National Integrated Health, Aged Care and Supported Living System

Comprehensive Policy and Implementation White Paper

This paper is written as a practical reform brief. It does not simply set out ambitions. It sets out how the Commonwealth could structure, fund, phase and govern a national model that integrates hospitals, aged care, supported senior living, workforce mobility, patient records, procurement, digital systems and emergency preparedness.

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1. Executive Summary

Australia does not lack health spending alone; it lacks an integrated structure that can turn funding into a reliable patient journey. The current model divides accountability between the Commonwealth, the states, public hospitals, aged care providers, home care programs and the private insurance market. The result is avoidable duplication, delayed discharge from hospital, inconsistent access by postcode, and an ageing population moving through care in crisis rather than by design.

This paper proposes a national integrated system built on four linked reforms. First, the Commonwealth assumes primary responsibility for funding and national standards across health and aged care. Second, hospital precincts are expanded to include step-down care, residential aged care and supported senior living. Third, the workforce is supported through a national nursing and care award, national training campuses, a flexible staffing pool and an interstate deployment framework. Fourth, the system is funded through a strengthened base Medicare levy, with optional Medicare Plus tiers for dental, private patient access within the national system and aged care support.

The practical objective is straightforward: a person should be able to move from acute hospital care to rehabilitation, supported living, residential aged care or home support through one planned continuum rather than several disconnected systems. The reform therefore focuses not just on money, but on governance, bed flow, workforce, infrastructure, digital systems, emergency preparedness, consumer protections and staged implementation.

The model incorporates a person-centred funding approach informed by NDIS principles, delivered within a nationally planned and regulated framework.

2. Why Reform Is Required

The case for reform should be understood in operational rather than ideological terms. Australia already carries the cost of fragmentation, but the cost is hidden. It appears as ambulances ramping because beds are unavailable, elective surgery delays because wards are blocked, families waiting for aged care placement, regional services unable to recruit nurses, and higher household spending on private cover that many people do not feel gives value for money.

A system built around separate administrative silos can cope when demand is modest. It fails when the population ages, care needs become more complex and staffing is tighter. The practical question for government is not whether to spend more in one isolated part of the system. It is whether to keep funding separate bottlenecks, or redesign the system so those bottlenecks are removed.

Australia's current arrangements also make it difficult to plan capacity rationally. Hospitals can be overwhelmed not because they lack acute expertise, but because patients who no longer require acute treatment have nowhere suitable to go. Families are left managing the gap between health care, aged care and housing. Providers duplicate procurement, policies and software. Staff face inconsistent pay structures and portability barriers. These are all symptoms of one underlying problem: the system is funded in pieces and administered in pieces.

The reform proposed in this paper treats those failures as connected. It is designed to improve patient flow, increase capacity where it matters most, reduce duplication, and create a more coherent public system capable of meeting the needs of an ageing population.

3. Reform Objectives

The reform objectives below are written as delivery objectives. Each one implies a change in structure, process and measurement.

3.1 Create a single national system with clear accountability

This objective means that one level of government must become unmistakably responsible for system design, funding logic and national standards. At present, when performance worsens, governments can shift responsibility between Medicare settings, state hospital budgets and aged care programs. A national model removes that ambiguity.

The Commonwealth would hold primary responsibility for the financing architecture, national service rules, workforce frameworks, data standards and strategic capacity planning. States would continue to deliver services, but under nationally agreed contracts with measurable outputs and enforceable reporting requirements.

In practical terms, clear accountability requires:

• a national funding authority able to track expenditure across hospitals, aged care, home care and supported living against a common framework;
• a single public performance report published at least annually and broken down by region, wait times, staffing and aged care transition indicators;
• service agreements that specify what states deliver, what the Commonwealth funds, how disputes are resolved, and what happens when benchmarks are not met;
• a common patient pathway design so citizens are not forced to navigate separate bureaucracies for each stage of care.

3.2 Reduce hospital congestion and wait times

This objective is not limited to emergency departments. It is about the whole hospital flow. A hospital bed occupied by a medically stable person waiting for aged care is still a lost acute bed. Reducing congestion therefore requires more than extra hospital staff; it requires downstream capacity.

The policy aim is to shorten the time between a clinician deciding a person no longer requires acute care and that person actually moving into the right setting. The operating target should be a measurable decline in delayed discharges, a reduction in patients awaiting aged care or step-down placement, shorter average emergency department transfer times, and improved elective surgery throughput.

The mechanism for doing this is co-located step-down care, integrated residential aged care, and supported senior living linked directly to hospital precincts.

3.3 Expand aged care and supported living capacity

Capacity expansion must not mean only more traditional nursing home beds. The system needs a wider ladder of accommodation and care. Some older Australians need high-care residential support. Others need medication management, meals, domestic support or a safer living environment, but not a full residential aged care placement.

This reform objective therefore includes three forms of capacity: residential aged care, step-down care attached to hospitals, and supported senior living for people who sit between full independence and full-time care.

This objective also requires the Commonwealth to plan capacity by region, not simply fund programs and hope providers fill the gaps. Capacity planning should use demographic projections, hospital flow data, waiting list information and regional workforce supply to determine where new beds, units and home-support packages are required first.

3.4 Build a national workforce pipeline

A system design is only as good as the workforce that can staff it. Building a national pipeline means government must manage recruitment, training, mobility and retention as one problem. It is not enough to announce more university places while the workplace remains too fragmented or unattractive to keep staff.

The proposal therefore combines a national award, a training-campus model, portability of entitlements, clinical placements linked to new precincts, rural incentives, a national deployment pool for shortage areas, and a national flexible staffing pool for short-term gaps.

A meaningful workforce pipeline should show how school leavers, mature-age workers, enrolled nurses, registered nurses, personal care workers and allied health graduates enter the system, progress within it, and remain in it. The objective is to make health and care work portable, understandable and professionally sustainable across Australia.

3.5 Deliver equitable access across all regions

Equity in this paper does not mean every town receives the exact same facility. It means Australians should be able to access a reasonable standard of care regardless of whether they live in a capital city, a regional centre or a smaller rural community.

The policy should therefore apply different delivery models to different geographies while keeping the same national entitlement. Metropolitan areas may support large integrated precincts. Regional hubs may use medium-scale hospital-linked campuses. Smaller communities may rely more heavily on supported living, telehealth, visiting clinical teams and transport linkages to regional nodes.

The point is that the Commonwealth funds a national right to care, while delivery is shaped sensibly by local conditions.

3.6 Provide sustainable long-term funding

Sustainability requires visibility. People should be able to see what the core system costs, what optional enhanced cover costs, and what outcomes the public is getting in return. The current mix of taxes, premiums, gap payments, aged care fees and delayed care hides the real cost.

A more transparent funding structure, anchored to Medicare and supplemented by resident contributions for accommodation where appropriate, gives government and the public a clearer view of what is being funded and why.

Sustainability also requires disciplined use of capital. Hospital beds are among the most expensive places to keep someone who no longer needs acute care. If a less intensive and more appropriate care setting can be provided for lower cost, that is both better care and better fiscal management.

4. Facility Classification and Hospital Capability Standards

Australia's current health system does not apply a consistent national definition of what constitutes a hospital. The term "private hospital" is used across facilities with significantly different levels of clinical capability, infrastructure and post-operative care capacity. In practice, this allows facilities that operate as procedural centres to be presented and funded as hospitals despite not maintaining the same level of clinical responsibility.

