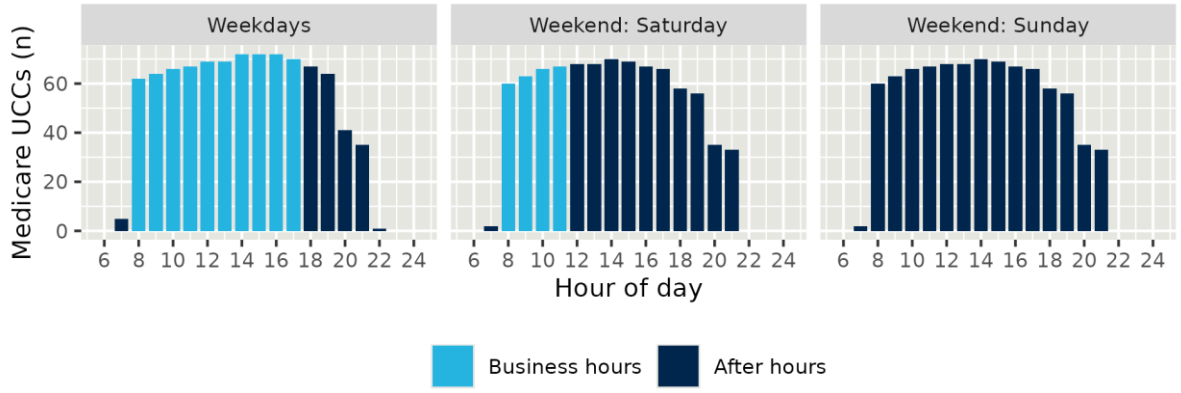
Day of week	Hours open (a)			Number of clinics open
	Mean	Minimum	Maximum	
Sunday	12.0	4.0	14.5	73

Note: Table includes data from 75 clinics open at 30 September 2024. (a) Excludes public holidays.

Medicare UCCs are mostly open by 8:00 am and close at 8:00 pm or later and operate for an average of 12 hours per day

Figure 7 shows the number of Medicare UCCs open by hour of day and day of week. On weekdays, 62 clinics (83 per cent) are open at 8:00 am and 41 (55 per cent) close at 8:00 pm or later. A similar pattern was seen across the weekends, with 60 Medicare UCCs (80 per cent) open at 8:00 am and 35 clinics (47 per cent) closing at 8:00 pm or later.

Figure 7 | Number of Medicare UCCs open by hour of day and day of week[29]



Data available for 75 Medicare UCCs.

The number of Medicare UCCs open by day of the week is consistent across remoteness categories, but the average operating hours are slightly lower outside of metropolitan areas, especially on weekends

Table 4 shows the number of clinics open by day of week and the average opening hours, by MMM category. The number of clinics open on weekdays versus weekends is consistent across MMM categories. The mean operating hours trend down outside of MM1 (Metropolitan areas), likely due to local workforce availability and conditions, although clinics in MM2 (Regional centres) are noted to have shorter average opening hours on weekends (ten hours), compared with those in MM3 to MM7 (Rural towns and remote communities, 10.3 hours).

Table 4 | Medicare UCC mean number of hours open per day by MMM category[30]

Day of week	Mean hours open (a)		
	MM1 Metropolitan areas (49 clinics)	MM2 Regional Centres (13 clinics)	MM3-7 Rural towns and remote communities (13 clinics)
Weekdays	13.2	11.0	10.4

[29] Ibid.
[30] Ibid.

Day of week	Mean hours open (a)		
	MM1 Metropolitan areas (49 clinics)	MM2 Regional Centres (13 clinics)	MM3-7 Rural towns and remote communities (13 clinics)
Saturday	12.9	10.0	10.3
Sunday	12.9	10.0	10.3

Note: Table includes data from 75 clinics open at 30 September 2024. (a) Excludes public holidays.

Medicare UCCs offer diagnostic services widely between 8:00 am and 5:00 pm on weekdays, with reduced access on weekends

According to Medicare UCC Operational Guidance, clinics should have an X-ray facility on-site or easily accessible across all hours of operation, access to ultrasound and CT across the majority of hours of operation and timely access to laboratory-based pathology (at a minimum basic results available same day).

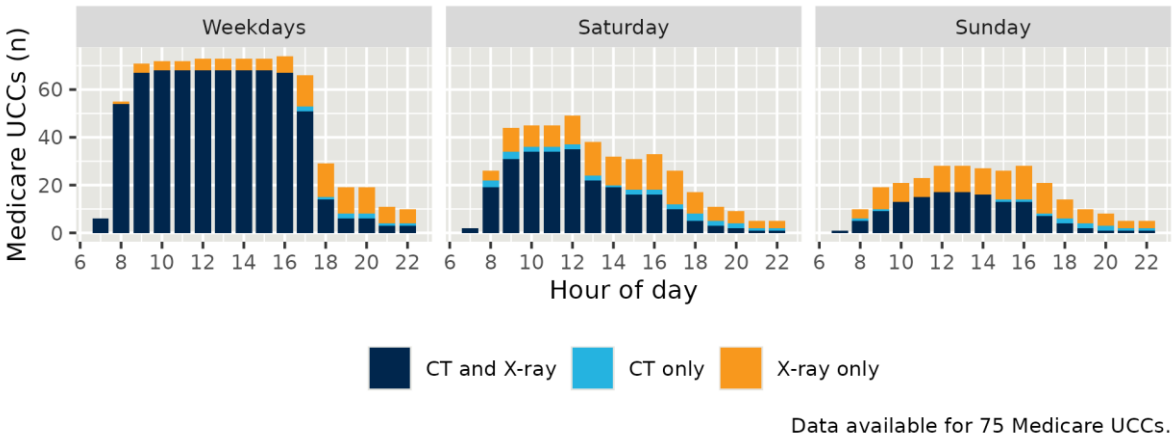
Medicare UCCs have varying arrangements in place to support access to diagnostic services, either on-site or off-site. Analysis of the distance from Medicare UCCs to diagnostic services will be included in Interim Evaluation Report 2.

Figure 8 shows the availability of CT and X-ray imaging at Medicare UCCs and Figure 9 shows the availability of ultrasound.

The availability of imaging services varies depending on the day of the week and time of day. On weekdays, most clinics offer imaging between 8:00 am and 5:00 pm. After 5:00 pm, the number of clinics offering these services reduces, especially in the evening.

Saturdays see a drop in availability of imaging compared with weekdays. Sundays have the lowest overall service availability. On weekends, there is a higher proportion of clinics offering X-ray only services compared with weekdays, though clinics providing both CT and X-ray services remain predominant during peak hours. Ultrasound availability drops off after 2:00 pm on both weekend days.

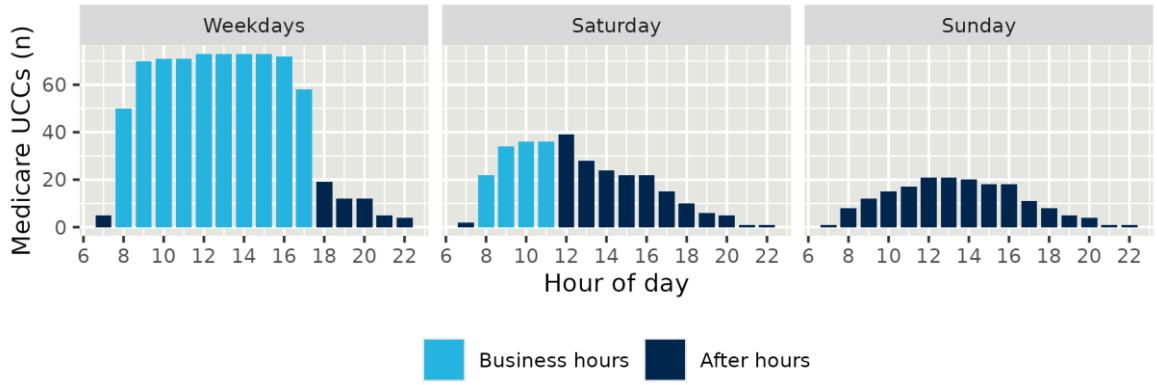
Figure 8 | Number of Medicare UCC that have access to X-ray and/or CT imaging by hour of day and day of week[31]



Data available for 75 Medicare UCCs.

[31] Ibid.

Figure 9 | Number of Medicare UCC that have access to ultrasound imaging by hour of day and day of week[32]

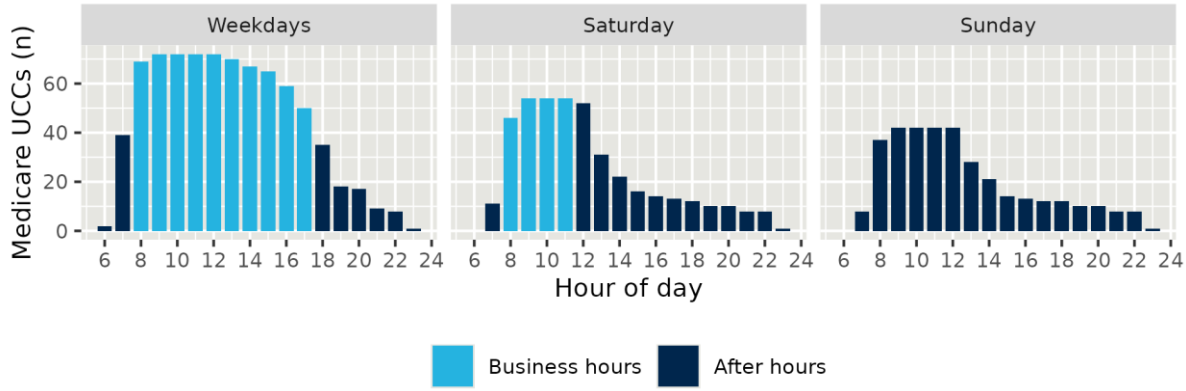


Data available for 73 Medicare UCCs.

Figure 10 shows the availability of pathology services. Weekdays show the most consistent availability of this service, with clinics generally offering it between 8:00 am and 6:00 pm.

Saturdays have reduced service availability compared with weekdays, particularly after 2:00 pm, but still provide access during the morning and early afternoon. Sundays offer the least access to pathology services, with clinics primarily offering service during the morning hours and very limited services available in the afternoon and evening.

Figure 10 | Pathology service: Availability of pathology services by hour of day[33]



Data available for 72 Medicare UCCs.

4.4 Medicare UCC workforce

The Medicare UCC Operational Guidance stipulates that Medicare UCCs will be GP-led, with staffing mix based on availability, local context and need. Minimum staffing requirements include one vocationally registered GP, one registered nurse and one receptionist. Both the GP and nurse are expected to have further skills in emergency medicine. Medicare UCCs may employ additional staff above the minimum requirement, for example, other suitably qualified medical practitioners, nurse practitioners, extended care paramedics, allied health and Aboriginal Health Practitioners.

Table 5 shows Medicare UCC workforce by staff category as reported by Medicare UCCs and commissioners. Medicare UCCs have a mean of 2.8 full-time equivalent (FTE) medical practitioners and a headcount of 8.8 per clinic. Most medical practitioners employed by Medicare UCCs are vocationally registered GPs, in line with Medicare UCC Operational Guidance.

[32] Ibid.
[33] Ibid.

There is a mean of 4 FTE nursing staff and a mean headcount of 8.5 per Medicare UCC. Nursing staff include nurse practitioners, advanced practice nurses, nurse managers, nurse educators, registered nurses and enrolled nurses.

There is a small number of other clinical staff reported to be working in 15 Medicare UCCs, including allied health practitioners, Aboriginal Health Practitioners, Aboriginal Health Workers and radiographers.

Clinical staff are supported by a mean FTE 3.1 administrative staff per clinic, with a mean headcount of 6.5 per Medicare UCC.

Table 5 | Medicare UCC workforce by staff category

Staff category	Medicare UCCs	Headcount		FTE	
		Total	Mean per UCC	Total	Mean per UCC
Medical practitioner	65	570	8.8	182.8	2.8
Nurse	66	563	8.5	261.3	4.0
Other clinical	15	45	3.0	15.6	1.0
Administration staff	63	408	6.5	195.2	3.1
Total	66	1,586	24.0	654.8	9.9

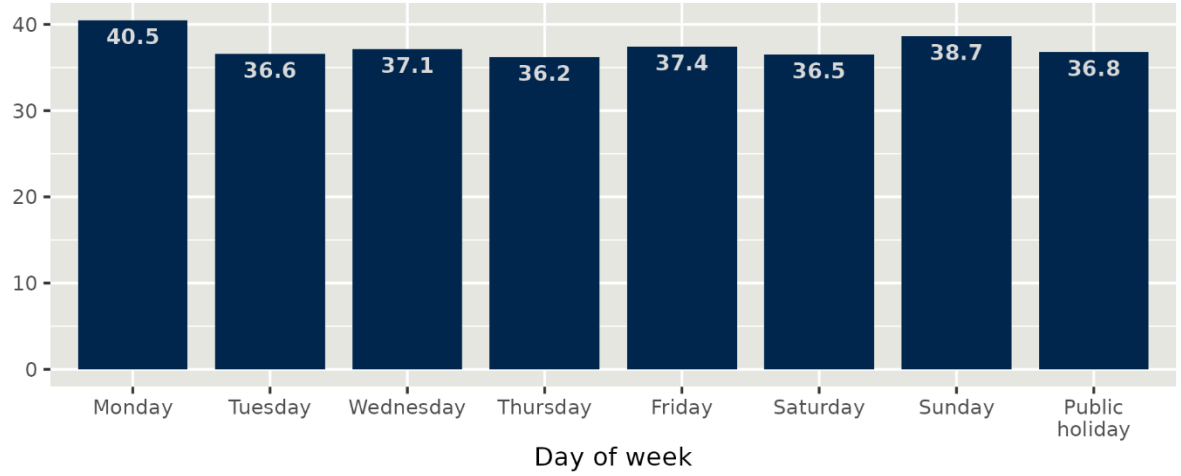
Note: Table includes data from 66 clinics that reported staffing data out of the 75 operational clinics at 30 September 2024. Data for ten clinics was collected in October to November 2024. In a few instances, Medicare UCCs reported a headcount but no FTE staff. In a few other instances, no headcount was reported but an FTE value was reported. Missing values were estimated by using ratios between headcount and FTE by staff type reported by other Medicare UCCs, or alternatively, utilising the explanation provided by the Medicare UCCs. This resulted in an increase in headcount of 15 and an increase in FTE of 30.5 across all staff types and clinic categories.

4.5 Presentations to Medicare UCCs

There were 784,071 presentations to Medicare UCCs between 30 June 2023 and 30 September 2024

As shown in Figure 11, mean presentations to Medicare UCCs per day range between 36.2 to 40.5. Mean presentations to Medicare UCCs were slightly higher on Sundays and Mondays, but otherwise relatively consistent throughout the week.

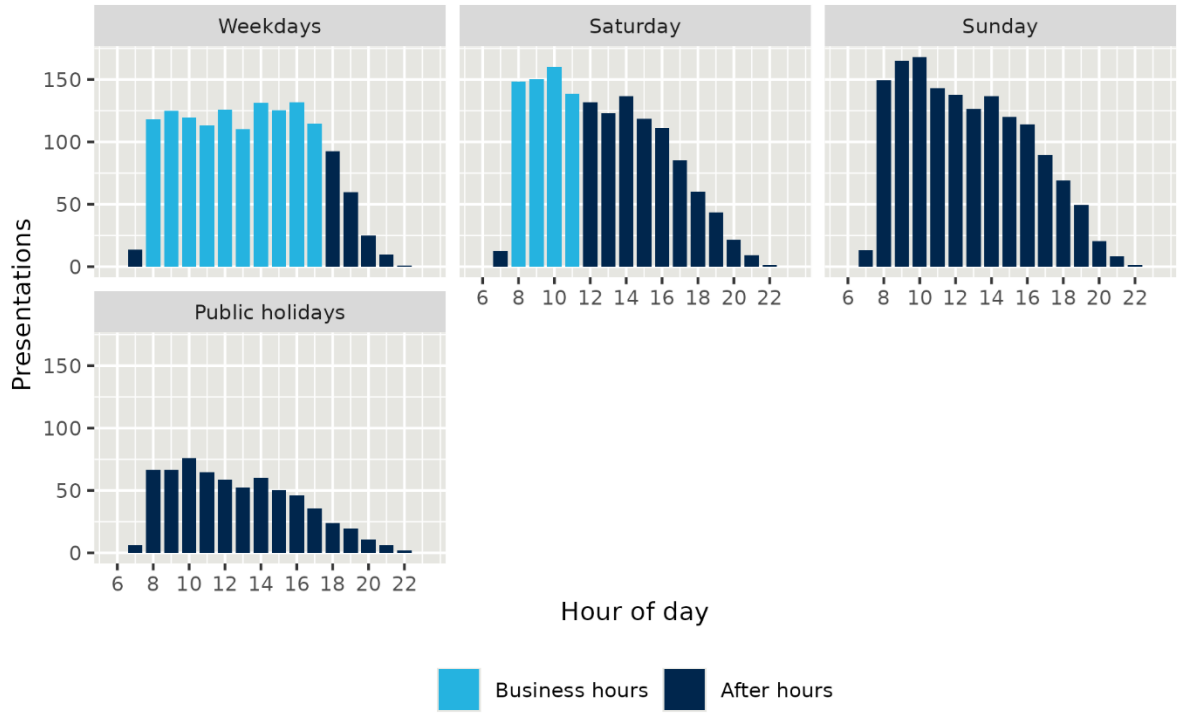
Figure 11 | Mean presentations per clinic by day of the week, 1 February 2024 to 30 September 2024



Note: Based on all data reported from 1 February 2024 to 30 September 2024 for 75 Medicare UCCs. This period was chosen to provide a more accurate reflection of activity once clinics were established. Includes aggregate counts for clinics where unit record data was not reported.

Presentations to Medicare UCCs are relatively consistent throughout the day and gradually decrease from 5:00 pm (Figure 12). In comparison, semi-urgent and non-urgent (triage categories four and five) presentations to EDs[34,35] peak at around 10:00 am and decrease gradually thereafter (Figure 13).

Figure 12 | Mean presentations by time of day and day of week, 1 February 2024 to 30 September 2024

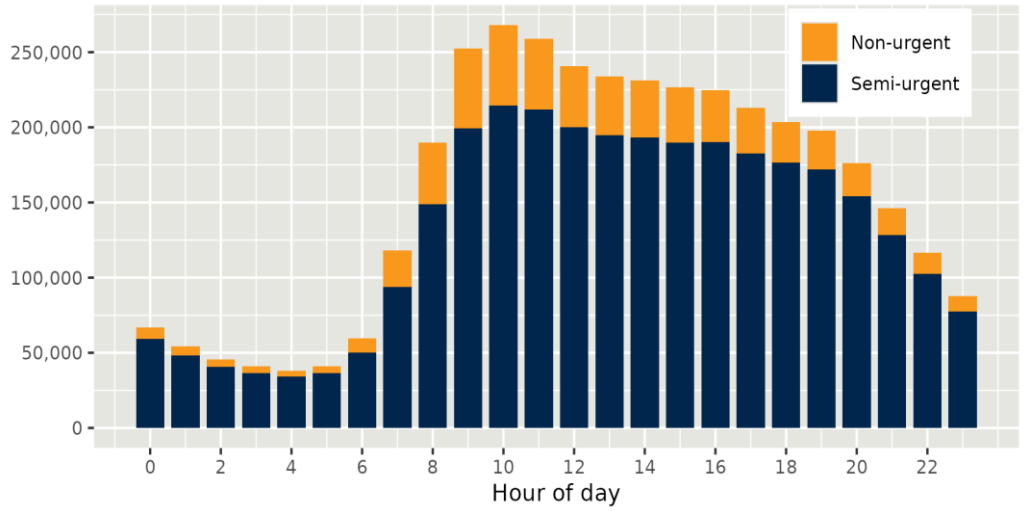


Note: Based on Medicare UCC Module data reported from 1 February 2024 to 30 September 2024. This period was chosen to provide a more accurate reflection of activity once clinics were established. Presentation time available for 358,297 presentations across 63 Medicare UCCs. Mean by day across all Medicare UCCs for the specified hour of day and day of week.

[34] Australian Institute of Health and Welfare. (2023b). *Emergency department care*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

[35] Semi-urgent and non-urgent (triage categories four and five) presentations to ED are considered to align with the types of conditions that Medicare UCCs aim to treat, and used in the indicator: Australian Institute of Health and Welfare. (2023c). *National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022*. https://meteor.aihw.gov.au/content/740847

Figure 13 | Time of day for presentations to ED assigned to triage categories four and five (2022-23)



Note: The ED data is based on AIHW 2024 ED care 2022-23: Australian hospitals statistics: Supplement Data Tables https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care Table S4.5

4.6 Comparison of characteristics of patients attending Medicare UCCs with ED patients

Available data indicates Medicare UCC patients tend to be younger than patients attending EDs for similar care

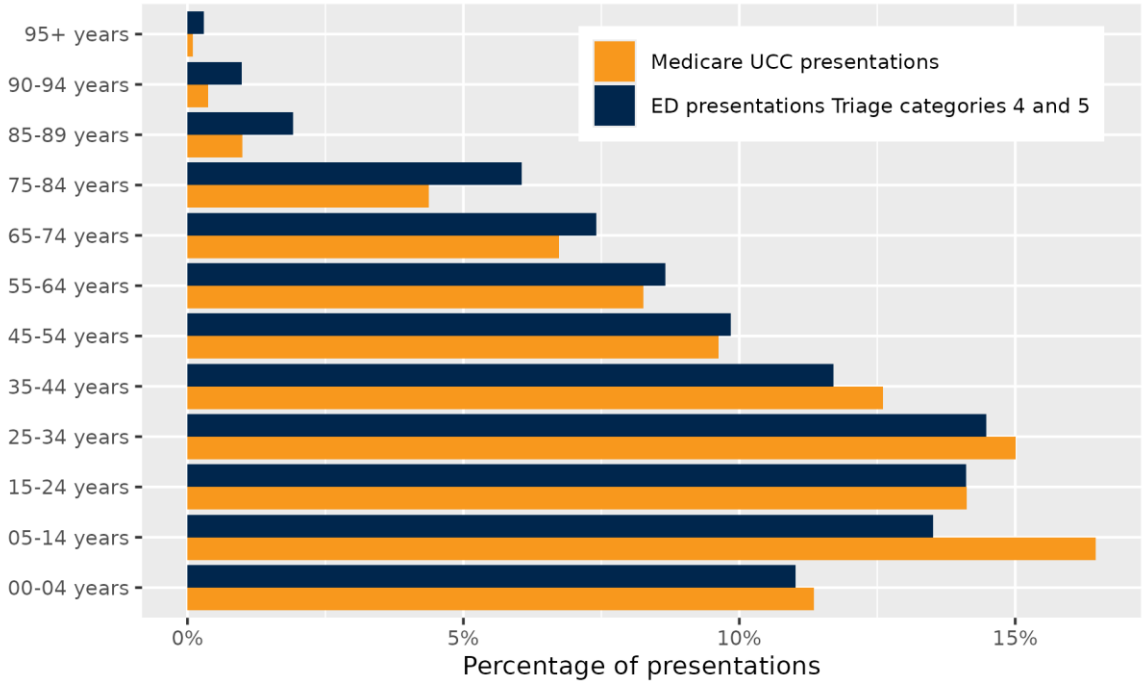
Of the patients attending Medicare UCCs, 45 per cent were male and 55 per cent were female.[36] This was slightly different to patients attending EDs in triage categories four (semi-urgent) and five (non-urgent care), where 51 per cent were male and 49 per cent female.[37]

Figure 14 shows available data for the age at presentation of Medicare UCC patients. Children up to four years made up 11 per cent of total presentations. This is similar to patients attending EDs in triage categories four and five. Children aged between five and 14 years accounted for 17 per cent of presentations to Medicare UCCs. Children in this age range made up 14 per cent of ED presentations in triage categories four and five.[38]

People aged 65 years and over made up 13 per cent of Medicare UCCs presentations, whereas they made up 17 per cent of ED presentations in triage categories four and five.

[36] This is based on the variable in source the practice management systems and may refer to either gender or sex. There is likely to be variation across practices in the recording of the variable.
[37] Australian Institute of Health and Welfare. (2023b). *Emergency department care*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care
[38] Ibid.

Figure 14 | Comparison of proportion of presentations by age group: Medicare UCCs (30 June 2023 to 30 September 2024) compared with ED triage categories four and five (2022-23)



Note: Medicare UCC data is based on presentations reported through the Medicare UCC Module data plus the Interim data extraction solution. Data was available for 63 Medicare UCCs. Proportions are calculated using available data only, rather than the proportion of all presentations. The ED data is based on AIHW 2024 ED care 2022-23: Australian hospitals statistics: Supplement Data Tables https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care Table 4.3.

Table 6 shows the Indigenous status of patients presenting to Medicare UCCs, with 6 per cent identifying as Aboriginal and/or Torres Strait Islander. This is slightly lower compared with EDs, where 8 per cent of patients overall identified as Aboriginal and/or Torres Strait Islander.[39] However, Indigenous status is not stated/recorded for 21 per cent of records in the Medicare UCC data, compared with only 0.8 per cent in the ED data. Removing these records, the percentage of Medicare UCC patients identifying as Aboriginal and/or Torres Strait Islander is closer to the percentage for EDs (8 per cent).

[39] Note that Indigenous status is not available by triage category for EDs and thus the comparison of percentages is with all ED attendances.

Table 6 | Indigenous status of patients attending Medicare UCCs compared with patients attending EDs

Indigenous status	Presentations	Percentage including "Not recorded"	Percentage excluding "Not recorded"	Patients attending ED 2022-23
Indigenous – Aboriginal	26,079	5.0%	6.3%	
Indigenous – Torres Strait Islander	1,030	0.2%	0.2%	
Indigenous – Aboriginal and Torres Strait Islander	3,922	0.7%	0.9%	
Total Indigenous	**31,031**	**5.9%**	**7.5%**	**8.4%**
Not Indigenous	383,285	72.9%	92.5%	90.7%
Not recorded	111,555	21.2%		0.8%
Total excluding "Not recorded" (from 63 Medicare UCCs)	414,316		100.0%	
Total including "Not recorded" (from 63 Medicare UCCs)	525,871	100.0%		
Aggregate counts	258,200			
Total presentations (from 75 Medicare UCCs)	**784,071**			

Notes: Table reflects data to from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024.

5 Interim evaluation against the nine Measures of Success

The nine Measures of Success were developed and agreed by all Australian Governments and form the key evaluation questions for this evaluation. These Measures will be assessed again for the second Interim Evaluation Report and the Final Evaluation Report. Interim findings and opportunities for improvement have been identified, based on the qualitative and quantitative evidence available. The opportunities for improvement are also summarised in section 6.

MEASURE OF SUCCESS 1

5.1 Timely treatment

Measure of Success 1 agreed by the Australian, state and territory governments is:

"Patients receive timely treatment for urgent non-life-threatening conditions in Medicare UCCs."

Timely treatment can differ significantly based on clinical context and location

Timeliness of care is one of the six commonly accepted dimensions of healthcare quality.[40,41] Receiving timely treatment means obtaining medical care or intervention at an appropriate and optimal moment to address a health issue effectively. It involves prompt access to healthcare services, allowing for early diagnosis and treatment, which can prevent the condition from worsening, reduce complications and improve overall outcomes. Timely treatment is crucial as delays in care can lead to more severe health problems, prolonged recovery, or in some circumstances, life-threatening consequences.

