Parliamentary Budget Office

Urgent Care Clinics	
Party:	Australian Labor Party

Summary of proposal:

The proposal would establish a trial of 50 urgent care clinics (clinics) with the objective of delivering services in a primary care or community health setting that would generally otherwise be performed in an emergency department.

Existing general practice or community health centres would be selected through a competitive tender process. Selected practices and health centres would receive capital and operating funding to support them in staying open for extended hours and to increase staffing numbers.

- Clinics would be located within the general vicinity of hospital emergency departments.
- Funding of $12.5 million would be available in 2023-24 for clinics to undertake capital upgrades.
- Funding of $37.5 million per year would be available in 2023-24, 2024-25 and 2025-26 for operational costs.
  - The amount of operational funding provided to individual clinics would be determined by factors such as size and expected level of activity.
- Clinics would be required to open every day of the year for a minimum of 14 hours (8am to 10pm).
- Patients attending these clinics would be entitled to receive Medicare benefits for the services provided to them.
  - A condition for being selected as an urgent care clinic is that all Medicare services provided by the clinic, that may otherwise have been provided in an emergency department, must be bulk billed.

Departmental funding of $10.6 million over 3 years would be provided to administer the program with $4.2 million for 2023-24 and $3.2 million per year for 2024-25 and 2025-26.

Clinics would be expected to commence operating from 1 July 2023 and funding for clinics would cease on 30 June 2026.

Costing overview

The proposal would be expected to decrease the fiscal and underlying cash balances over the 2022-23 Budget forward estimates period by around $136 million. This reflects an increase in administered expenses of around $125 million and departmental expenses of around $11 million.

The proposal would have an ongoing impact beyond the 2022-23 Budget forward estimates period. A breakdown of the financial implications (including public separate public debt interest (PDI) tables) over the period to 2032-33 is provided at Attachment A.

The financial implications are sensitive to both the implementation of the quantifiable components and the impact of the proposal on the unquantifiable component, see *Uncertainties*.

The Parliamentary Budget Office (PBO) notes that this proposal would be a trial and that at the conclusion of this trial there may be a deeper understanding of the impact the clinics would have on the overall health system such that more detailed funding arrangements and cost implications could be determined.

Table 1: Financial implications ($m)[(a)(b)]

	2022-23	2023-24	2024-25	2025-26	**Total to 2025-26**
Fiscal balance	-	-54.2	-40.7	-40.7	**-135.6**
Underlying cash balance	-	-54.2	-40.7	-40.7	**-135.6**

(a) A positive number represents an increase in the relevant budget balance; a negative number represents a decrease.
(b) PDI impacts are not included in the totals.
- Indicates nil.

Uncertainties

Quantifiable components – Grant and specified departmental costs

The quantified financial implications of this proposal reflect only the capital and operational funding amounts for clinics and the specified departmental funding. The quantified financial implications are relatively certain but are sensitive to the capacity of the Department of Health to undertake a competitive tender process that would allow all 50 clinics to commence operating in 2023-24.

The unquantifiable component – Impact on existing Australian Government health funding expenses

The PBO has reviewed international evidence and considered the potential behavioural responses, including of patients and hospitals, to this proposal. We have concluded the impacts on existing Australian Government health expenses to be unquantifiable. While we have drawn this conclusion from the available data, it appears clear from both the relative costs of emergency and primary care to the Australian Government, and international experience, that an arrangement which successfully diverts patients to primary care could reduce health costs to the Australian Government.

Three key determinants of the unquantified costs are:

- the number of patients serviced by clinics
- the relative costs of the treatment in the clinic, compared to treatments in the baseline
- any institutional responses from those treating patients in the baseline, such as public hospitals.

The different aspects of these key drivers are discussed below.

Number of patients serviced by clinics

The number of patients serviced by clinics depends on factors including the incentives for clinics to opt in, the chosen location of clinics and the available workforce.

The capped operational grant funding coupled with a requirement that clinics bulk bill would need to be sufficient for clinics to opt into the trial.

- On the reasonable assumption that the average fully functioning clinic could provide around 25,000 services per year, operational funding of $750,000 (the average annual amount that would be provided per clinic) equates to an extra $30 per service. The current level of bulk billing (where

no out-of-pocket is charged) for general practitioner services is around 90%. The average out-of-pocket cost per general practitioner service, when not bulk billed, is currently around $40.

