



Australian Government

Department of Health, Disability and Ageing

Ongoing Funding for the Medicare Urgent Care Clinics Program - 2025 Impact Analysis

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Contents

About this Impact Analysis	1
Executive Summary	1
Medicare Urgent Care Clinics (Medicare UCCs)	1
The policy problem	1
The policy response	2
Selecting the preferred policy option	2
Background.....	4
Medicare Urgent Care Clinics.....	4
1. What is the policy problem you are trying to solve and what data is available?	5
1.1 Underlying causes of the problem.....	6
Affordable access to healthcare.....	6
Primary care access.....	7
System integration and patient information.....	7
Patient flows.....	8
1.2 Who is affected and how?	8
Patients.....	8
Staff at EDs.....	8
Governments.....	9
1.3 What is currently being done?.....	10
Existing urgent care models.....	10
Emergency department diversion programs.....	11
Bulk Billing reforms.....	12
1800MEDICARE	12
1.4 Why isn't it working?	12
2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?	14
3. What policy options are you considering?.....	17
3.1 Option 1 – Maintain the status quo.....	17
Impact on the community.....	17

Impact on healthcare providers.....	18
Impact on Government.....	18
3.2 Option 2 – Ongoing funding for Medicare UCCs.....	18
Impact on the community.....	19
Impact on healthcare providers.....	19
Impact on government	19
4. What is the likely net benefit of each option?.....	20
4.1 Option 1 – Maintaining the status quo	20
Individuals	20
Businesses and communities	20
Government.....	21
4.2 Option 2: Ongoing funding for Medicare UCCs	22
Individuals	22
Businesses and communities	24
Broader health system.....	25
Government.....	26
RBE Estimates Table.....	27
5. Who did you consult and how did you incorporate their feedback?	28
Principle views of stakeholders	29
6. What is the best option from those you have considered and how will it be implemented?.....	33
Identifying the preferred option	33
Best option and benefits.....	33
Implementation and timing.....	35
Implementation issues and risks.....	36
7. How will you evaluate your chosen option against the success metrics?.....	38
Ongoing monitoring and evaluation.....	38
Appendix 1: Status of Policy Impact Analysis at each major decision point.....	40

About this Impact Analysis

This Policy Impact Analysis considers options to ensure Australians can access affordable urgent care across extended hours and ease the pressure on emergency departments (EDs).

For an overview of the issue, the executive summary and initial chapters provide a concise foundation. For a more detailed exploration, readers can focus on the sections covering the seven key questions for an in-depth discussion.

Executive Summary

Medicare Urgent Care Clinics (Medicare UCCs)

Medicare UCCs were first established across Australia as a pilot program in 2023 to improve local access to urgent care and reduce low-acuity presentations in public hospital EDs, allowing EDs to focus on life-threatening cases. Since then, Medicare UCCs have started to become an embedded feature of the health system and have already delivered significant benefits for Australians.

The policy problem

Public hospital EDs across Australia are facing growing pressure due to an increase in presentations. This surge has led to longer wait times in some regions, particularly for patients with semi-urgent and non-urgent presentations at EDs. These cases are generally more appropriate for management within the primary care sector, and their presence in emergency departments contributes to avoidable strain and increased costs across the broader health system. As at 30 September 2024, the [Medicare UCC First Interim Evaluation](#) report (Interim Evaluation Report) estimates that 334,000 presentations to partner hospital EDs would have been avoided annually due to the availability of Medicare UCCs. As at October 2025, there have been over 2 million presentations to Medicare UCCs.

At the same time, recent declines in GP bulk billing rates and GP services have made it more difficult for many patients to access affordable, timely, face-to-face GP care in the community. In some areas, this has caused patients to visit EDs for affordable access to non-urgent care.

Current funding arrangements for the 84 existing Medicare UCCs are due to expire from 30 June 2026. Funding for 3 existing clinics and 50 new clinics to be established in 2025-26 expire on 30 June 2028.

The policy response

This Policy Impact Analysis considers options to ensure Australians can access affordable urgent care across extended hours and ease the pressure on EDs, allowing them to focus on life-threatening conditions. This Impact Analysis considers the following two options to achieve this objective:

Option 1: Maintain the status quo – no further funding provided and the program would cease at the end of existing arrangements.

Option 2: Ongoing funding for Medicare UCCs.

Focusing on two options represents the most beneficial approach to address this policy problem as it provides the opportunity for a clear comparison for evaluation. This approach also acknowledges other urgent care models currently operating in Australia which are attempting to reduce ED presentations but have not achieved the significant and consistent outcomes required.

Selecting the preferred policy option

Selection of the preferred option was established through consideration of comprehensive stakeholder feedback, regulatory impacts, and cost and benefit analysis for patients, healthcare providers, and all Australian Governments.

Option 1 fails to address the current problems of increased ED presentations. This will put further strain on the healthcare system and workforce within hospitals.

Option 2 provides the most effective solution, addressing the key objectives to ease the pressure on our hospitals and give families more options to see a health care professional when they have an urgent, but not life threatening, need for care. Ongoing funding for all Medicare UCCs will support continued accessibility of bulk-billed urgent care services for all Australians and further increase public adoption of these services as a permanent feature of the health landscape. In addition, it will give longer term funding security to Medicare UCC providers. This will support workforce retention allowing clinics to stabilise their service delivery; and invest further to build upon their integration within the local health system.

Further, **Option 2** supports ongoing funding for Medicare UCCs leading to better health outcomes for Australians, as well as significant cost savings for government. Early findings from the Interim Evaluation Report shows that each avoided ED visit saves the government approximately \$368 per presentation, factoring in reduced ED costs and the cost of clinic visits. In 2024-25, the department estimates around 372,900 presentations to EDs were avoided by people visiting a Medicare UCC instead.

This Policy Impact Analysis has been developed by the Department of Health, Disability and Ageing (the department) in accordance with The Australian Government Guide to Policy Impact Analysis

and in consultation with the Office of Impact Analysis. It will be used to inform the Australian government regarding the decision to provide ongoing funding to Medicare UCCs.

Background

Medicare Urgent Care Clinics

The establishment and trial of Medicare UCCs formed part of the Australian Labor Party's election commitments in 2022.¹ Since then, the Australian Government has committed \$1.4 billion over seven years from 2022-23 to establish 137 Medicare UCCs across Australia. Medicare UCCs aim to ease the pressure on our hospitals and give families more options to see a health care professional when they have an urgent, but not life threatening, need for care. The establishment of Medicare UCCs complements the government's broader response to recommendations of the [Strengthening Medicare Taskforce Report](#).

As at October 2025, 90 Medicare UCCs have been implemented. When the further 47 clinics are implemented in 2025-26, it is estimated that four in five Australians will live within a 20-minute drive of a Medicare UCC.

Medicare UCCs are generally:

- Based in existing GP clinics, community health centres and Aboriginal Community Controlled Health Services, and provide free services for patients;
- Open extended hours and accept walk-in patients;
- Responsive to the needs of the local community; and
- Accessible to all people, including vulnerable people and young people.

While Medicare UCCs are predominantly GP led, a flexible approach has been adopted in considering alternative operating models to deliver services to local communities, where very unique local context applies (for example, workforce availability in remote Northern Territory) while ensuring the program intent continues to be delivered.

People can attend a Medicare UCC for non-life threatening acute episodic care for minor injuries and illnesses. This includes closed fractures, simple eye injuries, minor burns, urinary tract infection, or an ear infection. Medicare UCCs are not intended to treat people with life threatening or non-urgent conditions. This includes chronic disease management or preventive health procedures such as cervical screening tests.

Since the first clinic opened in 2023, as at September 2025, Medicare UCCs have serviced over 2 million presentations, establishing themselves as a key feature of Australia's Health system. The largest proportion of Medicare UCC patients have been children, with over 1 in 4 (30 per cent) visits from individuals aged under 15 years old.

¹ [Urgent Care Clinics](#). (n.d.). Parliamentary Budget Office. Retrieved September 12, 2025.

1. What is the policy problem you are trying to solve and what data is available?

There is increasing pressure on public hospital EDs. In 2023–24, public hospital EDs across Australia recorded 9 million presentations, equating to a rate of 333 presentations per 1,000 people.²

Presentation rates per 1,000 population have seen a slight increase in this period from 329 presentations per 1,000 people in 2018-19 to 333 presentations in 2023-24. This continued rate of ED presentations has had an associated increase in workforce and resourcing pressures for EDs and emergency services.

The rise in ED presentations has resulted in longer wait times for patients in triage categories 4 and 5. In 2020-21, 93% of category 5 patients were seen within 4 hours, compared to 85% in 2023-24 – well above recommended response times.³ Further information on ED triage categories is described below.

TABLE 1: DESCRIPTION OF TRIAGE CATEGORIES

Triage category	Description
4 – Semi-urgent	Conditions including broken arms or legs. Patients in this category should be seen within 60 minutes of presenting to the emergency department.
5 -Non-urgent	For problems or illnesses such as cough or cold. Patients in this category should be seen within 120 minutes of presenting to the emergency department.