There is no agreed clinical definition of what is considered timely treatment. It can differ significantly based on clinical context, urgency of the condition and factors such as resource availability, geographic location and patient circumstances. The perception of patients and doctors about what is considered timely care can also differ widely for many common medical conditions.[42] The ATS is the clinical tool used in Australia to establish the maximum acceptable waiting time for medical assessment and treatment of a patient in an ED.[43] The acceptable standard for patients in ED triage category four (semi-urgent) is a maximum waiting time of 60 minutes and for triage category five (non-urgent care) it is 120 minutes.[44] A comparable Australian standard for maximum GP urgent care waiting time is not available. There is no definition of timely care for Medicare UCCs.

Considering these different ways to interpret timely care, this Interim Evaluation Report 1 considers timely care through the statistical analysis of patient waiting times at Medicare UCCs and comparison with public hospital EDs for patients in triage categories four and five. Note that the figures provided here include the period until 30 September 2024. Qualitative evidence in the form of patient stories is described in Measure of Success 4 (section 5.4). Appropriateness of care for urgent non-life-threatening conditions is described further in Measure of Success 2 (section 5.2).

[40] World Health Organisation. (2024). *Quality of Care*. Retrieved 26 November 2024 from https://www.who.int/health-topics/quality-of-care#tab=tab_1
[41] Barry, D., Melhado, T., Chacko, K., Lee, R. S.-M., Steiner, J., & Kutner, J. (2006). Patient and Physician Perceptions of Timely Access to Care. *Journal of General Internal Medicine*, *21*(2), 130-133. https://doi.org/10.1111/j.1525-1497.2005.0299.x
[42] Ibid.
[43] Australasian College of Emergency Medicine. (2024). *Triage*. Retrieved 21 November from https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Triage
[44] Ibid.

The national median waiting time at Medicare UCCs is 14.5 minutes

As shown in Table 7, the national median waiting time at Medicare UCCs is 14.5 minutes. Most patients (70.5 per cent) are seen within 30 minutes at Medicare UCCs. Medicare UCC data indicates that 12 per cent of patients waited longer than 60 minutes to be seen at Medicare UCCs, while only 2.4 per cent of presentations had a waiting time of over two hours.

Wait times can be affected by a range of factors, such as variability in patient needs and complexity, or the time of day. Stakeholders reported instances where the Medicare UCCs have experienced high demand in the evenings and reached capacity several hours before closing time. It has not been possible to assess time to treatment for those patients who could not be seen by a clinician due to this high demand based on current data. This will be explored further through consultations with stakeholders in future phases of the evaluation. Opportunities for improving Medicare UCCs' service efficiency are described further in Measure of Success 4 (section 5.4).

Table 7 | Medicare UCC waiting times

Waiting time category	Presentations (a)		Mean waiting time (minutes)	Median waiting time (minutes)
	Number	Percentage		
<15 minutes	180,496	50.9%	5.4	4.4
15 to <30 minutes	69,421	19.6%	21.7	21.3
30 to <60 minutes	62,230	17.5%	42.5	41.4
60 to <120 minutes	34,090	9.6%	81.7	78.2
120+ minutes	8,538	2.4%	164.7	147.8
Total(a)	**354,775**	**100.0%**	**26.3**	**14.5**

Notes: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. Waiting time calculated as the difference in minutes between the time of presentation and the first interaction (episode) recorded in the practice management system involving a clinician (GP, other doctor, nurse or allied health professional), which is based on a time-stamped interaction with the patient's records in the practice management system. Waiting times reported here should be interpreted with caution. In some instances, the interaction with a clinician may be related to triage. In other instances, clinical care may have commenced prior to an interaction with the patient's record. (a) Derived from presentations recorded in the UCC Module data. Excludes 71,704 presentations where there was no valid waiting time or the end status was 'Did not wait'. This presents a potential limitation to the conclusions that can be drawn from the data (see section 3.4 for an overview of limitations related to the Medicare UCC data).

Median waiting times at Medicare UCCs are lower than reported waiting times for urgent GP care

The national median waiting time at Medicare UCCs is notably lower than the waiting time for urgent GP care reported by the ABS Patient Experience Survey.

Based on the ABS Patient Experience Survey, in 2023-24, 46 per cent of patients who saw a GP for urgent medical care self-reported that they waited for 24 hours or more, 41.7 per cent were seen within four hours and 12.5 per cent waited between four to 24 hours.[45]

Note that while the ABS Patient Experience Survey offers a point of comparison for Medicare UCC wait times, GPs are often seen by appointment while clinicians at Medicare UCCs are not. GP wait time captured in the survey is between the time a person contacts a health service to make an appointment to commencement of clinical care, which is different from ED and Medicare UCCs. Additionally, the definition

[45] Australian Bureau of Statistics. (2024). *Patient Experiences*. Retrieved 21 November from https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#waiting-times

of "urgent medical care" used in the survey is self-defined by survey participants and does not align with the definition used for Medicare UCC wait times or ED triage categories four and five wait times.

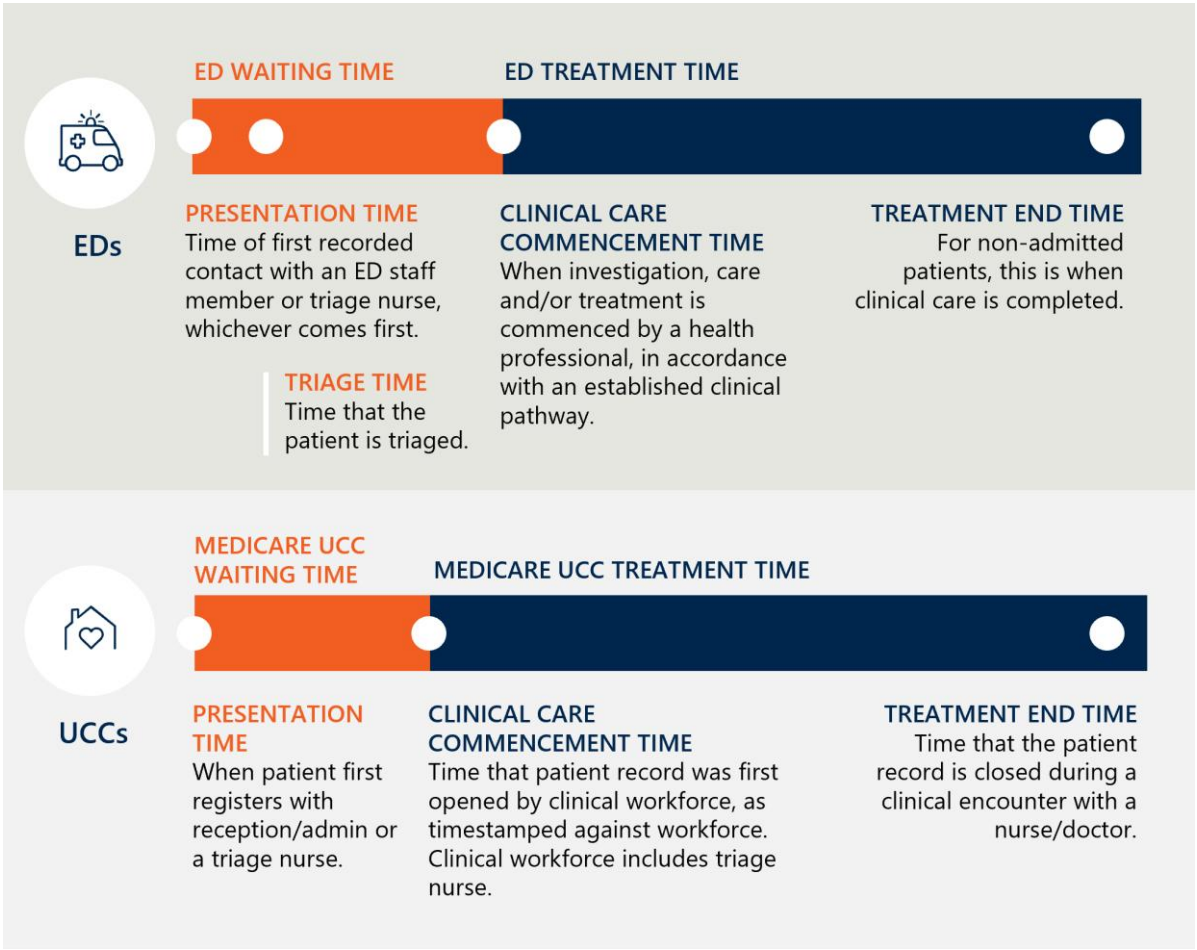
Median waiting times at Medicare UCCs are lower than ED waiting times for national public hospital ED triage categories four and five presentations

The national median waiting time at Medicare UCCs is also notably lower than the national median ED waiting times. As noted above, the national median waiting time at Medicare UCCs is 14.5 minutes (Table 7), while the national public hospital median ED waiting times for triage category four is more than double this at 31 minutes and is 24 minutes for category five presentations (2022-23).[46]

Twelve per cent of patients waited longer than 60 minutes to be seen at Medicare UCCs. In EDs, 32 per cent of patients in triage category four are seen outside of the 60-minute benchmark and 12 per cent of category five patients are seen outside the 120-minute benchmark.

While these figures appear favourable, Figure 15 shows that these comparisons need to be interpreted with caution, as differences in how waiting times are recorded in each setting affect the ability to calculate directly comparable times.

Figure 15 | Comparison of waiting time definitions, EDs and Medicare UCCs



For Medicare UCCs, waiting time is defined as the interval between the patient's initial registration with reception staff (or with a triage nurse) and the time at which a clinical workforce member opens the patient record, as indicated by a timestamp linked to that workforce member. The clinical workforce member may be the triage nurse. Medicare UCCs are not required to use the ATS to triage patients.

[46] Australian Institute of Health and Welfare. (2023b). *Emergency department care*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

For EDs, waiting time is defined as the interval between the patient's presentation (which may include registration with reception or a triage nurse) and the commencement of clinical care, marked by the initiation of investigation and/or treatment.[47]

INTERIM FINDINGS

In the period to 30 September 2024, median waiting times at Medicare UCCs were estimated at 14.5 minutes. This was shorter than the median waiting times at EDs for triage categories four and five, noting that these waiting times are not directly comparable.

A small proportion of Medicare UCC patients (12 per cent) waited longer than 60 minutes to be seen. In EDs, 32 per cent of patients in triage category four are seen outside of the 60-minute benchmark and 12 per cent of category five patients are seen outside the 120-minute benchmark.

IMPROVEMENT OPPORTUNITY

For more accurate monitoring and reporting of waiting times, triage time should be split out from clinical commencement time in the Medicare UCC Module data. This will also allow a more accurate comparison with ED waiting times.

Next steps

Future reports will identify any trends or changes in treatment waiting times at Medicare UCCs (building on previous data sources). Waiting time comparisons with EDs will be refined using data from partner hospital EDs. Patient, provider and stakeholder reflections of timeliness of access to treatment will also be explored further in future reports.

MEASURE OF SUCCESS 2

5.2 Safe and quality treatment

Measure of Success 2 agreed by the Australian, state and territory governments is:

"Medicare UCCs provide safe and quality treatment to patients."

There are multiple dimensions to safety and quality

The evaluation of the Medicare UCCs will encompass the six commonly accepted dimensions of healthcare quality:[48,49,50]

1. Safety: avoiding harm to people for whom care is intended.
2. Effectiveness and appropriateness: providing evidence-based healthcare services aligned to the needs of patients and within scope of the Medicare UCCs.
3. Timeliness: reducing waiting time and sometimes harmful delays in care (see Measure of Success 1 (section 5.1)).

[47] Emergency department stay – waiting time, total minutes NNNNN, see https://meteor.aihw.gov.au/content/746119
[48] World Health Organisation. (2024). Quality of Care. Retrieved 26 November 2024 from https://www.who.int/health-topics/quality-of-care#tab=tab_1
[49] Institute of Medicine (US) Committee on Quality of Health Care in America. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. National Academies Press (US).
[50] Australian Commission on Safety and Quality in Health Care. (2011). Improving quality and safety through partnerships with patients and consumers. https://www.safetyandquality.gov.au/sites/default/files/migrated/PCC_Paper_August.pdf

4. Patient-centred: providing care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers (see also Measure of Success 4 (section 5.4)).
5. Equity: providing care that does not vary in quality on account of gender, ethnicity, geographic location and socioeconomic status.
6. Efficiency: maximising the benefit of available resources and avoiding waste (see Measure of Success 9 (section 5.9)).

As timeliness, patient-centred care and efficiency are addressed in other Measures of Success (as noted above), this section will focus on the evaluation of the remaining three dimensions, including the Department's approach to assessing Medicare UCC safety and readiness to operate, appropriateness of care and equitable access for priority populations.

Clinical assessments have been completed for all Medicare UCCs, either by an independent assessor or commissioner-led assessment processes

Clinical assessments of the Medicare UCCs were conducted prior to their opening to confirm the clinics' safety and readiness to operate. The assessments were based on the Medicare UCC Operational Guidance[51] and outlined the protocols and standards for the Medicare UCCs to deliver safe and high-quality care across various clinical components, including:

- scope of conditions
- triage and patient direction
- accessibility
- follow up and communication with a patient's usual GP
- follow up of diagnostic tests and referrals
- referral pathways and integration with health services
- staffing
- monitoring activity and clinical safety
- facilities infrastructure and equipment
- infection prevention and control.

Methods used to conduct the assessments included document reviews, interviews with staff, medical records reviews, direct observation and equipment reviews. Medicare UCCs were then either:

- advised of critical recommendations that required resolution before opening, or
- deemed safe and ready to open, sometimes with non-critical recommendations to be implemented after opening.

The Medicare UCC Operational Guidance focuses on the delivery of urgent care rather than broader aspects of clinical governance or the overall quality and safety of patient care. Consequently, Medicare UCCs are also required to be accredited to another recognised and relevant standard, such as the RACGP's *Standards for general practice*.

The Department commissioned Quality Practice Accreditation (QPA), an organisation that specialises in the accreditation of general practices, to undertake independent assessments of Medicare UCCs not being assessed under state or territory commissioner-led assessment processes. As of 30 September 2024, QPA had conducted independent clinical assessments for 57 (76 per cent) of the Medicare UCCs. For the remaining 18 clinics, local independent assessors or pre-existing clinical assessment processes were used, with agreement from the Department, due to unique local contexts or commissioners' knowledge of the communities. Table 8 describes the processes and rationale for these variations by state and territory.

[51] Department of Health and Aged Care. (2022). Operational Guidance for Urgent Care Clinics.

Table 8 | Variations to the national independent clinical assessment process by state and territory

State or territory	Medicare UCCs	Protocol and rationale
ACT	5	These clinics are existing walk-in centres operated by CHS since 2010. It was agreed that the clinical readiness assessments for ACT Medicare UCCs will be conducted post-opening if required as the Walk-in Centre framework for operations aligns closely with the Medicare UCC Operational Guidance.
NT	3	These clinics are in remote communities in the NT. NT Health conducted the clinical readiness assessment rather than QPA, based on their strong understanding of the remote clinics and the environments in which they operate.
TAS	3	The Tasmanian Department of Health arranged for an experienced independent GP to inspect each site prior to opening and assess it against the Medicare UCC Operational Guidance. The independent assessor has conducted follow up visits at sites where necessary and will perform follow up inspections to coincide with the 12- and 24-month contract reviews.
VIC	7	These clinics previously operated under the Victorian Priority Primary Care Centre framework for operations, which closely aligns to the Medicare UCC Operational Guidance. It was agreed that the clinical readiness assessments for Victorian UCCs will be conducted post-opening if required.

INTERIM FINDING

The Medicare UCC Program implements a robust clinical assessment process prior to opening to ensure clinics meet safety standards and are ready to operate in accordance with the Medicare UCC Operational Guidance.

Most Medicare UCCs patients presented with conditions that are appropriate to be managed by these services

The evaluation is assessing the appropriateness of services provided by examining the type of conditions treated by the Medicare UCCs. These clinics are intended to provide short term, episodic care for urgent conditions that are not immediately life threatening, including minor illnesses, minor injuries and acute exacerbations of chronic disease. They are not intended to provide ongoing care for chronic conditions. Medicare UCCs are expected to have systems in place to inform users when their condition falls outside of the clinic's scope and to refer them to their usual primary care provider or ED as needed.[52]

Most presentations to Medicare UCCs align with the scope of conditions defined in the Medicare UCC Operational Guidance. Table 9 shows the types of conditions patients presented with at Medicare UCCs. Among those with recorded condition types, the majority (63 per cent) sought care for an acute illness only, followed by an acute injury (26 per cent).

[52] Ibid.

Table 9 | Condition type (mutually exclusive categories) of patients attending Medicare UCCs

Condition type	Presentations	Percentage of presentations that recorded a response
Acute injury	103,127	26.3%
Acute injury + other condition (a)	2,127	0.5%
Acute illness	247,501	63.1%
Acute illness + other condition (b)	1,986	0.5%
Acute exacerbation	11,197	2.9%
Acute exacerbation + other condition	26	0.0%
Medicare UCC follow up appointment	4,164	1.1%
Other	21,818	5.6%
Total excluding "Not recorded" (from 63 Medicare UCCs)	391,946	100.0%
Not recorded	34,533	
Total including "Not recorded" (from 63 Medicare UCCs)	426,479	
Aggregate and other unit records counts	357,592	
Total presentations (from 75 Medicare UCCs)	**784,071**	

Notes: Table reflects data from 30 June 2024 to 30 September 2024 and extracted on 6 November 2024. More than one condition/type of condition can be reported for a single presentation. Mutually exclusive categories have been reported to provide insights into where multiple types of conditions are reported. (a) "Acute injury + other condition" includes the following: "Acute injury + Acute illness": 1,611 episodes (0.4 per cent), "Acute injury + Acute illness + Acute exacerbation": 179 episodes (0 per cent), "Acute injury + Acute exacerbation": 17 episodes (0 per cent), and other combinations that include an acute injury: 320 episodes (0.1 per cent). (b) "Acute illness + other condition" includes the following: "Acute illness + Acute exacerbation": 1,685 episodes (0.4 per cent) and other combinations that include an acute illness: 301 episodes (0.1 per cent). See section 3.4 for an overview of limitations related to the Medicare UCC data.

Table 10 shows the episode end status of Medicare UCC presentations. Most presentations (84 per cent) return home at the end of their visit, suggesting that patients are presenting with conditions that are in scope for the Medicare UCCs to manage. Ten per cent of presentations were referred to a GP and 5 per cent were referred to an ED, suggesting that Medicare UCCs are utilising diversion and escalation protocols to redirect patients to other settings where appropriate.

Stakeholder perspectives on appropriateness of care and redirections from Medicare UCCs will be explored in future phases of the evaluation.

Table 10 | Episode end status of Medicare UCC presentations

Episode end status	Presentations	Percentage of presentations that recorded a response
Did not wait	4,288	1.1%
Referred home	318,920	83.5%
GP referral	37,313	9.8%
Referred to ED	19,909	5.2%
Referred to hospital ward	397	0.1%
Left at own risk	372	0.1%
Other	943	0.2%
Total excluding "Not recorded" (from 63 Medicare UCCs)	382,142	100.0%
Not recorded	44,337	
Total including "Not recorded" (from 63 Medicare UCCs)	426,479	
Aggregate and other unit records counts	357,592	
Total presentations (from 75 Medicare UCCs)	**784,071**	

Notes: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. See section 3.4 for an overview of limitations related to the Medicare UCC data.

INTERIM FINDING

Medicare UCCs are primarily treating patients with conditions that fall within the scope of the Medicare UCC Operational Guidance, with most patients presenting with acute illnesses (63 per cent) and acute injuries (26 per cent). The majority of patients (84 per cent) return home after receiving care and a small proportion are referred to an ED (5 per cent) or redirected to their usual GP (10 per cent) when appropriate.

Medicare UCCs have policies to promote equitable, quality care for priority populations

Medicare UCC Operational Guidance[53] states that Medicare UCCs should ensure they are welcoming, accessible and safe places for priority populations and maintain connections with relevant services to support quality and continuity of care.

In addition, a range of policies and processes have been developed by the Department to ensure all Medicare UCCs are able to provide appropriate care to priority populations. Examples include:

[53] Ibid.

- Identifying and funding (in certain circumstances) training for Medicare UCC staff regarding First Nations cultural awareness, providing healthcare to people with a disability and for victim-survivors of family, domestic and sexual violence.
- Encouraging Medicare UCCs to work with local ACCHSs to establish clinical referral pathways for First Nations patients, understand regional needs and establish relationships with surrounding First Nations communities.
- Encouraging Medicare UCCs to include a Health Assessment reminder in discharge summaries for people with intellectual disability.
- Outlining use of appropriate reporting, anonymity and establishing referral pathways for victim-survivors of family, domestic and sexual violence.

Implementation of these policies will be explored with Medicare UCC providers during the evaluation in 2025 and 2026.

Use of the Medicare UCCs by priority populations

The quality of data on utilisation of Medicare UCCs by priority populations is variable. There is reasonable reporting on Indigenous status, reflective of reporting by the broader primary care sector. There is limited data available on utilisation of Medicare UCCs by other priority populations, due to poor data quality and consistency for variables relating to cultural and linguistic diverse communities and people with a disability (see section 3.4).

As shown previously in Table 6, 6 per cent of patients presenting to a Medicare UCC identified as Aboriginal and/or Torres Strait Islander. This is slightly lower than for EDs, where 8 per cent of patients identified as Aboriginal and/or Torres Strait Islander.[54,55]

INTERIM FINDING

As of 30 September 2024, 6 per cent of those Medicare UCC patients with recorded status identified as Aboriginal and/or Torres Strait Islander, which is slightly lower than for EDs (8 per cent). There is limited data available on utilisation of Medicare UCCs by other priority populations.

Cultural and linguistic diversity can encompass a range of aspects, including a person's country of birth, their ancestry, where their parents were born, what language/s they speak and their religious affiliation. There is no single definition of cultural and linguistic diversity, and often a range of information is required to identify the unique characteristics of a person that may affect their health care needs.[56]

There are issues in the way the Medicare UCC data on cultural and linguistic diversity is collected that could be given some attention. Examples include:

- Country of birth data is collected using ethnicity variables, mixing concepts with separate definitions.[57,58]

[54] Australian Institute of Health and Welfare. (2023b). *Emergency department care*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

[55] Indigenous status is not stated/recorded for 21 per cent of records in the Medicare UCC data, compared with only 0.8 per cent in the ED data. Removing these records, the percentage of Medicare UCC patients identifying as Aboriginal and/or Torres Strait Islander is closer to the percentage for EDs (8 per cent). Note that this is not a mandatory piece of information provided during a consultation, so may be higher than presented in the data.

[56] Australian Institute of Health and Welfare. (2024b). *Culturally and Linguistically Diverse Australians*. Retrieved 1 December from https://www.aihw.gov.au/reports-data/population-groups/cald-australians/overview

[57] "Ethnicity" refers to the shared identity or similar of a group of people on the basis of one of more distinguishing characteristics. These include: a long-shared history, cultural tradition, common geographic origin, common language, common literature, common religion, being a minority, being racially conspicuous. Australian Bureau of Statistics. (2019). *Australian Standard Classification of Cultural and Ethnic Groups (ASCCEG)*. Retrieved 3 December from https://www.abs.gov.au/statistics/classifications/australian-standard-classification-cultural-and-ethnic-groups-ascceg/latest-release

[58] Australian Bureau of Statistics. (2016). *Country of Birth Standard*. Retrieved 3 December from https://www.abs.gov.au/statistics/standards/country-birth-standard/latest-release

- Just 1.4 per cent of patients attending Medicare UCCs reported speaking a language other than English at home, which is likely related to the proportion of presentations for whom an interpreter was engaged (1.1 per cent) and may under-represent use of Medicare UCCs by CALD communities. Alternatively, it may also suggest that CALD communities are under-represented among Medicare UCC patients. This will be explored further in future phases of the evaluation.

Among Medicare UCC patients for whom disability status was recorded, 14 per cent were reported to have a disability, with physical disability being the most common type reported. Recording of disability status has been subject to varying interpretations by Medicare UCCs and comparable reporting in EDs is not available.

IMPROVEMENT OPPORTUNITY

There is an opportunity to improve the accuracy of reporting and provide clearer insights into utilisation of Medicare UCCs by priority populations. Refining the response options for "country of birth" and enhancing consistency of reporting processes for "language spoken at home" and "disability status" by Medicare UCCs will assist with this.

Expectations around cultural awareness, training and access for priority populations were established during the tender process and followed through in implementation

Commissioners reported that equitable access to appropriate care for priority populations was a weighted part of the tender process. However, the groups considered to be a priority population – and therefore what was considered to be culturally safe and responsive care – shifted with geography, as the demographic makeup of even neighbouring regions could differ significantly.

Some stakeholders reported working closely with First Nations partners during the tendering process to ensure that the Medicare UCCs in the area could demonstrate capacity to support access for Aboriginal and Torres Strait Islander clients. For example, in one PHN First Nations partners – including a nearby Aboriginal Community Controlled Health Organisation (ACCHO) and a regional Indigenous doctor's association – were involved with testing and validation to ensure that the PHN's commissioning approach was culturally responsive. The success of this co-design process led this PHN to apply a similar approach in their rollout of a new Medicare UCC in a CALD part of their region.

Other commissioners also reported strong engagement with First Nations partners to support Medicare UCC access for First Nations clients. Examples include:

- Working with the local ACCHO to create a welcoming environment and establish referral pathways.
- Formal audit or feedback on cultural safety by a First Nations stakeholder invited to the Medicare UCC.
- Ensuring that Aboriginal health workers at the hospital were aware of the Medicare UCC and the services that it provides.
- Uplifting culturally appropriate care at the Medicare UCC through a training program developed in conjunction with a respected regional First Nation health partner.

Cultural awareness training for all staff was cited as a priority by most stakeholders. Several commissioners reported providing additional locally tailored training for their clinicians from their own budget as well as the national resources and training provided by the Department, to ensure staff had adequate training for the circumstances of their region.

Stakeholders reported confusion amongst Medicare UCCs around subsidised access to the Translation and Interpreting Service (TIS) provided by the Department of Home Affairs. The free interpreting service provided by TIS is available to general practices, whereas Medicare UCCs are expected to utilise their grant funding to cover TIS costs, as is the case for other services that receive substantial government funding.

The cost of immediate telephone interpreting of a 20-minute appointment by TIS is relatively low ($43.56 including GST).[59] Nonetheless, cost of interpreter services was identified as a challenge for some Medicare UCCs with large CALD communities, with one PHN offering to subsidise these costs for the Medicare UCCs within their region. At a national level, this issue appears to be minor, with interpreters reported to be required for just 1.1 per cent of presentations to Medicare UCCs (data as of 30 September 2024).[60] However, as stated previously, this may be underestimated.

Next steps

In future phases of the evaluation, patient surveys will gather perceptions of safety and quality across clinics. Medicare UCCs will also be surveyed on their safety practices, incident and complaint management processes, and clinical quality indicators, with analyses to explore model-based variations. Stakeholder perspectives will be sought on appropriateness of care and redirections from Medicare UCCs. There will also be an opportunity to review Medicare UCC Operational Guidance in future evaluation phases, now that the program has been better established.

MEASURE OF SUCCESS 3

5.3 Coordinated care

Measure of Success 3 agreed by the Australian, state and territory governments is:

"Medicare UCCs deliver coordinated care for Medicare UCC patients."