Evidence suggests that the location of the clinics relative to public hospital emergency departments is a driver of the success in diverting services from public hospital emergency departments to urgent care clinics. The extent of collaboration between stakeholders (clinic and hospital administrators, Australian and state government officials) may also play a factor.

The supply of health professionals to staff clinics may affect the number and size of clinics, and the volume of services they provide.

- Australia has a documented uneven distribution of general practitioners, particularly in rural and regional areas. This may affect the number and location of clinics that participate in the trial and the volume of services that are provided by these clinics.

Relative costs of treatment

In the baseline scenario, services performed in urgent care clinics are likely to be performed:

- in public or private hospital emergency departments
- in other GP clinics (which may or may not bulk bill)
- in state-funded services such as walk-in clinics or community health centres
- outside the health system – that is, patients may seek treatment under this policy where they would otherwise have been treated in the home, by other practitioners, or not at all.

It is intended that a majority of services provided by urgent care clinics would be diverted from public hospital emergency departments. In choosing to attend an urgent care clinic as opposed to a public hospital emergency department, patients are transferring the mechanism for funding those services from the *2020-25 National Health Reform Agreement* (which is jointly funded by the Australian Government and state and territory governments) to the Medicare system (which is solely funded by the Australian Government).

- The cost to the Australian Government of providing less complex, emergency department-like services in a primary care or community health setting is likely to be less than in an emergency department.
  - Advice from the Department of Health suggests that a reasonable estimate of the average Medicare billing cost for services provided in urgent care clinics could be around $65.
  - Analysis of the types of services likely to be diverted suggests that the cost to the Australian Government of these services being provided in hospitals is around $270.

However, the number of such diverted services as a share of all services provided by the clinics would also influence the net cost to the Australian Government.

In addition, the baseline treatment for other services would also have an influence on costs. Services that simply move from one general practice clinic to another are unlikely to add a material net cost. Services that would move from being provided in private hospital emergency departments are similarly unlikely to add a material net cost. Services that would come from providers that were otherwise wholly state government funded, and situations where someone would have been treated at home by other practitioners or untreated, are likely to be a pure additional cost to the Australian Government.

Institutional responses from public hospitals

Should the establishment of urgent care clinics lead to a material reduction in presentations to public hospital emergency departments the response by hospitals would play a role in the cost impact to the Australian Government.

- Should hospitals operate at a lower level of activity, noting the relative cost differences detailed above, this may result in a net reduction in Australian Government health expenditure.
- Should hospitals use those resources freed up to reduce wait times in emergency departments or increase service provision in other areas of health care that are jointly funded by Australian and state governments, this would be less likely to result in a net reduction in Australian Government health expenditure. In such a scenario, the Australian Government would meet the costs of urgent care clinics through the proposed grant funding and Medicare billing for services provided by the clinics while also continuing to pay for the same or similar level of hospital activity under the *2020-25 National Health Reform Agreement*.
  - Should the trial lead to a demonstrable reduction in resources needed to operate public hospital emergency departments the Australian Government may be able to amend public hospital funding arrangements to reflect the transfer of services between funding mechanisms.

Other issues

Allowing non-emergency departmental specialists to claim Medicare items that cover emergency department-like services when provided in a primary or community-care setting is likely to require legislative and/or regulatory changes.

Under funding arrangements as set out in the *2020-25 National Health Reform Agreement*, the Australian Government contribution to hospitals in any given financial year is the starting point for determining the contribution for the subsequent year. Given this arrangement, any impact on Australian Government hospital funding during the trial period is likely to have ongoing impacts beyond the end of the trial period.

Key assumptions

The PBO has made the following assumptions in costing this proposal.

- In order for clinics to commence operating from 1 July 2023, a competitive tender process would be run in 2022-23.
- Noting no departmental costs were specified for 2022-23, departmental costs for conducting the tender process in that year would be met from within the existing resources of the Department of Health.
- There would be full uptake of the capital and operational grant funding in the year it is made available.

Methodology

Capital and operational grant funding that would be provided to clinics reflect policy specifications made by the Australian Labor Party.

Departmental costs are as specified by the Australian Labor Party.