This lack of clarity has practical consequences. Patients reasonably expect that a hospital will be capable of managing their full episode of care, including complications. When that expectation is not met, the burden shifts to the public system. This contributes to avoidable pressure on public hospitals, disrupts planned care for public patients, and obscures the true cost of treatment pathways.

A nationally integrated system requires a clear and enforceable classification framework that distinguishes between hospital-level care and procedural services.

4.1 Definition of a Hospital (Hospital-Level Facility)

For the purposes of the national system, a hospital—whether publicly or privately operated—must provide comprehensive, continuous and clinically accountable care across the full episode of treatment.

At a minimum, a hospital-level facility must provide 24-hour clinical care, maintain capacity for overnight and extended patient stays, and include access to an Intensive Care Unit or equivalent critical care capability, either on-site or through formally integrated and immediate access arrangements. It must be equipped to manage post-operative complications within its declared clinical scope without routine reliance on transfer to external facilities, and must maintain access to essential support services including diagnostics, pharmacy and allied health.

Facilities must also operate within a comprehensive clinical governance framework, including participation in national reporting systems and the national patient record.

Facilities that do not meet these requirements should not be classified, funded or represented as hospitals within the national system.

Established not-for-profit and private providers, including major institutions such as Mater and St Vincent's, demonstrate that private operators can meet full hospital-level capability. The distinction is therefore not between public and private ownership, but between facilities that meet hospital-level standards and those that do not.

4.2 Procedural Facilities (Surgical Clinics and Day Procedure Centres)

Facilities that do not meet hospital-level capability requirements should be classified as procedural facilities, including surgical clinics and day procedure centres.

These facilities perform an important role in delivering efficient, lower-complexity care. However, they are not designed to provide extended post-operative care or manage complex complications. Their role should therefore be clearly defined and limited to procedures that align with their clinical capability.

Procedural facilities must not be represented, regulated or funded as hospitals.

4.3 Post-Operative Care and Clinical Responsibility

All facilities undertaking surgical procedures must operate within their clinical capability and retain responsibility for patient outcomes within that scope.

Facilities must not undertake procedures that exceed their capacity to safely manage post-operative care. Where complications arise within the expected scope of the procedure, the originating facility must retain responsibility for management rather than relying on transfer as a routine practice.

Transfer to public hospitals should be limited to cases that genuinely exceed the declared clinical scope of the facility. Public hospitals should not be relied upon as a default provider of post-operative or complication care for privately initiated procedures.

4.4 Classification, Funding and System Integrity

Facility classification must be directly linked to funding eligibility and system participation.

Hospital-level funding and private patient subsidy arrangements should apply only to facilities that meet the hospital definition. Procedural facilities may participate in appropriate service delivery but should not receive hospital-level funding.

Private health insurer partnerships must align with this classification framework. Public subsidy should not support models that rely on the public system to complete the patient journey.

This approach ensures that patients receive care in appropriately resourced settings, that public hospital capacity is protected, and that funding reflects actual service capability.

5. Institutional Design and Governance Model

The reform should not attempt to abolish state delivery systems overnight. Instead, it should separate who funds and sets standards from who operates local services. The Commonwealth would own the national framework. States and approved delivery entities would operate under national agreements.

The recommended governance structure is as follows:

• a National Health and Aged Care Funding Authority responsible for pooled funding, regional capacity planning, expenditure tracking and public reporting;
• five-year intergovernmental service agreements with each state and territory, including activity targets, aged care transition targets, workforce obligations and regional delivery commitments;
• a national care classification framework so hospital, step-down, supported living and residential aged care can be measured on one scale rather than in disconnected categories;
• a ministerial council or equivalent governance forum for implementation disputes, but with the Commonwealth retaining final funding authority.

This structure allows the Commonwealth to be genuinely accountable without requiring all facilities to be directly operated from Canberra. It also creates a usable contracting model: the Commonwealth funds against outcomes; states and other operators deliver against agreed service rules.

The governance model should also include clear audit, compliance and review functions. Without independent oversight, national funding risks becoming another opaque transfer mechanism rather than a disciplined public system. The national authority should therefore be empowered to publish regional performance comparisons, identify areas of undersupply and recommend capital and workforce reallocations.

6. Integrated Health, Aged Care and Supported Living Precincts

The central infrastructure reform is the creation of integrated precincts. These are not just bigger hospitals. They are care campuses that physically and administratively link acute care, rehabilitation, step-down care, supported senior living and residential aged care.

6.1 What a precinct contains

Each precinct should include:

• the existing acute hospital or major health campus;
• a step-down or transitional care unit for patients leaving acute care but still requiring monitoring, rehabilitation or short-term nursing support;
• residential aged care beds for high-care residents who require continuous care;
• supported senior living units for people who can live semi-independently with support services;
• a co-located training facility for nursing, aged care and allied health students;
• integrated pharmacy, allied health and care coordination services.

6.2 How precincts should be selected

The first wave should target hospitals that show the highest combination of bed pressure, delayed discharge, older patient demand, and regional significance. Site selection should include acute bed occupancy, number of patients awaiting aged care placement, projected growth in the over-75 population, land availability, regional referral role, and local training provider presence.

6.3 Operational pathway within a precinct

The patient pathway should be treated as an internal flow, not a sequence of separate bureaucratic referrals.

1. A patient enters hospital for acute treatment.
2. Once clinically stable, the patient is assessed against a common national transition tool.
3. If the patient needs rehabilitation or monitoring, they move to step-down care on the same campus.
4. If they cannot safely return home but do not require acute treatment, they move into supported living or residential aged care depending on assessed need.
5. Care coordination staff manage funding, records and family communication through one pathway instead of separate referral systems.

6.4 Planning suggestion

Precinct design could use a combination of conventional and modular construction where possible so supported living wings, step-down beds and residential care units can be added in stages. This reduces capital shock and allows government to expand sites according to demonstrated demand.

6.5 Surgical Clinics and Procedural Care Facilities

The current system permits a structural imbalance in which some privately delivered procedural services undertake elective surgery without retaining responsibility for the full episode of care.

Where complications arise, patients are frequently transferred into the public system. This creates unplanned demand on public hospital beds, interrupts capacity allocated for public patients, and contributes directly to delays in elective surgery.

A nationally integrated system should not normalise this model. Procedural facilities must operate within clearly defined clinical limits aligned to their capability. Procedures must only be undertaken where the facility can safely manage the expected post-operative course.

Transfer to public hospitals should occur only where clinically necessary and should not be embedded as a routine component of care delivery.

Transparency in complication rates and transfer patterns should be supported through national reporting so that system performance reflects the full patient journey.

7. Supported Senior Living Framework

A major gap in the current system is the absence of a public, nationally regulated tier between independent living and high-care residential aged care. This paper refers to that missing tier as Supported Senior Living.

7.1 Purpose of the tier

Supported Senior Living is designed for people who are too vulnerable for ordinary independent housing, but who do not yet require a nursing-home-style placement. It reduces avoidable hospital presentations, delays entry into high-care settings, and gives families a safer transition option before crisis occurs.