Source: Use of emergency departments for lower urgency care 2020–21 and 2021–22. (2024). Australian Institute of Health and Welfare. Retrieved October 10, 2025. From: www.aihw.gov.au/reports/primary-health-care/use-eds-lower-urgency-care-2020-21-and-2021-22/contents/glossary

The triage categories described above are generally suitable for management within the primary care sector and contribute to the avoidable strain and cost on the broader health system. Note, this data does not include patients who did not wait to receive care or left at their own risk.

² *Emergency department care.* (14 May 2025). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

³ *Australasian Triage Scale: Descriptors for categories.* (2023). Australasian College for Emergency Medicine. Retrieved September 12, 2025.

1.1 Underlying causes of the problem

Affordable access to healthcare

Australians are finding it harder in many locations to access face to face urgent care from their usual GP or any GP.⁴ Over the past five years there has been a decline in bulk-billing practices (where the patient is not charged a co-payment) which has resulted in out-of-pocket costs for some Australians. The Royal Australian College of General Practitioners' (RACGP) *'General Practice: Health of the Nation Report'* indicates that the median percentage of patients who had all of their GP services bulk billed in 2018-19 was 64%.⁵ The bulk billing rate peaked in 2020 at the start of the COVID-19 pandemic due to the impacts of mandated requirements to bulk bill certain services for all age groups: 94% for the 0-15 age group, 87% for the 16-64 group and 93% for the 65+ age group.⁶ Since then, it decreased to 77% in 2023 before increasing slightly to 78% in the first 10 months of 2024.⁷ This occurred after the government's investment of \$3.5 billion in 2023-24 to triple the bulk billing incentives for GPs as part of the Strengthening Medicare reforms.⁸

The average out of pocket costs for GP attendances varies across states and territories.⁹ People in the Australian Capital Territory (ACT) paid the highest annual average out-of-pocket cost of \$50 during 2023, compared to people in South Australia paying an average annual out-of-pocket cost of \$36 in the same period.¹⁰

The impact of co-payments on accessing affordable primary care can be seen in the demographic make-up of those attending EDs. According to the Australian Institute of Health and Welfare (AIHW), 46% of semi-urgent and 45% of non-urgent ED presentations were from individuals residing in areas classified in the two lowest socioeconomic status categories.¹¹ This disproportionate representation of individuals from lower socioeconomic backgrounds highlights how limited access to primary healthcare may lead some patients to view the ED as their only viable option for receiving treatment and care. In addition, this could also result in patients deferring care, potentially resulting in poorer health outcomes, worsening of initial urgent health concerns, or resulting in higher cost treatment options. First Nations people and Culturally and Linguistically Diverse Communities are also impacted by this limited access to primary care. With

⁴ *6 reasons why it's so hard to see a GP.* (2025, February 14). Hippocampus. Retrieved October 3, 2025, from: www.newcastle.edu.au/hippocampus/story/2023/6-reasons-why-its-so-hard-to-see-a-gp

⁵ *General Practice: Health of the Nation Report.* (2021). In *General Practice Health of the Nation 2024*. Royal Australian College of General Practitioners. Retrieved September 12, 2025.

⁶ *Medicare bulk billing and out-of-pocket costs of GP attendances over time.* (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

⁷ *Medicare bulk billing and out-of-pocket costs of GP attendances over time.* (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

⁸ *Upcoming changes to bulk billing incentives in general practice.* (2025, August 15). Department of Health, Disability and Ageing. Retrieved September 12, 2025.

⁹ *Medicare bulk billing and out-of-pocket costs of GP attendances over time.* (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

¹⁰ *Medicare bulk billing and out-of-pocket costs of GP attendances over time.* (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

¹¹ *Emergency department care.* (14 May 2025). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

significant needs for culturally safe and appropriate care, these groups can face greater challenges when navigating the health care system.^{12 13}

Primary care access

As mentioned above, one of the underlying causes for increasing presentations to EDs is due to patients not being able to access same day care from a GP. The proportion of people who waited for 24 hours or more to see a GP for urgent medical care has increased since 2020-21 (33.9%) but remained similar between 2022-23 (45.6%) and 2023-24 (46%).¹⁴¹⁵ Longer wait times for urgent primary care are particularly significant when viewed alongside the rise in lower triage category ED presentations during the same time period, suggesting that more patients are turning to EDs in search of timely care.

The number of junior doctors applying for general practice declined from 2,301 places in 2015 to 1,329 places in 2020.¹⁶ Although this downward trend has been evident in recent years, the Royal Australian College of General Practitioners (RACGP) has reported a positive shift for the 2025 Australian General Practice Training (AGPT) Program intake, with a nearly 20% increase in uptake compared to the previous year.¹⁷ While this is a positive shift, the demand for general practitioners continues to be a health system challenge. This places a significant burden on primary care and increases pressures on the healthcare system.

System integration and patient information

Prior to the commencement of the Medicare UCCs there was a variety of disparate and unconnected service types in the urgent care ecosystem. These include afterhours GPs, telehealth triage lines, medical advice lines, state run urgent care and ED diversion initiatives and home visits. Each of these provides a bespoke service offering which can introduce a lack of clarity to consumers about where they should go for advice or treatment for urgent primary care. These patients identify EDs as "one stop shops" and a known entity for treatment and thus inappropriately present to EDs despite their health needs being semi- or non-urgent. Medicare UCCs are increasingly becoming a critical feature of the health system and help to address this fragmentation through a national delivery model, and have already delivered significant benefits for Australians, servicing over 2 million patients since June 2023.

There is also a lack of information to help guide these patients to more appropriate services. A South Australian study on patient journey to the ED found 60.2% were self-referred to the ED with

¹² [Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper.](#) (2022, August 4). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

¹³ [Cultural safety in health care for Indigenous Australians: monitoring framework.](#) (2023, July 7). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

¹⁴ [Patient Experiences in Australia: Summary of Findings, 2019-20 financial year.](#) (2020b, November 16). Australian Bureau of Statistics. Retrieved September 12, 2025.

¹⁵ [Patient Experiences, 2023-24 financial year.](#) (2024, November 18). Australian Bureau of Statistics. <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>. Retrieved September 12, 2025.

¹⁶ [National Medical Workforce Strategy 2021–2031.](#) (2022). In *Department of Health, Disability and Ageing*. Department of Health, Disability and Ageing. Retrieved September 12.

¹⁷ [newsGP - Record number of GPs in training to start in 2025.](#) (n.d.). NewsGP. Retrieved September 12, 2025.

the patient seeking no advice from other health services.¹⁸ This gap in information is a barrier to patients seeking and receiving care appropriate for their needs and results in unnecessary presentations to EDs. The perception of ED as a “one stop shop” for treatment contributes to it being an easier choice for patients who can avoid the uncertainty of incorrectly self-triaging or navigating other health services¹⁹.

Patient flows

There are other contributing factors to ED pressure which this policy initiative does not propose to address but needs to be considered in the broader context of ED pressure. Of particular note is the impact of poor patient flows throughout the rest of the hospital and bed block and ambulance ramping (further information on this below).

1.2 Who is affected and how?

Patients

The harm involved with extended wait times is substantial as patients could decide to leave an ED without being seen by a doctor or health professional. 11% of non-urgent and 7% of semi-urgent categories did not wait to be seen in the ED by a health practitioner in 2023-24.²⁰ In 2023-24, triage category 4 represented 51% of the total number of people who did not wait to receive care.²¹ Note, the data does not capture individuals who may delay presentation at EDs to avoid lengthy wait times. This could lead to poorer patient outcomes or experiences.

These extended wait times can also impact on carers and families as it can contribute to further distress and uncertainty. This is particularly true for parents of children who are too young to explain their symptoms or advocate for themselves.

The Productivity Commission *Interim report on Delivering Quality Care More Efficiently* highlights the importance of high-quality care services—including urgent care—to enable people to live independently and participate more fully in the economy. Care services such as health care have many benefits, including improved physical and mental health and enabling greater participation in the community and the economy.²²

Staff at EDs

The health workforce has been impacted by ED pressures as hospitals attempt to secure workers and manage increased rates of furloughing in the context of the pandemic which has led to

¹⁸ Robinson, C., Verrall, C., Houghton, L., & Zeitz, K. (2015). Understanding the patient journey to the Emergency Department – A South Australian study. *Australasian Emergency Nursing Journal*, 18(2), 75–82. <https://doi.org/10.1016/j.aenj.2015.01.001>

¹⁹ Willson, K. A., Lim, D., Toloo, G., FitzGerald, G., Kinnear, F. B., & Morel, D. G. (2022). Potential role of general practice in reducing emergency department demand: A qualitative study. *Emergency Medicine Australasia*, 34(5), 717–724. <https://doi.org/10.1111/1742-6723.13964>

²⁰ [Emergency department care](#). (14 May 2025). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

²¹ [Emergency department care](#). (14 May 2025). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

²² [Improving efficiency to deliver better care – Interim Report](#). (n.d.). Productivity Commission. Retrieved September 12, 2025.

increased individual workloads.²³ COVID-19 has also led to increased mental health issues for health care workers, with higher predominance of pandemic-related stress, increased post-traumatic stress disorder (PTSD), anxiety and depression being observed in healthcare workers.²⁴ Increasing ED presentations continues to put pressure on staff who've been under significant stress since 2020.