Financial implications were rounded consistent with the PBO's rounding rules as outlined on the PBO Costings and budget information webpage.[1]

Data sources

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Australian Institute of Health and Welfare (2018) *Emergency department care 2017-18: Australian hospital statistics*, Australian Institute of Health and Welfare, Australian Government, accessed 26 June 2022.

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Royal New Zealand College of Urgent Care (2021) *What is urgent care*, accessed 26 June 2022.

[1] https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Budget_Office/Costings_and_budget_information

Attachment A – Urgent Care Clinics – financial implications

Table A1: Urgent Care Clinics – Fiscal and underlying cash balances ($m)[(a)(b)]

	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33	**Total to 2025-26**	**Total to 2032-33**
Expenses													
Administered													
Grants for capital upgrades	-	*-12.5*	-	-	-	-	-	-	-	-	-	***-12.5***	***-12.5***
Grants for operational costs	-	*-37.5*	*-37.5*	*-37.5*	-	-	-	-	-	-	-	***-112.5***	***-112.5***
Impact on existing Australian Government health funding expenses [(b)]	-	*	*	*	*	*	*	*	*	*	*	*	*
Total – administered	**-**	***-50.0***	***-37.5***	***-37.5***	*	*	*	*	*	*	*	***-125.0***	***-125.0***
Departmental													
Departmental expenses	-	*-4.2*	*-3.2*	*-3.2*	-	-	-	-	-	-	-	***-10.6***	***-10.6***
Total – departmental	**-**	***-4.2***	***-3.2***	***-3.2***	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***-10.6***	***-10.6***
Total (excluding PDI)	**-**	**-54.2**	**-40.7**	**-40.7**	*	*	*	*	*	*	*	**-135.6**	**-135.6**

(a) A positive number for the fiscal balance indicates an increase in revenue or a decrease in expenses or net capital investment in accrual terms. A negative number for the fiscal balance indicates a decrease in revenue or an increase in expenses or net capital investment in accrual terms. A positive number for the underlying cash balance indicates an increase in receipts or a decrease in payments or net capital investment in cash terms. A negative number for the underlying cash balance indicates a decrease in receipts or an increase in payments or net capital investment in cash terms.

(b) While the trial clinics run for 3 years, the unquantifiable impacts would continue. Under funding arrangements as set out in the *2020-25 National Health Reform Agreement*, the Australian Government contribution to hospitals in any given financial year is the starting point for determining the contribution for the subsequent year. Given this arrangement, any impact on Australian Government hospital funding during the trial period is likely to have ongoing impacts beyond the end of the trial period.

* Unquantifiable – not included in totals.

\- Indicates nil.

Table A2: Urgent Care Clinics – Memorandum item: Public Debt Interest (PDI) impacts – Fiscal and underlying cash balances ($m)[(a)(b)]

	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33	**Total to 2025-26**	**Total to 2032-33**
Fiscal balance	-	*-0.6*	*-1.7*	*-2.7*	*-3.2*	*-3.3*	*-3.4*	*-3.5*	*-3.6*	*-3.7*	*-3.8*	***-5.0***	***-29.5***
Underlying cash balance	-	*-0.5*	*-1.6*	*-2.6*	*-3.1*	*-3.3*	*-3.4*	*-3.5*	*-3.6*	*-3.7*	*-3.8*	***-4.7***	***-29.1***

(a) As this table is presented as a memorandum item, these figures are not reflected in the totals in the table above. This is consistent with the approach taken in the budget where the budget impact of most measures is presented excluding the impact on PDI. If the reader would like a complete picture of the total aggregate, then these figures would need to be added to the figures above. For further information on government borrowing and financing please refer to the PBO's online budget glossary[2].

(b) A positive number for the fiscal balance indicates an increase in revenue or a decrease in expenses or net capital investment in accrual terms. A negative number for the fiscal balance indicates a decrease in revenue or an increase in expenses or net capital investment in accrual terms. A positive number for the underlying cash balance indicates an increase in receipts or a decrease in payments or net capital investment in cash terms. A negative number for the underlying cash balance indicates a decrease in receipts or an increase in payments or net capital investment in cash terms.

\- Indicates nil.

[2] Online budget glossary – Parliament of Australia (aph.gov.au)