7.2 Service package

The service offer should include:

- accessible accommodation designed for ageing in place;
- scheduled domestic support, meals and laundry where needed;
- medication support and health monitoring;
- onsite nursing presence or rapid nursing response depending on scale of site;
- social support, transport coordination and links to allied health;
- escalation pathway into step-down or residential care without leaving the precinct or broader system.

7.3 Accommodation models

To reduce pressure on public capital while preserving equity, the system should offer multiple accommodation models inside the same framework.

All accommodation provided under the Supported Senior Living framework is intended for resident use only. Occupancy should be limited to the approved resident as their principal place of residence. Subletting, leasing to third parties, or use of any dwelling as an investment or secondary property should not be permitted under any model. This ensures the system remains focused on care delivery, appropriate housing outcomes and equitable access, rather than asset speculation.

Public rental model

No large upfront contribution. The resident pays an income-based weekly or fortnightly fee. This ensures access for lower-income residents and must remain available in every region where supported living is offered.

Refundable deposit model

The resident pays a deposit similar in principle to current refundable accommodation deposit arrangements. Ongoing fees are lower. The balance is returned to the resident or estate subject to clear and capped deductions.

Purchase or premium lease model

The resident buys or leases a higher-standard unit within the precinct. This option is intended for those who want more space, greater independence or premium accommodation while remaining inside the public care framework.

All ownership or leasehold arrangements must be structured on an owner-occupier basis, with the dwelling required to be the resident's principal place of residence for the duration of occupancy.

Shared equity (co-ownership) option

A shared equity model may be incorporated within the purchase pathway, enabling residents to acquire a partial interest in supported living accommodation alongside a retained Commonwealth equity stake. This approach reduces upfront capital requirements for residents while allowing the public sector to maintain a long-term financial interest in supported living assets.

Under this model, the Commonwealth's equity share would be realised proportionally upon resale or transfer of the dwelling. This creates a capital recycling mechanism, enabling government to recover and reinvest funds into future supported living developments and system expansion.

From a fiscal perspective, the model supports more efficient use of public capital by leveraging private contributions, reducing the need for fully grant-funded accommodation, and maintaining a balance sheet interest in underlying assets.

All shared equity arrangements should be governed by nationally consistent rules covering valuation methodology, equity proportions, resale conditions, consumer protections and fee limitations.

All accommodation pathways should be available across multiple care levels where practical, so that choice of payment model does not dictate clinical entitlement.

7.4 Consumer protection rules

The supported living system should include:

- plain-language standard contracts approved nationally;
- clear refund rules and maximum time frames for repayments to estates;
- caps on deferred management or exit-type fees;
- transparent disclosure of what is accommodation, what is care, and what is optional service;
- an independent complaint and review pathway.

8. Workforce Reform: National Nursing and Care Award

No integrated system will work if staff remain trapped in fragmented industrial and administrative arrangements. The workforce reform therefore needs to sit alongside infrastructure reform from the outset.

8.1 Purpose of a national award

The award would establish nationally portable classifications, core pay bands, recognition of experience, minimum conditions and a common structure for nurses, care workers and relevant support staff. States and employers could still add site-specific incentives, but the base framework would be portable across the country.

8.2 Why portability matters

A nurse moving from one state system to another, or from hospital care into aged care or supported living, should not effectively restart their employment position. The system needs portable service recognition, consistent credentialing, and a clear transfer mechanism for leave and entitlements. Without that, national reform will still operate like a patchwork.

8.3 National deployment pool

The Commonwealth should establish a voluntary national workforce pool for temporary placements in high-demand locations. This pool would be relevant for regional shortages, new precinct commissioning, seasonal surges and emergency situations. The pool would not replace permanent staffing; it would stabilise system gaps while local recruitment catches up.

Participants should retain their core award classification and entitlements. Government should fund travel, temporary accommodation and relocation support where required. Additional loadings should apply for remote or difficult-to-fill placements. Placement lengths should be long enough to be useful operationally, such as eight to twenty-six weeks.

8.4 Award portability and system integration

The national award should align with credentialing systems, digital rostering, workforce data systems, and national training standards so that staff movement across jurisdictions is administratively simple rather than procedurally burdensome.

9. National Training and Workforce Development Framework

9.1 Overview

A nationally integrated health, aged care and supported living system requires a workforce model that is equally integrated. Training, education and workforce development must be aligned with system design, rather than operating as a separate pipeline disconnected from real service demand.

Australia’s current training system produces qualified professionals, but it does not consistently produce a workforce that is:

- distributed according to need;
- prepared to work across care settings;
- supported to remain in the system long term;
- able to move easily between regions and service types.

The purpose of this framework is to create a continuous, nationally coordinated workforce pipeline, linking education, training, employment and career progression across the entire system.

9.2 Core principles

The national training and development model should be built on the following principles:

- training must be aligned to actual system demand, not just enrolment capacity;
- education pathways must be clear, portable and progressive;
- clinical training must occur within real service environments, not separate systems;
- workforce entry should be accessible to school leavers and mature-age workers;
- career progression should be visible and supported across the system;
- regional and rural workforce development must be embedded, not treated as an afterthought.

9.3 Integrated training campuses

Each major integrated precinct should include a co-located training campus delivered in partnership with:

- universities;
- TAFEs;
- registered training organisations;
- health services and aged care providers.

These campuses should operate as live training environments, not purely classroom-based institutions.

Key features include:

- student rotation through acute hospital care, step-down and rehabilitation, supported senior living and residential aged care;
- shared supervision between clinical staff and educators;
- exposure to the full patient journey rather than isolated care settings;
- embedded use of national digital systems and patient records.

This model produces a workforce that is immediately familiar with integrated care delivery.

9.4 Structured entry pathways

The system should provide multiple entry points into the workforce.

School Leaver Pathways

Direct entry into nursing, allied health or care roles, supported placements within integrated precincts, and structured transition from education into employment.

Vocational Entry

Aged care and support worker qualifications, pathway into enrolled nursing, and credit transfer into higher qualifications.

Mature-Age Entry

Fast-track training programs for career changers, recognition of prior learning, and flexible study options linked to employment.

Internal Progression Pathways

Care worker to enrolled nurse to registered nurse, supported study with employer partnerships, and paid training models where possible.

The objective is to create a ladder, not a series of disconnected steps.

9.5 National skills framework and standardisation

Training must align with the national system structure.

This requires:

- a national skills and competency framework across hospitals, aged care and supported living;
- standardised qualifications and role definitions;
- consistent clinical training requirements;
- alignment with the National Nursing and Care Award.

This ensures that qualifications are recognised across all states, staff can move without retraining, and employers understand skill levels consistently.

9.6 Clinical placement reform

Clinical placements are currently a bottleneck in workforce development.

The integrated model addresses this by:

- embedding placements within precincts;
- increasing placement capacity through hospitals, aged care and supported living;
- aligning placement supply with workforce demand;
- reducing competition between institutions for limited placements.

Students should graduate having worked across multiple care environments, not just one.

9.7 Workforce retention and career development

Training is only effective if staff remain in the system.

Retention should be supported through:

- clear career progression pathways;
- portable entitlements under the national award;
- access to ongoing professional development;
- opportunities to move between regions, care settings and roles.

Career pathways should include clinical specialisation, leadership and management, education and training roles, and regional and remote practice incentives.