There are many dimensions to coordinating a patient's healthcare services across multiple providers and settings

Coordination of care is the intentional organisation of patient care activities among multiple participants, including the patient, to ensure appropriate healthcare delivery.[61] In general, Medicare UCCs are not intended to provide follow-up care or to be the primary coordinator of care, instead patients should be referred to their usual GP or GP practice.[62]

The evaluation of the Medicare UCCs will encompass the following dimensions:

- Effectiveness and consistency of clinical handover. Medicare UCCs effective sharing of patients' care summaries with their usual primary care provider.
- Medicare UCCs assistance with referrals. Medicare UCCs proactive support for patients in booking necessary appointments and coordinating further care, especially for those without a regular GP or those with chronic conditions, ensuring they can access ongoing, primary care.
- Medicare UCCs' use of referral pathways. Assessment of patient transition from Medicare UCCs home or to other services (such as GP follow-ups, EDs, allied health, or mental health services) to understand the continuity of care and identify potential gaps in referral pathways.
- Access to multidisciplinary and diagnostic services. Availability and integration of multidisciplinary and diagnostic services that support efficient, coordinated care and allow Medicare UCCs to address patient needs more comprehensively.

[59] Department of Home Affairs. *Translation and Interpretation Service - Calculate the cost of your booking*. Retrieved 3 October from https://www.tisnational.gov.au/Our-services/Pricing/Cost-calculator
[60] Approaches to data collection regarding use of interpreters may vary between clinics.
[61] Agency for Healthcare Research and Quality. (2024). *Care Coordination*. Retrieved 21 November from https://www.ahrq.gov/ncepcr/care/coordination.html
[62] Department of Health and Aged Care. (2022). *Operational Guidance for Urgent Care Clinics*.

- Patient experience of care coordination. Patients' perspectives on the extent to which Medicare UCCs provide a coordinated care experience, including receiving clear care summaries, feeling supported in follow-up arrangements and being connected to a regular GP if they lack one.
- Primary care provider experience of care coordination. Provider experience of care coordination is addressed in Measure of Success 5 (section 5.5).

For this Interim Evaluation Report, channels of clinical handover and Medicare UCCs' use of referral pathways have been assessed using the Medicare UCC data and consultations with commissioners. Other dimensions will be explored in future evaluation phases. Points of entry to Medicare UCCs are discussed in Measure of Success 8 (section 5.8).

Medicare UCCs use various channels for clinical handover to primary care providers

To ensure continuity of care, the Medicare UCC Operational Guidance[63] requires clinics to have in place mechanisms for a clinical handover to be provided to the patient's usual GP or other primary care provider. Information included in the clinical handover should include a summary of case notes, referrals and tests requested. This may be the same information that is provided to other services the patient is directed to (for immediate or later follow up). Further discussion about these other services and coordinated care between Medicare UCCs and the broader health ecosystem including PHNs, Healthdirect, EDs and hospital outpatient services are discussed in Measure of Success 8 (section 5.8). Medicare UCC Operational Guidance specifies several channels for providing handovers of clinical information are available, including:

- Electronic provision of a discharge summary to the patient's usual GP or primary care provider, for example, by fax or secure messaging.
- Uploading information to the patient's MyHR.
- If electronic transfer is not possible, providing a hard copy of the discharge summary to the patient.
- Copying the patient's usual GP provider into all diagnostic test requests and other referrals.

Table 11 identifies the channels used by Medicare UCCs for clinical handover to patients' usual primary care provider, noting more than one channel can be used and recorded per presentation.

Table 11 | Channel of clinical handover provided back to patients' usual primary care provider

Clinical handover	Presentations	Percentage of presentations that recorded a response
Electronic provision to usual GP +/- upload to MyHR and/or provided to patient	266,213	68.1%
Electronic provision to usual GP/primary care provider only	210,854	53.9%
Electronic provision to usual GP + upload to MyHR	38,998	10.0%
Electronic provision to usual GP + provided to patient	10,240	2.6%
Electronic provision to usual GP + upload to MyHR + provided to patient	6,121	1.6%

[63] Ibid.

Clinical handover	Presentations	Percentage of presentations that recorded a response
Upload to MyHR only	34,851	8.9%
Upload to MyHR + provided to patient	3,762	1.0%
Provided to patient only	41,987	10.7%
Other (a)	44,328	11.3%
Total excluding "Not recorded" (from 63 Medicare UCCs)	391,141	100.0%
Not recorded	35,338	
Total including "Not recorded" (from 63 Medicare UCCs)	426,479	
Aggregate and other unit records counts	357,592	
Total presentations (from 75 Medicare UCCs)	**784,071**	

Notes: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. More than one method for handover can be reported for a single presentation. Mutually exclusive categories have been reported to provide insights into where multiple handover methods have been used. Reported values of "Other" were ignored when another value was available for the same presentation. (a) "Other" is not well defined and may be open to variable interpretation. See section 3.4 for an overview of limitations related to the Medicare UCC data.

INTERIM FINDING

In the period to 30 September 2024, 89 per cent of presentations had a clinical handover provided by at least one method outlined in the Operational Guidance (provided directly to usual GP, uploaded to MyHR or paper copy given to the patient). A small proportion (11 per cent) had a clinical handover provided by 'other' means.

Electronic provision of a discharge summary from the Medicare UCC is the preferred method of receiving handovers

Electronic provision of a discharge summary from the Medicare UCC directly to the patient's usual GP/GP practice was used for 68 per cent of presentations (excluding "Not recorded").

Commissioners reported receiving feedback from local GPs that electronic provision of a discharge summary is their preferred method of handover and the only channel that notifies the GP that their patient has attended a Medicare UCC.

Upload by Medicare UCC clinicians to MyHR is limited as shown in Table 11. MyHR does not generate a notification when information, such as a discharge summary, is uploaded to the system. Therefore, the patient's usual GP/primary care provider is not aware of the need to follow up. This challenge is not unique to the Medicare UCC Program; GPs have reported similar experiences in relation to information uploaded to MyHR by other health services, for example hospital discharge summaries.[64] Use of MyHR and the opportunities it presents for coordination of care will be explored further in future reviews.

[64] Though it is noted that lack of system notifications does not negate other benefits of discharge summaries being accessible on the MyHR system to a broader range of providers.

Several commissioners reported that the preferred approach to sending clinical handovers to patients' usual GP/primary care provider is via practice secure messaging platforms, rather than fax or email. More than 90 per cent of GP clinics have one or more secure messaging systems installed and numbers are similar for most other medical specialists and healthcare organisations.[65] However, use of secure messaging platforms more broadly in primary care varies nationally, and therefore, alternative approaches of fax and email are accepted under the Medicare UCC Operational Guidance.

Where patients do not have a usual GP or primary care provider, the Medicare UCC Operational Guidance indicates that the patient should be given a hard copy of the discharge summary and supported to identify, and book in with, a primary care provider. Medicare UCC data indicates that 11 per cent of patients presenting to the clinics report that they do not have a regular GP. These figures suggest that not all patients with a usual GP are currently receiving a clinical handover directly back to their usual GP, highlighting an opportunity for Medicare UCCs to improve clinical handover.

Future phases of the evaluation will consider whether the Medicare UCCs are filling a gap for the 11 per cent of patients who report that they do not have a regular GP and whether they are supporting those patients to identify and connect with a regular GP.

Ensuring continuity of care between the Medicare UCCs and local primary care providers, via consistent and quality clinical handovers was noted to be essential in building trust and confidence in the service among local clinicians and embedding the Medicare UCCs in the local health ecosystem.

INTERIM FINDING

Approximately 68 per cent of presentations had a handover directly back to the patient's usual GP/practice in the period to 30 September 2024. A further 10 per cent of presentations had information uploaded to MyHR (but not provided directly to the patient's usual GP). Approximately 11 per cent of presentations received a hard copy of a discharge summary only, which is consistent with the proportion of Medicare UCC patients that did not identify a usual GP/practice (11 per cent). Commissioners reported receiving feedback from local GPs that electronic provision of a discharge summary direct to the GP/practice was their preferred method of receiving clinical handovers.

IMPROVEMENT OPPORTUNITY

The proportion of patients who receive a handover directly back to their usual GP/practice should be increased. Commissioners and Medicare UCCs should consider working together to achieve this, informed by learnings from other clinics.

Ways to improve clinical handovers to GPs are being developed

One commissioner reported working closely with their Medicare UCCs to improve electronic provision of clinical handovers directly back to usual primary care providers as a development strategy. Some of the ways they are working with Medicare UCCs in this area include:

- Enhancing collection and documentation for the patient's usual GP details upon their arrival at the clinic.
- Conducting periodic audits of mechanisms being used to provide handovers.
- Requesting clinics to provide clinical handovers via multiple channels (upload to MyHR, electronic provision and a hard copy to the patient) to support optimal communication to the patient and their usual primary care provider about their visit to the Medicare UCC.

[65] Royal Australian College of General Practitioners. (2021). *Safe and effective electronic transfer of information to and from general practice*. Retrieved 21 November from https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/safe-and-effective-electronic-transfer#

There is opportunity to improve data collection and reporting on clinical handovers

Currently, 11 per cent of clinical handovers are reported to be provided by 'other' means. This category is open to varied interpretation and may include referrals back to the same clinic during hours when the clinic is not operating as a Medicare UCC. Further consultation with providers is required to clarify this category, or additional categories could be introduced in the Medicare UCC Module data to more precisely capture these alternative handover methods.

IMPROVEMENT OPPORTUNITY

In the Medicare UCC Module data consider refining the definition of the "other" response option for the question, "*How was a clinical handover provided to the patient's usual GP?*". Alternatively, consider introducing additional categories to more precisely capture alternative handover methods. This will improve the quality of reporting and provide clearer insights into the channels of clinical handovers.

Most patients are sent home following their visit to a Medicare UCC and referrals are provided to a small number of other services

Referrals may include redirection of patients to a more appropriate provider following initial triage/management and post-treatment complementary care.

Medicare UCC Operational Guidance[66] states that Medicare UCCs should maintain systems that inform users when their condition is not in scope and referral to the patient's usual primary care provider or ED is more appropriate. As described in Measure of Success 2 (section 5.2), most (84 per cent) patients were sent home at the end of their visit to the Medicare UCC. Ten per cent were redirected to a GP and 5 per cent of patients were referred to ED.

The Operational Guidance also states that Medicare UCCs should have referral pathways to other services including inpatient hospital services, outpatient clinics, mental health services, community and primary care services (for example, allied health), hospital in the home, other community support services and virtual care options.

Medicare UCCs provided referrals to a small number of other services, with 3 per cent of presentations referred to allied health and less than 1 per cent referred to mental health services or outpatient clinics. This is in comparison to the approximately 6 per cent of GP presentations that result in a referral to allied health services,[67] noting that GP presentations have a different case mix to Medicare UCCs where GPs generally attend to a higher proportion of patients with chronic conditions, rather than acute care needs. Development and implementation of these pathways is analysed in more detail in Measure of Success 8 (section 5.8).

Next steps

Subsequent phases of the evaluation will continue to analyse the rates of clinical handover. In addition, Medicare UCCs will be asked about their care coordination processes, barriers and enablers to effective coordination, including use of MyHR and how they support patients without a regular GP to identify and connect with one. Patient experience of care coordination will also be sought through patient feedback mechanisms.

[66] Department of Health and Aged Care. (2022). *Operational Guidance for Urgent Care Clinics*.
[67] Swerissen, H., & Duckett, S. (2018). *Mapping primary care in Australia*. https://grattan.edu.au/wp-content/uploads/2018/07/906-Mapping-primary-care.pdf

MEASURE OF SUCCESS 4

5.4 Patient and carer experience

Measure of Success 4 agreed by the Australian, state and territory governments is:

"Medicare UCCs provide a positive experience for patients and carers."

Patients are people who receive treatment and/or care from primary care providers, hospitals or other health services.[68] Carers are people who look after someone who needs help with their day-to-day living. Under the *Australian Government Carer Recognition Act 2010*, a carer is someone who gives unpaid care and support to a relative or friend who has a disability, chronic or terminal medical condition, mental illness or is frail and elderly.[69]

Evidence shows there are positive associations between patient experience, patient safety and clinical effectiveness across a wide range of disease areas.[70] Improving patient experience can improve clinical outcomes.[71] Patient experience may encompass elements such as waiting time, time spent by the attending health professional, being listened to by the clinician and being shown respect.[72]

For this Interim Evaluation Report 1, very limited insights on patient experience were gained through interviews with the commissioning organisations (PHNs, states and territories) and the CHF executive. The Department also provided a selection of written patient stories and a high-level summary of the complaints it received.

Based on the available evidence for this Interim Evaluation Report 1, the evaluation was not able to provide a balanced assessment of the extent to which Medicare UCCs provide a positive patient experience.

Commissioners reported a range of views about patient experience

Commissioners reported that a key benefit of the Medicare UCC Program from their perspective was improved access to urgent care in the community, as an alternative to ED, and when patients are unable to get an appointment with their regular primary care provider. Commissioners reported receiving feedback that patients appreciated avoiding extended waits in the local ED. As described in Measure of Success 1 (section 5.1), median waiting time at Medicare UCCs was 14.5 minutes (to the period up to 30 September 2024), whereas the median waiting time at EDs for triage category four was 31 minutes and category five was 24 minutes, noting that these waiting times are not directly comparable.

One remote NT Medicare UCC reported that transitioning into the Medicare UCC Program has enabled the clinic to expand opening hours overnight in response to local demand and improved patient experience. Patients can walk in and access healthcare quickly when they need to, rather than waiting for on-call staff to be available or have care re-directed to the next day. This change has resulted in a significant reduction in patient complaints.

Commissioners also reported receiving feedback that patients appreciated access to bulk-billed care and no out-of-pocket expenses at the Medicare UCCs. Based on the ABS Patient Experience Survey,[73] in 2023-

[68] Australian Institute of Health and Welfare. (2024a). *Admitted patients*. Retrieved 1 December from https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients

[69] Carer Gateway. Who are carers? 2024. Accessed 9 December 2024.

[70] Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, *3*(1), e001570. https://doi.org/10.1136/bmjopen-2012-001570

[71] ZEST Health Strategies. (2023). *Patient experience measurement in primary health care*. Australian Commission on Safety and Quality in Health Care. https://www.safetyandquality.gov.au/sites/default/files/2023-07/literature_review_on_patient_experience_in_primary_health_care_-_april_-_2023.pdf

[72] Australian Bureau of Statistics. (2024). *Patient Experiences*. Retrieved 21 November from https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#waiting-times

[73] Australian Bureau of Statistics. (2024). *Patient Experiences*. Retrieved 21 November from https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#waiting-times

24, 8.8 per cent of people reported cost was a reason for delaying or not seeing a GP when needed and 6.4 per cent of people reported cost was a reason for not seeing an after-hours GP when needed. This was noted to be particularly important for accessibility in lower socioeconomic areas (SEIFA IRSD Quintiles 1 to 2) where 49 per cent of Medicare UCCs are located (Table 2 in section 4.2).

Patient stories provided to the Department offer examples of patient experiences at Medicare UCCs

A sample of patient stories provided to the Department echo sentiments reported by commissioners and offer examples of patient experiences at Medicare UCCs.

Figure 16 presents the story of a patient from North QLD who went to the Medicare UCC instead of an ED when experiencing a migraine. This patient appreciated being treated by staff with care and compassion, having her appointment bulk-billed and avoiding ED.

Figure 16 | Patient story – North QLD[74]

Experience of a patient attending a Medicare UCC in North QLD with a migraine

"Recently I had the unfortunate experience of a migraine. It was not my first, and I could not get on top of it with the medications I usually take. In the past, I attended the ED at Cairns Hospital and received excellent care, however, this time I let my partner drive me to the Edmonton Medicare UCC.

On my arrival, I was treated well with care and compassion – placed in a quiet dark room and medications for my symptoms were administered in a timely manner. After a few hours when the symptoms had eased, I offered to go home to sleep the rest of the attack off, but at no stage did I feel like I was being pressured to make way for other patients. The services were bulk-billed with no out-of-pocket expenses.

I found this service to be excellent for my minor medical needs and was glad I didn't tie up a bed in the already overstretched ED at Cairns Hospital."

Figure 17 presents the story of a 12-year-old child who was brought to a Medicare UCC with an urgent respiratory condition whilst away on holidays. The girl and her mother were at the clinic for one hour, and were reportedly appreciative that the Medicare UCC was available so they could avoid a lengthy wait in ED.

Figure 17 | Patient story (child) – South East Melbourne[75]

Experience of a child and her mother attending a Medicare UCC in South East Melbourne

A 12-year-old girl was brought into the Medicare UCC by her mother with a "barking" cough. Her mother reported they were unable to get into their regular GP as they were away on holidays. The child had a diagnosis of asthma and was triaged by the nurse and assessed by the GP not long after, who started her on antibiotics and prednisolone.

The girl and her mother were at the clinic for a total of one-hour from walking in the front door to leaving. Her mother was very appreciative of the care and that the clinic was available to them, which prevented them from having to wait an extended amount of time in the local ED.

[74] Patient story provided to Nous by the Department of Health and Aged Care.
[75] Ibid.

Figure 18 describes the story of a mother bringing her 18-month-old son to a Medicare UCC in the NT with a urinary tract infection and the quality of care she received from the GP.

Figure 18 | Patient story – NT[76]

Experience of a mother bringing her 18-month-old son to a Medicare UCC in NT

An 18-month-old boy was brought into a Medicare UCC in NT by his mother with a deteriorating urinary tract infection and fever. They were the first patients to arrive at the clinic and were welcomed in by staff.

They were seen promptly by the GP who they had also seen at a nearby GP super clinic on occasions. The mother stated that the GP was excellent with her son and her. He provided a thorough assessment and was very calming to her unwell child. He allowed appropriate time between different parts of the assessment to gain her son's trust. He allowed her to talk through what she had done to date to manage her son's condition and made some recommendations for further medications. Most importantly, the GP reassured her that being there was the right thing to do and that if they needed to return later in the day, he welcomed it and would review her son again.

The mother stated it was overall an excellent service with a thorough GP who allowed them to return home comfortably with a great plan of action.

INTERIM FINDING

Based on available evidence, it is too early to provide a balanced assessment of how satisfied patients are with Medicare UCCs and the extent to which Medicare UCCs are providing a positive experience for patients and carers. Feedback received from commissioners indicated their consistent view that patients appreciated avoiding extended waits in ED and having access to bulk-billed care.

Stakeholders identified early opportunities to improve patient experience

Managing demand for Medicare UCC services

As described in Measure of Success 1 (section 5.1), there have been some reports of patients experiencing challenges accessing care at the Medicare UCCs during peak periods as awareness and demand for the services have increased. There have been instances where Medicare UCCs have been at capacity several hours before closing time and have had to turn patients away. For example, in one state, some clinics have had to turn away patients after 8:00 pm during peak periods, despite not closing until 11:00 pm. In these circumstances, patients were advised to either attend ED or present the next day to the Medicare UCC or their usual GP, depending on the acuity of their condition.

There have also been some reports of long waiting times at Medicare UCCs. As described in Measure of Success 1 (section 5.1), 12 per cent of patients waited longer than 60 minutes to be seen at Medicare UCCs and 2 per cent of patients waited longer than two hours. The Department has advised that Medicare UCCs are expected to provide walk-in services. Individual clinics may implement booking systems locally in addition to offering walk-in services, but this is not a requirement of the program. Some commissioners noted challenges with managing patients' expectations when they have booked an appointment but are required to wait while higher urgency patients are seen, in accordance with Medicare UCC Operational Guidance on triaging. There is currently no data on the number of patients who book or attempt to book an appointment at Medicare UCCs.

[76] Ibid.

To address challenges associated with high demand, some clinics have implemented scale up plans (with support from the Department and commissioners) involving extending opening hours and rostering additional staff to meet demand. This is explored in more detail in Measure of Success 5 (section 5.5).

Several commissioners reported collecting data locally to assess unmet demand when the Medicare UCCs reach maximum capacity. This data is currently collected in a variety of ways, including reporting the number of instances where the Medicare UCC closed early, the number of patients turned away and the proportion of patients referred to ED due to the clinic reaching capacity. Consistent reporting of unmet demand across the program would facilitate a greater understanding of this issue and clarify the need for a more systemic response.

IMPROVEMENT OPPORTUNITY

A consistent approach to collecting data on when patients are being turned away because the Medicare UCC is unable to meet demand, should be established at a national level.

Enhancing clarity of communication about local Medicare UCC services

There have been significant investments in promoting the Medicare UCC Program nationally and regionally (see Measure of Success 7 (section 5.7) for further details). However, stakeholder reports and the summary of patient complaints received by the Department indicate a perceived lack of clarity regarding local service offerings at the Medicare UCCs, for example:

- scope of conditions able to be treated at the Medicare UCC
- access to diagnostic imaging during Medicare UCC opening hours
- distinction between fee structures at the Medicare UCC and co-located GP or other services
- clinic details such as opening hours or phone numbers.

These issues have resulted in potential misalignment of patient expectations and the local Medicare UCC service offering, resulting in some examples of poorer patient experience. This will be explored with stakeholders in future stages of the evaluation.

IMPROVEMENT OPPORTUNITY

There is opportunity for clinics to enhance their communications to the community about local Medicare UCC service offerings, for example, opening hours of affiliated diagnostic imaging services, and the distinction between fee structures at the Medicare UCC and co-located services.

Improving physical infrastructure at some Medicare UCCs

Stakeholders reported some concerns with the physical infrastructure at some clinics, such as security lighting in the evenings, sufficient parking, wheelchair access including ramps and easily moveable doors. Feedback and complaints of this nature suggest potential non-adherence by some clinics to the accessibility requirements related to physical infrastructure outlined in the Medicare UCC Operational Guidance.

IMPROVEMENT OPPORTUNITY

Upgrades to physical infrastructure (such as security lighting, parking and wheelchair access) to support accessibility could be considered at some clinics, to ensure adherence to accessibility requirements outlined in the Medicare UCC Operational Guidance.

INTERIM FINDING

Early opportunities to improve patient experience in some clinics include better management of demand during peak periods, improved communication about local Medicare UCC service offerings and upgrades to physical infrastructure to support accessibility.

Methods of collecting feedback on patient experience vary across clinics

The Medicare UCC Operational Guidance[77] requires clinics to have systems in place to improve clinical quality and safety, including the use of patient reported experience measures (PREMs). However, it does not specifically define the methods or tools for collecting these data. Similarly, the RACGP *Standards for general practices (5th edition)* does not prescribe specific methods for gathering patient feedback. Instead, the RACGP strongly encourages practices to choose approaches that best align with the needs of their practice and patients.

Commissioners reported that while Medicare UCCs are generally collecting patient feedback, the methods used vary widely. Feedback on patient experience is gathered through channels such as Google reviews, patient surveys, incidental feedback and complaints. Patient surveys in particular use diverse questions, tools and platforms, with reported response rates between 1 per cent and 8 per cent.

Commissioners advocated strongly for a consistent, standardised patient survey mechanism (PREM) across all clinics to enable benchmarking across the program. This would aid commissioners with performance and contract management as well as identifying areas for quality improvement at local and national level.

IMPROVEMENT OPPORTUNITY

A consistent, standardised mechanism for collecting patient experience feedback (patient reported experience measures – PREMs) across Medicare UCCs should be established at a national level.

Next steps

For subsequent evaluation phases, the evaluators will work closely with the CHF and seek to conduct a patient survey to obtain patient feedback on their experience at the Medicare UCCs and an understanding of how experience differs across Medicare UCC models.

MEASURE OF SUCCESS 5

5.5 Experience for providers at Medicare UCCs, partner hospital EDs and local GP practices

Measure of Success 5 agreed by the Australian, state and territory governments is:

"Medicare UCCs provide a positive experience for providers at Medicare UCCs, in partner hospital EDs and in local GP practices."

For Measure of Success 5, the evaluation of the Medicare UCCs will encompass the following dimensions:

- Experiences of Medicare UCC staff providing services.
- Experiences of partner hospital EDs and local GP practices with Medicare UCC services.
- The impact of Medicare UCCs on other GP practices and workforce availability.

[77] Department of Health and Aged Care. (2022). *Operational Guidance for Urgent Care Clinics*.

For this Interim Evaluation Report 1, insights into provider experiences were limited. While interviews were conducted with all commissioning organisations, interviews with providers were limited to one NSW Medicare UCC as well as one remote NT UCC and the ACT Medicare UCCs to support greater understanding of unique models of care operating within the program. Preliminary analysis of workforce availability has also been undertaken.

Limited stakeholder engagement indicated that staff are enjoying the variety and style of work at Medicare UCCs

As noted elsewhere, stakeholder engagement for this Interim Evaluation Report 1 was limited. However, feedback from some commissioners indicated that GPs enjoyed the style of work at their Medicare UCC. They reported that staff enjoyed applying procedural skills – such as suturing and plastering – they had learnt during their medical training but rarely had the opportunity to apply in their regular work in general practice.

Commissioners also reported there was a positive team environment at the Medicare UCCs and the acuity of the caseload offered a refreshing change to the normal patient case mix in general practice. Some reported that the flexible hours available at the Medicare UCCs were attractive to many GPs.

Commissioners held the view that Medicare UCCs were reducing burnout of primary care staff in remote clinics, as they are easing the burden of regular on-call hours, enabling them to take holidays and take breaks outside of their regular working hours.

However, high workloads at some clinics were noted to impact staff experiences. Stakeholders suggested that rostering additional GPs and nurses during peak periods could help staff better manage demand and take necessary meal breaks, though this may be challenging in some areas with workforce shortages, as described below.

Future evaluation rounds will include opportunity for greater direct feedback from providers (including GPs, nursing staff and other workforce groups) regarding their experience of working at the Medicare UCCs.

INTERIM FINDING

Although direct consultations with Medicare UCC staff were very limited, feedback from commissioners indicated that Medicare UCC staff appreciated the variety and style of work at Medicare UCCs, though high workloads at some clinics were noted to impact staff experiences.

Building confidence in the program among local GPs remains a key focus

The evaluation has not yet engaged with local GPs, limiting the ability to provide a balanced assessment of the extent to which Medicare UCCs have provided a positive experience for local GPs. Instead, key themes regarding GP perspectives of the program have been identified through interviews with commissioners and public statements from peak bodies.

Commissioners reported apprehension about the program from many local GPs who had raised concerns that they would lose staff and patients to the Medicare UCCs due to the Medicare UCCs offering bulk-billed care and a fear that they may not hand patients back to their regular GP after the urgent episode.

> **"There is concern from our GP community, particularly as we've transitioned from an urgent care service that was heavily triaged to an Urgent Care Clinic, that we might end up being the surrogate bulk-billing practice in the area."** [Commissioner]

> **"A thing we have come across is the distrust of the local general practices. When the [Medicare] UCCs first opened, they felt that the [Medicare] UCCs were going to be stealing patients, didn't feel they would be returning patients once they had been seen, that they would keep them as their clinic patients. So, there was a lot of work that we had to do around that."** [Commissioner]

Commissioners also received feedback from some local GPs that they had not received clinical handovers when patients have attended Medicare UCCs, negatively impacting continuity of care. As discussed in detail in Measure of Success 3 (section 5.3), electronic provision of a discharge summary from the Medicare UCC directly to a patient's usual GP/GP practice was used for only 68 per cent of presentations.

These reports were echoed in a position statement released by the National Council of Primary Care Doctors[78] in November 2024,[79] raising concerns about fragmentation of care and the impact of Medicare UCCs on workforce supply and urgent care training opportunities for surrounding local general practices.