Paramedics have also come under increasing pressure as episodes of ramping in most major cities become more frequent, due to EDs being at capacity.²⁵ Some states are increasingly using paramedic workforce to prevent ED presentations and keep people at home to avoid adding on to ED pressure.

While "ambulance ramping" continues to increase, most jurisdictions have seen a small improvement in the amount of time taken for ambulances to transfer patients to the ED. For instance, New South Wales reported a 1% increase in performance in 2023-24, with 78 per cent of patients being transferred within 30 minutes.²⁶

Governments

In conjunction with funding from the Commonwealth, State and Territory governments are the administrators of the public hospital system. States and Territories have oversight as system managers of public hospitals and are responsible for determining the mix of services and functions delivered in their jurisdiction.²⁷ The Commonwealth funds primary care through the MBS and Primary Health Networks (PHNs) to commission the delivery of health care services. Medicare UCCs operate in both primary care and the ED landscape and therefore require a close partnership between the Commonwealth and jurisdictions to ensure better integration of hospital services with primary care.

Rising ED presentations lead to greater impacts on government services and funding. Patient presentations to EDs have significantly higher associated costs to governments than in the primary care system. For example, as at 30 September 2024, it is estimated that around 334,000 ED visits per year, each costing around \$616, were avoided by people attending a Medicare UCC instead (approximately \$248 per presentation).²⁸ This is largely attributable to the workforce profile (patients may see a nurse, doctor, radiologist or specialists) difference but also the larger reliance on diagnostic imaging and pathology conducted. The Independent Health and Aged Care Pricing Authority's *Australian Hospital Patient Costing Standards* indicates that ED costs comprise of approximately 70% of staff costs.²⁹ Comparing with primary care environments where patients will

²³ [Health workforce](#). (2024, July 2). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

²⁴ [Health workforce](#). (2024, July 2). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

²⁵ AUSTRALIAN MEDICAL ASSOCIATION. (2025). [Ambulance ramping Report Card 2025](#). Retrieved September 12, 2025.

²⁶ AUSTRALIAN MEDICAL ASSOCIATION. (2025). [Ambulance ramping Report Card 2025](#). Retrieved September 12, 2025.

²⁷ [National Health Reform Agreement](#). (2025, September 1). Department of Health, Disability and Ageing. Retrieved September 12, 2025.

²⁸ [Medicare Urgent Care Clinics Program Evaluation: First Interim Report](#). (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025

²⁹ [Australian Hospital Patient Costing Standards](#). (2021). In Independent Hospital Pricing Authority. Independent Hospital Pricing Authority. Retrieved September 12, 2025.

typically interact with only their GP or a nurse, there would be significant cost savings if patients with urgent but not life threatening conditions presented to primary care settings rather than EDs.

1.3 What is currently being done?

Existing urgent care models

The Medicare UCC 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, 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 Medicare UCC Program have different jurisdictional funding arrangements, operational requirements and in some instances, different eligibility criteria. Beyond the Medicare UCC program, there is currently no universal approach to delivering urgent care (outside of the ED) across Australia.

The following table provides an overview of some of the urgent care models currently funded by states and territories.

TABLE 2: EXISTING STATE-FUNDED MODELS

Service	Model
Urgent Care Services (UCSs) (NSW)	<ul style="list-style-type: none"> • Five models: <ul style="list-style-type: none"> ○ Urgent Care Clinics – face-to-face, predominantly located in general practice ○ Urgent care access line – such as Healthdirect ○ Rapid response hospital team – health professionals delivering outreach care ○ In-home urgent care service – community-based specialist care ○ Virtual urgent care service – delivered via phone or video conference • Some UCSs have been granted ss19(2) Direction under the Commonwealth Program and must adhere to Medicare UCC Operational Guidance. • Preferred entry via referral from Healthdirect, though walk-ins accommodated (but not advertised). • Free for Medicare eligible patients and community-based asylum seekers. • Open 8am-8pm, 7 days. • Commissioned through PHNs.

<p>Victorian Urgent Care Clinics [previously Priority Primary Care Centres] (Vic)</p>	<ul style="list-style-type: none"> • GP-led. • Open extended hours (14-16 hours per day), 7 days. • See people with low acuity conditions, such as fractures, burns and mild infections. • Subject to ss19(2) under the Commonwealth Program and must adhere to Medicare UCC Operational Guidance. • Walk-in services. • Free regardless of Medicare eligibility. • Commissioned through PHNs.
<p>Satellite Hospitals (South East Qld)</p>	<ul style="list-style-type: none"> • Minor injury and illness clinics • Walk in, urgent care services • Open 8am until 10pm, seven days a week, with health staff working until 11:30pm • Medical imaging and diagnostic services • Additional referral-based outpatient services offered e.g. mental health support, kidney dialysis, medical and allied health specialty clinics • 7 locations, supporting Metro North, Metro South, West Moreton and Gold Coast hospital and health services
<p>Priority Care Centres (SA)</p>	<ul style="list-style-type: none"> • GP-led with support from nurses. • Community-based health care for urgent but non-life threatening conditions. • Referrals only, no walk-ins. • Free for Medicare card holders. • Co-located with Elizabeth Medicare UCC, Marion Medicare UCC and Para Hills Medicare UCC. • Commissioned through Adelaide PHN.

Emergency department diversion programs

Jurisdictions have implemented diversion programs to reduce ED presentations. These programs make up the urgent care ecosystem and include afterhours GPs co-located at hospitals, nurse advice lines, and increasingly a shift to virtual care at home. Other programs like the increased use of paramedic practitioners in some jurisdictions are also examples of attempts to reduce the number of people seeking treatment from ED, particularly in the semi-urgent and non-urgent triage categories.

Bulk Billing reforms

As part of the 2025-26 Budget, the Australian Government announced a \$7.9 billion investment to support GPs to bulk bill more patients.³⁰ The investment will expand eligibility for Medicare Benefit Schedule (MBS) bulk billing incentive items to all Australians and introduce a new Bulk Billing Practice Incentive Program for general practices who commit to bulk billing every patient. This measure aims to significantly increase the GP bulk billing rate and reduce cost as a barrier to receiving GP care.

To support this goal, Medicare UCCs must be co-located with, or partnered alongside, General Practices that offer full bulk billing where local circumstances allow.

Bulk billing reforms will increase affordable access to GP care in the community. They have not been designed to provide urgent care – including on-site diagnostic imaging and pathology – or to increase access to after-hours GP services. This limits its effectiveness in solving the policy program of reducing pressure on EDs.

1800MEDICARE

From 1 January 2026, 1800MEDICARE, a free, nationwide 24/7 health advice line and after-hours GP telehealth service, will provide a safety net for all people living in Australia. It is designed to complement and support local care, not replace it. Callers to 1800MEDICARE will be assessed by registered nurses who will triage and refer consumers to the most appropriate care based on their needs and the time of day. This may include the after-hours GP helpline, local GPs, Medicare Urgent Care Clinics, hospital emergency departments, or self-care options.

1.4 Why isn't it working?

As discussed in Section 1, there are currently a wide variety of urgent care options available to patients and limited consistent messaging on service offering or price signals. There is also no consistency across urgent care model opening hours. Some are open extended afterhours, some 24/7 and some solely during normal business hours. There is also limited consistency on the type of support patients will receive, some employ GPs while others are nurse-led. Likewise, the services provided can often be unclear and confusing to patients who may have lower health literacy levels and be unfamiliar with how to self-triage to seek appropriate care.

Finally, there is an inconsistency with clinics about whether appointments are offered on a walk-in or referred basis. All this culminates confusion in the urgent care market making patients less likely to attend these services and instead present at an ED where service offering, no-cost and easy access is assured.

Lastly these clinics are often set up in isolation with poor systematic integration into existing health care services and supports. This is especially true for private businesses, which often do not have

³⁰ *Budget 2025–26: Strengthening Medicare – More bulk billing*. (2025, March 25). Department of Health, Disability and Ageing. Retrieved October 21, 2025.

the same level of integration that a clinic co-located in a hospital might. Integration is necessary to ensure effective patient pathways for escalation and back to usual GP care as well as facilitating appropriate referrals to related health services like fracture clinics or mental health providers. Without this integration poor patient outcomes are more likely as is their eventual presentation to the ED.

2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?

With the increasing pressure on EDs, including limited accessibility of primary care, less hospitals will be able to manage the increasing workload and patient outcomes are expected to decrease. Successful (and clinically appropriate) diversion of non-urgent or semi-urgent patients would allow hospital resources to be focused on higher urgency and life-threatening conditions.