The system should be structured so that remaining in the workforce is the easiest and most attractive option.

9.8 Regional and rural workforce strategy

Regional workforce shortages are a persistent challenge.

This framework addresses them by:

• locating training campuses within regional precincts;
• prioritising local recruitment and training;
• providing bonded or supported training pathways;
• offering relocation incentives and housing support;
• using the national deployment pool to stabilise shortages.

People trained in regional areas are more likely to remain in regional practice. The system should therefore train where it needs staff.

9.9 Workforce data and planning

A national system requires national workforce planning.

This should include:

• real-time workforce data across hospitals, aged care and supported living;
• forecasting based on population ageing, regional demand and service expansion;
• alignment between training intake and system needs.

The National Health and Aged Care Funding Authority should work alongside education providers to ensure that workforce supply matches system demand.

9.10 National Flexible Workforce Pool

In addition to permanent staffing and the national deployment pool, the system should establish a National Flexible Workforce Pool consisting of casual and part-time nurses, care workers and allied health staff available to support short-term staffing gaps.

This pool would operate as a public alternative to private nursing agencies, providing a centrally coordinated, cost-controlled and clinically consistent staffing solution across the national system.

The purpose of the flexible workforce pool is to:

• provide rapid coverage for unplanned absences and short-term shortages;
• reduce reliance on high-cost private agency staffing;
• improve workforce flexibility for clinicians seeking part-time or casual roles;
• ensure consistent standards, credentialing and system familiarity across all placements;
• support regional and high-demand areas without requiring permanent relocation.

The pool should function as a nationally coordinated staffing service with:

• a central digital platform linked to national workforce systems;
• real-time visibility of staffing shortages across facilities;
• a roster of pre-credentialed staff available for same-day shifts, short-term placements and recurring part-time roles;
• standardised pay rates aligned with the National Nursing and Care Award;
• transparent booking and allocation processes.

The pool would be open to part-time nurses and care workers seeking additional shifts, semi-retired or returning clinicians, staff preferring flexible work arrangements, clinicians balancing family or study commitments, and regional staff seeking occasional metropolitan shifts or vice versa.

The current reliance on agency staffing introduces higher hourly costs, inconsistent clinical familiarity, fragmented credentialing processes and limited integration with local systems. A national public pool would reduce staffing costs through standardised rates, ensure all staff are trained in national systems and protocols, improve continuity and quality of care, and retain workforce capacity within the public system rather than external agencies.

9.11 Emergency workforce integration

The training system should also support emergency preparedness.

This includes:

• maintaining a register of trained personnel available for surge deployment;
• incorporating emergency response training into standard education;
• enabling rapid upskilling where required;
• linking training institutions into emergency workforce planning.

This ensures the workforce can scale during crises without relying solely on ad hoc arrangements.

9.12 Funding and support mechanisms

Workforce development requires sustained investment.

Funding should support:

• training campuses within precincts;
• clinical supervision and placement capacity;
• scholarships and incentives for priority areas;
• paid training pathways where feasible;
• digital training systems aligned with national platforms.

This investment should be treated as core system infrastructure, not discretionary spending.

9.13 Strategic impact

A national training and development framework delivers long-term system stability. It strengthens workforce supply, improves staff mobility, reduces recruitment pressure, supports regional services, improves quality and consistency of care, and aligns workforce capability with system design.

Without workforce reform, infrastructure reform will fail. With it, the system becomes sustainable.

10. Funding Architecture

This reform requires a funding model that is understandable to taxpayers and workable for government. The guiding principle is that universal essential care should remain tax-funded, while optional enhanced tiers and accommodation contributions can broaden consumer choice without weakening the public base.

10.1 Base Medicare levy

The proposal uses an indicative increase in the base Medicare levy from 2.0 percent to a range of approximately 3.0 to 3.5 percent of taxable income. The purpose of the increase is to fund a strengthened national universal system covering public hospitals, primary care, essential specialist care, mental health and core system administration.

This range is presented as a planning assumption rather than a final recommended rate. Treasury and the Department of Health would need to model the exact rate against projected expenditure, demographic demand and interaction with existing Commonwealth health spending.

10.2 Medicare Plus optional tiers

To reduce pressure on the base levy while still allowing an expanded public offer, optional tiers would sit alongside the universal system. These tiers are intended to operate like a public framework for additional cover rather than a compulsory second tax.

1. Dental option: indicative additional contribution of 1.5 to 2.0 percent. Intended to cover preventive dental care, routine restorative work and a defined share of major dental costs.
2. Private patient option: indicative additional contribution of 1.5 to 2.5 percent. Intended to allow a person to elect to be treated as a private patient within the new national system, helping avoid waiting times while remaining inside a publicly regulated framework.
3. Aged care support option: indicative additional contribution of 1.0 to 1.5 percent. Intended to expand residential aged care, step-down capacity, home-support packages and supported living operations.
4. Combined option: indicative additional contribution of 3.5 to 5.0 percent for those opting into a full enhanced package.

These percentages are not presented as final tax recommendations. They are policy design ranges intended to show how the system could separate the universal base from optional enhanced cover. A full actuarial model would be needed before implementation.

10.3 Capital funding

Capital should come from a combination of direct Commonwealth infrastructure funding, targeted state contributions under national agreements, and resident accommodation contributions where relevant. Acute clinical infrastructure should remain a public capital responsibility. Supported living accommodation can reasonably include resident deposits or purchase-style contributions so long as the care entitlement remains public and regulated.

10.4 Transition funding

Major reform fails when governments fund the destination but not the transition. A dedicated transition envelope should therefore be established for at least the first five years. It should fund project offices, pilot-site staffing, digital integration, industrial transition work, training expansion and temporary parallel-running costs while old and new systems overlap.

10.5 Public reporting

The public will accept reform more readily if the system shows where money goes. Annual statements should therefore report, at minimum, revenue raised from the base levy and optional tiers, expenditure by stream, number of supported living places created, number of hospital beds freed through reduced delayed discharge, and regional workforce growth.

10.6 Individualised Funding and Service Access (NDIS-informed model)

The proposed national system may incorporate elements of an individualised funding approach, informed by aspects of the National Disability Insurance Scheme (NDIS), while recognising the operational and fiscal challenges that have emerged under that model.

The NDIS has demonstrated the value of person-centred funding, allowing individuals to access services tailored to their needs rather than being confined to provider-based allocations. It has improved transparency for participants and increased flexibility in how care and supports are delivered.

However, the NDIS has also experienced significant structural challenges, including:

• rapid and often unpredictable expenditure growth;
• inconsistent assessment outcomes and funding allocations across participants and regions;
• administrative complexity for participants, providers and government;
• variable pricing and limited cost control in parts of the service market;
• thin markets and service gaps, particularly in regional and remote areas;
• evidence of over-servicing, inappropriate claims and fraud in some segments;
• fragmentation between funding allocation and actual service availability.

These challenges demonstrate the risks of a fully market-driven and individually administered funding model in a system that requires coordinated national planning, consistent standards and controlled expenditure.

The model proposed in this paper adopts a hybrid approach, combining the strengths of individualised funding with the discipline of a nationally planned system.