Commissioners reported that they are working with Medicare UCCs to build confidence in the program and strengthen relationships with local GPs through:

- Meetings with local GPs to explain the aims of the Medicare UCC Program and challenge pre-conceptions by reiterating the Medicare UCC Operational Guidance that clinics are there to provide short-term episodic care for urgent conditions and that they will refer patients back to their regular GP for follow up.
- Arranging walk throughs of the Medicare UCCs with local GPs.
- Encouraging ongoing communications between the Medicare UCC and local GPs, with assistance from PHN staff where required.

Commissioners reported that the early concerns raised by GPs about losing patients to the Medicare UCCs were starting to dissipate in some instances. A survey of 795 GPs conducted by medical education company Healthed in November 2024 indicated that 70 per cent of GPs support Medicare UCCs in principle, with the majority citing that they felt it had a positive impact on timely delivery of care, reduced pressure on local EDs and having a positive impact on patient health outcomes.[80] Building relationships, awareness and reliable channels of communication with local GPs remains an important area of focus for many commissioners and the Medicare UCCs they work with. This will be further explored through expanded stakeholder consultations in future evaluations.

ED staff experiences with Medicare UCC services will be examined in future phases of the evaluation

The evaluation has not yet engaged with ED staff, so their experiences and perceptions of Medicare UCC services cannot be assessed at this stage. This will be addressed in future reports.

Commissioners reported that Medicare UCCs have focussed on establishing relationships with partner hospital ED staff and this is explored in more detail in Measure of Success 8 (section 5.8).

INTERIM FINDING

At this early stage, the evaluation cannot draw conclusions about the concerns expressed from some GPs that Medicare UCCs will interfere with established relationships between GPs and their patients and attract patients who do not have urgent care needs. The evaluation notes that commissioners are aware of these concerns and are working to improve communications and build stronger relationships locally.

[78] The National Council of Primary Care Doctors represents the interests of general practice and primary care in Australia, comprising leaders from the Australian Medical Association, RACGP, Rural Doctors Association of Australia, Australian College of Rural and Remote Medicine, General Practice Supervisors Australia, General Practice Registrars Australia and Australian Indigenous Doctors Association.
[79] National Council of Primary Care Doctors. (2024). *Urgent Care Centres Position Statement*
[80] Healthed. (2024). *Shock poll: Most GPs support urgent care clinics*. Retrieved 5 December from https://www.healthed.com.au/clinical_articles/most-gps-support-urgent-care-clinics-poll/

Medicare UCCs are facing similar GP workforce challenges to primary care more broadly

Commissioners highlighted challenges related to GP workforce availability, particularly in recruiting enough GPs to meet the minimum and sufficient workforce requirements for extended opening hours in regional, rural and remote areas. Similar issues were acknowledged in the recently published After Hours Review.[81] Recent reports show that the number of GPs increased by 1.5 per cent in 2023 compared with 2022, however, this growth remains insufficient to meet the healthcare needs of Australians.[82]

> **"Some of the biggest challenges with this model are around workforce and sourcing the GPs to be able to staff these clinics."** [Commissioner]

The Medicare UCC Operational Guidance requires the clinics to be GP-led,[83] with workforce mix based on availability, local need and context. At a minimum, clinics are to be staffed by:

- one vocationally registered GP
- one registered nurse
- one receptionist.

The Department has advised the minimum workforce requirements specified in the Medicare UCC Operational Guidance were established upfront to ensure Medicare UCCs are able to deliver the full scope of intended services and maintain clinical safety. Medicare UCCs seeking approval for a minimum workforce mix that differs from this requirement must demonstrate how they will still meet core functional and operational parameters, while maintaining clinical safety requirements and provide sufficient reasoning and context to support the Department's consideration.

Commissioners reported challenges with the requirement to roster a vocationally registered GP on all shifts across extended opening hours. Commissioners noted that recruitment of vocationally registered GPs to regional and rural areas was particularly hard, with some clinics relying on staff from expensive locum agencies to fill gaps in their rosters. Others described instances where the clinics had been unable to open because the GP was sick and there was not a sufficient pool of local vocationally registered GPs to source a replacement at late notice. Clinics in metropolitan areas were also experiencing difficulties. For example, commissioners noted that in some metropolitan areas, clinics were having challenges with covering Medicare UCC shifts in the evenings, weekends, public holidays and holiday periods.

> **"We've tried to work with our Medicare UCCs to develop different models. The difficulty is that the Operational Guidance are strict in saying that it must be a vocationally registered GP-led service. That's great if you've got a lot of vocationally registered GPs to pick from."** [Commissioner]

> **"One of our biggest problems being regional is we just don't have the workforce to be open for the hours that these practices should be open for."** [Commissioner]

The Department reported that the ACT Medicare UCCs and remote NT Medicare UCCs had been granted exemptions to operate as nurse-led clinics, without vocationally registered GPs, due to the unique operating context in the NT and the existing Walk-in Centre infrastructure within the ACT.

Commissioners reported that Medicare UCCs delivered by larger providers appeared to have benefited from central recruitment and rostering functions, which eased workforce pressures. These providers were able to cover gaps in their rosters with staff from across their network of clinics. Commissioners noted that

[81] Department of Health. A better after hours system. 2024. https://www.health.gov.au/our-work/after-hours-review#:~:text=The%20After%20Hours%20Review%20investigated,improvements%20and%20longer%2Dterm%20reform.
[82] Department of Health and Aged Care. (2024). *Supply and Demand Study - General Practitioners in Australia*.
[83] Unless specifically exempt.

in some communities, these larger providers have also been able to attract additional GP workforce into the region.

> **"[Our providers are] quite large, they've got 31 clinics around the country, they've got a separate recruitment function recruiting GPs and other clinicians, nurses and receptionists too, so we didn't really have to provide much support to them…a lot of it [recruitment] was national…and some of the GPs that were in their regular general practice transitioned to work in the UCC part of the clinic as well, so they've got that nice blend happening within the clinic."** [Commissioner]

INTERIM FINDING

Recruitment of vocationally registered GPs to achieve the minimum workforce requirements outlined in the Medicare UCC Operational Guidance across extended hours is a significant and ongoing challenge for Medicare UCC providers, particularly in regional and rural areas.

Medicare UCCs are working with commissioners to address GP workforce challenges

Commissioners are providing support and linking Medicare UCCs to other supports available for recruitment in a variety of ways including:

- advertising via PHN websites
- hosting GP information evenings
- arranging tours of the clinics for local GPs
- offering relocation grants in accordance with wider workforce strategies
- accessing surge or locum health workforce providers to manage temporary or short-term rostering gaps.

Medicare UCCs in communities where the GP workforce is scarce have needed to approach local recruitment carefully. One PHN reported receiving complaints in response to recruitment campaigns targeting local GPs due to fears that the Medicare UCCs would impact their workforce availability and practice capacity.

> **"There's a fear, not just of losing patients, but of losing doctors. When one of our UCCs put out a bit of publicity that there might be some time for GPs to pick up shifts we got some really big backlash…. [saying] that it's a small GP pool up here and if they [the Medicare UCC] steal our GPs, then we're going to be short and we're not going to be able to support our own patients."** [Commissioner]

According to the Medicare UCC Operational Guidance,[84] Medicare UCCs may adopt flexible workforce models in addition to the minimum workforce requirements, in response to local context and to meet demand. This additional workforce may include, but is not limited to, administrative staff, other suitably qualified medical practitioners, nurse practitioners, paramedics, allied health and Aboriginal Health Practitioners.

Commissioners advocated for adoption of flexible workforce models in line with local service demand and workforce availability and identified a range of examples of flexible workforce models that Medicare UCCs have implemented or are exploring, detailed in Figure 19. However, employment by Medicare UCCs of other clinical staff types nationally has been limited, with just 15 Medicare UCCs employing a total of 15.6

[84] Department of Health and Aged Care. (2022). *Operational Guidance for Urgent Care Clinics*.

FTE clinical staff other than medical practitioners, nurses and administration staff (see section 4.4). There may be an opportunity to expand the use of flexible workforce models if benefits and sustainability can be established. This will be explored with commissioners and Medicare UCC providers in future stages of the evaluation.

Figure 19 | Workforce models

Medicare UCCs have adopted or are currently exploring a variety of flexible workforce models to meet local demand. Examples include but are not limited to:

In QLD, a Medicare UCC is trialling a rapid nurse triage model involving one GP and two registered nurses, rather than a receptionist.

In SA, several clinics have incorporated nurse practitioners and non-vocationally registered GPs in addition to the minimum workforce requirements to meet demand during busy periods.

In NSW and the NT, some Medicare UCCs are exploring incorporating paramedics in addition to the minimum workforce requirements to meet demand during busy periods.

In the ACT, the Medicare UCCs utilise a nurse-led model of care, agreed by Government, based out of the existing Walk-in Centre infrastructure. The workforce includes nurse practitioners, advanced practice nurses, clinical nurse educators, clinical nurse managers, receptionists and a GP advisor, who provides education, reviews treatment protocols and liaises with the local GP community. The ACT Medicare UCCs are also seeking to recruit a sonographer, radiographer and advanced musculoskeletal physiotherapist.

In the NT, the Remote Medicare UCCs utilise a remote area nurse (RAN)-led model of care, agreed by Government, in recognition of their unique local context. RANs can seek medical advice through the NT Health District Medical Officer (DMO) service via telephone or refer to GPs (where available).

IMPROVEMENT OPPORTUNITY

There is opportunity for more widespread exploration and uptake of flexible workforce models by Medicare UCCs (informed by learnings from existing workforce trials) to meet demand whilst adhering to minimum program requirements.

MBS items available to Medicare UCCs for prescribed medical practitioners have been expanded

As described previously section 1.3, Medicare UCCs have a hybrid funding model that aims to support flexible workforce models. The funding model consists of:

- operational grants from the Australian Government
- rebates for specific MBS items for provision of urgent care services, accessible through a sub-section 19(2) exemption to the *Health Insurance Act 1973*.

The Department advised that operational grant funding provided to Medicare UCCs may be used to support employment of health professionals who are ineligible to bill MBS for services provided at

Medicare UCCs. Many commissioners reported that despite the grant funding provided, the main barrier to adopting flexible workforce models above the minimum workforce requirements is that it is financially unviable for the Medicare UCCs to employ additional staff who have limited or no options to claim MBS rebates.

MBS items available to Medicare UCCs through sub-section 19(2) directions have been expanded to include selected MBS items for prescribed medical practitioners as of July 2024, to support further workforce to claim MBS for services provided. Some stakeholders advised that despite these changes, MBS billing available to non-vocationally registered GPs was still restricted and was not financially viable for some practices.

Two Medicare UCCs in WA and TAS were noted to have been granted exemptions to claim MBS telehealth items due to significant workforce scarcity.[85] These exemptions allow them to claim MBS rebates when patients attend the Medicare UCC for care and are assessed remotely via a video call by a GP located elsewhere. Commissioners noted that despite having the exemption to claim MBS items for care provided in this way, this modality was yet to be utilised by the Medicare UCCs.

Medicare UCCs are experiencing challenges with radiology workforce shortages and after-hours radiology service availability

Medicare UCC Operational Guidance states that Medicare UCCs should have an X-ray facility onsite or easily accessible during all hours of operation, along with timely access to ultrasound and CT services across the majority of operating hours. Stakeholders reported experiencing challenges meeting this requirement, due to radiology workforce shortages in regional and rural areas (particularly in QLD, NT, ACT and TAS) and after-hours service availability more broadly. Analysis of opening hours for Medicare UCC affiliated diagnostic imaging services in provided in section 4.3. Proximity of the diagnostic imaging services to the Medicare UCCs will be considered in future reports.

Expectations regarding access to bulk-billed radiology services was noted as a deterrent for some radiology providers. Commissioners reported that remaining open after hours was not financially viable for some providers, as MBS revenue alone could not offset the low patient volume.

> **"There are no private providers that are willing to stay open and no extra radiographers around that want to pick up hours."** [Commissioner]

Several Medicare UCCs have arrangements for local health services to provide access to diagnostic imaging services, in the absence of available and interested private providers, and/or when their existing providers are closed after hours.

Outside of these arrangements, stakeholders reported that after hours patients are either referred to ED or, where appropriate, advised to return during business hours, noting literature suggests after-hours diagnostic imaging should only occur if there is reasonable probability of changing the patient's after-hours management.[86]

Stakeholders in WA and TAS reported that they had explored flexible workforce models to address radiology workforce shortages, for example, training other staff to operate diagnostic imaging equipment after hours when radiology staff are unavailable as per arrangements in the NT. However, local regulatory barriers (independent of the state health departments) prevented implementation of these alternatives.

[85] Telehealth items are not within the scope of the Medicare UCC program based on the current commitments of the Australian Government. To be eligible for most GP telehealth services, the GP is required to have an established clinical relationship with the patient, meaning that a patient must have had a face-to-face consultation with the GP (or another practitioner at the same practice) in the 12-months prior to their telehealth consultation.

[86] Gardiner, F., & Zhai, S. (2016). Are all after-hours diagnostic imaging appropriate? An Australian Emergency Department pilot study. *Annals of Medicine and Surgery*, *12*, 75-78.

INTERIM FINDING

Medicare UCCs face ongoing challenges with offering access to X-ray services across all hours of operation and ultrasound/CT services across the majority of hours of operation (as per the Medicare UCC Operational Guidance) due to radiology workforce shortages and after-hours service availability.

IMPROVEMENT OPPORTUNITY

More Medicare UCCs could consider developing pathways with local hospital services for Medicare UCC patients to bypass ED if diagnostic imaging is required after-hours, using learnings from Medicare UCCs that already have these pathways in place.

Next steps

For subsequent evaluation phases, stakeholders will be engaged more widely about their experiences of services provided by Medicare UCCs and the impact of Medicare UCCs on local GP practices and workforce availability. Medicare UCCs will be surveyed to provide further insights on provider experience as well as barriers and enablers to adopting flexible workforce models.

MEASURE OF SUCCESS 6

5.6 ED presentations at partner hospitals

Measure of Success 6 agreed by the Australian, state and territory governments is:

"Medicare UCCs reduce pressure on hospital ED presentations at partner hospitals."

In this Interim Evaluation Report 1, Measure of Success 6 is assessed through:

- Analysis of reported responses to "Where patient would have gone otherwise", captured through the Medicare UCC Module data.
- Early indications of the impact of Medicare UCCs on partner hospital ED presentations in triage categories four and five and the proportion of patients seen on time.

Insights are based on Medicare UCC data and publicly available partner hospital ED data from the AIHW and jurisdictions (where such data have been released publicly).

For the Interim Evaluation Report 2, an ITS analysis will be undertaken with more comprehensive data to determine if Medicare UCCs impact the underlying trend in ED presentations at partner hospitals. For the Final Evaluation Report, a DiD analysis will be applied. These analytical approaches are phased across the three reporting periods of the evaluation based on data availability. Data linkage would also allow more robust program monitoring and assessment in the future but is not in scope for this evaluation.

Forty-six per cent of patients would have sought ED care if the Medicare UCC was not available

Table 12 shows that if the Medicare UCCs were not available, most patients would have sought care from a GP (50 per cent) or a local ED (46 per cent), based on the Medicare UCC data. After hours,[87] the proportion of patients reporting they would have sought care from a GP decreases from 50 to 47 per cent,

[87] After hours is defined as presentation time before 8:00 am or after 6:00 pm Monday to Friday, before 8:00 am or after 12:00 pm Saturday, any time Sunday or Public Holidays. Australian Government Department of Health and Aged Care. (2024b). *MBS Online: Medicare Benefits Schedule - Associated Notes After Hours Attendances*. Retrieved 21 November from https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=599&qt=item

while the proportion indicating they would have sought care at a local ED increases from 46 to 49 per cent. This shift likely reflects the limited alternative service options during these times.

Using this variable, it was estimated that up to 30 September 2024, 183,507 of 400,564 presentations for which there was data, potentially avoided an ED visit (Table 12). Annualised, the number of avoided ED visits is estimated to be 334,000. The methods for deriving the annualised estimates are discussed under Measure of Success 9 (section 5.9) and Appendix D.

Table 12 | Where patient would have gone otherwise, including when presentation was after hours

Where patient would have gone otherwise	Presentations	Percentage of presentations with this response	After hours (a)	
			No	Yes
Would not have sought medical care	4,601	1.1%	1.1%	1.4%
GP	201,363	50.3%	52.4%	47.0%
Telephone or virtual triage service	2,690	0.7%	0.6%	0.9%
Other health professional	5,960	1.5%	1.5%	1.5%
Ambulance	1,076	0.3%	0.3%	0.3%
Local ED	183,507	45.8%	43.9%	48.6%
Other	1,367	0.3%	0.3%	0.4%
Total excluding "Not recorded" (from 63 Medicare UCCs)	400,564	100.0%		
Not recorded	25,915			
Total including "Not recorded" (from 63 Medicare UCCs)	426,479			
Aggregate and other unit record counts	357,592			
Total presentations (from 75 Medicare UCCs)	**784,071**			

Notes: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. (a) After hours is defined as presentation time before 8:00 am or after 6:00 pm Monday to Friday, before 8:00 am or after 12:00 pm Saturday, any time Sunday or Public Holidays. See section 3.4 for an overview of limitations related to the Medicare UCC data.

Caution should be applied when considering responses captured under the variable "where would the patient have gone otherwise?", for a range of reasons, including:

- Responses may be overstated or understated depending on how the question was phrased for patients and how they interpreted it.
- Although this variable is intended to be collected by asking patients *where they would have gone or sought advice from* if a Medicare UCC was not available, some commissioners reported that clinic staff sometimes make this assessment on behalf of the patient.

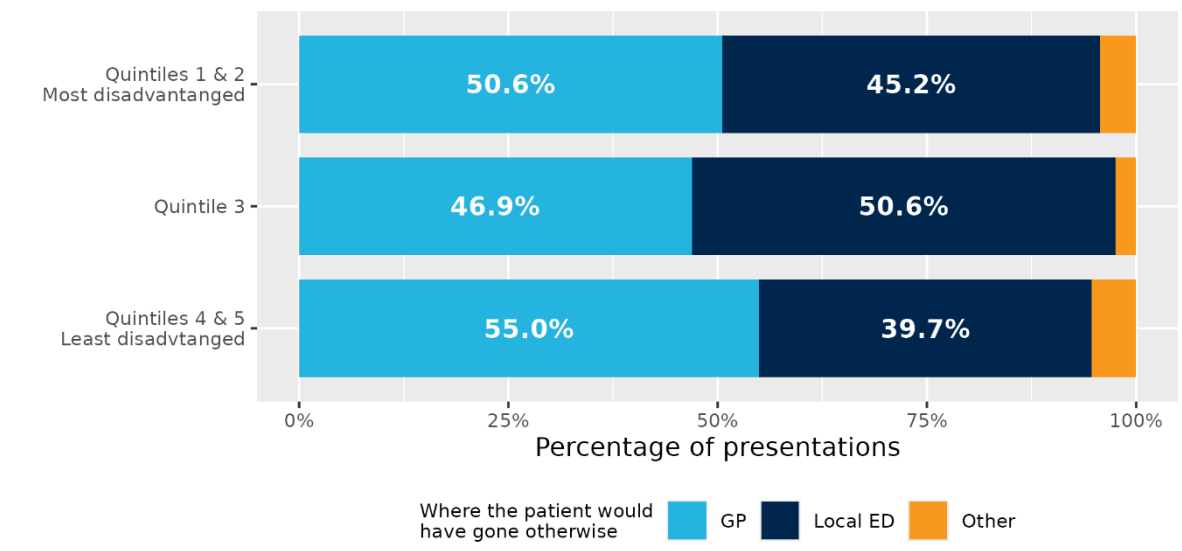
- Some patients who reported they would have gone to an ED might still attend or be referred to one following their Medicare UCC visit. As noted in Measure of Success 2 (Table 10), 5 per cent of patients at Medicare UCCs were referred to EDs.
- Similarly, some patients who reported they would have sought care from a GP might also be referred (or self-present) to an ED.
- There is no alternative data source against which the rates reported in the Medicare UCC context can be verified. This limitation makes it difficult to assess whether the self-reported intentions of patients regarding where they would have sought care align with actual patterns or behaviours observed in other settings.
- Data is incomplete, covering only 400,564 of 784,071 presentations. Detailed data is unavailable for the three small remote clinics in the NT, five ACT Medicare UCCs and four Medicare UCCs that opened after 1 September 2024. Some clinics only provided aggregate counts of activity prior to implementation of the Medicare UCC Module data. Additionally, aggregate counts are provided where the patient specifically requested that data not be released through the Medicare UCC Module. See section 3.4 for further information regarding data issues.

INTERIM FINDING

In the period to 30 September 2024, it was reported that 46 per cent of patients (183,507 of 400,564 presentations for which there was data) would have sought care at an ED if the Medicare UCC was unavailable. This increased to 49 per cent after hours, presumably due to limited service availability. The evaluation estimates that 334,000 presentations to partner hospital EDs would have been avoided across a year due to the Medicare UCCs.

Figure 20 shows where patients would have otherwise gone based on a measure of relative socio-economic disadvantage, using the quintiles of the ABS IRSD. This shows that the option of attending an ED was slightly higher for patients living in Quintile 3 areas, but lower for patients living in Quintiles 4 and 5 (least disadvantaged) areas. This suggests that for people living in less disadvantaged areas requiring urgent care, there may be greater access to alternatives other than EDs. This pattern may also reflect a slightly different pattern of urgent care needs among people attending Medicare UCCs in less disadvantaged areas.

Figure 20 | Where patient would have gone if the Medicare UCC were not available: comparison across grouped quintiles of the ABS IRSD

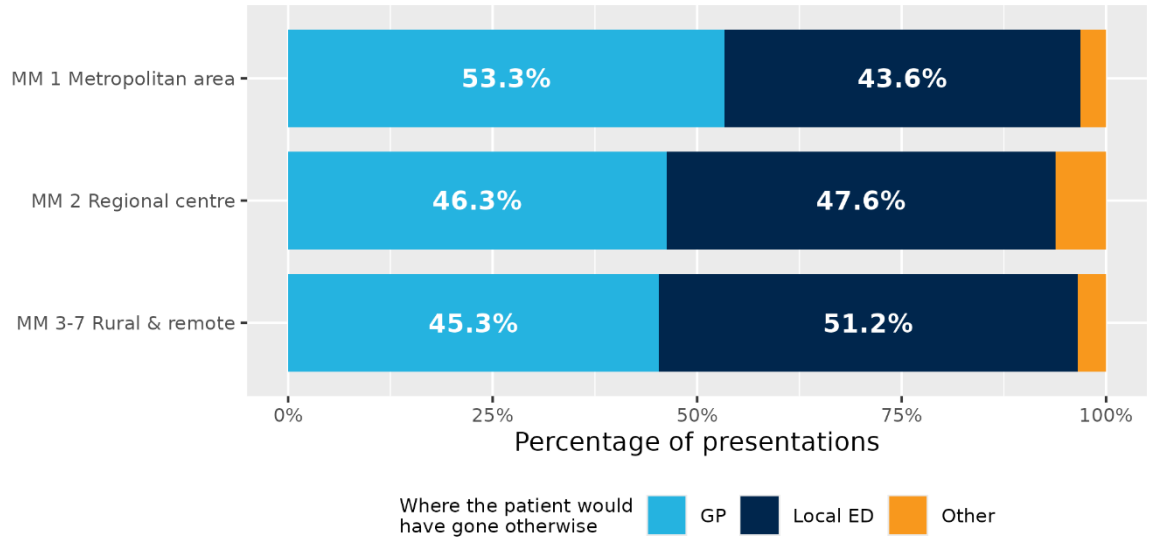


Notes: Comparison is across quintiles of IRSD based on the location of the Medicare UCC. Chart reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. "Not recorded" presentations were excluded when calculating percentages. The

variable "where the patient would have gone" was not recorded for: 23.8 per cent of presentations (14,154) in Quintiles 1 and 2; 23.3 per cent of presentations (5,170) in Quintile 3; 24.8 per cent of presentations (6,591) in Quintiles 4 and 5. See section 3.4 for an overview of limitations related to the Medicare UCC data.

Figure 21 shows where it was reported patients would have gone based on metro/regional/rural and remote using the MMM categories. It was reported that 44 per cent of patients living in MM1 (Metropolitan areas) would have attended a local ED if the Medicare UCC was not available. This increased to 48 per cent for MM2 (Regional centres), 51 per cent for MM3-7 (Rural and remote areas). This suggests that for people living in metropolitan areas requiring urgent care, there may be greater access to alternatives other than EDs, such as a local GP, while for regional, rural and remote areas, the local ED is often the default option for urgent care needs.

Figure 21 | Where patient would have gone if the Medicare UCC were not available: comparison by MMM grouped categories



Notes: Chart reflects data from 30 June 2023 to 30 September 2024 and extracted 6 November 2024. Comparison is across MMM categories based on the location of Medicare UCC. "Not recorded" presentations were excluded when calculating percentages. The variable "where patient would have gone" was not recorded for 26.6 per cent of presentations (19,076) in MM1; 20.6 per cent of presentations (5,937) in MM2; 18 per cent of presentations (902) in MM3-7. See section 3.4 for an overview of limitations related to the Medicare UCC data.

INTERIM FINDING

In the period to 30 September 2024, based on available data, the proportion of patients who would have attended an ED if the Medicare UCC was not available was higher in:

- Areas of median socio-economic disadvantage (ABS IRSD Quintile 3) (51 per cent) and high socio-economic disadvantage (Quintiles 1 and 2) (45 per cent) compared with areas of low socio-economic disadvantage (Quintiles 4 and 5) (40 per cent).
- Rural and remote areas (51 per cent), compared with regional centres (48 per cent) and metropolitan areas (44 per cent).

