National Integrated Health System

Comprehensive Policy and Implementation White Paper

This paper is a practical reform brief. It sets out how the Commonwealth could structure, fund, phase and govern a national health system linking hospitals, primary care, workforce mobility, patient records, procurement, digital systems and emergency preparedness.

Its central infrastructure proposal is a three-building hospital campus: a public hospital building, a shared central clinical-services building and a separately financed private hospital building operating under firm public-interest safeguards.

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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. Accountability is divided between the Commonwealth, states and territories, public hospitals, primary care, private hospitals and insurers. The result is avoidable duplication, inconsistent access by postcode, workforce shortages and unclear responsibility when a patient moves between providers.

This paper proposes a national health system built on four linked reforms. First, the Commonwealth assumes primary responsibility for financing, standards and strategic capacity planning while states and approved providers continue local delivery. Second, major hospital redevelopments use a three-building campus model that separates public and private inpatient operations while sharing expensive clinical infrastructure transparently. Third, workforce reform improves portability, training and regional deployment. Fourth, common patient records, procurement and emergency arrangements make the system operate as a national network.

The three-building model consists of a Central Clinical Services Building, a Public Hospital Building and a Private Hospital Building. Emergency, theatre, intensive care, diagnostic and other high-cost services are concentrated in the central building. Public inpatient and community-facing services sit in the public building. Private inpatient accommodation is physically and financially distinct, with the private operator paying full-cost charges for every shared service used.

The public system remains the priority. Private activity must add capacity, not displace public patients or rely on routine transfer of complications into public beds. The private operator retains responsibility within its declared clinical scope, and any clinically necessary transfer remains funded as part of the private episode.

This revision removes the earlier extended aged-care and supported-living proposal. It retains only the hospital functions required for safe discharge, rehabilitation, transitional care and coordination with external community and residential services.

2. Why Reform Is Required

The case for reform is operational rather than ideological. Fragmentation appears as ambulance ramping, long waits, postponed elective surgery, repeated tests, workforce gaps and households paying for private cover without a clear guarantee that the private provider will manage the full episode of care.

The present split in funding also makes long-term capacity planning difficult. The Commonwealth controls Medicare and major funding levers, while states operate public hospitals. Private hospitals and insurers make separate investment decisions. Each part can optimise its own budget while costs and clinical risk are shifted elsewhere.

Regional communities carry the greatest consequences. A single missing service can require long-distance transfer, separate families and delay time-critical treatment. Regional hospitals therefore need a defined capability standard, reliable referral networks and capital planning based on population health need rather than historical labels.

A national framework would not require Canberra to operate every hospital. It would establish clear accountability for funding, standards, data and capital strategy, while preserving local delivery and clinical decision-making.

3. Reform Objectives

3.1 Create one national framework with clear accountability

The Commonwealth should hold primary responsibility for financing rules, national service standards, workforce frameworks, data standards and strategic capacity planning. States and territories should deliver services under five-year agreements with measurable outputs and transparent reporting.

3.2 Reduce congestion and waiting times

Capacity must be planned across emergency care, diagnostics, theatres, intensive care, wards, rehabilitation, outpatient care and community follow-up. The aim is faster movement through the complete episode of care, not simply more beds in one part of the hospital.

3.3 Strengthen regional access

Australians should have access to a reasonable standard of care regardless of postcode. Regional hospitals should be classified by the services they are required to deliver, supported by population health data, referral times and clear escalation pathways.

3.4 Build a national workforce pipeline

Recruitment, education, credentialing, mobility and retention should be managed as one problem. Nationally portable classifications, regional training partnerships and public staffing pools should reduce persistent shortages and dependence on high-cost agencies.

3.5 Protect the public system while using private capacity

Private participation may add investment and choice, but it must be clinically accountable and financially separate. Public patients retain priority for publicly funded services and must not subsidise private activity.

3.6 Provide sustainable long-term funding

Funding should be visible, predictable and tied to capacity and outcomes. Capital decisions should be staged, independently assessed and accompanied by published operating-cost assumptions.

4. Facility Classification and Hospital Capability Standards

Australia should apply a consistent national definition of a hospital. The term is currently used for facilities with very different levels of clinical capability, infrastructure and capacity to manage complications. Funding and public representation should reflect what a facility can actually deliver.

4.1 Hospital-level facility

A hospital-level facility, whether public or private, must provide continuous and clinically accountable care across its declared scope. It should provide 24-hour clinical coverage, overnight care, access to critical care, diagnostics, pharmacy and allied health, and the capacity to manage expected post-operative complications without routine reliance on another hospital.

4.2 Procedural facility

A surgical clinic or day-procedure centre may deliver lower-complexity care efficiently, but it should not be represented or funded as a full hospital. Its permitted procedures, staffing, recovery capability and transfer arrangements must match its classification.