Under this approach:

• individuals would receive assessed care allocations aligned to a national care classification framework;
• funding would follow the person across care settings, including home support, supported living, step-down care and residential aged care;
• the Commonwealth would retain responsibility for price setting, service definitions and funding limits;
• provider participation would be limited to approved and regulated entities operating within national standards;
• regional capacity planning would ensure services exist before funding is allocated;
• digital systems would support real-time visibility of service use, expenditure and outcomes.

Unlike the NDIS, this model would not operate as an open-ended entitlement with fully individualised purchasing power. Instead, it would function within defined service envelopes and nationally managed pricing, ensuring fiscal sustainability and equitable access.

The objective is to retain the benefits of choice, transparency and portability, while avoiding cost escalation, administrative burden and market fragmentation.

The lesson from the NDIS is not that individualised funding should be abandoned, but that it must be anchored within a disciplined, nationally coordinated system.

10.7 Private Health Insurer Partnerships and Facility Alignment

The current private health insurance system includes contractual arrangements between insurers and healthcare providers that do not consistently reflect clinical capability.

In practice, some insurer networks include facilities that do not meet hospital-level standards but are presented to consumers as equivalent pathways of care. This creates a disconnect between expectation and reality, particularly where those facilities rely on the public system to complete the episode of care.

Under a nationally integrated system, insurer participation should align with facility classification. Hospital-level insurance pathways should be limited to facilities that meet the hospital definition, including critical care capability and post-operative management capacity.

Public subsidy should support models that contribute genuine system capacity rather than those that rely on the public system to absorb risk.

10.8 Continuity of Funding Responsibility for Transferred Patients

A nationally integrated system requires that funding responsibility follows the patient across the full episode of care.

Where a patient undergoes a procedure in a private hospital or procedural facility and is subsequently transferred to a public hospital for complications or ongoing treatment, the patient should remain classified as a private patient for that episode.

The relevant private health insurer should be responsible for the full cost of treatment, including inpatient care and post-operative management.

This approach ensures that the system initiating care retains responsibility for its outcomes, reduces cost shifting to the public system, and protects access for public patients.

11. Total System Efficiency and Savings

11.1 Overview

The proposed national integrated health, aged care and supported living system is not solely a cost expansion model. It is a structural reform designed to reduce systemic inefficiencies, eliminate duplication and redirect existing expenditure toward more effective care delivery.

Australia's current system carries significant hidden costs arising from fragmentation. These costs are not always visible in budget papers, but they manifest through:

- duplicated administrative structures across jurisdictions;
- inconsistent procurement and purchasing arrangements;
- incompatible digital systems requiring parallel investment;
- delayed patient flow through hospitals;
- avoidable hospital admissions and extended lengths of stay;
- workforce inefficiencies caused by lack of mobility and standardisation.

The reform addresses these inefficiencies directly and converts them into measurable system savings.

11.2 Administrative consolidation savings

Australia currently maintains multiple layers of administrative and policy infrastructure across the Commonwealth, states and territories. While some local administration is necessary, a substantial portion of system design, procurement, digital management and policy development is duplicated.

Under a national framework:

- policy design, funding architecture and system standards are centralised;
- procurement and digital systems are coordinated nationally;
- reporting, compliance and planning frameworks are standardised.

This allows for a gradual reduction in duplicated administrative functions. Savings are expected to arise from consolidation of policy and planning units, reduced duplication in procurement teams, unified reporting and compliance systems, and shared digital infrastructure and support services.

These savings should be realised progressively through natural attrition, redeployment and system integration, rather than abrupt workforce reduction. Even modest efficiency gains across multiple jurisdictions represent a substantial redirection of funding capacity into frontline services.

11.3 Procurement and supply chain savings

The shift to national procurement is one of the most immediate and quantifiable efficiency gains.

Current fragmentation results in:

- variable pricing for identical goods;
- reduced bargaining power;
- duplicated contract negotiation processes;
- inconsistent supply resilience.

Through aggregated national purchasing:

- unit costs for consumables, equipment and services are reduced;
- supplier contracts are streamlined;
- administrative overhead decreases;
- supply chain stability improves.

A practical example of inefficiency is that even basic consumables and fittings used in clinical environments, such as clips, connectors and tubing components, can vary between hospitals and jurisdictions due to separate procurement decisions and supplier arrangements. This creates higher unit costs, incompatibility between equipment and consumables, increased training requirements for staff moving between facilities, and reduced ability to share stock across sites during shortages.

Standardising common consumables and equipment interfaces at a national level would reduce cost, improve safety and support workforce mobility.

11.4 Digital system rationalisation

Australia's current health system operates multiple overlapping digital platforms across jurisdictions, including electronic medical records, aged care management systems, workforce systems, procurement platforms and reporting tools.

This results in duplicated licensing costs, expensive system integration requirements, repeated staff training, and limited interoperability.

A national digital platform would reduce licensing and maintenance costs, eliminate redundant systems over time, simplify training and onboarding, and improve operational efficiency. Digital consolidation represents both direct cost savings and indirect productivity gains, particularly in clinical and administrative workflows.

11.5 Hospital flow and bed utilisation savings

One of the largest hidden costs in the current system is inefficient use of hospital beds.

Acute hospital care is the most expensive form of care. When patients remain in hospital due to lack of aged care or step-down capacity, the system incurs avoidable costs.

The integrated model improves flow by enabling earlier transfer to step-down care, expanding aged care and supported living capacity, reducing delayed discharges, and preventing avoidable admissions through early intervention.

The financial impact includes reduced cost per patient episode, improved throughput of existing hospital infrastructure, reduced need for new acute hospital expansion driven purely by congestion, and improved elective surgery capacity.

11.6 Workforce efficiency gains

The current workforce model produces inefficiencies through limited interstate mobility, inconsistent pay and conditions, duplication of credentialing processes, uneven distribution of staff across regions, and heavy use of agency staffing to fill routine gaps.

The National Nursing and Care Award, combined with national deployment mechanisms and the National Flexible Workforce Pool, enables more efficient allocation of staff across the system, reduced reliance on short-term agency staffing, improved retention through clearer career pathways, and faster response to regional shortages.

11.7 Avoided future costs

A critical but often overlooked benefit of structural reform is the avoidance of future cost escalation.

Without reform, Australia is likely to face increasing hospital demand driven by ageing, rising aged care costs without integrated planning, continued duplication in digital and procurement systems, and growing pressure for ad hoc infrastructure expansion.

By integrating the system now, the Commonwealth can reduce the need for reactive infrastructure spending, better align capital investment with actual system demand, and avoid compounding inefficiencies over time.

11.8 Reinvestment of savings

Savings generated through efficiency and consolidation should not be treated as general budget reductions. They should be reinvested into system improvement, including expansion of aged care and supported living capacity, reduction of hospital congestion, workforce development and training, regional service strengthening, and digital system implementation and maintenance.

11.9 Strategic position

The reform is not based on the assumption that Australia must simply spend more on health and aged care. It is based on the understanding that Australia is already spending significant resources, but not in a way that delivers a coordinated system.

By removing duplication, standardising systems, improving patient flow, and aligning workforce and infrastructure, the Commonwealth can build a system that is both more effective and more financially sustainable.

12. Legislative and Administrative Program

A minister considering this reform needs a view of the legal and administrative steps required. The proposal could be advanced through a staged package of legislation and intergovernmental action.