The early impact of Medicare UCCs on triage categories four and five presentations and waiting times at partner hospital EDs is variable

Publicly available data has been used to explore the early impact of Medicare UCCs on ED presentations and waiting times. These sources include data recently released by the AIHW for ED measures by financial year and publicly released data by health agencies from NSW, VIC, QLD, TAS and WA.[88]

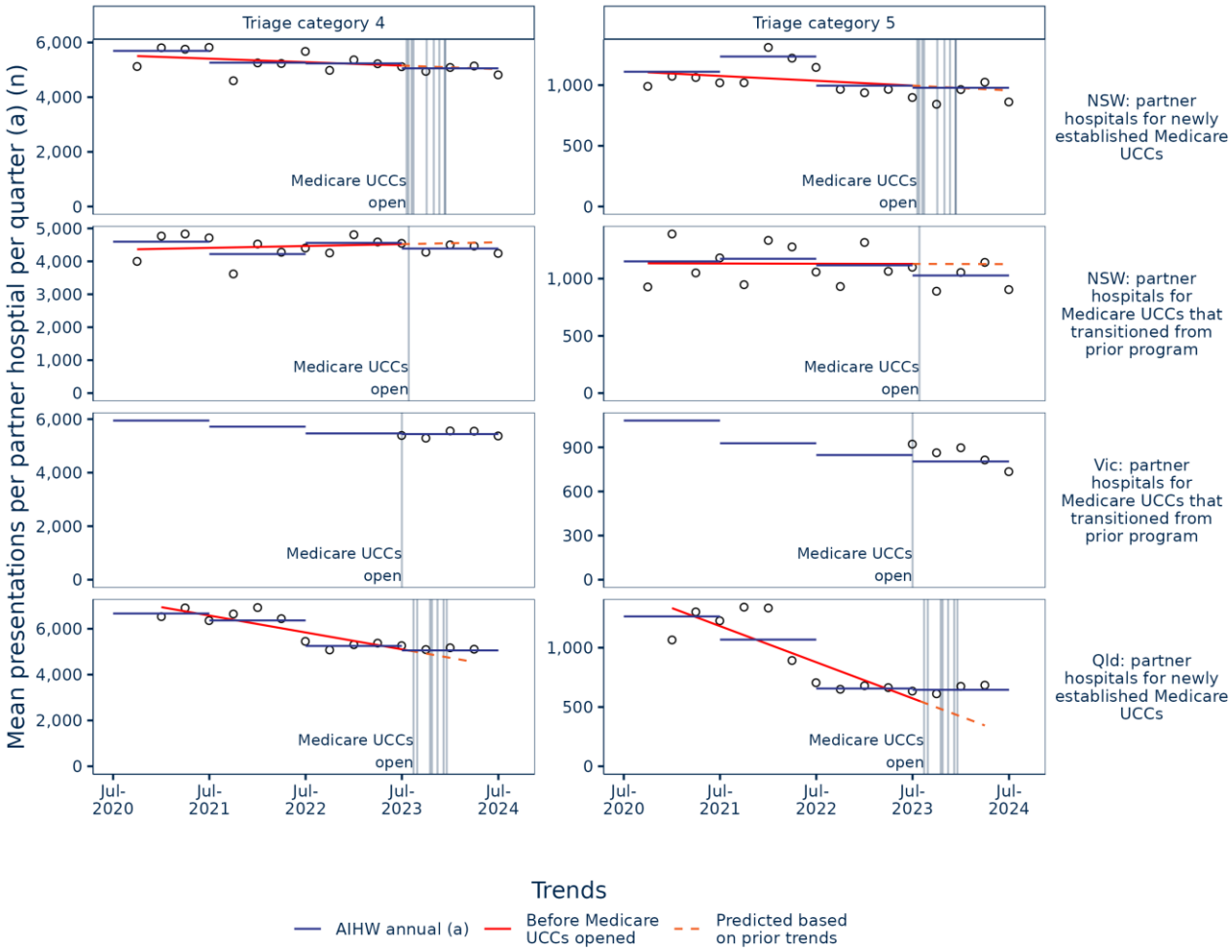
Table 24 summarises trends for ED activity for triage categories four and five in partner hospitals for the Medicare UCCs, and compares these with other hospitals, based on data reported by the AIHW.[89] Trends for these data together with data from state sources – where these are available – are summarised in Figure 22 and Figure 23, based on the mean number of presentations per hospital per quarter. The charts have been broken into panels to shows trends by triage category, state/territory and whether the Medicare UCC transitioned from a prior program. Partner hospitals for Medicare UCC commencing after 1 July 2024 have been excluded from the charts.

The number of ED presentations for triage categories four and five generally declined between 2020-21 and 2022-23, and this trend continued in 2023-24, although at a reduced rate of decline. For the 43 partner hospitals of Medicare UCCs that were newly established and operational prior to 31 December 2023, ED presentations in 2023-24 declined by 2.3 per cent for triage category four and 3.3 per cent for triage category five, compared with the previous year. For the partner hospitals of Medicare UCCs that had transitioned from previous programs, ED presentations increased by 0.7 per cent for triage category four and decreased by 8.3 per cent for triage category five. For hospitals that are not partner hospitals, presentations increased by 0.3 per cent for triage category four and increased by 1.1 per cent for triage category five.

[88] Note limitations of publicly available data from states and territories for assessing the impact of the Medicare UCC program:
This data considers triage four and triage five presentations to ED, but granular reporting of urgent care equivalent presentations according to the National Healthcare Agreement indicator definition described in section 1.2, is not available.
The evaluators are unable to combine data from different states and territories as different definitions and reporting methods are used across states and territories. Published data from ACT and NT Health Departments were not available (at the time of writing this report) across the period being used by evaluators to estimate impact based on trends before and after the Medicare UCCs opened.
Most states and territories provide more granular partner hospital data directly to the Department under data sharing agreements, however, data prior to Medicare UCC implementation is not provided through these agreements, which is required to estimate the impact of the program.

[89] Australian Institute of Health and Welfare. (2023-24). *Emergency department care 2023-24 data tables*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care%23more-data, Tasmanian Government Department of Health. (2024). *Emergency department - presentations*. Retrieved 21 November from https://www.health.tas.gov.au/health-system-dashboard/monthly/emergency-department

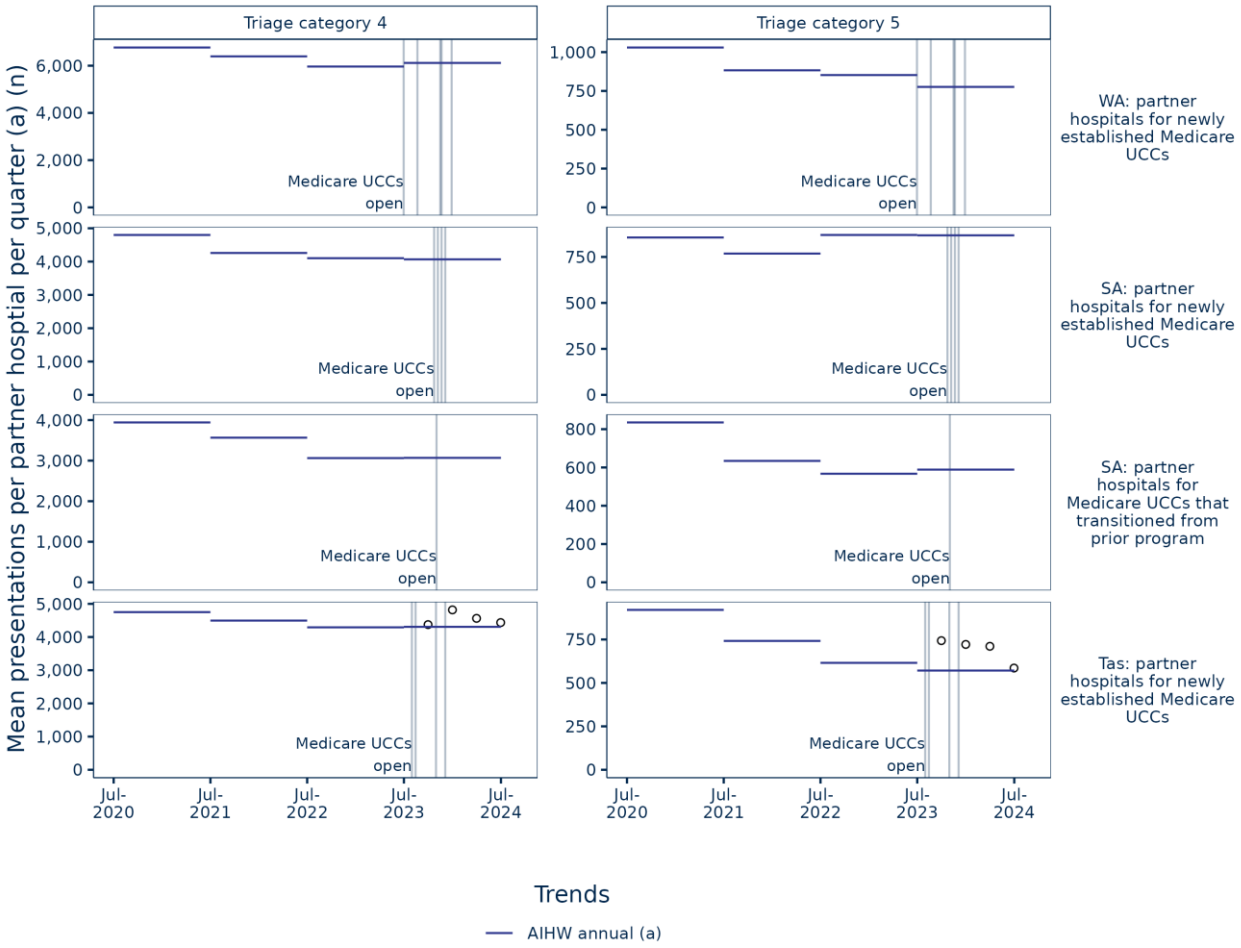
Figure 22 | Mean ED presentations per partner hospital triage categories four and five, NSW,[90] VIC[91] and QLD,[92] July 2021 to June 2024



Notes: Data extracted from publicly available source on 21 November 2024. Medicare UCC opening dates in the corresponding state are indicated by the grey vertical lines. The open points show quarterly data from hospital level data published by states (NSW, VIC and QLD) where these are available for quarters between 2020-21 and 2023-24. Trends – shown in red – are based on these data. The solid line shows the trend for all quarterly data points available for 2020-21, 2021-22 and 2022-23. Predicted trends for 2023-24 based on trends from the previous year are shown as a dashed line. (a) The AIHW is shown as a line/segment across the financial year. Annual data were converted to a quarterly value by dividing by four, so that these could be plotted along with quarterly data from state publicly released data. The source for the AIHW data is: Australian Institute of Health and Welfare. (2023-24). *Emergency department care 2023-24 data tables*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care%23more-data

[90] NSW Bureau of Health Information. (2024). *Data portal*. Retrieved 3 December from https://www.bhi.nsw.gov.au/data-portal
[91] Victorian Agency for Health Information. (2024). *Reports*. Retrieved 3 December from https://vahi.vic.gov.au/reports
[92] Queensland Government. (2024). *Emergency departments - quarterly report*. Retrieved 3 December from https://www.data.qld.gov.au/dataset/emergency-departments-quarterly-data

Figure 23 | Mean ED presentations per partner hospital triage categories four and five, WA, SA and TAS,[93] July 2021 to June 2024



Notes: Data extracted from publicly available source on 21 November 2024. Medicare UCC opening dates in the corresponding state are indicated by the grey vertical lines. The open points show quarterly data from hospital level data published by states (TAS only) where these are available for quarters between 2020-21 and 2023-24. (a) The AIHW is shown as a line/segment across the financial year. Annual data were converted to a quarterly value by dividing by four, so that these could be plotted along with quarterly data from state publicly released data. The source for the AIHW data is: Australian Institute of Health and Welfare. (2023-24). Emergency department care 2023-24 data tables. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care%23more-data. Data for the ACT and NT have not been included in these charts. AIHW data for the NT did not include 2023-24.

Partner hospitals also experienced an improvement in the proportion of presentations where clinical treatment commenced within 60 minutes for triage category four and 120 minutes for triage category five. Presentations seen within these benchmarks are referred to "being seen on time". Table 25 (Appendix E) summarises trends for ED presentations seen on time for triage categories four and five. For the 43 partner hospitals of Medicare UCCs that were newly established and operational prior to 31 December 2023, the proportion of presentations meeting the benchmarks in 2023-24 increased by 1.8 per for triage category four and 0.4 per cent for triage category five, compared with the previous year. For the partner hospitals of Medicare UCCs that had transitioned from previous programs, there was an increase of 9.4 per cent for triage category four and an increase of 4.7 per cent for triage category five. For hospitals that are not partner hospitals presentations there was also an increase in these measures of 1.8 per cent for triage category four and 0.8 per cent for triage category five.

However, conclusions cannot yet be made about the impact of Medicare UCCs on reducing pressure on partner hospital EDs for a range of reasons, including:

[93] Tasmanian Government Department of Health. (2024). *Emergency department - presentations*. Retrieved 21 November from https://www.health.tas.gov.au/health-system-dashboard/monthly/emergency-department

- The evaluation estimates that ED data would need to be observed for 16 months from the Medicare UCC commencement date to assess the impact of the program. This includes four months for Medicare UCCs to stabilise their activity following establishment and 12 months beyond that time. Data that has been released publicly is currently available up to 30 June 2024 for most jurisdictions and 30 September 2024 in some instances.
- For many partner hospitals, the 2023-24 financial year includes periods prior to the opening of the Medicare UCC as well as post opening. Where states reported quarterly data points, these have also been included in the charts. In some instances, this includes the September quarter for 2024. These data do not provide clear evidence of trends.
- It is not clear that the observed trends for 2023-24 are due to the availability of Medicare UCCs. Ideally this requires comparison with the experience of populations that have no or limited access to Medicare UCCs, an approach that is planned in the next stages of the evaluation using a DiD method. The future phases of the evaluation will also benefit from more comprehensive, granular data over a longer time span post the opening of all the Medicare UCCs.
- With the publicly available data, it was not possible to fully isolate urgent care-equivalent ED presentations within triage categories four and five. Additionally, most partner hospitals have larger catchments compared with the Medicare UCCs and it was not possible to focus the analysis of ED presentations to the geographic regions of Medicare UCCs.
- There are limitations in using waiting time data for triage category four and five presentations to EDs to assess the impact of Medicare UCCs on partner hospital EDs. It is acknowledged that waiting times for triage category four and five presentations to EDs are impacted by the volume of triage category one to three presentations to EDs, as they are prioritised ahead of others. Medicare UCCs were not designed or intended to impact triage category one to three ED presentations and trend analysis for these presentations has not been considered for this Interim Evaluation Report 1.

The available data also suggests there is substantial variation in trends between partner hospitals and across states/territories. In most states the percentage decline in triage category five presentations has been greater compared with triage category four. Across the 43 partner hospitals for newly established Medicare UCCs, 65.1 per cent experienced a decline in presentations for triage category four and 60.5 per cent for triage category five. For the 12 partner hospitals for Medicare UCCs that transitioned from a previous arrangement, 50 per cent experienced a decline in presentations for triage category four and 66.7 per cent for triage category five.

Local factors, such as population growth, differences in need for urgent care between regions and the level of availability of alternatives for urgent care are likely to influence this variation. These, and other relevant national factors, will be further explored in later evaluation reports and incorporated into analysis of the impact of Medicare UCCs.

> **INTERIM FINDING**
>
> At this early stage, the evaluation cannot draw valid conclusions about the impact of the program on triage categories four and five presentations and waiting times at partner hospital EDs, based on the publicly available hospital data.

Next steps

For Interim Evaluation Report 2, an ITS analysis will be undertaken with more comprehensive and granular data collected over a longer timeframe to determine if Medicare UCCs have an impact on the underlying trend in ED presentations at partner hospitals (for urgent care-equivalent presentations).

For the Final Evaluation Report, a DiD analysis will be undertaken, where outcomes are compared between an intervention group – residents in regions with Medicare UCCs – and a control group – residents in other regions. Since individuals are not randomly assigned to regions with or without Medicare UCCs, the analysis will control for pre-existing differences between the groups. The DiD method estimates what

would have occurred for the intervention group if the Medicare UCCs had not been introduced, producing a "counterfactual" outcome.

The analytical approaches are phased across the reporting periods of the evaluation based on data availability. Future analysis will also consider other factors that may impact changes in triage category four and five presentations to EDs, for example, population growth.

MEASURE OF SUCCESS 7

5.7 Consumer behaviour

Measure of Success 7 agreed by the Australian, state and territory governments is:

"There is a change in consumer behaviour over time to use Medicare UCCs where available instead of EDs for urgent non-life-threatening conditions."

For this Interim Evaluation Report 1, Measure of Success 7 is assessed through the following dimensions:

- Presentations to Medicare UCCs.
- Use of Medicare UCCs instead of EDs for urgent non-life-threatening conditions.
- The impact of national and local communications campaigns on consumer awareness and understanding of Medicare UCCs.

Insights presented are based on analysis of Medicare UCC data, interviews with commissioners, the CHF executive and the previously identified Medicare UCCs. It also draws on Department-commissioned research assessing performance and impact of a national communications campaign on patient awareness.

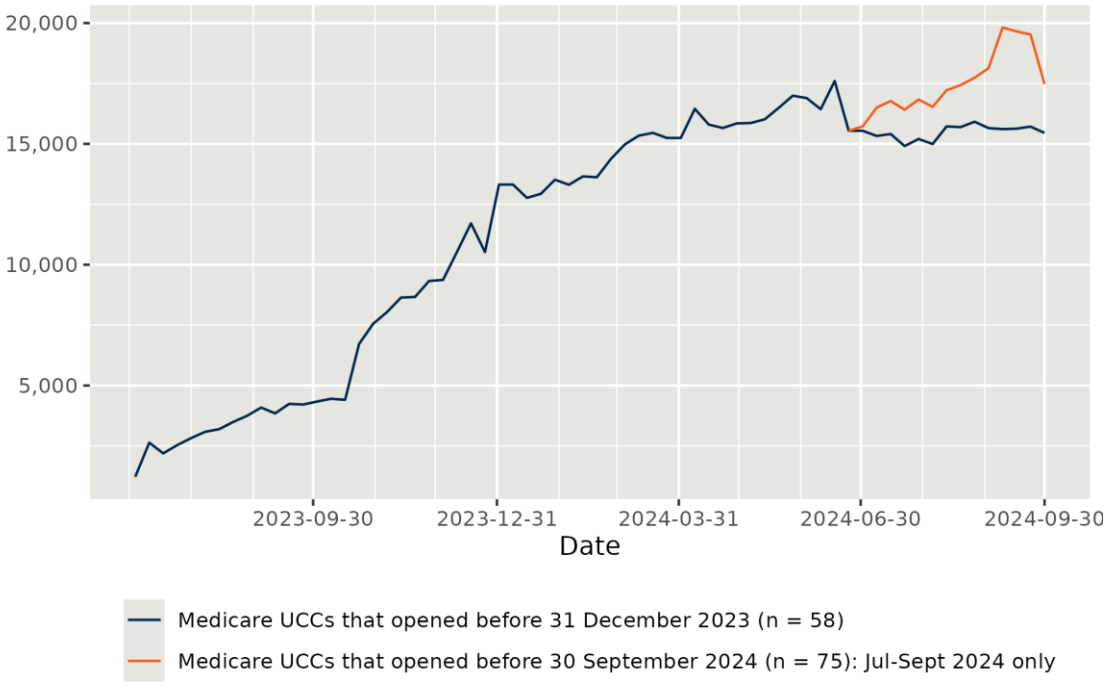
Newly established Medicare UCCs experienced a rapid growth in activity that stabilised within four months

Growth in presentations was primarily driven by new clinics opening prior to 31 December 2023 and from 1 July 2024 (see Figure 24). Medicare UCCs that were newly established experienced a rapid increase in activity in the first four months (see Figure 25). There is also some evidence that Medicare UCCs that transitioned from a previous state arrangement increased their level of activity after commencing as a Medicare UCC. For many clinics that transitioned from previous state arrangements, this is likely due to moving from a referral-based intake model to a walk-in model.

For the 58 clinics that opened before 31 December 2023, presentations decreased slightly between June and September 2024. This may reflect seasonal patterns. For example, there were decreases in national COVID-19, influenza and respiratory syncytial virus activity reported during this period.[94] Changes in activity in the Medicare UCCs will be examined further in future phases of the evaluation when data is available over a longer period.

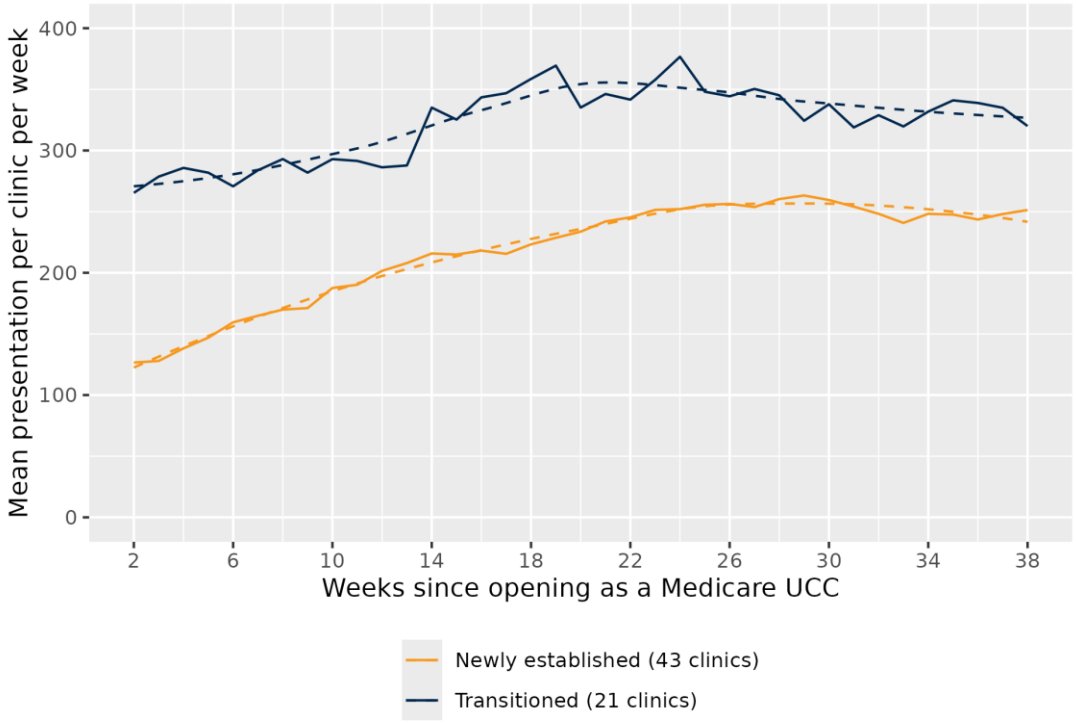
[94] Australian Centre for Disease Control. (2024). *Australian Respitatory Surveillance Report*. Department of Health and Aged Care. https://www.health.gov.au/sites/default/files/2024-10/australian-respiratory-surveillance-report-15-7-october-2024-to-20-october-2024_0.pdf

Figure 24 | Presentations to Medicare UCCs per week 30 June 2023 to 30 September 2024



Notes: Based on all data reported between 30 June 2023 and 30 September 2024, including aggregate counts. Data extracted 3 December 2024. A small number of Medicare UCCs had no activity reported for the last week of September 2024.

Figure 25 | Mean weekly presentations to Medicare UCCs from date of opening or transitioning: Medicare UCCs open for at least 12 weeks, June 2023 to September 2024



Notes: Based on data for the period 30 June 2023 to 30 September 2024, extracted 3 December 2024, for 64 clinics that opened between 30 June 2023 and 1 July 2024 that were open for at least 12 weeks as of 30 September 2024.

INTERIM FINDING

Medicare UCCs that were newly established experienced a rapid growth in activity, which stabilised within four months. There is also some evidence that Medicare UCCs that transitioned from a previous state urgent care arrangement increased their level of activity after commencing as a Medicare UCC.

There are fluctuations in the proportion of presentations where it was reported that patients would have gone to an ED or called an ambulance if the Medicare UCC was not available

As described previously in Measure of Success 6 (section 5.6), available data indicates that 46 per cent of patients would have sought help from a local ED if the Medicare UCC was not available.

Figure 26 shows the proportion of presentations where it was reported that the patient would have gone to an ED or called an ambulance if the Medicare UCC was not available, by week, from 1 February 2024 to 30 September 2024.[95] At newly established clinics, a slight decrease is observed in this proportion, over the period 1 February 2024 to 30 September 2024.

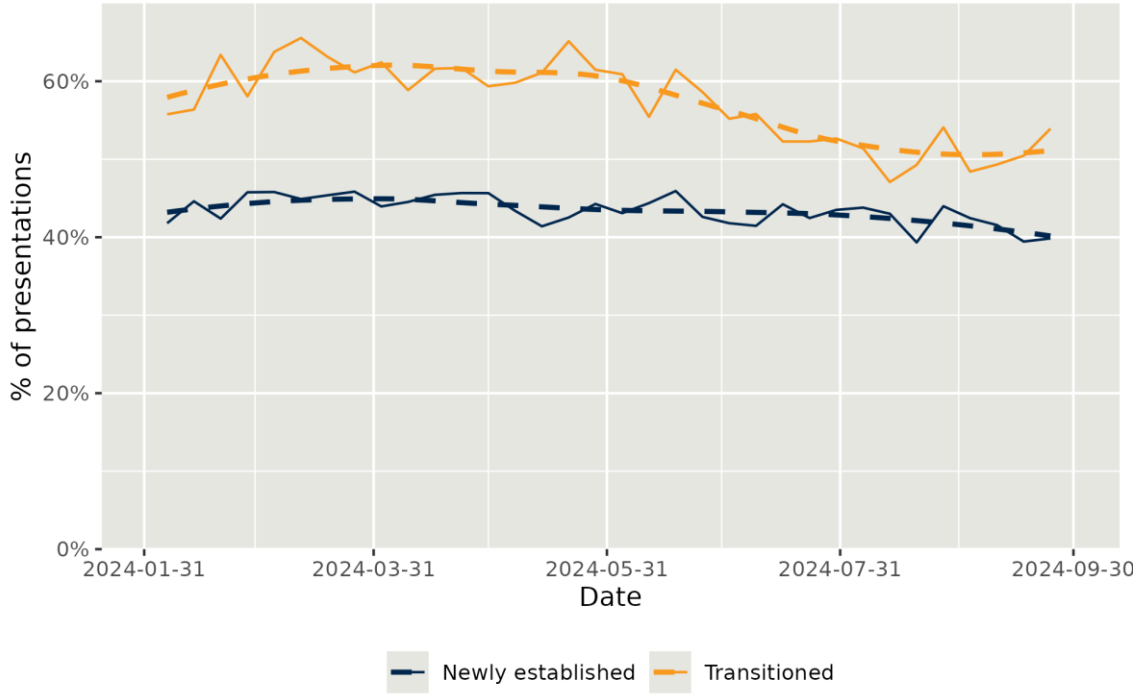
A more pronounced decrease is observed in clinics that transitioned from previous state arrangements over the period 1 February 2024 to 30 September 2024. As previously described, several clinics that transitioned from previous state arrangements, changed from a referral-based intake model to a walk-in model. It is likely that patients who were triaged and referred to UCCs by other clinicians would have higher acuity conditions than patients who walked-in and this was reflected in where they would have sought care if the Medicare UCC was not available. Despite the shifts observed over time, these clinics had consistently higher proportions of patients for whom it was reported that they would have attended an ED or called an ambulance compared with the newly established clinics.

These proportions are still fluctuating and will need to be explored in future phases of the evaluation when data is available over a longer period. Future phases of the evaluation will also explore the proportion of patients who present due to affordability and access to bulk billing. The evaluation notes that the data linkage would allow more robust program monitoring and assessment in the future but is not in scope for this evaluation.

The impact of Medicare UCCs on presentations to partner hospital EDs is discussed in Measure of Success 6 (section 5.6).

[95] Although this variable is intended to be collected by asking patients *where they would have gone or sought advice from* if a Medicare UCC was not available, some commissioners reported that clinic staff sometimes make this assessment on behalf of the patient.

Figure 26 | Presentations where it was reported that patient would have attended ED or called an ambulance if the Medicare UCC was not available, by week, February 2024 to September 2024



Notes: Based on data from 53 clinics that opened before 31 December 2023 and had Module data available. Trends shown by week from 1 February 2024 to 30 September 2024, extracted 3 December 2024. This period was chosen to provide a more accurate reflection of activity once clinics were established.

Most patients are presenting directly to the Medicare UCCs rather than being referred from other services

Medicare UCC data indicates that most patients are coming directly to the Medicare UCCs, with 89.2 per cent presentations reported as walk-ins, as shown in Table 13. There were minimal diversions from other services, with just 3.8 per cent of presentations reported to have been referred by a GP, 2.6 per cent from Healthdirect and 1.5 per cent from ED.