Taking pressure off emergency departments, overworked staff, and saving hospital resources is a clear objective for all levels of government. In December 2023, National Cabinet agreed to a \$1.2 billion package of Strengthening Medicare measures to take pressure off hospitals, support and grow the health workforce, while reducing unnecessary presentations to emergency departments.³¹

Less patients arriving at ED for categories 4 & 5, including by ambulance, police, and helicopter or through referral and walk in, will allow additional time and resources for other patients. This diversion of patients presenting in ED is expected to reduce wait times for categories 3 and up in ED, providing improved and efficient health care for patients.

High out-of-pocket costs are a significant barrier to people accessing certain health care services in Australia, and in particular, for people living in lower income socioeconomic areas.³² The average out-of-pocket cost for GP attendances has increased over time since the start of Medicare in 1984.³³ In 2023, Australians paid an average out-of-pocket cost of \$43 for a non-bulk billed GP attendance.³⁴ Rising healthcare expenses, combined with broader cost of living pressures and limited access to same-day GP appointments, have likely driven more people to seek care at EDs, where services are bulk-billed.

The government is working to improve affordable equitable access to healthcare through initiatives to strengthen Medicare, including expansion of Medicare bulk billing incentives announced in the 2025-26 Budget.³⁵ A critical element of addressing access issues and further reducing pressure on EDs includes providing more options to families for accessing affordable care at short notice particularly outside ordinary business hours.

³¹ [Meeting of National Cabinet – the Federation working for Australia](#). (2023, December 6). Prime Minister of Australia. Retrieved September 12, 2025.

³² [Allen + Clarke Consulting – After Hours Review evaluation report](#). (2024). In *Department of Health, Disability and Ageing*. Allen + Clarke. Retrieved September 12, 2025.

³³ [Medicare bulk billing and out-of-pocket costs of GP attendances over time](#). (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

³⁴ [Medicare bulk billing and out-of-pocket costs of GP attendances over time](#). (2024, December 13). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

³⁵ [Upcoming changes to bulk billing incentives in general practice](#). (2025, August 15). Department of Health, Disability and Ageing. Retrieved September 12, 2025.

As mentioned above, there is limited consistency in service offerings across jurisdictions for patients seeking urgent care outside of an ED. This lack of consistency can be confusing for patients, and most will present at an ED for ease of use. To ensure clear communication and community awareness of care options, the government has the responsibility to ensure close collaboration and integrate with existing healthcare systems and services. This collaboration will inform integration with existing diversion pathways to avoid creating processes. Health care services should not be duplicating state and territory initiatives aimed at reducing non-urgent presentations to emergency departments.

The government plays an important role in ensuring all Australians have access to affordable, high-quality healthcare when and where they need it. This can be achieved through stringent Medicare UCC [Operational Guidance](#) that sets the minimum requirements for Medicare UCCs including activities, infrastructure and staffing while allowing sufficient flexibility for services to adapt to local conditions and needs. This ensures governance and compliance measures are upheld and supports increased for patient protection.

Stakeholder views and existing health services need to be considered carefully in the implementation of this initiative, particularly in the private sector. Any urgent care services should not be replacing usual general practice services. These two considerations and boundaries in scope of care will be strictly adhered to and success in this is facilitated by extensive stakeholder consultation and clear operational guidance.

Ongoing funding for Medicare UCCs may provide an opportunity for clinics to more strategically plan resource allocation to better manage workforce risk. Extending contracts for existing Medicare UCC providers will enable them to streamline workforce planning and allocate resources more efficiently, as they can manage staffing and support needs across a larger stable network.

When the Medicare UCC program was launched as a pilot program in 2023, the Commonwealth, states and territories agreed to nine Measures of Success for the program. These include:

1. Patients receive timely treatment for urgent non-life-threatening conditions in Medicare UCCs.
2. Medicare UCCs provide safe and quality treatment to patients.
3. Medicare UCCs deliver coordinated care for their patients.
4. Medicare UCCs provide a positive experience for patient/carer.
5. Medicare UCCs provide a positive experience for providers at Medicare UCCs, in partner hospital EDs, and in local GP practices.
6. Medicare UCCs reduce pressure on hospital ED presentations at partner hospitals.
7. There is a change in consumer behaviour over time to use Medicare UCCs where available instead of EDs for urgent non-life-threatening conditions.
8. Medicare UCCs, PHNS, healthdirect, jurisdictions and the health ecosystem have established an effective coordinated care option for people with urgent non-life-threatening conditions.
9. Medicare UCCs are cost-effective.

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. The Interim Evaluation Report provides some initial insights into the nine Measures of Success for the period 30 June 2023 to 30 September 2024, to inform program improvement.

Successful implementation and ongoing support for the Medicare UCCs will ensure these objectives of the Medicare UCC Program.

3. What policy options are you considering?

This Policy Impact Analysis covers two policy options to address the policy problem:

- **Option 1:** Maintain the status quo – no further funding provided and the program would cease at the end of existing arrangements.
- **Option 2 (preferred):** Ongoing funding for Medicare UCCs.

Focusing on two options represents the most beneficial approach to address this policy problem as it provides the opportunity for a clear comparison for evaluation. This approach also acknowledges other urgent care models currently operating in Australia which are attempting to reduce ED presentations but have not achieved the significant and consistent outcomes required.

3.1 Option 1 – Maintain the status quo

Under this option, existing Medicare UCCs will cease operation.

Current funding arrangements for the existing Medicare UCCs are due to expire from 30 June 2026 for 84 clinics and from 30 June 2028 for 53 clinics. Without ongoing funding, existing clinics will close or commence charging patients out-of-pocket costs, also creating uncertainty for the sector and jeopardising access to urgent and timely care for all Australians.

Impact on the community

This option would limit people's ability to access same-day healthcare resulting in patients presenting to the ED for urgent but non-life threatening conditions, which could be appropriately managed within the community. This will likely impact on the quality of care provided to patients resulting in longer wait times and potentially worse outcomes.

Prior to the establishment of Medicare UCCs, there has been inconsistent service offerings for patients seeking urgent care outside of an ED. In some regions, the absence of alternate care options is likely to lead patients to seek treatment at EDs for urgent but non-life threatening conditions that could be effectively managed within community-based services.

During the pilot period of the Medicare UCC program (between 30 June 2023 and 30 September 2024), the clinics recorded a total of 784,071 presentations, with children under the age of 15 accounting for 28 per cent of all presentations.³⁶

³⁶ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

Impact on healthcare providers

In this option, general practices currently operating as Medicare UCCs will lose access to Commonwealth funding to support Urgent Care services. This may result in patients seeking alternate access to care for providers who are not currently operating as a Medicare UCC which may increase demand on other primary care clinics. It is anticipated this will also increase non-urgent and semi-urgent presentations to EDs and put pressure on surrounding GP practices, and likely disproportionately impact those from disadvantaged backgrounds where cost is a barrier to seeking treatment via alternate care options.

In addition, significant Commonwealth investment has already been made to establish, promote, and position Medicare UCCs as a trusted and accessible model of care within local communities. This includes expenditure on capital works, clinical infrastructure, and national advertising campaigns to raise public awareness. Discontinuing the model would risk undermining the value of such investments and could reduce community confidence in Commonwealth-supported primary care services, particularly in areas which have come to rely on Medicare UCCs as a visible and trusted point of care.

Impact on Government

The government will continue to pay into the National Health Reform Agreement (NHRA) and other existing funding arrangements supporting hospitals and primary care. If funding to Medicare UCCs ceased, the demand on hospitals may increase which could result in increased funding requirements to maintain services.

Workforce availability and support care in regional and remote locations will continue to be a priority of government. Jurisdictions and private practices will continue to supply their existing, diverse urgent care models.

3.2 Option 2 – Ongoing funding for Medicare UCCs

Under this option, ongoing funding for Medicare UCCs will ensure Australians in 137 locations can continue to access affordable urgent care across extended hours.

Commonwealth funding will continue to be provided to PHNs and the Northern Territory and Australian Capital Territory governments to commission practices and/or community centres through an open competitive grants process, or via Federated Funding Agreements. Medicare UCC commissioners would continue to be responsible for managing the contract with providers and monitoring the operations and performance of clinics in their regions.

Ongoing funding under this option will allow all existing Medicare UCC commissioners to re-contract the existing 84 Medicare UCCs (from 1 July 2026), or 137 Medicare UCCs (from 1 July 2028).

Impact on the community

This option ensures that Australians can continue to access affordable urgent care across extended hours for non-life threatening acute episodic care for minor injuries and illnesses. When all 137 Medicare UCCs are operational in 2025-26, around four in five Australians will live within a 20 minute drive of a Medicare UCC. This includes some Australians living in some regional, rural and remote locations, providing more options for families to see a health professional and access to bulk billed care when they have an urgent, but not life threatening, need for care. Promoting the Medicare UCCs as a permanent fixture in the health system can help the community identify them over time, as a reliable consistent go-to place for urgent but non-life threatening conditions, in the same way people currently see EDs.