1. Legislate the National Health and Aged Care Funding Authority and define its functions.
2. Amend Medicare-related legislation to permit an expanded levy structure and optional public contribution tiers, subject to later detailed design.
3. Create a statutory basis for Supported Senior Living as a recognised care and accommodation category.
4. Establish a national care classification and transition assessment tool by regulation or delegated instrument.
5. Negotiate replacement or supplementary National Health Reform Agreements with states and territories.
6. Develop industrial transition arrangements, including the pathway to a national nursing and care award.

Not every element needs to be legislated on day one. Some can begin through pilot agreements, delegated standards and funding contracts. The main requirement is that the legislative pathway support rather than delay pilots.

Administrative preparation should also include national planning templates, digital standards, procurement transition rules and a public reporting framework so that implementation begins with operating discipline rather than retrospective patching.

13. Legislative Safeguards Against Privatisation

A national system of this scale should not be established in a way that leaves it exposed to gradual dismantling through future administrative change. If the Commonwealth is to take primary responsibility for funding, standards, patient records, digital systems and strategic infrastructure planning, the public character of that system should be protected in legislation.

The purpose of legislative entrenchment is not to eliminate all private participation. Private providers may still perform roles within the system, particularly in contracted service delivery, accommodation construction, technology support or supplementary care models. The purpose is instead to ensure that the core obligations of the national system remain public, universal and legislatively protected.

The Commonwealth should enact a National Health and Aged Care Act with several key protections.

First, the Act should define healthcare, aged care, supported senior living and associated patient-record infrastructure as essential public services.

Second, the Act should require that the core service streams funded through the national system remain publicly funded and universally accessible, regardless of who operates individual sites under contract.

Third, the Act should place restrictions on the wholesale divestment of public hospitals, step-down units, aged care infrastructure and supported living assets funded under the national model.

Fourth, the Act should preserve Medicare, or its successor public funding vehicle, as the primary mechanism for universal health-system financing.

For stronger long-term protection, Parliament could also consider:

- a requirement for a supermajority vote for legislation that would substantially privatise the national system or dismantle universal public entitlements;
- a mandatory public review and independent inquiry before any major structural divestment of public health or aged care assets;
- statutory reporting obligations requiring government to disclose the likely impact of proposed changes on access, regional equity, workforce stability and patient outcomes.

These safeguards would create planning certainty for patients, workers, training institutions and governments alike. The key principle is simple: if the Commonwealth is to federalise and integrate the system, it should do so on terms that prevent the integrated model from later being stripped for parts.

14. National Patient Record System

A national health, aged care and supported living system cannot operate efficiently if patient information remains trapped inside disconnected local systems. At present, Australians often encounter a fragmented record environment in which hospital records, GP files, specialist correspondence, aged care assessments and medication histories sit across different platforms with inconsistent accessibility. This causes repetition, delay, avoidable clinical risk and frustration for both clinicians and families.

A person who moves interstate, transfers from hospital to aged care, or enters supported living should not effectively have to start their clinical history again. A national system therefore requires a National Patient Record System that supports continuity of care across all jurisdictions and service types.

The preferred approach is not to discard every existing digital system and begin from scratch. It is to create a nationally governed architecture that consolidates, standardises and interoperates with current systems where feasible, while progressively replacing incompatible or obsolete platforms.

The core features of the National Patient Record System should include the following:

- records must be nationally accessible to authorised providers across all states and territories;
- the system must support the full continuum of care proposed in this paper, including public hospitals, primary care, aged care facilities, supported senior living, allied health and relevant community care settings;
- the system should support real-time or near-real-time updating of clinically important information, including medication history, allergies, recent admissions, discharge summaries, pathology and imaging results, care plans, aged care assessments and transition decisions;
- patients should retain appropriate visibility and control over their records, including audit visibility over who has accessed them;
- the system must be built on secure public digital infrastructure, with encryption, audit logging, role-based access controls and compliance with national privacy and cyber-security standards.

Implementation should occur in stages.

In the first stage, the Commonwealth should build on existing national infrastructure where practical, including lessons from My Health Record and existing hospital EMR environments, while mandating interoperability standards across providers.

In the second stage, participation should become mandatory for hospitals, aged care providers and publicly funded primary-care settings, with support made available for smaller or regional providers that require technical uplift.

In the third stage, the system should move to real-time operating capability with nationally consistent access protocols, integration into discharge and transfer workflows, and links to the common care-classification and transition tools described elsewhere in this paper.

The benefits are substantial. A national patient record system would reduce medication errors, avoid repeated tests, shorten discharge times, improve continuity for mobile and regional populations, and support workforce mobility by giving clinicians a consistent information environment wherever they practise.

Without a national patient record, the reform would still suffer from hidden fragmentation. With one, the system begins to function as a genuine national network.

15. National Procurement, Standards and Digital Systems Framework

A national system cannot achieve its full efficiency if every jurisdiction continues buying separately, writing separate clinical policies and operating incompatible software. Even if funding is federalised and care pathways are integrated, the system will continue to waste money unless it also standardises procurement, best-practice procedures and core digital platforms.

This paper therefore proposes a National Procurement, Standards and Digital Systems Framework as the operational backbone of the federalised model.

15.1 National procurement and purchasing contracts

The current approach to procurement is unnecessarily fragmented. States and territories often negotiate separately for clinical consumables, medical devices, non-PBS pharmaceuticals, information systems and facility services. This weakens national bargaining power, produces inconsistent pricing and duplicates procurement effort across multiple bureaucracies.

A federalised system should establish a National Health Procurement Authority responsible for aggregating demand and negotiating national purchasing contracts where standardisation makes operational and financial sense.

The Authority should:

• consolidate demand data from hospitals, aged care facilities, supported living sites and related public services;
• negotiate national contracts for common equipment, consumables and relevant digital systems;
• develop preferred supplier panels;
• standardise product categories where clinically appropriate;
• manage strategic procurement planning for shortages, surge events and supply resilience.

This would not require every site in Australia to use identical products in every clinical context. Specialist exceptions would still be necessary. The principle is that routine and large-scale procurement should take place with the bargaining power of a national system rather than in eight separate negotiations.

15.2 National clinical policies and procedures

Variation in clinical and operational procedures across states, hospital networks and aged care providers creates inefficiency and inconsistency. Policy teams in different jurisdictions often duplicate similar work, while staff moving between systems must relearn local procedures that should not materially differ.

The Commonwealth should therefore establish a National Clinical Standards Framework covering hospitals, step-down care, supported senior living and residential aged care.

This framework should include:

• standardised clinical protocols for common transitions and patient groups;
• best-practice guidelines for discharge planning, medication management, aged care assessment, infection control and escalation pathways;
• national operational procedures for core services where consistency improves quality and mobility;
• regular review mechanisms so standards are updated in line with evidence and practice.

The objective is not to impose unnecessary uniformity where local flexibility is justified. It is to eliminate needless procedural fragmentation in areas where best practice should be shared.

15.3 National digital and software systems

Perhaps the largest hidden inefficiency in the current system lies in digital fragmentation. Health services use a patchwork of electronic medical record systems, aged care software products, rostering tools, procurement systems and reporting platforms. The result is duplicated licensing, expensive interfaces, repeated training burdens and poor interoperability.