As previously described in Measure of Success 2 (Table 9), most patients are presenting to Medicare UCCs with acute illnesses (63 per cent) and acute injuries (26 per cent). Available data also indicates Medicare UCC patients tend to be younger than patients attending EDs for similar care (Figure 14), as described previously in section 4.6 (Implementation). Characteristics of patients attending Medicare UCCs will be explored in further detail in future phases of the evaluation.

Table 13 | Point of entry to Medicare UCCs

Point of entry to Medicare UCC	Presentations	
	Presentations	Percentage of presentations that recorded a response
Walk-in	362,298	89.2%
Local ED	6,051	1.5%
Healthdirect	10,603	2.6%

Point of entry to Medicare UCC	Presentations	
	Presentations	Percentage of presentations that recorded a response
Ambulance	3,082	0.8%
GP	15,386	3.8%
Other health professional	5,934	1.5%
Other	2,686	0.7%
Total excluding "Not recorded" (from 63 Medicare UCCs)	**406,040**	**100.0%**
Not recorded	20,439	
Total including "Not recorded" (from 63 Medicare UCCs)	**426,479**	
Aggregate and other unit records counts	357,592	
Total presentations (from 75 Medicare UCCs)	**784,071**	

Note: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. See section 3.4 for an overview of limitations related to the Medicare UCC data.

A comprehensive National Communication Strategy was implemented across multiple channels

The Department developed an overarching National Communication Strategy to support rollout of the Medicare UCCs and a change in consumer behaviour to use Medicare UCCs instead of EDs. The Strategy included:

- Increasing awareness of the location and opening of each Medicare UCC in local communities.
- Increasing understanding of the services available at Medicare UCCs to support appropriate presentations.
- Supporting patients to understand when they need to go to a Medicare UCC instead of their regular GP or the ED.

Bursts of targeted paid advertising were conducted across multiple channels, including social media, radio, press and signage at clinics and in the community, at 52 Medicare UCC locations between December 2023 and April 2024. This was supported by national public relations and education activities, including social media content, video case studies and a webpage with an interactive map of Medicare UCCs and a range of resources that have been translated into over 15 languages and tailored for First Nations communities and people living with disabilities.

Separate analysis was conducted on the performance and early impact of the National Communications Strategy

Performance reporting undertaken by the Department and provided to the evaluation shows that during the national communications campaign there were 148 million Medicare UCC social media impressions[96] with a click through rate of 0.15 per cent and 504,000 visits to the Department's Medicare UCC website.

The Department commissioned research to analyse the early impact of the National Communications Strategy. An online survey of adults aged 18 and over living within a defined radius of selected Medicare UCCs was undertaken between 30 November and 9 December 2023. Data to compare those who were and were not exposed to the campaign was not available. The survey was completed by 1,140 respondents, with results showing:

- About 40 per cent of respondents had some awareness of Medicare UCCs and 25 per cent knew about a Medicare UCC in their local community. Relatively younger adults (18 to 54 years) and those with caregiving responsibilities, including parents and carers of individuals with disabilities or chronic conditions, showed higher awareness.
- About 50 per cent of respondents were confident in identifying when to use a Medicare UCC over a GP, though slightly fewer were confident about choosing Medicare UCCs over EDs.
- For respondents who had recently seen, heard, or read about Medicare UCCs, about 50 per cent understood that Medicare UCCs accept walk-in patients without appointments, provide bulk-billed services and have extended operating hours.

Commissioners have led complementary local communications strategies

The Department has also provided support to commissioners in sharing information to their local area, such as providing information that could be placed at key health service referral touchpoints like general practices, maternal and child health centres, and hospitals.

Commissioners in some states and regions reported that they had deployed their own local communications strategies with some success. Examples discussed included:

- A local community Facebook group with regular posts on what urgent care is and is not, cases the UCC sees and seasonal health updates on conditions that might be more prevalent at certain times of the year.
- Proactive advertising on local commercial radio, in the newspaper and on bus wraps on the public transit buses.
- Reaching out to local schools and sporting clubs (which cover a demographic that commonly has certain sporting, muscle and bone injuries) and letting them know about the Medicare UCCs as an alternative option for care.

Other commissioners said that they had not seen a need to do any additional promotion because the national media campaign had been very effective in their locale. For example, team members from one PHN mentioned that the geo-targeted advertising in their area effectively spread the message within a particular radius via social media about their Medicare UCC, running small videos about the Medicare UCC's existence and the circumstances it was suitable for.

[96] Impressions are defined as the number of times that an advert appears on screen. Meta. (2024). *Business Help Centre: Impressions*. https://www.facebook.com/business/help/675615482516035?locale=en_GB

Consumers continue to face challenges in understanding what urgent care entails and navigating the variety of available service options

Stakeholders reported that there is still confusion among consumers between the role of urgent care and the role of the ED. Similar issues were acknowledged in the recently published After Hours Review.[97] Challenges with the word 'urgent' were noted across several circumstances, including:

- The difficulty for a lay person to distinguish between an incident that is 'urgent' versus one that is an 'emergency'.
- Distinguishing between what is urgent after-hours versus what can wait until the next day.
- The difference in a consumer's baseline for urgent care, based on their individual past experiences and upbringing.
- How it is interpreted by consumers who do not speak English as a first language, including those from CALD and First Nations communities.

Stakeholders reported that the term 'Medicare UCC' could also be problematic because it might suggest to consumers that the service is only available to people with a Medicare card. The Department has advised that Medicare UCCs may make a business decision to not routinely treat patients who are not eligible for Medicare. However, no patient treated at a Medicare UCC can be charged a fee and any presenting patient who is not treated must be referred to an appropriate service.

Beyond Medicare UCCs, there is a large variety of other urgent care options, which adds to a consumer's challenges in navigating the system. These options offer slightly different services and operate under a variety of different names, including private EDs, private urgent care centres, state managed urgent care centres, after hours services, virtual urgent care services and satellite hospitals. These are different across jurisdictions, with different eligibility, referral criteria and fees.

Adjacent services such as Healthdirect and 13-Health add to a consumer's choices, potentially creating an environment that may confuse consumers.

Medicare UCCs, being a new addition to primary care, will inherently take time to embed into the landscape. Stakeholders reported the continued need for clear communications about service navigation and where consumers should go to for what services. They flagged the need to work with any state operated services in the region that offer similar services, to align public messaging, and clearly articulate each service's role and capacity.

INTERIM FINDING

Stakeholders report that understanding what urgent care is and navigating the variety of local service options continues to be a challenge for consumers, despite comprehensive national and local communications campaigns.

IMPROVEMENT OPPORTUNITY

There is ongoing need for continued clear communications both nationally and locally about what urgent care is and to assist with service navigation.

Next steps

In future phases of the evaluation, insights will be broadened through a survey of Medicare UCC patients and additional stakeholder engagement to understand reasons for changing behaviour over time to use Medicare UCC services, and barriers and enablers to using Medicare UCCs services for consumers.

[97] Department of Health. A better after hours system. 2024.

Differences by state and territory will also be considered for future phases of the evaluation.

MEASURE OF SUCCESS 8

5.8 Coordinated care within the health ecosystem

Measure of Success 8 agreed by the Australian, state and territory governments is:

"Medicare UCCs, PHNs, Healthdirect, jurisdictions and the health ecosystem have established an effective coordinated care option for people with urgent non-life-threatening conditions."

Care coordination within the health ecosystem improves integration and efficiency for urgent non-life-threatening conditions

As discussed under Measure of Success 3 (section 5.3), coordination of care refers to an organised approach to managing a patient's health care across various providers and services.[98] It involves collaboration among health care professionals to ensure patients receive comprehensive, integrated, efficient and cost-effective care tailored to their individual needs. The aim is for all providers involved in a patient's care to be well-informed and aligned in the patient's treatment.[99,100]

While Measure of Success 3 (section 5.3) focusses on Medicare UCCs' role in facilitating care coordination through effective clinical handover and referrals, Measure of Success 8 focusses on collaboration between the various groups involved in the health ecosystem – including Medicare UCCs, PHNs, state and territory-run health services and Healthdirect – to provide effective care options for people with urgent non-life-threatening conditions. At this system level, care coordination involves establishing clear roles and pathways, fostering communication and aligning efforts across providers within the ecosystem, enabling a consistent and connected health care experience.

Coordination at this system level delivers benefits for managing urgent non-life-threatening conditions by:

- Improved access to timely and appropriate care due to streamlined communication and collaboration across system entities, enabling faster referrals and better resource allocation.
- Reduced likelihood of duplicate tests and procedures due to enhanced information sharing and alignment of processes across providers and organisations.
- Enhanced comprehensive management of interacting conditions and medications by leveraging shared information for a holistic view of a patient's medical history.

This Measure of Success focuses on assessing how effectively Medicare UCCs are integrated into and coordinated within the local health system and surrounding health services. For this Interim Evaluation Report 1, insights for this Measure of Success were gathered from interviews with commissioners.

Trusted stakeholder relationships, essential for successful integration of Medicare UCCs into the local health ecosystem, are being fostered

Commissioners reported variability in how Medicare UCCs are integrated within the health ecosystem across different regions, with some areas experiencing better integration and stronger relationships than others. Acknowledging that this is a new model of care in the primary care setting, commissioners initially focussed on establishing the Medicare UCCs. They are now shifting their efforts toward strengthening their integration and building partnerships.

[98] Agency for Healthcare Research and Quality. (2024). Care Coordination. https://www.ahrq.gov/ncepcr/care/coordination.html
[99] NSW Agency for Clinical Innovation. (2024). *Care Coordination*. Retrieved 29 November from https://aci.health.nsw.gov.au/projects/consumer-enablement/how-to-support-enablement/care-coordination
[100] Australian Institute of Health and Welfare. (2023a). *Coordination of health care*. Retrieved 29 November from https://www.aihw.gov.au/reports-data/health-welfare-overview/health-care-quality-performance/coordination-of-health-care

For some commissioners, the process of establishing the Medicare UCCs served as an opportunity to build trust and familiarity amongst key stakeholders within the local ecosystem. Examples of these initiatives included:

- Co-design workshops held during procurement of the Medicare UCCs to develop pathways between local services.
- Establishing local working groups to address emerging issues, such as ensuring paramedics feel confident transporting patients to Medicare UCCs instead of EDs when appropriate or managing inappropriate drop-offs.

Some of these initial initiatives evolved into ongoing advisory or working groups, which supported continued alignment among stakeholders and fostered building new pathways where required. Examples of these early developments are referral pathways to outpatient clinics at local hospitals for follow up care for conditions such as fractures and burns. These are described further in the case study in Figure 27.

Commissioners reported that personal engagement was particularly effective in building the confidence of local stakeholders in Medicare UCCs as a legitimate care option for appropriate patient presentations. For instance, Medicare UCC staff visited EDs to explain the scope and capabilities of their services, which helped strengthen trust and collaboration between the two settings. Similarly, ED staff were invited to Medicare UCCs.

> **"We've actually had some triage teams that have gone out to the site, met the staff, get familiar... They then have that level of comfort of, 'Yep, it's a real service.'"** [Commissioner]

> **"We've spent a lot of time in building that relationship... so they're at the point where they can pick up the phone to each other and really smooth those working relationships over and they're working as one as much as possible."** [Commissioner]

Several stakeholders noted Medicare UCCs transitioning from state or territory run urgent care services were ahead in their relationship building and integration into the health ecosystem. These clinics benefited from pre-existing connections, which they could leverage to raise community awareness and further strengthen relationships with surrounding services and clinicians.

INTERIM FINDING

Activities focused on relationship building and fostering trust and familiarity between Medicare UCCs and key local health stakeholders are in place in some regions and are helping to foster an integrated local health care system.

Effective referral pathways are still under development

Commissioners reported that while effective relationships were built at a high level, a remaining challenge was operationalising these partnerships consistently across various settings.

Several commissioners noted difficulties in getting ED staff to refer patients to Medicare UCCs, as frontline practices sometimes diverged from Local Hospital Network (LHN) directives.

> **"There's a really big disconnect between what the executive of the [LHN] believe, would like to see and advocate for, and then operationalising that. That everybody would be getting triaged away to urgent care, if the executive of the [LHN] had had their desired outcome, but actually getting that happening on the ground is very difficult."** [Commissioner]

These operational barriers often stemmed from several factors, including:

- variability in ED staff understanding of Medicare UCC services

- reluctance to refer patients
- lack of clear, unified policies within the ED about which patients can be referred to Medicare UCCs, how and when.

For example, staff understanding varied significantly, with some ED teams unaware of Medicare UCCs or not having the confidence to refer patients. Even when pathways were established, staff reluctance to redirect patients persisted due to concerns about duty of care.

Medicare UCC data indicates that 1.5 per cent of Medicare UCC patients are redirected from local EDs (see Table 13). This suggests an opportunity to strengthen awareness of, trust in and collaboration with Medicare UCC services.

Some regions have made a strong start in this. For example, in one regional area, when an ambulance picks up a patient with an urgent but non-life-threatening condition, they will call ahead to one of the local Medicare UCCs to provide a warm handover and bring them to the Medicare UCC instead of the local hospital ED. Stakeholders stressed that a high level of communication and engagement with the ambulance service – including as part of the co-design process for the stand up of the Medicare UCCs, education and flyer drops at local ambulance depots – have been critical in getting to this stage. In this region, there are plans to expand the current system to include a shared management plan for the LHN, EDs and ambulance service for high frequency presentations.

IMPROVEMENT OPPORTUNITY

Ongoing work is required by Medicare UCCs and commissioners to strengthen awareness, relationships and trust of key local stakeholders (including local ED and ambulance staff) in Medicare UCC services.

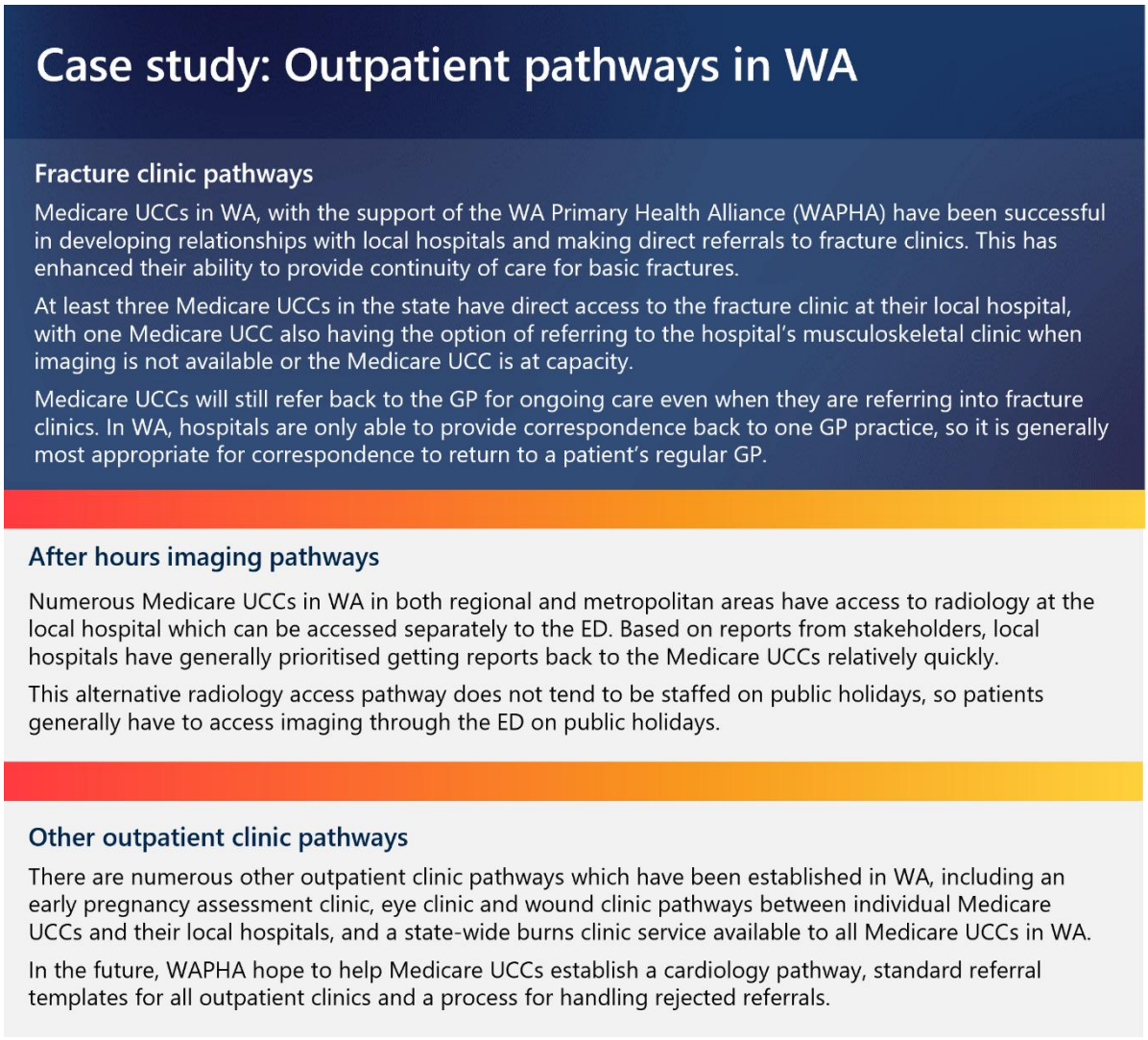
Barriers to effective referral pathways were also present in the other direction, from the Medicare UCCs to other services. The ability of Medicare UCCs to refer patients into hospital outpatient clinics has posed challenges for many Medicare UCCs. Early on, barriers including a lack of after-hours imaging services and reluctance of hospital outpatient clinics to accept non-hospital referrals prevented Medicare UCC staff from making direct referrals to hospital-based clinics. This was particularly true for management of fractures by Medicare UCCs. This hindered their ability to provide continuity of care for basic fractures as per the Operational Guidance. WA has made significant progress in addressing this issue, as described in the case study in Figure 27.

Commissioners reported that they worked closely with local EDs and outpatient departments to overcome these barriers and establish more seamless referral pathways, avoiding situations where patients might need duplicate X-rays or unnecessary additional appointments.

IMPROVEMENT OPPORTUNITY

Addressing barriers to effective referral pathways will increase efficiency and effectiveness of care. This requires continuous engagement, education and efforts to ensure that all staff members understand and follow agreed-upon pathways.

Figure 27 | Outpatient pathways in WA



Integration may differ between rural and urban Medicare UCCs due to variations in service availability and access

Commissioners suggested that Medicare UCCs in rural and regional areas face distinct challenges compared to their metropolitan counterparts, largely due to differences in service availability. The nature of these reported challenges has also differed across jurisdictions. Some examples include:

- A broader scope of presentations sometimes stretching beyond typical urgent care criteria in rural settings where primary care access is limited.
- Entrenched practices in some regional areas where EDs are treated as comprehensive healthcare hubs after hours.
- A sole primary care provider in remote communities that functions as the de facto ED and is also now the Medicare UCC.

These issues and other differences between rural and urban Medicare UCCs will be explored further in future evaluation reports.

Communities of practice promote consistent practices and strengthen local partnerships

The establishment of national and local communities of practice as shared learning platforms have allowed commissioners and Medicare UCCs to exchange experiences, share triage protocols and develop strategies to enhance patient coordination and care.

> **"It would be very much led by the clinics and …that conversation is really valuable because there are a lot of shared learnings."** [Commissioner]

Examples of session content described by commissioners included:

- Presentations from established Medicare UCCs that had worked with their LHNs to develop suitable care and referral pathways, which helped enable emerging Medicare UCCs navigate challenges they had engaging with their LHNs.
- A presentation from one of the city's major hospitals providing an update on fracture management guidelines and central referral pathways.
- A presentation from a major hospital burns unit on burns referral pathways.
- A virtual whiteboard where participants shared highlights and barriers from the first year of the Medicare UCC's operation.
- Specific sessions for regional Medicare UCCs to connect and discuss issues that are specific to regional areas, which may be different to challenges faced by clinics in metropolitan areas.
- Guest speakers from the ambulance service provider, local GPs and local Medicare UCCs.

By facilitating these shared learning opportunities, communities of practice have provided a valuable platform for Medicare UCCs to enhance their integration and operational effectiveness within the broader health system.

INTERIM FINDING

Communities of practice have helped Medicare UCC staff share experiences and learn from each other and local health system stakeholders. They are helping to build local health ecosystem relationships and integration.

Support from commissioning organisations and PHNs has helped Medicare UCCs build local relationships

The nature of support from commissioning organisations (PHNs and state and territory governments) has evolved as the Medicare UCC Program has matured.

Commissioners reported providing significant hands-on support to Medicare UCCs during their establishment. This included help with recruitment, establishing policies/procedures (including triaging and use of the Module data), facilitating provider training, building community and local provider awareness and establishing local governance arrangements.

Evolving areas of focus identified by commissioners contain many of the factors critical to effective coordinated care discussed earlier, including:

- Building relationships in the local health ecosystem, including with local EDs, ambulance services, Healthdirect and local general practices.
- Refining referral pathways that were developed during establishment.
- Establishing and growing local communities of practice with Medicare UCCs.

- Exploring flexible workforce models to support the clinics during periods of peak demand, such as nurse practitioners and extended scope paramedics.
- Using insights from patient experience surveys and other data to prioritise quality improvement activities.
- Ongoing communications campaigns to build community awareness.
- Ongoing recruitment support, including advertising on PHN websites.

In some jurisdictions, PHNs not acting in a commissioning capacity also have an important role to play in the integration of Medicare UCCs in the local health ecosystem. Recognising this, the Victorian Department of Health as a commissioning organisation has agreements in place with selected PHNs to manage some commissioning functions, including local contract management and supporting integration of the Medicare UCCs within the local health ecosystem.

> **"The PHNs have set up these local working groups to develop the bidirectional referral pathways between the health service, Ambulance Victoria and the Medicare UCCs. That localised approach has been really successful in building that trust and forging really good integrated models."** [Commissioner]

For example, North West Melbourne PHN receives funding from the Victorian Department of Health for two state-wide coordination roles. These positions coordinate a Medicare UCC Community of Practice (CoP) and support PHNs in VIC to manage the Medicare UCCs in a more consistent way, which North West Melbourne PHN reports has enabled some efficiencies when dealing with common providers.

Stakeholders report that in some other jurisdictions PHNs not acting in a commissioning capacity have not played an active role in supporting integration – this will be explored in future evaluations.

INTERIM FINDING

Commissioning organisations (PHNs and state and territory governments) are playing a beneficial role in building relationships with local GPs and health services and navigating workforce challenges.

Next steps

In later evaluation phases, a broader range of stakeholders will be engaged and Medicare UCCs will be surveyed to provide additional insights on this Measure of Success. Staff and other healthcare providers perspectives on referrals to other services and ways for Medicare UCCs to understand referral pathways and relationships will be explored moving forwards.

MEASURE OF SUCCESS 9

5.9 Cost effectiveness

Measure of Success 9 agreed by the Australian, state and territory governments is:

"Medicare UCCs are cost effective."

The Australian Government has allocated $759.9 million over five years from 2022-23 to pilot the Medicare UCC Program. A total of 87 Medicare UCCs are expected to be in place across Australia by the full roll out. Of these, 58 clinics were implemented by 31 December 2023, with a further 29 clinics being implemented progressively from 1 July 2024. By 30 September 2024, a total 75 Medicare UCCs had opened.

Through the program, grants have been made to Medicare UCCs through Medicare UCC commissioners. As described previously, in some jurisdictions, the state or territory government has taken on the role of Commissioner (VIC, TAS, NT and ACT), while in the remainder of the states, PHNs have taken on this role. Grants to the Medicare UCCs cover operational costs, and capital and equipment costs. Medicare UCCs

may also receive funding support from state or territory governments, and for one Medicare UCC, the operational grant is provided by the state government.

In addition to grants, clinicians at Medicare UCCs may be able to submit MBS claims through exemptions under s19(2) of the *Health Insurance Act 1973*. These claims are limited to specified MBS items and are required to be bulk billed. Section 19(2) exemptions have not been made for some Medicare UCCs, including the ACT Medicare UCCs. In addition to grants to Medicare UCCs, program funding has also been allocated to facilitate implementation of other aspects of the program. This includes allocations to the commissioners for managing funding, monitoring and ongoing management of the relationships with Medicare UCCs.

For this Interim Evaluation Report 1, Measure of Success 9 is assessed through:

- **Unit cost per Medicare UCC presentation.** Costs assessed for this measure are the costs to the Australian Government, based on grants made to Medicare UCCs, aggregate counts of presentations at each Medicare UCC, other Medicare UCC data and MBS data.
- **Costs for avoided ED attendances.** Costs assessed for this measure are the costs to the Australian and state/territory governments, based on funding at the NEP recommended by the IHACPA, offset by the unit cost per Medicare UCC presentation.

Methods for deriving these measures are described in Appendix D.

Australian Government funding per Medicare UCCs presentation is estimated to be $216 on an annualised basis

Table 14 shows that during quarters three (January to March) and four (April to June) of 2023-24, Australian Government funding per Medicare UCC presentation was $319. In quarter one of 2024-25 (July to September), this amount decreased to $234 per presentation. The main factor influencing this reduction is the increase in presentations that occurred following the opening of each Medicare UCC. As described elsewhere in this report, Medicare UCCs generally took up to four months to achieve a stable level of activity (see discussion in Appendix D). The impact of longer term factors influencing demand, such as population growth and improved community awareness, are not yet evident. If all Medicare UCCs were operating at their stable activity levels post-opening (referred to as the "annualised" estimate), the funding would be $246.50 per presentation, excluding the five ACT Medicare UCCs, where MBS claims cannot be made, and the seven Medicare UCCs in which Module data, including MBS items, is not yet reported. The annualised Australian Government's funding across all Medicare UCCs is $216 per presentation. This value also varies across different subsets of Medicare UCC presentations. For example, for the 63 Medicare UCCs, the value is $248 per presentation where it is reported the patient would have attended an ED or called an ambulance if the Medicare UCC was not available.

Table 14 | Estimates of government funding support per presentation for Medicare UCCs

Period analysed/Medicare UCC group	Clinics	Presentations	Australian Government funding per presentation $		
			Grants	Estimated MBS	Total
2023-24 quarters three and four					
Medicare UCCs where Module and MBS was reported	53	330,402	289.7	83.4	373.1
ACT Medicare UCCs	5	63,903	40.2	0.0	40.2
Total	58	394,305	249.2	69.9	319.1

Period analysed/Medicare UCC group	Clinics	Presentations	Australian Government funding per presentation $		
			Grants	Estimated MBS	Total
2024-25 quarter one					
Medicare UCCs where Module and MBS was reported	63	193,365	176.5	84.2	260.7
ACT Medicare UCCs	5	32,763	28.6	0.0	28.6
Remote NT Medicare UCCs where Module and MBS was not reported	3	2,175	292.6	0.0	292.6
Other Medicare UCCs where Module and MBS was not reported	4	4,175	464.3	84.2	548.5
Total	75	232,478	161.9	71.6	233.5
Annualised estimate					
Medicare UCCs where Module and MBS was reported	63	833,259	163.8	82.7	246.5
ACT Medicare UCCs	5	128,796	29.1	0.0	29.1
Remote NT Medicare UCCs where Module and MBS was not reported	3	13,567	187.6	0.0	187.6
Other Medicare UCCs where Module and MBS was not reported	4	68,081	113.9	82.7	196.6
Total	**75**	**1,043,703**	**144.3**	**71.4**	**215.7**

Notes: The methods for these analyses are described in Appendix D. The mean value of MBS benefits is estimated based on data reported in the Medicare UCC Module. Pathology and diagnostic imaging provided on the same day and billed under a provider number that was not a Medicare UCC was also estimated ($16.76 per presentation, sourced from MBS data). MBS benefits are not claimed for ACT Medicare UCCs and were not reported for seven other clinics (as the Medicare UCC Module data was yet to be fully implemented). For these seven clinics, MBS payments per presentation were based on the mean for other Medicare UCCs that reported MBS data. The estimate of MBS benefits per presentation shown in this table are based on the Module data and are close to the estimate derived directly from analysis of MBS data for Medicare UCC provider numbers. Some minor adjustments were made to the Module data to take account of situations where an MBS item was reported but was unlikely to have been claimed. Reported MBS items and benefits were set to zero for presentations where the episode end status was "Did not wait" and where it was reported the patients did not have a Medicare Card. Where more than one consultation item was reported in the Module data (that is, consultations Levels A – D), the item with the highest benefit level was included in the analysis and other consultations items set to zero. Additional variation arises from estimating the value of MBS benefits where this was missing in the Module data. The mean from available data for each Medicare UCC was applied to presentations in which MBS data was not available, for example, where aggregate counts of activity only were available. An additional point is that the annualised estimate for MBS is slightly lower than the estimate for quarter one of 2024-25. This arises from a different mix in activity at the Medicare UCCs level from quarter one of 2024-25.