Impact on healthcare providers

This option will provide long term funding security to Medicare UCC providers and enable Medicare UCCs to stabilise their service delivery with reduced disruptions. This also supports Medicare UCCs to continue building upon integration and referral pathways, plan and make investments in future improvements, and attract and retain workforce.

Under this option, Medicare UCC commissioners would re-contract existing clinics, which will support workforce retainment allowing clinics to stabilise their service delivery; and invest further to build upon their integration within the local health system.

Impact on government

Affordable and accessible access to healthcare is a priority for government and contributes to national health and social wellbeing. Ongoing investment for Medicare UCCs supports the government's commitment to improving access to urgent bulk-billed health care, and to the Medicare UCC model and its continued role in the provision of cost-effective healthcare services alongside EDs and GPs.

4. What is the likely net benefit of each option?

This section outlines the primary benefits and costs for each of the two policy options proposed in this Policy Impact Analysis. The preferred policy option, **Option 2**, has been selected based on balances when comparing the extent each option meets the policy objectives, the regulatory burden and associated costs and the overall net benefit.

4.1 Option 1 – Maintaining the status quo

The net benefit of maintaining the status quo is marginal, with cost savings to government likely to be superseded by increase costs to government and strain on other parts of the health system, and negative impacts on individuals, businesses and communities.

Individuals

Benefits

Without further funding, Medicare UCCs will cease operation. This could result in more people returning to general practice or seeking care at EDs for urgent care needs. Patients seeking care through their regular GP, may lead to comprehensive ongoing care that supports improved health outcomes

Costs

People seeking care via general practice or EDs for urgent care needs as a result of Medicare UCC closures may face out-of-pocket costs related to a general practice consult and cost of any ancillary services, including increased wait times to access care free-of-charge.

This will result in increased cost to governments to fund increase in demand to EDs put further strain on the healthcare system and workforce within hospitals. This may impact on the quality of care provided to patients resulting in longer wait times and potentially worse outcomes.

Businesses and communities

Benefits

Without ongoing funding, existing Medicare UCCs may cease operations, which may increase demand for other health services in the local area, such as neighbouring general practices and after-hours services. From a workforce perspective, healthcare providers currently working in Medicare UCCs may be freed up to work in other parts of the health system.

There will be no regulatory burdens associated for either private clinics or community health organisations as neither will have to change their methods of data collection, evaluation or training requirements.

Costs

Maintaining the status quo would see a return and/or further exacerbation of current problems of increased ED presentations, which on average costs more per presentation to manage when compared to a Medicare UCC. Increasing demand on neighbouring health services may not be met by remaining health services, exacerbating current strain on the broader health system.

Increased demand on other health services may also place additional pressure on general practices, potentially causing unnecessary stress and increasing demand on already stretched resources.

There is a risk that current trends will continue and worsen without intervention. For instance, without intervention the limited access to primary care will continue to send more patients to ED who are seeking affordable and timely urgent care.

Government

Benefits

There would be limited benefits if the existing Medicare UCC program were to expire. Cessation of the program would likely result in savings for government as future funding would not be required to provide ongoing support for the program. This will likely divert people back to other health services such as general practices and EDs.

Costs

Increased presentations to EDs will cost government more, with average costs per presentation (\$616) higher than compared to a Medicare UCC (\$248).³⁷

While this option will likely increase the availability of GPs to work in general practice, the increased demand on the sector may put further pressure on government to solve workforce challenges and provide additional funding to general practice.

Table 3: Regulatory burden estimate (RBE) table

Average annual regulatory costs (from business as usual)

Change in costs (\$ million)	Business	Community organisations	Individuals	Total change in costs
Total, by sector	\$0	\$0	\$0	\$0

³⁷ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

4.2 Option 2: Ongoing funding for Medicare UCCs

The net benefit of ongoing funding for Medicare UCCs encompasses improved health outcomes, as well as cost savings to government, which far outweighs costs to program delivery.

The First Interim report indicated that savings for government associated with avoided ED visits are estimated to be \$368 per presentation. This is made up of reduced ED funding which is offset by the cost of the associated Medicare UCC attendances.

Individuals

Benefits

Medicare UCCs provide broad benefit, supporting free and equitable access to urgent care to all population cohorts as they need it. They play an important role in diverting Category 4 (semi-urgent) and Category 5 (non-urgent) presentations from hospital ED. This includes minor illnesses and injuries such as closed fractures, burns, insect bites or wound care. Medicare UCCs improve access by increasing available options for affordable health care services, particularly in the after-hours periods and for same day healthcare.

Although there is no agreed clinical definition of timely treatment (based on differences between clinical urgency, resources, availability, location and patient circumstances), the Interim Evaluation Report found a median patient wait time of 14.5 minutes (for the period of 30 June 2023 to 30 September 2024). This was shorter than the median waiting times at EDs for triage categories 4 which is 31 minutes, and category 5 which is 24 minutes, noting that these waiting times are not directly comparable.³⁸

These shorter wait times at Medicare UCCs could translate into cost benefits for patients, including:

- reduced time away from work or caregiving responsibilities, lowering indirect costs.
- Faster treatment of minor conditions, potentially preventing escalation and avoiding more expensive interventions.
- Improved patient experience and satisfaction, which may reduce repeat visits and associated costs.

These themes will be further contemplated in the second interim evaluation report due in late 2025.

The largest proportion of Medicare UCC patients have been children, with over 1 in 4 (30 per cent) visits from individuals aged under 15 years old. Over 1 in 4 (29 per cent) visits have taken place on the weekend. Of visits that took place during weekdays, 1 in 4 (25 per cent) have taken place at 5pm or later. The top reasons for visits include acute illness (around 60 per cent) and acute injury.

³⁸ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

Ongoing funding for Medicare UCCs can help ensure a consistent predictable model of urgent care regardless of jurisdiction. When fully implemented, it is estimated that four in five Australians will live within a 20 minute-drive of a Medicare UCC. Over time people will start to think of the Medicare UCCs in a similar way they think of EDs – as a trusted free place for treatment for urgent but non-life-threatening conditions. Medicare UCCs provide culturally safe and appropriate care for vulnerable communities such as First Nations Peoples and Culturally and Linguistically Diverse populations. Communications campaigns will be managed on a local level to ensure highly diverse populations receive appropriate and translated information.

By maintaining Medicare UCCs in 137 locations, the government will have the opportunity to clarify existing differences in urgent care models and ensure a nationally consistent model for Medicare UCCs moving forward. Consistent service offering will make it easier for individuals to navigate the care options available.

Patient story: 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.

Medicare Urgent Care Clinics Program Evaluation: First Interim Report. (2025)

Costs

Early findings from the Interim Evaluation Report show that consumers’ still struggle to understand urgent care and navigate the local service options, despite comprehensive national and local communications campaigns. This could lead to delays in treatment if individuals present at a Medicare UCC with an emergency issue.

With ongoing access to affordable healthcare via Medicare UCCs, there is a risk they are misused as a regular GP clinic rather than for episodic care as intended.³⁹ To reduce these risks, the Commonwealth has developed the [Medicare UCC Operational Guidance](#) which outlines which patients the Medicare UCCs are allowed to see, which excludes managing patients’ chronic conditions. In addition, the government’s initiatives to increase Bulk Billing and introduce Medicare Bulk Billing Clinics, set to commence in late 2025, aims to increase access to general practitioners for usual episodes of care.⁴⁰

³⁹ Baier, N., Geissler, A., Bech, M., Bernstein, D., Cowling, T. E., Jackson, T., Van Manen, J., Rudkjøbing, A., & Quentin, W. (2018). Emergency and urgent care systems in Australia, Denmark, England, France, Germany and the Netherlands – Analyzing organization, payment and reforms. *Health Policy*, 123(1), 1–10. <https://doi.org/10.1016/j.healthpol.2018.11.001>

⁴⁰ [Upcoming changes to bulk billing incentives in general practice](#). (2025, August 15). Department of Health, Disability and Ageing. Retrieved September 12, 2025.

Businesses and communities

Benefits

Existing Medicare UCC providers will benefit from more predictable funding for participation in the program. The surrounding community will benefit from local infrastructure and maintaining job opportunities.

PHNs will be able to leverage existing known networks of primary care and community services to support Medicare UCC providers to develop patient pathways and referral sites which would provide a more holistic support for patients. This will include social services and alcohol and other drug programs. PHNs have existing relationships with practices to support the UCC activities. Practices which are performing the Medicare UCC function will likely have flow on benefits to their usual practice from elements of the initiative like pathology and diagnostic imaging, workforce training and enhanced relationships with the local health system.

Costs

There is a risk that maintaining a free urgent care service could destabilise or interfere with the market of general practice that exists in regions around the Medicare UCC. In areas with larger populations, Medicare UCCs increase choice and competition in the market for some care services and patients. Medicare UCCs are required to adhere to the Medicare UCC Operational Guidance that outlines the scope of conditions and services eligible for treatment at a Medicare UCC. Access to affordable routine primary care with a patient's regular general practice is a priority for the Australian Government. Practices who continue to bulk bill are predominantly those in rural and remote locations or cater to patients in low socio-economic areas. This risk of diverting patients from usual GPs will be mitigated by restricting scope of practice to low acuity, episodic care and mandating the provision of patient records back to usual GPs (where patients have one and provide consent). The Medicare UCC Operational Guidance also requires providers to provide discharge summaries to a patient's usual general practitioner at the end of an episode of care.