A national system should therefore move toward a National Health Digital Platform. This does not necessarily mean one monolithic software product for every service in the country. It does mean one nationally governed digital environment with common standards, shared licensing logic and interoperable platforms.

The digital program should include:

- a standardised EMR environment or nationally approved interoperable EMR suite;
- integrated aged care and supported living software capability;
- full compatibility with the National Patient Record System;
- standard workforce, procurement and reporting modules where practical;
- nationally negotiated licensing and support arrangements.

Implementation should begin by selecting the preferred architecture, defining interoperability requirements and identifying which existing systems can be retained, adapted or retired. Legacy systems should be phased out according to risk and value, not left indefinitely in place because they already exist.

The Commonwealth should also fund standardised training and national support arrangements so digital capability does not vary wildly by location.

Taken together, national procurement, national standards and national digital systems represent one of the clearest efficiency dividends in the whole reform package. They are central to turning federalisation into a practical operating system rather than a change in funding labels alone.

16. National Emergency and Pandemic Management Framework

A nationally integrated health, aged care and supported living system should also function as a national resilience system during emergencies. Australia's experience with pandemics, natural disasters, supply shocks and regional health crises has shown that fragmented governance creates delays in response, uneven resource allocation and inconsistent public communication.

Emergency management should not operate as an improvised overlay on top of a fragmented system. It should be built into the architecture of the national system from the beginning.

16.1 Why a national framework is necessary

Australia's current arrangements rely heavily on coordination between jurisdictions at the point of crisis. In ordinary times, this can appear workable. In emergencies, it creates delay, duplication and inconsistent decision-making.

The main structural weaknesses are already familiar:

• separate state-based operating systems and command structures;
• variable hospital surge capacity;
• inconsistent access to staff across borders;
• fragmented procurement and stockholding;
• different patient-record and reporting systems;
• inconsistent public health messaging and escalation triggers;
• uneven integration between hospitals, aged care, disability support and primary care.

A national framework would reduce those risks by ensuring there is one core structure for command, information, workforce and logistics.

16.2 Core objectives

The framework should be designed to:

• preserve continuity of essential care;
• protect acute hospital capacity;
• enable rapid workforce deployment;
• protect high-risk care environments;
• standardise command, data and communication;
• maintain sovereign capability in essential supply.

16.3 National emergency health command structure

A national system requires a clear emergency command model. This should not replace local operational leadership, but it should provide a legally and administratively defined framework for national coordination.

The proposed structure would include:

• a National Health Emergency Coordination Authority operating within or alongside the National Health and Aged Care Funding Authority;
• pre-defined emergency powers for national coordination of beds, staffing, procurement and inter-jurisdictional support;
• a national command protocol for public health emergencies, pandemics, mass casualty events and major system disruptions;

• mandatory participation by state and territory health authorities through standing intergovernmental agreements.

16.4 Integrated surge capacity model

Under the integrated model proposed in this paper, emergency surge capacity would be drawn from five linked layers:

• acute hospital surge;
• step-down and transitional surge;
• supported living and community care surge;
• residential aged care outbreak isolation capacity;
• regional transfer networks.

This model is stronger than simply adding more acute beds because it keeps patients moving through the system instead of allowing hospitals to become blocked at every downstream point.

16.5 Workforce emergency mobility and reserve capacity

Emergency response fails quickly if staffing cannot be moved at speed. The National Nursing and Care Award should therefore include an emergency mobility function.

This should be supported by:

• a national emergency workforce register;
• pre-cleared credentialing across all jurisdictions;
• portable entitlements and standard deployment terms;
• accommodation, travel and hardship support for emergency placements;
• emergency loadings for high-risk or remote deployments;
• a reserve pool of recently retired clinicians, educators and qualified professionals willing to undertake temporary supervised roles.

16.6 National patient record and emergency data use

The National Patient Record System becomes even more critical in an emergency. During a pandemic or disaster, the system should support immediate access to medication, allergy and comorbidity data, rapid sharing of discharge summaries and transfer decisions, visibility of aged care residents and high-risk patients moving between settings, and outbreak and capacity reporting using common national data standards.

16.7 National procurement, stockpiles and supply chain coordination

The emergency framework should establish a national health emergency supply model including:

• strategic national stockpiles of essential items;
• national purchasing triggers for rapid emergency procurement;
• domestic supply resilience for a limited but critical basket of goods.

16.8 Aged care and supported living emergency protection plans

Every integrated precinct, aged care facility and supported senior living site should be required to maintain an emergency protection plan covering infection control, staffing contingencies, medication continuity, outbreak isolation procedures, resident transfer thresholds, family communication arrangements, and links to regional hospitals and emergency workforce support.

16.9 Public communication and national triggers

A federalised system should establish common emergency stages and public communication rules, including nationally defined trigger levels, standard language for public-health advice, coordinated communication between Commonwealth and state authorities, and common reporting formats.

16.10 Implementation approach

This framework should not be treated as a separate reform stream. It should be built into the main implementation roadmap from the outset and tested through pilot regions and simulation exercises.

Embedding emergency and pandemic management into the national system would improve ordinary bed management, strengthen workforce portability, improve digital interoperability, support better procurement planning, reduce vulnerability in aged care and regional services, and create a more disciplined, nationally coherent public system.

17. Pilot Site Strategy and the Burnie Hospital Redevelopment

A reform of this scale should begin with carefully selected pilots rather than a simultaneous national rollout. The purpose of a pilot is not simply to demonstrate political intent. It is to test infrastructure design, workforce deployment, patient transitions, funding flows, governance arrangements and digital integration in real operating environments.

Pilot sites should therefore be selected using operational criteria, not merely visibility. Relevant criteria include:

• high hospital congestion or evidence of delayed discharge pressure;
• shortages in aged care capacity or step-down care;
• regional workforce constraints;
• projected population ageing;
• available land or redevelopment opportunity;
• the presence of local training partners such as TAFEs or universities;
• regional significance as a referral or hub hospital.

On that basis, the Burnie Hospital redevelopment in Tasmania presents as a particularly suitable first-wave pilot.

Burnie has several strategic advantages. It is a regional setting with an ageing population profile, an existing and visible redevelopment context, and a manageable scale for testing the integrated model without the complexity of a very large metropolitan campus. It also reflects the kind of setting where fragmentation has an outsized effect: when a regional hospital is blocked, the pressure is felt quickly across admissions, transfers, ambulance access and family burden.

The Burnie pilot should be designed not as a hospital redevelopment alone, but as a regional integrated care precinct. The pilot should include:

• co-located aged care capacity adjacent to the hospital;
• a step-down and rehabilitation unit linked directly to the discharge pathway;
• supported senior living units across all three accommodation models, being rental, refundable deposit and purchase or premium lease;
• an on-site training partnership with TAFE Tasmania and relevant university providers;
• integrated care coordination across hospital, step-down, supported living and aged care;
• digital readiness for patient-record integration and common transition tools;
• emergency and pandemic planning capability integrated from the outset.

The operational model at Burnie should be straightforward. A patient entering acute care should move, once clinically stable, into the next appropriate setting on the same campus or within the same integrated governance model. Staff should be trained locally. Transfer should be clinical and administrative flow, not a multi-agency negotiation. Families should deal with one system, not four.