The Australian Government's funding for Medicare UCCs consists of grants and MBS payments, with grants making up the largest share. For example, under the annualised estimate, $144 per presentation comes from grants, while the remaining $71 represents the estimated MBS costs for items billed by the clinic ($54 per presentation on average), and pathology and imaging services billed by providers outside of the Medicare UCCs ($16.76 per presentation on average). Pathology and imaging billing is averaged across all patients, as not every patient undergoes diagnostic testing. About 99,000 Medicare UCC

presentations (19.4 per cent) had an additional pathology or diagnostic imaging item claimed on the same day as the Medicare UCC presentations under a provider number that was not associated with a Medicare UCC.

Grants to Medicare UCCs started in 2022-23 and will continue through to 2025-26. They are for operational expenses, equipment and capital. There is considerable variation in the level of Australian Government funding per presentation. This is driven by:

- The level of activity at each Medicare UCC. Medicare UCCs with lower levels of activity have higher levels of grant funding per presentation.
- Medicare UCC location. From 2024-25 selected Medicare UCCs operating in regional, rural and remote regions received additional funding – an MMM adjustment – that recognises higher costs for workforce and extended opening hours in these regions. Location also impacts the level of demand for Medicare UCCs, with those located in rural and remote locations generally having lower levels of activity.
- Medicare UCCs that transitioned from a previous arrangement did not receive equipment or capital grants. This recognised that required infrastructure to operate as a Medicare UCC was generally in place for these services.
- Access to MBS. For example, the ACT Medicare UCCs do not claim MBS, as the services receive additional state funding contributions through the National Health Reform Agreement.

The figures above do not include grants or other financial contributions made by state and territory governments. Details of these were not available at the time this report was prepared but will be sought for future reports.

Savings for governments associated with avoided ED visits are estimated to be $368 per presentation made up of reduced ED funding which is offset by the cost of the associated Medicare UCC attendances; this is an interim estimate only

This Interim Evaluation Report 1 estimates the savings to government from Medicare UCC attendances that substitute for ED visits. These are those Medicare UCC presentations for whom it was reported they would have attended an ED if the Medicare UCC was not available. The issues in using this variable from the Medicare UCC Module data have been discussed under Measure of Success 6 (section 5.6). As described in Appendix D, presentations have been excluded from this analysis where the patient did not wait or was subsequently referred to an ED. It is acknowledged that there are issues in relying solely on this variable to estimate the level of ED avoidance. Other methods to triangulate this estimate will be applied in further evaluation reports (see discussion under Measure of Success 6, section 5.6).

During quarters three (January to March) and four (April to June) of 2023-24, it was estimated that approximately 135,000 ED visits were avoided due to the availability of the 53 Medicare UCCs that opened before 31 December 2023 and where Module data was available. During the first quarter of 2024-25, it was estimated a further 74,000 ED visits were avoided, for 63 clinics that opened before 30 September 2024 and where Module data was available. On an annual basis, the number of avoided ED visits is estimated to be 334,000 per year for the 63 clinics. With the average cost of an avoided ED visit estimated at $616.

These estimates exclude the five ACT Medicare UCCs and seven Medicare UCCs where Module data including associated MBS items was not available.

Table 15 | Estimates of savings for government per presentation arising from ED presentations avoided

Period	Medicare UCC presentations (a)	ED presentations avoided	
		Number	Commonwealth and state/territory funding per presentation
2023-24 quarters three and four (53 clinics) (b)	135,484	135,484	$578
2024-25 quarter one (63 clinics) (c)	73,755	73,755	$618
Annual estimate (63 clinics) (c) (d)	334,133	334,133	$616

Notes: (a) Includes presentations where it is reported that the patient would have attended an ED or called an ambulance if the Medicare UCC were not available. Within this selection, presentations were excluded where the episode end status is reported as "Did not wait" or "Referred to local ED". An ED presentation is potentially avoided where it is reported the patient would have "Called ambulance" or attended a "Local ED". It is less likely an ED presentation is avoided where the episode end status for these patients is "Did not wait" or "Referred to local ED". (b) Based on 53 Medicare UCCs reporting Module data that include associated MBS items. Excludes the five ACT Medicare UCCs. (c) Based on 63 Medicare UCCs reporting Module data that include associated MBS items. Excludes the five ACT Medicare UCCs and seven Medicare UCCs where Module data, including associated MBS items, was not reported. (d) The Annual estimate is derived for each Medicare UCC through the approach described in Appendix D.

The average estimated price per avoided ED visit ($616) is based on the national pricing model for ED presentations. The steps used to calculate are described in Appendix D. In summary these involved:

1. Reasons for visit recorded by the Medicare UCCs for each presentation were coded using the International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM), Twelfth Edition. Examples of reasons for visit were *abdo pain*, *right pressure sore*, *tietze's disease*, *acute viral urti* and *left ulnar collateral ligament injury (provisional)*. Some presentations did not have a reason for visit recorded and some had multiple reasons. Where multiple reasons were reported, a main reason for visit was selected following a review of the records.
2. The ICD-10-AM codes were mapped to the IHACPA's ED ICD-10-AM Principal Diagnosis Short List (ED Short List) code set. This code set is used to assign AECC classes to presentations, which are in turn used for pricing.
3. In addition to ED Short List codes, the AECC uses arrival by ambulance, age group, triage category and departure status to assign individual presentations to classes. Triage category is not available for Medicare UCC patients. However, the AECC does not differentiate between triage categories four and five, therefore, all presentations were set to triage category five. Departure status was set to "Discharged home" for all patients.
4. Each AECC class has a National Weighted Activity Unit (NWAU) assigned, representing the relative value of the class to the NEP.[101,102] In addition, adjustments to the NWAUs were applied as per the NEP Determination, specifically, a 4 per cent uplift for Aboriginal and/or Torres Strait Islander patients and a 30 per cent uplift for patients living in remote areas. The NEP 2023-24 was $6,032 per NWAU for 2023-24 and $6,465 per NWAU for 2024-25.

[101] Independent Health and Aged Care Pricing Authority (IHACPA), 2023. *National Efficient Price Determination 2023–24. For Australian public hospital services*. Appendix L – Price weights for emergency department patients – AECC V1.0.
[102] Independent Health and Aged Care Pricing Authority (IHACPA), 2024. *National Efficient Price Determination 2024–25. For Australian public hospital services*. Appendix L – Price weights for emergency department patients – AECC V1.0.

5. Medicare UCC presentations missing an AECC class (for example, due to no reason for visit reported or recording of an ICD-10-AM code that is ineligible for ED funding were assigned the NWAU for "Other factors influencing health status Complexity level B" (0.0805 NWAU).

Therefore, $616 per presentation represents an estimate of the cost governments would have incurred under the national pricing model if Medicare UCC patients, for whom it was reported they would have gone to an ED in the absence of a Medicare UCC, had instead been treated in an ED.

To estimate the net cost to government of ED avoidance, the estimated cost of associated Medicare UCC presentations needs to be deducted. Using the annualised estimates, the estimated cost per presentation for this subset of Medicare UCCs presentations related to avoided ED presentations was $248. This is slightly higher than the estimate of $246.50 for all presentations to Medicare UCCs. These calculations yield estimated net savings of around $368 per ED presentation avoided.

Considerable caution needs to be applied in using this estimate. The estimate of avoided ED presentations is based on Medicare UCC Module data item "where would the patient have gone otherwise?", which needs to be interpreted cautiously as discussed previously (see page 66). Additionally, the analysis will be extended to include an assessment of the cost impact for presentations in which it is indicated the patient would have taken actions other than attending an ED or calling an ambulance. Additional issues are:

- There is considerable variation between Medicare UCCs in the average cost per presentation. Variation in average costs is impacted by several factors including the location and scale of Medicare UCCs. Future evaluation reports will further unpack these key cost drivers.
- For many Medicare UCCs, estimates have been based on part of the financial year, including an initial period in which the UCCs were not operating at their full capacity. Future evaluation reports will have access to data across a full year of operation for Medicare UCCs.
- Estimates of the cost to government of avoided ED presentations reflect funding of EDs using the NEP recommended by the IHACPA. From the perspective of EDs, reductions in costs associated with avoided ED presentations in the short term are likely to be lower than this, due to relatively high fixed costs associated with providing ED services.
- The analysis does not include the net cost per Medicare UCC presentation in which the patient would have taken an action other than attend an ED or call an ambulance.

INTERIM FINDING

The annualised Australian Government funding support for Medicare UCCs is estimated to be $246.50 per presentation, excluding the five ACT Medicare UCCs, where MBS claims cannot be made, and the seven Medicare UCCs in which Module data, including MBS items, was not yet reported at the time of undertaking the analysis. Across all Medicare UCCs, the annualised Australian Government's funding is $216 per presentation. These preliminary results do not include contributions to the operation of Medicare UCCs by state and territory governments.

Based on reports of where patients attending a Medicare UCC would have sought care if the clinic was not available, it is estimated that around 334,000 ED presentations would be avoided annually if all Medicare UCCs were operating at their stable activity levels post-opening. This estimate is based on the 63 clinics in which there is sufficient information available. It excludes the five ACT Medicare UCCs, where MBS claims cannot be made, and the seven Medicare UCCs in which Module data, including MBS items, was not yet reported at the time of undertaking the analysis. As discussed under Measure of Success 6, this is an interim estimate which relies on the accuracy of the reporting against the Medicare UCC Module question "where would the patient have gone otherwise?" This may under or over-estimate the level of ED attendances avoided due to the data limitations described previously.

The average funding that would be paid by the Australian Government and state and territory governments for these avoided ED attendances is estimated by the evaluation team to be $616 per presentation. This estimate is based on analysis of the reasons for attending the Medicare UCC and applying the classification and prices currently applied for ED funding. The estimate reflects

government funding (Commonwealth, state and territory) based on the NEP recommended by IHACPA. However, the marginal cost reductions for EDs are likely to be lower due to relatively high fixed costs associated with providing ED services. These savings are offset by the cost of the subset of Medicare UCC attendances related to avoided ED presentations, estimated to be $248 per presentation – which is slightly higher than the average for all Medicare UCC attendances. This yields a net saving to governments of around $368 per presentation.

These results will be revisited and refined through additional analyses in subsequent phases of the evaluation, including inclusion of data for all jurisdictions, costs associated with presentations to a Medicare UCC where the patient would have taken an alternative action other than attending an ED, time savings for patients accessing urgent care through a Medicare UCC compared to an ED and costs incurred by patients (for example, travel expenses) to access a Medicare UCC, ED or alternative. The analyses will also examine the sensitivity of the results to various assumptions and inputs, including estimates of the level of ED presentations avoided.

Next steps

This analysis will be revisited in subsequent phases of the evaluation and expanded to include:

- Medicare UCCs where data was not available to undertake the analyses presented in this report, including the ACT Medicare UCCs, and seven other Medicare UCCs in which Module data, including MBS items, is not yet reported.
- State and territory contributions to the operation of Medicare UCCs.
- Costs associated with presentations to a Medicare UCC where the patient would have taken an alternative action to attending the Medicare UCC.
- Time savings for patients accessing urgent care through a Medicare UCC compared with EDs, as well as the monetary value of these time savings.
- Costs incurred by patients and their families or carers, such as travel expenses to access a Medicare UCC or an ED.

The analyses will also examine the sensitivity of the results to various assumptions and inputs, including the estimates of:

- costs of the Medicare UCC presentations
- the level of ED presentations avoided, which will be supplemented with the results of the DiD analysis
- costs of ED presentations avoided
- costs of other pathways that a patient may have followed
- impact of assumptions around missing data.

6 Improvement opportunities

A range of program and data improvement opportunities were identified throughout this Interim Evaluation Report 1. These are summarised in Table 16, together with context from the associated Measure of Success.

Table 16 | Summary of program improvement opportunities and relevant context

Improvement opportunity	Context
Program improvement opportunities	
1. The proportion of patients who receive a handover directly back to their usual GP/practice should be increased. Commissioners and Medicare UCCs should consider working together to achieve this, informed by learnings from other clinics.	Interim evaluation against Measure of Success 3 identified that 68 per cent of patients receive a handover directly back to their usual GP/practice. Electronic provision of the discharge summary direct to the practice is GPs' preferred method of receiving a clinical handover.
2. A consistent, standardised mechanism for collecting patient experience feedback (patient reported experience measures – PREMs) across Medicare UCCs should be established at a national level.	Interim evaluation against Measure of Success 4 indicated that while Medicare UCCs are generally collecting patient feedback, the methods used vary widely, limiting the insights able to be drawn across clinics.
3. A consistent approach to collecting data on when patients are being turned away because the Medicare UCC is unable to meet demand, should be established at a national level.	Interim evaluation against Measure of Success 4 identified instances where Medicare UCCs have been at capacity before closing time and have had to turn patients away. Commissioners are collecting data on this issue in a variety of ways and consistent national reporting would facilitate greater understanding of this issue and clarify the need for a more systemic response.
4. There is opportunity for clinics to enhance their communications to the community about local Medicare UCC service offerings, for example, opening hours of affiliated diagnostic imaging services, and the distinction between fee structures at the Medicare UCC and co-located services.	Interim evaluation against Measure of Success 4 identified that national and local communications are in place but confusion about local Medicare UCC service offerings has resulted in some instances of poorer patient experience.
5. Upgrades to physical infrastructure (such as security lighting, parking and wheelchair access) to support accessibility could be considered at some clinics, to ensure adherence to accessibility requirements outlined in the Medicare UCC Operational Guidance.	Interim evaluation against Measure of Success 4 identified concerns with physical infrastructure at some clinics, suggesting potential non-adherence to accessibility requirements outlined in the Medicare UCC Operational Guidance.
6. There is opportunity for more widespread exploration and uptake of flexible workforce models by Medicare UCCs (informed by learnings from existing workforce trials) to meet demand whilst adhering to minimum program requirements.	Interim evaluation against Measure of Success 5 indicated that recruitment of GPs to achieve minimum workforce requirements and meet demand has been challenging, particularly in regional and rural areas. Some Medicare UCCs have adopted or are currently exploring flexible workforce models to meet local demand whilst adhering to workforce requirements outlined in the Medicare UCC Operational Guidance.

Improvement opportunity	Context
7. More Medicare UCCs could consider developing pathways with local hospital services for Medicare UCC patients to bypass ED if diagnostic imaging is required after-hours, using learnings from Medicare UCCs that already have these pathways in place.	Interim evaluation against Measure of Success 5 indicated that some Medicare UCCs have arrangements for local health services to provide access to diagnostic imaging services when the Medicare UCC affiliated imaging services are closed. Outside of these arrangements, patients are being referred to ED or advised to return during business hours where appropriate.
8. There is ongoing need for continued clear communications both nationally and locally about what urgent care is and to assist with service navigation.	Interim evaluation against Measure of Success 7 indicated that comprehensive national and local communications campaigns are in place, but stakeholders reported that understanding what urgent care is and navigating the variety of local service options continues to be a challenge for consumers.
9. Ongoing work is required by Medicare UCCs and commissioners to strengthen awareness, relationships and trust of key local stakeholders (including local ED and ambulance staff) in Medicare UCC services.	Interim evaluation against Measure of Success 8 indicated that while relationships were being built with EDs and ambulance services, operationalising these partnerships consistently across various settings remained a challenge.
10. Addressing barriers to effective referral pathways will increase efficiency and effectiveness of care. This requires continuous engagement, education and efforts to ensure that all staff members understand and follow agreed-upon pathways.	Interim evaluation against Measure of Success 8 indicated that Medicare UCCs had experienced barriers when referring to other services, for example, a reluctance of some hospital fracture clinics to accept referrals from outside the hospital.
Data improvement opportunities	
11. There are opportunities to improve the quality of data reported through the Medicare UCC Module, through the following steps: • Explore with Medicare UCCs and clinicians the data items within the Module data that are the most challenging to capture, seeking their views on improvements that could be made. • Review and refine definitions of key data items and add guidance for interpreting areas identified as problematic within the Medicare UCC data dictionary. This would be particularly useful on "Reason for visit" and "Where patient would have gone otherwise". • Develop a short list of "Reasons for visit" that could be implemented in the Module data. A starting point for this could be the ED ICD-10-AM Diagnosis Short List, but this will need to be modified to be more suitable for urgent care settings. This could be provided as a pick list for clinicians to select the appropriate reason(s) for visit. • Associated with the short list, implement an approach to flag reasons for visit that relate to a prior condition or medical events that may be relevant to the current	Section 3.4 outlines a range of data limitations identified through this Interim Evaluation Report 1. The Department is working with commissioners to uplift the quality of data captured, for example, through development of the data manual and support with onboarding clinics to the Medicare UCC Module.

Improvement opportunity	Context
presentation, but are not the reason for the current presentation. • Identify Medicare UCCs with low reporting of Indigenous status, country of birth, language spoken at home and interpreter use and request that commissioners troubleshoot with these Medicare UCCs the reasons for low reporting and identify steps to improve reporting.	
12. For more accurate monitoring and reporting of waiting times, triage time should be split out from clinical commencement time in the Medicare UCC Module data. This will also allow a more accurate comparison with ED waiting times.	Interim evaluation against Measure of Success 1 identified that differences in how waiting times are recorded in each setting affect the ability to calculate directly comparable times.
13. There is an opportunity to improve the accuracy of reporting and provide clearer insights into utilisation of Medicare UCCs by priority populations. Refining the response options for 'country of birth' and enhancing consistency of reporting processes for 'language spoken at home' and 'disability status' by Medicare UCCs will assist with this.	Interim evaluation against Measure of Success 2 identified that whilst there is reasonable reporting on Indigenous status, data on utilisation of Medicare UCCs by other priority populations is limited, due to poor data quality and consistency of variables relating to CALD communities and people with a disability (see section 3.4).
14. In the Medicare UCC Module data, consider refining the definition of the 'other' response option for the question, "How was a clinical handover provided to the patient's usual GP?". Alternatively, consider introducing additional categories to more precisely capture alternative handover methods. This will improve the quality of reporting and provide clearer insights into the channels of clinical handovers.	Interim evaluation against Measure of Success 3 identified that 11 per cent of clinical handovers are reported to be provided by 'other' means. This category is open to varied interpretation and may include referrals back to the same clinic during hours when the clinic is not operating as a Medicare UCC.

Appendix A Logic model

Figure 28 | Medicare UCC logic model

SITUATION

Community members requiring urgent non-life-threatening health care are attending or being referred to EDs due to lack of comparably accessible, affordable and trusted service alternatives. This results in increased pressure on EDs, increased wait times for patients and inefficient urgent care provision.

OBJECTIVE

Create an effective alternative to ED for people requiring urgent non-life-threatening care, to reduce pressure on hospitals.

INPUTS

The Department
- Medicare UCC Program funding ($759.9 million as at July 2024)
- MBS funding
- Medicare UCC Program oversight, guidance and management
- Medicare UCC locations

Knowledge and expertise (the Department)
- Relevant policies, strategies and standards
- Clinical advice, research and evidence
- Data
- Program evaluation insights

Medicare UCC Commissioners
- Commissioning of services
- Medicare UCC contracts
- Referral pathways and relationships with local health services

Medicare UCCs
- Healthcare professionals
- Physical infrastructure – facilities and equipment
- Technological infrastructure
- Referral pathways and relationships with local health services
- Development of local models and research
- Policies, procedures and clinical standards

ACTIVITIES

Establishment

The Department
- High-level policy decisions by Minister for Health and Aged Care and the Department
- National communication
- Program design and requirements

Medicare UCC Commissioners
- Undertake needs assessments, site identification and commissioning of Medicare UCCs

Medicare UCCs
- Educate community and providers on Medicare UCC role
- Establish relationships with acute and primary care
- Train clinical and support staff to work in Medicare UCCs
- Establish quality standards and patient care protocols

Operations

The Department
- National communication
- Policies
- Evaluation
- Governance

Medicare UCC Commissioners
- Integrate UCCs within Local Health System
- Local communication
- Support Medicare UCC operational activities

Medicare UCCs
- Assess and triage urgency of patient condition
- Administer diagnostic tests and timely treatment
- Access and share medical summaries with care partners
- Facilitate patient referrals to other services where required
- Coordinate follow up by primary care provider
- Share de-identified data with the Department for monitoring and evaluation

Monitoring, assurance and compliance

The Department and Medicare UCC Commissioners
- Carry out operational, contractual and legislative assurance activities
- Data collection, analysis and monitoring

OUTPUTS

- Community, including all priority populations, are aware and informed about local Medicare UCCs
- Medicare UCCs establish triage systems
- Medicare UCCs are established in appropriate locations and are accessible
- Staff available to provide services
- Medicare UCCs have systems in place to improve clinical quality and safety
- Medicare UCC staff undertake necessary training to ensure all competencies are met during hours of operation
- Data collection embedded and established to support evaluation and ongoing monitoring
- Comprehensive planning undertaken to embed Medicare UCCs in local health service landscape, including establishment of referral pathways and follow up care

OUTCOMES

Short term
- Appropriate patient throughput and utilisation of Medicare UCCs (MOS 7)
- Patients receiving treatment for non-life-threatening conditions in Medicare UCCs (MOS 1)
- Medicare UCCs provide a positive experience for patient/carer (MOS 4)
- Medicare UCCs provided safe and quality treatment to patients (MOS 2)
- Medicare UCCs present an attractive employment option for GPs, nurses and other clinicians (MOS 5)
- Established referral pathways between Medicare UCCs, partner EDs and other local providers (MOS 3 and 8)
- Improved connection of patients with chronic conditions to a GP where they do not have a regular GP (MOS 3)

Medium term
- Change in consumer behaviour over time to use Medicare UCCs instead of EDs for urgent non-life-threatening conditions (MOS 7)
- Medicare UCCs provide positive experience for providers at Medicare UCCs, partner hospital EDs and local GP practices (MOS 5)
- Medicare UCCs deliver coordinated care for Medicare UCC patients (MOS 3)

Long term
- Medicare UCCs reduce pressure on hospital ED categories four and five presentations at partner hospitals (MOS 6)
- Improved health outcomes for patients receiving care and treatment at Medicare UCCs (MOS 2)
- Medicare UCCs are cost-effective (MOS 9)
- Medicare UCCs, PHNS, healthdirect, jurisdictions and the health ecosystem have established an effective coordinated care option for people with urgent non-life-threatening conditions (MOS 8)

ASSUMPTIONS

- Sector and community will be supportive and utilise Medicare UCCs
- Medicare UCC program will be implemented with feedback from monitoring that will be used for continuous improvement, which may result in changes to activities
- Unique features will be determined by local conditions and some Medicare UCCs may test innovative approaches
- Assumptions utilised to inform the funding model were accurate at that point in time to deliver intended outcomes

EXTERNAL FACTORS

- Local demographics and socio-economic characteristics
- Interoperability between health providers for coordinated care
- Public transport infrastructure
- Local workforce availability
- Telecommunications infrastructure
- Environmental factors, for example, natural disasters

Appendix B Medicare UCC data sources and analysis methodology

B.1 Data sources

There are three primary sources of data on Medicare UCC activity, as outlined in Table 17. To provide overall counts of presentations across all data sources, these were summarised and consolidated into a single dataset, which includes aggregated counts of presentations by Medicare UCC and date. This aggregation enables the analysis of presentation trends over time. Additionally, we describe a method used to estimate the annual number of presentations for each Medicare UCC. The presentation counts can also be analysed according to specific characteristics of each Medicare UCC.

Table 17 | Medicare UCC activity data sources

Type of data	Activity data source	Description
Unit record for each presentation to the Medicare UCC	Medicare UCC Module	These are patient level data extracts from a Medicare UCC Module that interfaces with the primary care service practice management system. The Module allows for deidentified data with a range of Medicare UCC-specific data elements to be securely extracted and transferred to the Department. The Module and extraction process is managed by PenCS. The extraction process excluded patients who have declined to allow de-identified data to be extracted from the practice management system.
	Interim practice data extract	This was used before the implementation of the Medicare UCC Module. These extracts allowed for the provision of deidentified data on patients attending Medicare UCCs. The extracts included a range of patient level characteristics, but not all the Medicare UCC-specific data items.
Aggregate counts of presentations by Medicare UCC by date	Aggregate counts reported directly by Medicare UCCs or derived from summary extracts from the Medicare UCC Module	This includes: (a) Aggregate counts of presentations where no patient data extract was available. (b) Aggregate counts of presentations for patients who have not consented to have de-identified data extracted from the primary care service practice management system. (c) Adjustments to address double counting of data sources.

Table 18 shows the data elements available for analysis based on the unit record data (that is, the Medicare UCC Module and the interim practice data extract). It also shows where multiple values are allowed to be recorded for a variable and individual presentation.

Table 18 | Medicare UCC unit record data and data elements

Unit of count	Data elements	Multiple values	Interim practice data extract	Medicare UCC Module
Presentations: This is the principal unit reported. A presentation is a single event in which the patient presents to the Medicare UCC and may receive treatment. It includes patients who "Did not wait" to receive treatment as well those who were seen by a clinician.	Date and time of the presentation		Yes	Yes
	Clinical care commencement time, defined as the time that the patient record is opened by a clinical staff member		Yes	Yes
	Treatment end date and time		Yes	Yes
	Reason for visit	Yes	Yes	Yes
	Condition type	Yes	No	Yes
	Cause of injury		No	Yes
	Pathology referral	Yes	Yes	Yes
	Diagnostic imaging	Yes	Yes	Yes
	Pharmacy	Yes	Yes	Yes
	Point of entry to UCC		No	Yes
	Does patient have a regular GP		No	Yes
	Clinical handover to usual GP or health care provider	Yes	No	Yes
	Episode end status		No	Yes
	Treatment end time three (episode end status completed)		No	Yes
	Other referrals provided (additional to clinical handover)	Yes	No	Yes
	Where patient would have gone otherwise		No	Yes

Unit of count	Data elements	Multiple values	Interim practice data extract	Medicare UCC Module
	Medicare card present			Not mandatory
Patient: A de-identified unique code is recorded. It allows counting of patients attending a specific Medicare UCC on multiple occasions. In general, this code will not be unique between Medicare UCCs. It may be unique for Medicare UCCs that are aligned with a single organisation.	Age at presentation		Yes	Yes
	Sex defined as the biological distinction between male and female represented by a code		Yes	Yes
	Indigenous status where the patient identifies as Aboriginal and/or Torres Strait Islander		Yes	Yes
	Post code of the current residence		Yes	Yes
	Country of birth		Yes	Yes
	Language spoken at home		No	Yes
	Was an interpreter required		No	Yes
	Disability status	Yes	No	Yes
Interactions (episode): This is a file based on an extraction from the presentations data variable that includes multiple values of all instances in which the patient record was opened by a Medicare UCC staff member.	Date/time of interaction		No	Yes
	Provider type – type of provider/role. This includes a range of provider types including clinical and non-clinical (for example, receptionist)		No	Yes

Table 19 shows a summary of presentations to Medicare UCCs and the total presentations versus those reported through the unit record data (which includes the interim practice data extract data as well as the Module data) and those coming through the Module data only.