4.3 Clinical responsibility

The originating provider remains responsible for the episode within its declared scope. Transfer to a public hospital should occur only where clinically necessary. When a privately funded patient is transferred, the private episode and its funding responsibility should continue until the complication or related treatment is resolved.

4.4 Funding integrity

Hospital-level subsidies, insurer network descriptions and public contracting should be limited to facilities that meet the national hospital standard. Transfer rates, complications and outcomes should be publicly reported in a comparable form.

5. Institutional Design and Governance Model

Reform should separate national funding and standards from local operation. The Commonwealth would own the framework; states, territories and approved delivery entities would operate services under national agreements.

- A National Health Funding Authority responsible for pooled funding, regional capacity planning, expenditure tracking and public reporting.
- Five-year intergovernmental service agreements containing activity targets, workforce obligations, regional delivery commitments and consequences for persistent underperformance.
- A national facility and service classification framework linked directly to funding eligibility.
- Independent audit, clinical-quality and capital-assurance functions, with regional performance comparisons published in accessible form.
- A ministerial forum for implementation disputes, while preserving the Commonwealth's final authority over national funding rules.

The authority should publish a national service map identifying undersupply, excessive travel times, workforce gaps and planned capital investment. Major projects should be assessed against transparent population, disease-burden, access and whole-of-life cost criteria.

6. Three-Building Integrated Hospital Campus Model

The central infrastructure reform is a three-building campus that combines efficient sharing of expensive clinical services with clear separation of public and private inpatient operations. The design can be adapted to local demand, but the governance and financial rules should remain consistent.

Public Hospital Building	Central Clinical Services	Private Hospital Building
Public wards; maternity and paediatrics; cancer care; renal and dialysis; mental health; rehabilitation; palliative care; outpatient and allied health services. Parking may be placed beneath the building.	Emergency department; GP and urgent-care front door; 6-10 theatres sized to demand; ICU and HDU; cardiac and stroke services; imaging; pathology and blood bank; sterilisation; pharmacy; ambulance access; direct helipad link.	Smaller 6,000-8,000 square metre shell for private inpatient care. Private tenants fund fit-out and equipment, pay commercial rent and meet the full cost of all shared clinical services. Parking may be placed beneath the building.

6.1 Central Clinical Services Building

The central building concentrates the services that are clinically interdependent, expensive to duplicate and required around the clock. It is connected directly to both inpatient buildings, with controlled patient, staff and supply routes. The helipad should sit behind or above the central building with a protected direct route to emergency, theatres and intensive care.

A GP and urgent-care service forms the non-life-threatening front door. Patients are assessed and treated there when appropriate, then referred directly to the adjoining emergency department if escalation is required. Ambulance arrivals and obvious emergencies bypass the GP stream. Triage and treatment must never be delayed while insurance status is checked.

6.2 Public Hospital Building

The public building contains the majority of inpatient and public-facing services. Its scale should be determined by population need, disease burden, travel times, projected demand and the hospital's regional referral role. Public capacity and staffing are commissioned first and cannot be reduced to create private capacity.

6.3 Private Hospital Building

The private building is a separate inpatient facility rather than a subsidised ward inside the public hospital. The preferred model is an investor-financed or long-term leased shell developed only after an open expression-of-interest process demonstrates demand. The private operator funds all internal fit-out, ward equipment and operating costs.

Private patients may use central theatres, diagnostics, critical care and other shared services under transparent agreements. Usage must be metered and charged at full cost, including capital recovery, staffing, consumables, maintenance and an appropriate share of overhead. The arrangement must not create an implicit public subsidy.

6.4 Public priority and scheduling

- Emergency and clinically urgent care is prioritised by need, not insurance status.
- Publicly funded theatre, imaging, ICU and workforce capacity is protected by minimum public allocations and escalation rules.
- Private bookings may use genuinely available capacity but cannot displace public activity or extend public waiting times.
- Shared-service performance, cancellations and cross-subsidies are independently audited and reported.

6.5 Clinical responsibility and transfers

The private operator remains responsible for its patients within its declared clinical scope and must maintain the staffing, ward capability and on-call arrangements required to manage expected complications. Physical proximity to the public building must not become a routine transfer pathway. A transfer occurs only when clinically necessary and is documented, reviewed and charged to the responsible private funder for the continuing episode.

6.6 Identification of private cover

Where appropriate, patients may be asked at or shortly after emergency registration whether they hold private cover. This supports informed choice and correct billing, but emergency assessment and treatment must not be delayed or made conditional on insurance. Patients must receive neutral information and retain the right to elect public treatment.

6.7 Shared workforce and specialist practice

Specialists may practise across the public and private buildings under credentialing, conflict-of-interest and roster rules. Public obligations must be met first. Employment, on-call and fee arrangements should be disclosed, and access to shared theatres or diagnostics should follow published scheduling rules.