The Burnie pilot would generate useful evidence in several areas:

• the reduction in delayed discharge days;
• the effect on acute bed availability and emergency flow;
• the take-up and performance of supported senior living models;
• workforce recruitment and retention outcomes in a regional campus model;
• the capital and operating cost profile of an integrated regional precinct.

If successful, Burnie should form part of a broader pilot architecture. The first stage should include Burnie plus at least one regional site in New South Wales and one regional site in Queensland. A second stage should include a metropolitan growth corridor, such as outer Western Sydney, together with regional pilots in Western Australia and South Australia. This would test the model across very different population and service contexts before national scaling.

18. Implementation Roadmap

18.1 Phase One - Design and enabling action (Years 1 to 2)

This phase establishes the machinery of reform. Government should create a small but empowered taskforce inside the health portfolio or the Department of Prime Minister and Cabinet, supported by Treasury, Finance and aged care expertise. The deliverables in this phase are not generic consultation papers; they are a draft funding model, draft service-agreement terms, shortlist of pilot sites, legislative instructions and workforce transition options.

Key actions should include:

- commissioning Treasury and departmental modelling on the levy structure and transition costs;
- identifying three to five pilot regions representing metropolitan, regional and high-ageing contexts;
- negotiating heads of agreement with participating states for pilots;
- drafting the industrial framework for award portability, the national deployment pool and the flexible workforce pool;
- beginning design work for a common digital referral and transfer platform;
- designing the legislative framework for emergency coordination and public system safeguards.

18.2 Phase Two - Pilots and proof of concept (Years 2 to 5)

Pilots should be designed to answer operational questions, not just produce ribbon-cutting opportunities. Each pilot precinct should include at least one step-down unit, a supported living component, residential aged care capacity and a training partnership.

Government should track delayed discharge days, hospital occupancy impact, staff recruitment outcomes, consumer satisfaction and comparative cost. During this phase, optional Medicare Plus products could be trialled as opt-in arrangements in limited form, or alternatively developed in parallel for later launch once the service offer is mature enough.

Emergency procedures, stockpile planning, workforce reserve arrangements and patient-record integration should also be tested during this phase.

18.3 Phase Three - Expansion and standardisation (Years 5 to 10)

Once pilots demonstrate which facility mix and workforce settings perform best, the Commonwealth should scale by region. Rollout should prioritise places with the largest hospital-flow gains first. Standard contracts, planning templates, design standards and transfer protocols should be issued nationally so every new site does not reinvent the model.

18.4 Phase Four - Optimisation (Year 10 onwards)

By this stage the main work becomes optimisation rather than design. Government should refine levy settings if required, shift resources toward the most effective service combinations, continue capital upgrades in areas where demographic demand keeps rising, and maintain emergency readiness as a routine function of the national system.

19. Planning Suggestions for Ministerial Consideration

A reform of this scale is more likely to proceed if it is framed as a practical solution to visible bottlenecks rather than an abstract system overhaul. The most persuasive entry point is hospital pressure. Ministers can credibly say the reform is designed to free hospital beds, speed discharge, improve aged care access and strengthen regional staffing. Once that rationale is accepted, the broader integration agenda becomes easier to explain.

It may also be prudent to separate the political timetable from the operational timetable. A government could announce the framework, commence pilots and industrial work early, and defer full levy implementation until pilot evidence and fiscal modelling are complete. That sequencing lowers political risk while keeping the reform alive.

The proposal can also be modular. If government does not wish to advance the whole package at once, the first tranche could include precinct pilots, supported living classification, training campuses, flexible staffing, award portability, patient-record integration and procurement reform. Those elements alone would still deliver meaningful system improvement.

20. Risks and Mitigation

• State resistance to funding centralisation: mitigate through long-term agreements, capital co-investment and retained local delivery roles.
• Public concern about levy increases: mitigate by publishing clear revenue-use statements and separating compulsory and optional elements.
• Workforce disruption during industrial transition: mitigate through no-disadvantage principles, staged portability and union consultation.
• Capital cost overruns: mitigate through standard design templates, modular construction and phased site expansion.
• Creation of a two-speed system: mitigate by keeping the universal base system strong and ensuring optional tiers enhance choice rather than substitute for essential care.
• Digital transition risk: mitigate through phased implementation, interoperability rules, support for smaller providers and strong cyber-security standards.
• Pilot failure through poor site selection: mitigate by using operational criteria and requiring each pilot to measure transfer flow, workforce performance and patient outcomes.
• Emergency framework drift: mitigate through mandatory exercises, public reporting on readiness and statutory preparedness obligations.

21. Measures of Success

The reform should be judged against operational indicators, not just policy announcements. Suggested measures include:

- reduction in delayed discharge days attributable to aged care or step-down shortages;
- reduction in average acute bed occupancy pressure in participating regions;
- increase in supported living units, step-down beds and aged care places by region;
- time from hospital discharge decision to actual transfer;
- staff vacancy rates and interstate transfer activity under the national workforce framework;
- use and performance of the National Flexible Workforce Pool in reducing agency dependence;
- consumer satisfaction and complaint resolution outcomes;
- longitudinal cost comparison between acute-bed occupancy and alternative care placements;
- uptake and performance of common digital systems and national record integration;
- procurement savings and reduced duplication in policy and software environments;
- emergency preparedness performance, including workforce mobilisation, stock availability and coordination effectiveness.

These measures should be publicly reported at regional and national levels so that performance is visible and the system can be adjusted where outcomes fall short.

22. Actions Requested

If the proposal is to move beyond a written submission, the next ministerial steps are modest and realistic. They do not require immediate commitment to the full reform envelope. They require a decision to test and design the model properly.

1. Request departmental advice on the feasibility of pilot integrated precincts and a supported living classification.
2. Seek Treasury and Finance modelling on a base levy range and optional contribution tiers.
3. Convene preliminary discussions with states on hospital-linked aged care expansion.
4. Commission advice on the pathway to a national nursing and care award, portability arrangements and a national flexible staffing pool.
5. Consider identifying one or more regional pilot locations where hospital pressure and ageing demand make a demonstration project compelling.
6. Seek advice on legislative options for entrenching the public character of the system and preventing future structural privatisation without parliamentary scrutiny.
7. Commission preliminary work on a national patient record architecture, common digital standards and national procurement options.
8. Seek advice on integrating emergency and pandemic management powers, stockpile design and workforce reserve arrangements into the broader national system model.

These are practical starting points. They are sufficient to move the reform from concept to structured consideration without requiring immediate full-scale adoption.

Appendix A - Indicative Funding and Reform Structure

The table below summarises the proposed architecture. Figures are indicative planning bands for policy development and would require formal costing.

Component	Indicative approach	Primary purpose
Base Medicare levy	3.0% to 3.5% total	Universal health system funding including hospitals, primary care and core administration
Dental tier	+1.5% to 2.0% opt-in	Preventive and routine dental cover inside public framework
Private patient tier	+1.5% to 2.5% opt-in	Allows people to be treated as private patients within the new system, helping avoid waiting times while remaining within a publicly regulated framework
Aged care tier	+1.0% to 1.5% opt-in	Expanded aged care, supported living and step-down operations
Capital program	Commonwealth-led with state and resident contributions where appropriate	Precinct builds, aged care expansion and supported living units
Resident accommodation contributions	Rental, refundable deposit or purchase/lease models	Share accommodation cost without privatising care entitlement