Where an existing general practice also becomes a Medicare UCC, there is risk this initiative could draw patients from other practices introducing unfair advantages in the market for GPs. This is mitigated in part as Medicare UCCs are limited in the range of conditions that can be treated and are eligible to bill only a subset of MBS items. This is primarily a risk in markets with higher competition, and not thin markets where there may be less competition for GP services.

Medicare UCCs are primarily co-located with an existing general practice, leveraging existing infrastructure, processes, and workflows. This represents a cost efficiency for the provider and the broader program. New Medicare UCCs are initially eligible for an upfront grant to support any new capital works, consumables and fit out of consulting rooms. This grant could also be beneficial to the co-located general practice, particularly if utilised on common areas e.g. waiting rooms, signage. The Interim Evaluation noted this grant as part of the Medicare UCC funding model. There is also a risk Medicare UCC GPs may refer patients for ongoing care at the co-located practice

diverting from the patients usual GP, establishing a conflict of interest which may not reflect the best interests of the patients and distorting referral behaviour. The mitigation for these risks is by enforcing practices to set up a separate legal entity for the Medicare UCC function to facilitate Commonwealth oversight of provider billings and behaviours through MBS patterns. This mitigation does not account for all of the advantages described above.

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. Given the existing health workforce pressures, finding appropriately trained staff for Medicare UCCs may have challenges. There is a risk that by incentivising healthcare workers to work in Medicare UCCs, further pressure may be placed on local health services also seeking to staff general practices potentially impacting available workforce for broader primary care. This could result in some GP practices struggling to maintain staff and being forced to close, limiting access to routine primary and preventive care accessed through a patient's usual general practice. Through the 2025-26 Budget, the government is investing an additional \$662.6 million into the GP workforce that will mitigate some workforce risks.⁴¹ This includes more funding to enhance GP and Rural Generalist training by providing an extra 200 training places per year starting in 2026, and this figure will rise to 400 additional places per year from 2028.

Medicare UCC providers receive funding via two streams including an operational grant and access to a sub-set of MBS items. Remuneration for staff at a Medicare UCC is a matter for the provider, however there is risk that the operational grant may distort the broader general practice market, for example capacity of the provider to offer salaried positions.

Broader health system

Benefits

The Medicare UCC program aims to reduce pressure on hospital EDs to allow hospitals to focus on life-threatening cases. For Medicare UCCs opened in 2023-24, almost 2 in 3 partner ED hospitals saw a decrease in Category 4 and 5 ED presentations from 2022-23 to 2023-24.⁴² Most recent publicly available data for the proportion of patients seen on time in EDs between 2022-23 and 2023-24 shows some substantial improvements at some hospitals, but some hospitals also had declines. For example, the proportion of people 'seen on time' in 2023-24 was 67%, up from 65% in 2022-23 but down from 74% in 2019-20.⁴³

Noting the likely presence of latent demand in the ED system, Medicare UCCs are intended to alleviate pressures on EDs and associated health workforce. This means reduced pressure on frontline workers, potentially reducing their overtime hours. By providing options for low acuity

⁴¹ *Budget 2025-26: Strengthening Medicare – Health workforce.* (2025, March 25). Department of Health, Disability and Ageing. Retrieved October 21, 2025.

⁴² *Emergency department care.* (14 May 2025). Australian Institute of Health and Welfare. Retrieved October 22, 2025.

⁴³ *Emergency department care.* (14 May 2025). Australian Institute of Health and Welfare. Retrieved September 12, 2025.

patients to attend another location, hospital resources can instead be focused on higher urgency, life-threatening conditions.

The establishment of Medicare UCCs provides an opportunity to work collaboratively across the acute and primary care sectors to address an issue at the interface between the public hospital system and the private primary care system. Agreed care and escalation pathways as well as mandatory clinical handover to each patient's usual GP (where the patient has one) will help avoid fragmentation of care. Medicare UCCs may also provide a better setting than EDs to discuss comprehensive follow up care and connect patients to broader primary and community care services. This may assist in addressing individuals at risk of readmission to ED and Medicare UCCs and reduce inappropriate non-urgent presentations.

There is an opportunity to complement the Medicare UCCs with other health services to support ED diversion including virtual telephone advice lines, to improve patient flow to Medicare UCCs or to prevent unwarranted physical presentations to Medicare UCCs and EDs.

The commissioning process for Medicare UCC providers is competitive and provides an opportunity for both private providers and state community services to be awarded contracts. This means that the most appropriate provider will be awarded a contract and should be able to respond to the local needs of the community. PHNs also have significant contacts within LHDs and with community services which could help integrate services provided by Medicare UCCs.

Costs

The relationship between PHNs and their local health systems is variable. There is potential for local level challenges in integrating Medicare UCCs with hospitals, particularly in states which already have Urgent Care models they fund, or do not have strong working relationships or history of working collaboratively with PHNs.

The PHNs are responsible for working with LHDs to ensure effective coordination and integration of services provided by Medicare UCCs. Practices will leverage existing GPs, however, the extended hours will require increased numbers of staffing than the practice has available. This will require practices to recruit more doctors and nurses and there is a risk of diverting doctors from other healthcare centres or even the emergency care workforce.

Government

Benefits

According to the Interim Evaluation Report, as at 30 September 2024, the Medicare UCC evaluation estimates that 334,000 presentations to partner hospital EDs would have been avoided annually due to the availability of Medicare UCCs.⁴⁴ It also estimates that a Medicare UCC presentation that otherwise would have gone to the ED costs \$248 compared to the cost of an ED visit of around

⁴⁴ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

\$616. This equates to over \$122 million savings annually.⁴⁵ These preliminary results do not include contributions to the operation of Medicare UCCs by state and territory governments.⁴⁶

Working with PHNs allows for greater national consistency as implementation can be managed by the Commonwealth and may assist in ensuring consistency across jurisdictions.

Costs

Indicative costs to run the Medicare UCC program is approximately \$428.1 million per year to provide ongoing funding for all 137 Medicare UCCs from 1 July 2028 onwards. This includes ongoing operational funding for Medicare UCCs, departmental funding to support ongoing implementation of the program, and ASL.

RBE Estimates Table

Regulatory costs associated with this proposal would be costs associated with the funding agreements with the PHNs and state and territory governments. This would include the regulatory costs associated with drafting documentation in relation to commissioning processes and fulfilling reporting requirements.

The funding agreements associated with this proposal would impose a small regulatory cost on organisations, however, the benefits of the proposed activities far outweigh this cost. The Medicare UCC providers engaged across Australia through these funding agreements improve health outcomes with their activities.

Overall, the average regulatory cost anticipated per funding agreement per year is \$4,829 a total of approximately \$661,592 per year for this proposal. This takes into account around 56.7 hours per year to draft documentation in relation to commissioning processes and to fulfil reporting requirements for each successful recipient, at a default hourly rate of \$85.17.

Table 4: Regulatory burden estimate (RBE) table

Average annual regulatory costs (from business as usual)

Change in costs (\$ million)	Business (per business)	Community organisations	Individuals	Total change in costs
Total, by sector	\$0.005	\$0	\$0	\$0.662

⁴⁵ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

⁴⁶ [Medicare Urgent Care Clinics Program Evaluation](#): First Interim Report. (2025). In *Department of Health, Disability and Ageing*. Retrieved September 12, 2025.

5. Who did you consult and how did you incorporate their feedback?

As Medicare UCCs were originally a 2022 election commitment, extensive consultation on the design and delivery of Medicare UCCs occurred once the Albanese Government came into office.⁴⁷ Medicare UCCs have a complex interaction with acute and primary health care systems and have established a nationally consistent service offering in the urgent care ecosystem which has not been achieved previously. As such, consultation has been essential to ensure appropriate and effective integration and positive patient experience. Key themes from stakeholder engagement include workforce flexibility, program costs and opportunities to strengthen system integration.

During early phases of development, the department regularly and extensively engaged with state and territory governments and PHNs, as well as a number of peak health bodies on the planning and establishment of Medicare UCCs. For example, the *UCC Senior Official Advisory Group (SOAG)* was established as a time-limited advisory body to discuss the design and implementation of the Medicare UCCs across all states and territories. It was not a decision-making body but instead facilitated collaborative and open discussion on the initiative and supported national consistency of approach in implementation. Membership included representatives from all state and territory health departments and was chaired by the Deputy Secretary of the Australian Department of Health and Aged Care (now Department of Health, Disability and Ageing), Primary and Community Care Group. Key outcomes of this committee include endorsement of the Medicare UCC program's Measures of Success and the Medicare UCC Operational Guidance, which have been fundamental to the program's implementation.