6.8 Education and research

A university and clinical-training hub may be linked to the campus, preferably near the private building and central services. It should proceed only with confirmed Commonwealth, university or other partner funding and must not divert the core hospital capital budget. Agreements should secure placements and research benefits for the public system.

6.9 Staged construction

1. Build and commission the Central Clinical Services Building and Public Hospital Building first, including utilities, transport access, parking, helipad connections and expansion capacity.
2. Test private-sector demand through an open expression-of-interest process. Proceed with the Private Hospital Building only where financing, tenancy and full-cost service agreements are credible.
3. Add the university and training hub only after external funding and operating commitments are secured.
4. Protect the master plan from land sales or later development that would block clinical expansion.

7. Workforce Reform: National Health Workforce Framework

Infrastructure cannot operate without a stable workforce. Reform should establish nationally portable classifications, recognition of experience, minimum conditions and consistent credentialing for nurses, allied health professionals and relevant hospital support staff. Jurisdictions may add local incentives, but the base framework should be portable.

7.1 Portability and retention

A clinician moving between states or between approved public facilities should not restart their employment position. Service recognition, credentialing and the treatment of accrued entitlements should be clear before transfer. Portability supports retention and allows staff to respond to regional demand without unnecessary administrative loss.

7.2 National deployment pool

A voluntary public deployment pool should provide temporary placements in regional shortages, new-hospital commissioning, seasonal surges and emergencies. Participants retain their classification and entitlements; travel, temporary accommodation and appropriate regional loadings are funded transparently.

7.3 Flexible workforce pool

A national pool of pre-credentialed casual and part-time staff can cover short absences and recurring roster gaps. It should operate as a cost-controlled public alternative to routine reliance on private agencies, supported by a common rostering platform and local clinical orientation.

8. National Training and Workforce Development Framework

Training intake, clinical placement capacity and regional workforce demand should be planned together. New or redeveloped hospital campuses should include education partnerships where they increase placement capacity and build a local workforce.

- Structured pathways for school leavers, vocational entrants, mature-age entrants and existing staff seeking progression.
- Standardised competencies and mutual recognition across jurisdictions.
- More supervised placements in regional hospitals, primary care, mental health, rehabilitation and allied health.
- Supported study, professional development and transparent progression into specialist, leadership and education roles.
- Regional incentives, housing support and bonded pathways where appropriate.
- National workforce data linking training places to forecast vacancies and service expansion.

For Burnie and other regional pilots, local TAFE and university partnerships should be negotiated alongside service design. A training promise without funded educators, placements and graduate positions will not solve shortages.

9. Funding Architecture

The funding model should make responsibility visible. A strengthened Medicare-based public funding stream should support universal hospital and primary care. Any optional private-patient contribution should be clearly separated from the universal entitlement and tied to genuine additional capacity.

9.1 National funding pool

Commonwealth and state hospital contributions should be brought into a transparent national pool governed by multi-year agreements. Funding formulas should reflect population, remoteness, disease burden, unavoidable regional scale costs and agreed service capability.

9.2 Capital funding

The central and public buildings are core public infrastructure and should be publicly owned. Business cases must disclose construction, equipment, workforce and whole-of-life operating costs. The private shell should proceed only on terms that transfer genuine financing and tenancy risk to private investors or operators.

9.3 Shared-service charges

The central building should operate with transparent service lines. Charges to the private building must recover direct clinical costs, consumables, staffing, maintenance, depreciation or capital recovery, digital services and administration. Independent audit should test that the public system is not subsidising private activity.

9.4 Private insurance alignment

Insurer partnerships should be limited to hospital-level facilities that meet national capability standards. Where a private patient requires transfer or additional treatment related to the original episode, the relevant insurer or private funder remains responsible for the full episode cost.

9.5 Costing discipline

All levy ranges, capital estimates and savings claims in this paper are policy-development concepts, not final costings. Treasury, Finance and independent infrastructure assurance should test them before government commitment.

10. Total System Efficiency and Savings

The proposal is a structural reform, not simply a spending expansion. Its financial case rests on reducing duplication, sharing high-cost infrastructure safely, improving purchasing power and using existing capacity more productively.

- Administrative consolidation through common policy, reporting and planning standards.
- Lower procurement costs through aggregated purchasing and standard equipment interfaces.
- Reduced duplication of theatres, sterilisation, imaging, pathology and critical-care infrastructure within a campus.
- Fewer repeated tests and delays through interoperable records.
- Lower agency expenditure through public deployment and flexible workforce pools.
- Better theatre and diagnostic utilisation where spare capacity can be scheduled without displacing public patients.
- Avoided cost shifting when private providers remain financially responsible for complications.

Savings should be measured after allowing for transition costs, capital maintenance and the additional staff required to operate new capacity. Verified savings should be reinvested in frontline services, regional capability and workforce development.