Table 19 | Summary of presentations to Medicare UCCs and source of data, 30 June 2023 to 30 September 2024

	Number of Medicare UCCs	Presentations		
		Total (a)	Unit record data: interim data extract + Module data (b)	Module data (c)
Initial 58 clinics operational prior to 31 December 2023				
Excluding ACT clinics	53	632,719	509,344	409,952
ACT Medicare UCCs	5	122,364	0	0
Total, initial 58 clinics operational prior to 31 December 2024	58	755,083	509,344	409,952
Clinics announced in the 2024-25 Budget, operational prior to 30 September 2024				
Clinics with unit record data	10	22,638	16,527	16,527
Clinics without unit record data, excluding remote NT	4	4,175	0	0
Remote NT clinics	3	2,175	0	0
Total, clinics announced in the 2024-25 Budget, operational prior to 30 September 2024	17	28,988	16,527	16,527
All clinics				
Subtotal of clinics operational at 30 September 2024	75	784,071	525,871	426,479
Clinics announced in the 2024-25 Budget, that are not yet operational	12			
Total	**87**			

	Number of Medicare UCCs	Presentations		
		Total (a)	Unit record data: interim data extract + Module data (b)	Module data (c)

Note: The table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. (a) Total presentations include aggregate counts for clinics where unit record data was not reported. (b) Unit record data includes data from the interim practice data extract and the Medicare UCC Module data. (c) Includes data extracted using the Medicare UCC Module only.

B.2 Publicly available data

A range of external data sources are used for comparisons, designed to provide a deeper understanding of the Medicare UCCs. Three primary types of comparisons are used at this stage of the evaluation:

1. Geographic distribution.
2. Demographic characteristics.
3. Service characteristic.

The **geographic comparisons** examine the alignment between the locations of Medicare UCCs and the distribution of the Australian population across different regions. Regions are characterised by the MMM and the IRSD. MMM categorises regions by remoteness and population size, allowing for an assessment of whether the placement of clinics corresponds with population density and access needs in metropolitan, regional, rural and remote areas. By comparing the proportion of Medicare UCCs in each MMM category with the percentage of the population residing in these regions, the analysis provides insight into the equity and accessibility of healthcare services across diverse geographic areas. ABS data are used for this purpose. IRSD is used to analyse the location of Medicare UCCs relative to socioeconomic conditions.[103] This comparison provides insight into how well the program is addressing socioeconomic disparities by placing clinics in areas with greater health and resource needs.

The **demographic comparisons** focus on the characteristics of patients attending Medicare UCCs, contrasted with patients attending EDs assigned to triage category four (semi-urgent) or five (non-urgent care) using the ATS. These ATS categories are considered to align with the types of conditions that Medicare UCCs aim to treat. The basis for this comparison is the National Healthcare Agreement indicator[104] of potentially avoidable GP-type presentations to EDs, although the indicator uses other variables (such as arrival mode and whether the patient was admitted to the hospital, referred to another hospital, or died). ED data with these other variables is not currently available to the evaluation team, therefore, comparisons are with all patients in triage categories four and five. The comparisons use 2022-23 national ED data.[105]

[103] Australian Bureau of Statistics. (2021). *Socio-Economic Indexes for Areas (SEIFA)*, Australia. ABS. https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release.
[104] Australian Institute of Health and Welfare. (2023c). *National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022*. https://meteor.aihw.gov.au/content/740847
[105] Australian Institute of Health and Welfare. (2023b). *Emergency department care*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

Service comparisons include comparisons of patient presentations by day of week and time of day, and waiting times for clinical care. These comparisons also restrict ED presentations to triage categories four and five. They use 2022-23 national ED data.

Appendix C Stakeholders consulted

Table 20 | Stakeholders consulted

Organisation
NSW
Central and Eastern Sydney PHN
Coordinare (South Eastern NSW PHN)
Healthy North Coast PHN
Hunter New England and Central Coast PHN
Murray PHN
South Western Sydney PHN
Sydney North Health Network
Wentworth Healthcare (Nepean Blue Mountains PHN)
WentWest (Western Sydney PHN)
Wollongong Medicare UCC
QLD
Brisbane North PHN
Brisbane South PHN
Central QLD, Wide Bay, Sunshine Coast PHN
Darling Downs and West Moreton PHN
Gold Coast PHN
Northern QLD PHN
SA
Adelaide PHN
Country SA PHN
VIC
North West Melbourne PHN
Victorian Department of Health

Organisation
NT
Mala'la – Maningrida UCC
NT Health
TAS
Tasmanian Department of Health
WA
WAPHA
ACT
ACT Health
ACT Medicare UCCs
CHS
Other
CHF
Medicare UCC Operational Advisory Group
CHS
Tasmanian Department of Health
NSW Health
North Western Melbourne PHN
NT Health
QLD Health
RACGP
Victorian Department of Health
WA Department of Health
WentWest (Western Sydney PHN)
Wellbeing SA

Appendix D Methodology for cost effectiveness analysis

Overview of methods

Cost effectiveness analysis is an economic evaluation approach through which alternatives are compared considering the costs and outcomes, with outcomes measured across a single important dimension. For the Medicare UCC evaluation, the two main options being compared are:

1. Absence of a Medicare UCC within the local community.
2. The availability of a Medicare UCC within the local community.

Interim Evaluation Report 1 has focused on setting the foundations for conducting an economic evaluation, specifically developing estimates of the cost to the Australian Government of urgent care being delivered through Medicare UCCs and estimating the cost savings to the Australian Government where a patient would have attended an ED had the Medicare UCC not been available. The key features and scope of the analysis for Interim Evaluation Report 1 is shown in Table 21.

Interim Evaluation Report 2 and the Final Evaluation Report will have broader focus, which is also described in Table 21.

This Appendix includes details of the analysis of costs conducted for Interim Evaluation Report 1.

Table 21 | Medicare UCC evaluation: Economic evaluation components

Components	Interim Evaluation Report 1	Interim Evaluation Report 2 and Final Evaluation Report
Perspective	Government funders, with separate analysis for Commonwealth and state/territory funders.	• Government funders, with separate analysis for Commonwealth and state/territory funders. • Whole population.
Population	People requiring urgent care equivalent services.	People requiring urgent care equivalent services.
Comparator	A. Absence of a Medicare UCC within the local community.	A. Absence of a Medicare UCC within the local community.
Intervention	B. Presence of a Medicare UCC within the local community.	A. Presence of a Medicare UCC within the local community.
Evaluation period	• Data from the first 15 months of the Program. • Annualised estimates have been developed for each measure and results are presented on an annualised basis.	• Data from the first 27 months (Interim Evaluation Report 2) and 36 months (Final Evaluation Report) of the Program. • Annualised estimates will be developed for each measure and results presented on an annualised basis.
Time adjustments	• The value of capital and equipment grants have been converted to annualised values.	• The value of capital and equipment grants have been converted to annualised values, guided by the Australian Taxation Office guidance on depreciation rates.

Components	Interim Evaluation Report 1	Interim Evaluation Report 2 and Final Evaluation Report
	• Benefits and costs of the program largely occur within the same time period, so a discounting factor is not required to reflect time preferences.	• Costs will be adjusted to a single period using an agreed price index. • Benefits and costs of the program largely occur within the same time period, so a discounting factor is not required to reflect time preferences.
Cost estimates	• Commonwealth grants to Medicare UCCs. • MBS payments. • For avoided ED: Commonwealth and state/territory contributions for public hospital EDs. Exclusions: • State/territory contribution to Medicare UCCs, which are not available for Interim Evaluation Report 1. • Pharmaceutical Benefits Scheme payments. • Out-of-pocket expenses related to travelling to a Medicare UCC will be excluded.	• Broader administrative costs to government of establishing and maintaining the Medicare UCC Program. • Commonwealth grants to Medicare UCCs. • MBS payments. • State/territory contribution to Medicare UCCs are not available. • For avoided ED: Commonwealth and state/territory contributions for public hospital EDs. • Costs of alternative actions by patients that would be taken if the Medicare UCC were not available. • Out-of-pocket expenses for patients related to travelling to a Medicare UCC.
Clinical outcomes	Clinical outcomes have been assumed to be equivalent between the alternatives.	Later evaluation reports will consider whether any available evidence of differences in clinical outcomes.
Non-clinical outcomes	Non-clinical outcomes have been assumed to be equivalent between the alternatives.	Time savings for patients in accessing care, both in terms of waiting times at a Medicare UCC compared with an ED and in travel to the location of the service.
Sensitivity analysis	Nil.	• Assumptions underpinning cost estimates for Medicare UCCs. • Range of estimates of effectiveness in avoiding ED attendances. • Assumptions related to time savings for patients and travel costs.

Calculation of unit costs per presentation for Medicare UCCs

This report has focused on Australian Government funding contribution for Medicare UCCs. These have been shown below as a funding contribution per Medicare UCC presentation. The focus has been on contribution to the Medicare UCC services through grants to the Medicare UCCs and through access to the MBS. The basis for these estimates is described in the following sections. Estimates were developed for three periods:

1. **January to June 2024**: Covering the first six months after 31 December 2023 and reflecting the 58 Medicare UCCs that had opened by this date.
2. **July to September 2024**: Covering the first quarter of 2024-25 and reflecting the 75 Medicare UCCs that had opened by 30 September 2024.
3. **Annualised estimates**: Representing estimated costs if Medicare UCCs were operating at their stabilised activity levels across a full financial year. The methodology for estimating stabilised activity is outlined in a following section of this Appendix.

Australian Government grants to Medicare UCCs

Grants to Medicare UCCs have been made or are planned between 2022-23 and 2025-26. Grants were made to cover operational expenses, equipment and capital costs. Operational grants for the 75 Medicare UCCs that opened prior to 30 September 2024 totalled $2.8 million in 2022-23 (eight Medicare UCCs received operational grants in late 2022-23), $89.2 million in 2023-24 and $124.2 million in 2024-25. From 2024-25, the additional costs of some Medicare UCCs operating in rural and remote regions has been recognised through an MMM adjustment grant, which totalled $8 million in 2024-25.

Capital and equipment grants were $23.5 million and $17.3 million respectively and were not identified against a specific financial year. The equipment and capital grants were amortised across three years of the Program. Including the amortised value of the capital and equipment grants adds around $17 to the estimate of the average Australian Government funding per presentation for the annualised estimates. The capital and equipment grants were largely allocated to newly established Medicare UCCs.

Table 22 describes how grants were brought together with levels of activity to develop and estimate the average level of grants per Medicare UCC presentation. There is considerable variation in level of grants per presentation. This is driven by a range of factors which are described in the discussion of Measure of Success 9 (section 5.9).

Table 22 | Estimates of Australian Government grants per Medicare UCC presentation

Period analysed	Cost data	Activity data	Grants per Medicare UCC presentation
January to June 2024 (58 Medicare UCCs)	Grant for 2023-24 divided by two (to estimate value for six months)	Aggregate counts of presentations January to June 2024	$249
July to September 2024 (75 Medicare UCCs)	Grant for 2024-25 were divided by four (to estimate value for three months)	Aggregate counts of presentations July to September 2024	$162
Annual estimate (75 Medicare UCCs)	Grant for 2024-25	Estimated annual level of presentations (see description on page 108)	$144

MBS payments associated with presentation to Medicare UCCs

MBS related payments for presentations to Medicare UCCs were derived from two sources:

1. The Medicare UCC Module data.
2. The MBS dataset extract held by the Department.

The Medicare UCC Module data was available for 61 Medicare UCCs. Items reported were mapped to the benefit level defined in the MBS. Using the Module data, **the average MBS payment was $71.80 per presentation,** based on around 348,000 presentations (Table 23). The Module data indicates that on average, 1.5 items were claimed per Medicare UCC presentation.

Where more than one MBS item was claimed, a **primary MBS item** was identified by selecting first a consultation item (Levels A-E) (if reported), then an urgent after-hours item (if reported).

The most common combination of items was a consultation item plus a bulk billing incentive item. Table 23 summarises the MBS claims, using the primary MBS item claimed for a presentation. This is generally a consultation item, the most common of which are Level B Standard (74 per cent) and Level C Long (19 per cent).

Table 23 | MBS benefit payments by the primary item claimed: Medicare UCC Module data

Primary MBS item (grouped) (a)	Number of presentations (b)	Mean items per presentation	Mean benefit per presentation ($)
Level A Brief	5,347	1.5	$33.2
Level B Standard (6-20 minutes)	257,661	1.5	$61.2
Level C Long (20+ minutes)	67,632	1.6	$102.0
Level D Prolonged (40+ minutes)	6,509	1.7	$147.5
Level E (60+ minutes)	1,384	1.6	$221.3
Urgent after hours	4,058	1.5	$150.9
Other non-referred (c)	302	1.7	$220.3
Nurse Practitioners	4,422	1.0	$33.5
Other items (d)	712	1.2	$75.6
Total (62 clinics)	348,027	1.5	$71.8

Note: Table reflects data from 30 June 2023 to 30 September 2024 and extracted on 6 November 2024. Data was available from 62 clinics open at 30 September 2024. (a) Where more than one MBS item was claimed, the primary MBS items was identified by selecting first a consultation item (Levels A-E) (if reported), then an urgent after item (if reported) and then the item with the largest associated benefit. The most common pairing of items was a consultation item with a bulk billing incentive item. (b) Presentations where at least one MBS item was recorded. (c) "Other non-referred" includes 302 presentations made up of: A5 Prolonged attendances to which no other item applies (184 presentations), A20 GP mental health treatment (68 presentations), A21 Professional attendances at recognised EDs of private hospitals (19 presentations) and items from other MBS groups (31 presentations) (d) "Other" includes 712 claims made up of T8 Surgical operations (527 presentations), A3 Specialist attendances to which no other item applies (114 presentations), M3 Allied health services (18 presentations) and items from other MBS groups (53 presentations)

For the MBS dataset Medicare UCC presentations were identified through provider numbers that have been assigned specifically to Medicare UCC clinicians. There were 67 Medicare UCCs with 1,221 provider

numbers specified. In analysing the data, there were 268 provider numbers for which no claims could be identified and one Medicare UCC with no claims.

Using this source, it was estimated that the average MBS benefit paid was $71.00 per presentation, based on around 511,000 presentations.

The two estimates are close. The small differences will arise due to fact the Medicare UCC data reflects a subset of presentations. Using the aggregate counts for each Medicare UCC, weights were developed and applied to observations within Module data so that analyses could be conducted that reflected the total of reported activity for each Medicare UCC. This provided an opportunity to undertake a broader range of analyses related to characteristics of the patient and presentations that were not feasible were the MBS data to be used. Therefore, the analysis presented below is based on the Module data, with the one exception related to estimating the value of diagnostic services ordered by Medicare UCC clinician but provided by non-Medicare UCC services.

MBS payments associated diagnostic services ordered for Medicare UCC clinicians and delivered by non-Medicare UCC providers

Through the MBS data set, additional diagnostic services could be identified for services ordered or referred by the Medicare UCC clinicians, but not delivered by Medicare UCC clinicians. Around 99,000 presentations (19.4 per cent) had an additional pathology or diagnostic imaging item claimed on the same day as the Medicare UCC presentations under a provider number that was not associated with a Medicare UCC. When averaged across all presentations, these additional claims account for **an additional $16.76 per presentation.**

Combined grants and MBS payments

Table 14 summarises the estimates of Australian Government funding per presentation across the three periods. The results for the Medicare UCC have been broken down to show the ACT Medicare UCCs and remote NT Medicare UCCs separately. In addition, there were four other Medicare UCCs in which Module and MBS data was not reported, where estimations have been made for the MBS components of costs.

Across the periods observed, MBS payment rates increased slightly. However, the mix of Medicare UCCs also changed, which meant the average MBS payment in the annualised data is slightly lower than the value in 2023-24 quarters three and four.

Estimating the annual level of activity for Medicare UCCs

Not all Medicare UCCs have been operating for a full year. Most newly established Medicare UCCs showed a relatively rapid increase in activity once they opened. Medicare UCCs that transitioned from other urgent care services also showed an increase in activity from when they opened as a Medicare UCC. Most Medicare UCCs reached a reasonably stable level of activity within three to four months, but when this stable level of activity was achieved varied widely.

To derive estimates of the annual 'stable' level of activity, the trends in activity from the time of opening was reviewed for each individual Medicare UCC and a point in time identified at which the level of activity appeared to have become reasonably stable and close to the average weekly presentations for the remaining weeks for which data was available. Using this point in time, the mean weekly presentations were calculated across the remaining weeks. This was then multiplied by 52.25 to yield an annual estimate.

This estimate will be reviewed in future evaluation reports, which will benefit from having data on the activity of Medicare UCCs over a longer period of time.

Assigning Medicare UCC presentations to AECC classes and pricing

This section describes how Medicare UCC presentations were priced to calculate the costs of avoided ED presentations to government.

Step 1: Coding reason for visit

Medicare UCCs recorded a reason for visit for each patient presentation. While multiple reasons could be recorded per presentation, 83,197 presentations (20 per cent of all those with Medicare UCC Module unit records) had no reason recorded.

The reasons were recorded as text, resulting in 12,184 unique entries across 426,500 presentations. Many reasons represented the same diagnosis in various formats, such as: "abdo pain", "abdominal pain" and "acute abdominal pain for investigation."

The International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM), Twelfth Edition, was used to code the reasons for visit. The coding was undertaken by clinical coders credentialled in ICD-10-AM coding. It involved manual coding of each reason for visit recorded for each presentation. Of the approximately 18,000 ICD-10-AM codes available, the reasons for visit used about 2,000 unique codes.

A qualified Health Information Manager working as part of the evaluation team mapped the ICD-10-AM codes to the ED ICD-10-AM Principal Diagnosis Short List, which has approximately 1,300 codes. Medicare UCC Reasons for Visit were mapped to 853 of these codes.

Challenges in coding the reasons for visit included:

- **Ineligible ICD-10-AM codes.** About 5,000 ICD-10-AM codes are not eligible as ED principal diagnoses. Examples include external causes of injury (for example, motor vehicle accident), personal factors affecting health status (such as a history of cancer or current smoker), presentations for medical care without the reasons for the visit being specified (for example, check up – well adult) and presentations for preparation of a certificate/report (for example, for insurance, for disabled parking, pre-employment), and preparation of care plans (GP management plan, Team Care Arrangement review, GP Mental Health Plan).
  Where possible, a diagnosis was inferred. For example, external causes such as motor vehicle accident were inferred as injuries (for example, coded as *T14.9 Injury, unspecified*). Overall, 74,240 presentations (17 per cent) remained could not be assigned an eligible ED Short List code.
- **Procedures instead of diagnoses.** Many reasons for visit were procedures that were unlikely to have been undertaken at the Medicare UCC. For example, appendicectomy, angioplasty and total abdominal hysterectomy. These were coded to *Z09.9 Follow-up examination after unspecified treatment for other conditions*. For other procedures that were likely to have been undertaken at the Medicare UCC, a diagnosis was inferred. For example, *syringe ear* and variations were coded as *H61.2 Impacted cerumen*.
- **Multiple diagnoses within a single field.** When multiple diagnoses were recorded within a single field (for example, "*UTI, abdo pain*"), the most definitive diagnosis was coded.
- **Diagnoses that may have been part of a patient's history.** Many presentations also had reasons for visit where it was not possible to tell whether the diagnosis was current, or part of the patient's history. This included diagnoses such as acute myocardial infarction (AMI), stroke, various forms of cancer, chronic kidney failure/disease and dementia. Where there was a string of these for a single presentation (for example, stroke, diabetes, cancer), it is likely that it was the patient's history that was being recorded using this field rather than the reason for visit. However, where only one diagnosis was recorded for a presentation, it was not possible to tell whether it was a current diagnosis or part of the patient's history. On examining the Episode End Status, patients with these acute diagnoses were only sometimes referred to a hospital ED or ward, indicating that they were unlikely to be presenting for a current stroke or AMI to the Medicare UCC. Nevertheless, they were coded as represented. These have implications for pricing the Medicare UCC presentations, described below.

Step 2: Grouping presentations to AECC classes

Members of the evaluation team with extensive experience in activity-based funding and classification systems grouped the presentations into AECC classes. The following variables are required to group presentations to AECC classes:

- ED Short List code

- arrival by ambulance
- age group
- triage category
- departure status.

Triage category was not available from the Medicare UCC Module. However, the AECC does not differentiate between triage categories four and five, therefore, all presentations were set to triage category five. Departure status was set to "Discharged home" for all Medicare UCC patients.

Where multiple reasons for visit were recorded, the code leading to the lowest NWAU AECC class was selected (see next step). This was because in most of these instances, the string of diagnoses appeared to be part of the patient's history rather than the reason for visit to the Medicare UCC (for example, stroke plus diabetes plus cancer reported together and alongside other diagnoses).

Step 3: Assigning NWAUs and pricing

NWAUs were assigned for each AECC class using IHACPA's *National Efficient Price Determination*.[106,107] As per the NEP policy, the NWAU for by AECC class was adjusted for the following factors:

- 4 per cent uplift for Aboriginal and/or Torres Strait Islander patients.
- 30 per cent uplift for patients from remote areas.

Records missing valid AECC groupings were assigned the NWAU for "Other factors influencing health status Complexity level B" (0.0805 NWAU).

NWAUs were multiplied by the NEP to derive the price per presentations.

Limitations

The price implied by the AECC NWAU may be higher or lower than calculated due to the following reasons:

- Despite the steps taken to reduce the influence of diagnoses that may have been part of a patient's history rather than the reason for visit to the Medicare UCC, in many instances it was not possible to differentiate between a historical and current diagnosis. There remained records in the dataset where patients with a reason for visit of stroke or AMI were discharged home and not referred to an ED, which are unlikely. In these cases, the NWAU may have been higher than what would have been estimated for the actual reason for visit.
- Presentations with Ineligible ED Short List codes (such as "preparation of care plans" or "certificate preparation") were assigned to an AECC class with a relatively high NWAU (0.0805), also possibly inflating the price.
- Where diagnoses were inferred (for example, external causes coded as injuries or a diagnosis inferred from a procedure), they may have overestimated or underestimated the NWAUs.

[106] Independent Health and Aged Care Pricing Authority (IHACPA), 2023. *National Efficient Price Determination 2023-24. For Australian public hospital services*. Appendix L – Price weights for emergency department patients – AECC V1.0.
[107] Independent Health and Aged Care Pricing Authority (IHACPA), 2024. *National Efficient Price Determination 2024-25. For Australian public hospital services*. Appendix L – Price weights for emergency department patients – AECC V1.0.

Appendix E ED measures for partner and other public hospitals 2020-21 to 2023-24

Publicly available data was sourced from the AIHW[108] on ED presentations and the percentage of patients seen on time[109] by hospital for 2020-21 to 2023-24. Hospitals were categorised into whether they were a partner hospital for a Medicare UCC, and if so, whether the Medicare UCC was newly established or transitioned from another program, as well as whether the Medicare UCC was established prior to 31 December 2023 or between July and September 2024. This allowed comparisons to be made between subgroups of hospitals, as shown in the following tables.

Table 24 | Mean number of presentations per ED by triage category: Partner and other hospitals by whether the Medicare UCC was newly established and commencement timeframe, 2020-21 to 2023-24

Triage category	Hospitals (n)	Presentations (n) year ended 30 June				Annual change year ended 30 June		
		2021	2022	2023	2024	2022	2023	2024
Partner hospitals for newly established Medicare UCCs: commenced prior to 31 December 2023								
Triage 4	43	23,064	21,692	20,391	19,920	-5.9%	-6.0%	-2.3%
Triage 5	43	4,928	4,207	3,102	2,999	-14.6%	-26.3%	-3.3%
Partner hospitals for Medicare UCC transitioned from prior arrangements: commenced prior to 31 December 2023								
Triage 4	12	22,596	21,824	20,891	21,042	-3.4%	-4.3%	0.7%
Triage 5	12	4,422	4,152	3,763	3,452	-6.1%	-9.4%	-8.3%
Partner hospitals for newly established Medicare UCCs: commenced July to September 2024								
Triage 4	2	12,534	13,504	15,312	14,407	7.7%	13.4%	-5.9%
Triage 5	2	3,574	4,825	4,554	3,644	35.0%	-5.6%	-20.0%
Partner hospitals for Medicare UCC transitioned from prior arrangements: commenced July to September 2024								
Triage 4	11	19,091	18,961	18,712	17,915	-0.7%	-1.3%	-4.3%
Triage 5	11	2,815	3,391	2,834	2,890	20.4%	-16.4%	2.0%
Comparison: other hospitals								
Triage 4	120	13,164	12,778	12,732	12,766	-2.9%	-0.4%	0.3%
Triage 5	120	4,080	3,637	2,423	2,449	-10.9%	-33.4%	1.1%

[108] Australian Institute of Health and Welfare. (2023-24). *Emergency department care 2023-24 data tables*. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care%23more-data

[109] Seen on time is defined as clinical treatment commenced within 60 minutes for triage category four and 120 minutes for triage category five.

Table 25 | Percentage of patients seen on time by triage category: Partner and other hospitals by whether the Medicare UCC was newly established and commencement timeframe, 2020-21 to 2023-24

Triage category	Hospitals (n)	Seen on time year ended 30 June				Annual change year ended 30 June		
		2021	2022	2023	2024	2022	2023	2024
Partner hospitals for newly established Medicare UCCs: commenced prior to 31 December 2023								
Triage 4	43	67%	61%	58%	60%	-8.7%	-3.9%	1.8%
Triage 5	43	90%	86%	81%	82%	-4.3%	-5.9%	0.4%
Partner hospitals for Medicare UCC transitioned from prior arrangements: commenced prior to 31 December 2023								
Triage 4	12	61%	59%	60%	66%	-4.1%	2.6%	9.4%
Triage 5	12	83%	82%	82%	86%	-1.4%	-0.1%	4.7%
Partner hospitals for newly established Medicare UCCs: commenced July to September 2024								
Triage 4	2	83%	83%	78%	83%	0.7%	-6.2%	6.1%
Triage 5	2	95%	96%	91%	93%	0.8%	-5.0%	2.0%
Partner hospitals for Medicare UCC transitioned from prior arrangements: commenced July to September 2024								
Triage 4	11	77%	73%	74%	79%	-5.5%	1.3%	7.3%
Triage 5	11	93%	91%	90%	92%	-1.8%	-1.4%	1.9%
Comparison: other hospitals								
Triage 4	115	77%	75%	72%	73%	-2.6%	-3.4%	1.8%
Triage 5	115	95%	94%	90%	90%	-1.0%	-4.4%	0.8%

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