Throughout program implementation, engagement with key stakeholders has occurred via governance committees, working groups and bilateral meetings to seek views on design and implementation elements, as well as continuous improvement. A summary of governance committees includes, but not limited to:

- *Medicare UCC Operational Advisory Group*, an advisory committee to facilitate expert discussion on the implementation of the Medicare UCC Program. Membership includes representatives from state and territory health departments, PHNs, and peak health bodies.
- *Medicare UCC Community of Practice*, a national platform for knowledge sharing, experiences and strategies for successful establishment and delivery of the Medicare UCC program. Membership is offered to all staff including - those working in Medicare UCCs, Providers, PHN and jurisdictional officials.
- *Strengthening Medicare Implementation Oversight Committee*, an overarching advisory committee comprising senior leaders and representatives from across the healthcare

⁴⁷ [Urgent Care Clinics](#). (2022). [Press release]. Retrieved September 12, 2025.

sector, and provide strategic advice on implementation, monitoring and evaluation of strengthening Medicare measures, which includes Medicare UCCs.

The department also uses regular bilateral discussions with each state and territory health department and PHN commissioners to discuss local level issues relevant to the implementation of the initiative.

An evaluation of the Medicare UCC program is underway based on Measures of Success that were developed and agreed by the Commonwealth, and state and territory governments. The evaluators are engaging with a number of stakeholders including Medicare UCC Commissioners, Medicare UCC Providers, Medicare UCC Operational Advisory Groups, Peak Health Bodies, staff and patients.

Principle views of stakeholders

State and territory governments

Given the intersection of the Medicare UCC program goal to ease pressure off hospital EDs, the department has worked closely with state and territory health departments to support the planning and implementation of the Medicare UCC program. Some jurisdictions have co-funded Medicare UCCs and also acted as commissioners of certain Medicare UCCs via Federation Funding Agreements; more than 25 state-funded UCCs in Victoria and New South Wales have already transitioned to the Medicare UCC program. National Cabinet, a forum comprising of the Prime Minister, Premiers and Chief Ministers, in December 2023 agreed to a package of measures to take pressure off hospitals, which included boosted funding for Medicare UCCs.⁴⁸ Further support was provided part of the Strengthening Medicare measures supported in the 2024-25 Budget to expand the program with a further 29 Medicare UCCs.

Primary Health Networks

PHNs are independent, not-for-profit organisations that commission health services to meet the needs of their community and as commissioners of Medicare UCCs, are key delivery partners for the Medicare UCC program. PHNs play an important role to directly commission the establishment of Medicare UCCs in their regions and support Medicare UCCs on an ongoing basis, including communication activities and ensuring integration of Medicare UCCs into the local primary health care system.

Peak health bodies

Given the intersections of the Medicare UCC program with the broader health system the department engages with peak bodies to support the implementation of the Medicare UCC Program. There are varying views between peak health bodies with respect to the Medicare UCC program.

⁴⁸ [*Meeting of National Cabinet – the Federation working for Australia*](#). (2023b, December 6). Prime Minister of Australia. Retrieved September 12, 2025.

Nursing peak health bodies, including the Australian College of Nurses highlighted that nursing staff are essential to the operations of the Medicare UCCs and have called for an expanded role of advanced practice nurses and nurse practitioners in urgent care settings to support workforce pressures.

The Australasian College of Paramedicine has also highlighted the increasing role paramedics can play in the urgent care model of care, given their experience in triage and early management. Following detailed engagement and in response to this feedback, updates to the Medicare UCC Operational Guidance have included changes to staffing model to enable paramedics to play a more active role in Medicare UCC service delivery.

Some medical peak bodies such as RACGP have been previously critical of the Medicare UCC Program, citing concerns over cost-effectiveness when compared to general practice, potential to further exacerbate GP workforce pressures, fragmentation of care, continuity of care and further roll-out without an evaluation. The department is cognisant of these concerns and is working on a number of initiatives to address broader workforce challenges. Given the pressure already on the general practice sector, it is not feasible to divert all urgent care to general practice, and cost analysis undertaken to date demonstrate health system cost savings when compared to ED. More recently, RACGP have acknowledged Medicare UCCs as a growing part of the Australian health care landscape, with many members working in clinics, and committed to advocating for maintained focus on primary care and establishment of clear standards.⁴⁹

Irrespective of the principle views, the department continues to regularly engage with peak health bodies (including RACGP, Australian Medical Association, Australian College of Rural and Remote Medicine, Australian College for Emergency Medicine, and Royal New Zealand College of Urgent Care) through the Medicare UCC Operational Advisory Group and as part of other policy and program developments, for example the Medicare UCC Operational Guidance Review. Program improvements, as a result of stakeholder engagement, have included greater flexibility in the minimum staffing requirements, an uplift in requirements for clinical handover and discharge summaries to be provided to a patient's usual GP, and improving triage and demand management requirements. Feedback and consultation with peaks aim to ensure implementation of the program is optimised.

An evaluation of the Medicare UCC program is underway based on the nine Measures of Success that were developed and agreed by the Commonwealth, and state and territory governments. As part of the Second Interim and Final Evaluation Reports peak health bodies are being consulted to gain their insights on the Medicare UCC Program and opportunities for improvement.

⁴⁹ [*newsGP - RACGP leaders discuss future of UCCs*](#). (n.d.). NewsGP. Retrieved September 12, 2025.

Patients and consumers

Beyond engagement with consumer representatives via existing governance committees such as the Strengthening Medicare Implementation Oversight Committee, there has been limited direct consultation with patients and consumers in the design and implementation of the Medicare UCC program to date, including in the First Interim Report. Limited early insights from the Interim Evaluation Report include patients value having an alternative to ED, appreciated avoiding extended waits in ED, and receiving care that is bulk billed.

***Patient story:** 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.*

Medicare Urgent Care Clinics Program Evaluation: First Interim Report. (2025)

This highlights an 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.

Anecdotally, the Australian public are supportive of the Medicare UCC program. This is evident in the 2 million presentations to Medicare UCCs around Australia since clinics first opened in June 2023. Additional Medicare UCCs were also promised as a key election commitment in the lead up to the May 2025 Federal election.⁵⁰

The department has a number of initiatives in place that will support improved consultation and feedback with patients and consumers, which will be used to support broader program improvements within the current funding envelope. These initiatives include:

- Consumer roundtable – the department has engaged the Consumers Health Forum of Australia (CHF) on 19 September 2025 for a roundtable to gather consumer insights on accessing urgent care services, in particular Medicare UCCs.
- Second Interim Report Evaluation – as flagged in the Interim Evaluation Report, work is underway to incorporate more comprehensive consumer insights into the Second Interim Evaluation Report. Evaluators are sourcing feedback via patient surveys and focus groups, as well as engagement via the Operational Advisory Group, peak bodies and commissioners.

- Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcomes Measures (PROMs) - the department have engaged Ipsos to design and deliver a national patient and staff experience survey in Medicare UCCs, which aims to capture patient and staff experiences to support Medicare UCCs in meeting their objectives and to promote continuous program improvement and quality service delivery. Ipsos will be working closely with Commissioners, providers, and other key stakeholders to design and deliver the survey which is being delivered in two phases, Phase 1 in 2025 and Phase 2 in 2026.

Outcomes from ongoing consultations will be built into the implementation approach provided to government for consideration and final decision.

⁵⁰ Lowrey, T. (2025, March 2). *Federal Labor commits nearly \$650m for new 50 new urgent care clinics*. ABC News. Retrieved September 12, 2025.

6. What is the best option from those you have considered and how will it be implemented?

Identifying the preferred option

To identify a preferred Option, a decision rule to ascertain the option that best meets the objectives of the Australian Government includes the outcomes of the cost-benefit analysis and feedback received through consultation feedback.

Option 1 – retains the status quo and continues the current problems of increased ED presentations when current funding expires. This will put further strain on the healthcare system and workforce within hospitals. This will likely impact on the quality of care provided to patients resulting in longer wait times and potentially worse health outcomes.

Option 2 - will address the key objectives to ease the pressure on our hospitals and give families more options to see a health care professional when they have an urgent, but not life threatening, need for care. Whilst some stakeholder groups may incur initial cost and some additional regulatory burden, the Policy Impact Analysis identifies that it is more likely to be effective in achieving the earlier outlined objectives and achieving the greatest net benefit, making it the preferred option.

Best option and benefits

The department considers **Option 2** - Ongoing funding for Medicare UCCs – as the best option for delivering on the government’s commitment to strengthen Medicare by taking pressure off hospitals, supporting and growing health workforce, and ensuring all Australians have access to affordable, high quality urgent health care, when and where they need it. The rationale for this position is:

- The Australian Government has already invested in the establishment of Medicare UCCs, resulting in a zero-sum cost for this aspect of the preferred option.
- Securing ongoing funding would cement Medicare UCCs as a key part of the health system and ensure continued access to urgent care for non-life-threatening conditions for patients across Australia.
- Medicare UCC providers would receive longer term funding and security, enabling the clinics to stabilise their service delivery with reduced disruptions.
- Ongoing funding for the Medicare UCC Program would further increase public adoption as these services evolve to become a permanent feature of the health landscape.

- The overall long-term benefits to the health system and patient outcomes outweigh any costs to primary care settings.

The benefits of **Option 2** far outweigh the benefits of Option 1 (see below) in comparison to the nine Measures of Success which were agreed by the Australian, and state and territory governments. 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.

TABLE 5: OVERVIEW OF BENEFITS FOR EACH OPTION UNDER MEASURES OF SUCCESS

Measure of Success	Option 1 benefits	Option 2 benefits
1. Patients receive timely treatment for urgent non-life-threatening conditions in Medicare UCCs.	Patients would need to rely on EDs or their regular GP if appropriate. Wait times for ED are longer than current UCCs. 29.2% of people delayed or did not use a GP when needed in 2023-24 (ABS Patient Experiences Survey).	UCC wait times are approximately 14.5 minutes, which is faster than ED wait times for urgent non-life-threatening conditions
2. Medicare UCCs provide safe and quality treatment to patients.	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to deliver safe and quality treatment with regular clinical assessments included
3. Medicare UCCs deliver coordinated care for Medicare UCC patients	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to continue building local relationships for coordinated patient care
4. Medicare UCCs provide a positive experience for patient/carer.	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to provide a positive experience for patients and carers through regular patient feedback for program improvement
5. Medicare UCCs provide a positive experience for providers at Medicare UCCs, in	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to ensure positive experiences for service

partner hospital EDs and in local GP practices.		providers through regular staff feedback for program improvement
6. Medicare UCCs reduce pressure on hospital ED presentations at partner hospital EDs.	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to continue seeing patients who otherwise would have gone to an ED
7. There is a change in consumer behaviour over time to use Medicare UCCs where available instead of EDs for urgent non-life-threatening conditions.	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support consumer behaviour change by ensuring UCCs remain a constant reliable place to go for treatment, open extended hours with no cost
8. Medicare UCCs, PHNs, Healthdirect, jurisdictions and the health ecosystem have established an effective coordinated care option for people with urgent non-life-threatening conditions.	In the absence of UCCs, PHNs, Healthdirect and jurisdictions would have limited options available to ensure coordinated care for people with urgent non-life-threatening conditions	Ongoing funding of UCCs will support PHNs, Healthdirect and jurisdictions to work with UCCs on delivering coordinated care for people with urgent non-life-threatening conditions
9. Medicare UCCs are cost effective	Not achievable as UCCs would not continue	Ongoing funding of UCCs will support clinics to operate in a cost-effective manner through implementation of a performance-based funding model

Implementation and timing

To achieve success, **Option 2** will be influenced by the continued establishment of Medicare UCCs. The final decision to provide ongoing funding for Medicare UCCs is a decision for government in a budget context.

Following the outcome of the May 2025 Federal election, the Program is now undergoing further expansion in Tranche three, which will establish an additional 50 Medicare UCCs in 2025-26.

Ongoing funding for all (137) Medicare UCCs from 1 July 2026 will ensure continuation of service delivery for clinics and continued accessibility of bulk-billed urgent care services for all Australians.

The Branch will continue with ongoing management, driving performance uplift, and evaluation of the existing Medicare UCCs.

To implement ongoing funding, key milestones include:

- Provide new grant opportunity guidelines for PHN Commissioners
- Execute funding agreement with Commissioners
- Commissioners to re-negotiate existing clinic contracts to reflect program extension.

Implementation issues and risks

The following issues and risks have been identified for the implementation of **Option 2**.

Key Risks	Current Controls and/or proposed mitigations
Delays in establishing new Medicare UCCs.	The department regularly engages with commissioners to discuss any issues with implementation of Medicare UCCs and can identify any mitigation strategies to avoid any significant delays.
The operation of the Medicare UCC Program does not meet its original policy intent as described by the measures of success.	The department regularly engages with commissioners to ensure understanding of program intent. Department reviews and updates project management documents as program evolves. Risks to program delivery are actively managed in a variety of ways, including risk workshops, branch stand ups, directors’ meetings, as well as fortnightly reports and meetings to the SRO. There are also clear escalation pathways to the Deputy Secretary and the Minister where required.
Medicare UCCs do not provide safe and quality treatment to patients.	Medicare UCC providers are required to be accredited to appropriate safety and quality standards. Independent Clinical Assessments are conducted prior to clinics opening to ensure compliance against Medicare UCC operational guidance, with non-critical outstanding recommendations followed up with commissioners. The program governance structure allows regular engagement with stakeholders and professional representative bodies on key program requirements. New operating model trials are supported where safe to do so and outcomes tracked to support program improvement opportunities.

Funding is not used effectively and efficiently by UCC Commissioners.

The department undertakes monitoring and compliance activities for contractual and operational streams, supporting understanding of funding utilisation and management issues. Data governance, sharing and protocols are established with commissioners and clinics.

The department does not or is unable to measure the performance of the Medicare UCC Program.

Reporting and monitoring requirements have been established between the department and commissioners within executed agreements. Measures of Success have been developed against which an independent evaluator is assessing the program. The department uses project management principles, bilateral meetings, and status updates to track and communicate with commissioners.

Breach of privacy, confidentiality or data usage obligations by Medicare UCCs, Commissioners or the department.

The department has developed and maintained a privacy impact assessment which highlights privacy risk areas and areas for improvement to help the department manage these identified risks and impacts. The department also maintains a data governance framework that outlines data collection practices and management procedures.

New Medicare UCCs do not meet government expectations.

The department has reviewed existing contract guidance and funding arrangements to ensure expectations around the delivery of the Medicare UCC program. The department is also considering the development of industry or commissioner briefings to clarify expectations of future providers prior to the procurement process.

New Medicare UCCs may not be viable due to limited workforce capacity, or limited interest and / or availability of local community healthcare services or GPs in Program participation.

The department is consulting with local state and territory governments as well as PHNs to ensure that future locations are selected with consideration of existing workforce in the area, and that selected providers have demonstrated their capacity to staff and deliver the program.

7. How will you evaluate your chosen option against the success metrics?

An independent evaluation of the Medicare UCC Program has commenced. The Interim Evaluation Report has been developed by the Nous Group (Nous) as the first of three reports that will progressively evaluate the program through to 2026. Interim Evaluation Report 2 is due in late 2025 and the Final Evaluation Report in 2026. The Interim Evaluation 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.

Ongoing monitoring and evaluation

The department undertakes continual comprehensive engagement, monitoring and analysis including regular engagement with Medicare UCC Commissioners, monitoring of data and performance. The department collects and has access to a range of data relevant to the Medicare UCC program including:

- Medicare UCC data module
- Emergency department data
- MBS and PBS data
- Healthdirect data
- Patient and staff experience survey data

A future approach to evaluation will involve ongoing monitoring through measures such as national patient surveys and potential data linkage projects. Plans for further evaluation will be developed in consultation with the Office of the Chief Health Economist, the Health Economics and Research Division and other relevant stakeholders to determine the recommended approach and most suitable timing. Consideration will be given to opportunities to streamline and comprehensively evaluate the urgent care landscape, Medicare UCC evaluation findings, extension of the program beyond 2026 and the implementation of other urgent care initiatives. Future data linkage projects will provide insights on patient pathways through the health system in geographic areas and will help inform areas of high demand for urgent care. Evaluation over a longer period will better inform patient behaviours change in the health system and impacts on EDs.

Future evaluation questions will aim to assess patient and provider satisfaction and perceptions of safety and quality of services through regular feedback surveys. These surveys align with current measures of success related to safe and quality treatment, timely treatment, positive patient and provider experiences, and coordinated care. Future data linkage projects will also support evaluation to determine whether Medicare UCCs and potentially other state funded models of urgent care are meeting unmet demand; diverting patients away from EDs; resulting in changes in patient behaviour when seeking primary care over time. The data linkage projects can help inform

current measures of success related to reducing pressure on EDs, and changes in consumer behaviour over time.

Appendix 1: Status of Policy Impact Analysis at each major decision point

Decision point/point in policy development	Timeframe	Status of the Policy Impact Analysis
Australian Labor Party election commitment to establish Medicare UCCs	April 2022	Nil
Australian Government announced funding over four years in October 2022-23 Budget to establish Medicare UCCs.	Oct 2022	Draft Regulation Impact Statement developed
Australian Government announced additional funding over three years in May 2023-24 Budget to establish Medicare UCCs, bringing total to 58.	May 2023	Draft Regulation Impact Statement
National Cabinet agreed to additional funding for Medicare UCCs.	Dec 2023	Draft Regulation Impact Statement
Australian Government announced funding to establish 29 new Medicare UCCs, as part of the 2024-25 Budget.	May 2024	Draft Regulation Impact Statement
Australian Government announced funding over three years in the March 2025-26 Budget to establish 50 new Medicare UCCs.	March 2025	Draft Regulation Impact Statement
First and Second Pass Assessment by OIA	September/October 2025	Draft Regulation Impact Statement updated to a Policy Impact Analysis and finalised for final assessment by the OIA.