11. Legislative and Administrative Program

1. Establish the National Health Funding Authority and define its funding, planning, audit and publication functions.

2. Negotiate new or supplementary National Health Reform Agreements with states and territories.

3. Create national hospital and procedural-facility classifications linked to licensing, insurer descriptions and public funding eligibility.

4. Legislate public-priority, financial-separation and full-cost-recovery rules for shared public-private campuses.

5. Create continuity-of-funding rules for privately initiated episodes transferred to public care.

6. Develop industrial and credentialing pathways for workforce portability and national staffing pools.

7. Mandate interoperable digital, procurement and performance-reporting standards.

Not every element must wait for primary legislation. Pilot agreements, design standards, transparent costing and procurement preparation can begin while the statutory package is developed.

12. Legislative Safeguards Against Privatisation

The public character of the national system should be protected without excluding accountable private participation. Core public hospitals, the central clinical-services building and essential digital infrastructure should remain publicly owned and universally accessible.

- Restrictions on the sale or long-term alienation of core public hospital and central clinical assets.
- A requirement for independent public-interest assessment before any material outsourcing or divestment.
- Published contracts and related-party disclosures for private use of public infrastructure, subject to legitimate commercial confidentiality.
- Minimum public-capacity and priority rules that cannot be waived by local contract.
- Parliamentary scrutiny of major structural changes and regular public reporting on access, workforce and financial separation.

The private building should be governed by a time-limited lease or operating agreement containing performance, solvency, step-in, handback and termination provisions. Failure of a private operator must not interrupt the public hospital or leave the state responsible for unpriced private liabilities.

13. National Patient Record System

A national system cannot operate efficiently if information remains trapped in disconnected local platforms. The preferred approach is a nationally governed architecture that interoperates with sound existing systems while progressively replacing obsolete or incompatible platforms.

- Authorised access across jurisdictions and participating public and private providers.
- Near-real-time medication, allergy, admission, discharge, pathology, imaging and care-plan information.
- Role-based access, encryption, audit logging and strong national privacy and cyber-security standards.
- Patient visibility of access history and clear correction and complaint processes.
- Direct support for referrals, discharge summaries, transfer decisions and emergency care.

Implementation should build on existing national infrastructure where practical, mandate interoperability and assist smaller regional providers with technical uplift. Private operators using the central clinical building must participate on the same safety and data standards.

14. National Procurement, Standards and Digital Systems Framework

Fragmented purchasing and incompatible technology create avoidable cost and clinical risk. National coordination should focus first on high-volume goods, critical supplies, common equipment interfaces, cyber-security requirements and interoperable data standards.

- National contracts for selected medicines, consumables, imaging and theatre equipment where aggregation provides value.
- Standard connectors, consumables and equipment interfaces to improve safety and stock sharing.
- Common minimum specifications while preserving clinically justified local choice.
- Open interoperability standards to prevent vendor lock-in.
- Transparent exemptions where remote logistics or specialised clinical requirements justify a different solution.
- Lifecycle costing that includes maintenance, training, software licensing, cyber-security and replacement.

15. National Emergency and Pandemic Management Framework

National health reform should include standing arrangements for pandemics, mass-casualty incidents, supply disruption and regional service failure. Emergency coordination must be designed before a crisis rather than improvised during one.

- A national health emergency coordination function with defined triggers and time-limited powers.
- Real-time visibility of beds, critical-care capacity, workforce availability and essential supplies.
- Pre-cleared interstate credentialing and deployment terms.
- Strategic stockpiles and rapid national purchasing mechanisms for a defined critical basket.
- Common public communication stages and reporting formats.
- Regular exercises covering cyber incidents, outbreaks, evacuation, major trauma and supply-chain failure.

The three-building campus adds resilience by concentrating emergency, theatre, intensive-care and diagnostic capability in a hardened central building while retaining separate inpatient zones. Business continuity plans must ensure that failure in one operator or building does not disable the whole campus.

16. Pilot Site Strategy and the Burnie Hospital Redevelopment

Reform of this scale should begin with pilots selected by operational criteria. Relevant factors include congestion, service gaps, regional referral importance, disease burden, travel times, workforce constraints, land availability and local education partners.

Burnie is a strong candidate for a regional pilot because the North West requires a durable hospital hub and a design capable of expanding specialist access without duplicating every high-cost service. The pilot should test the full three-building model and its governance rules, not merely construct a new ward block.

16.1 Proposed Burnie campus

- A new Central Clinical Services Building containing emergency care, the GP and urgent-care front door, theatres, intensive and high-dependency care, cardiac and stroke capability, imaging, pathology, sterilisation, pharmacy, ambulance access and a direct helipad link.
- A Public Hospital Building sized for regional demand, including wards, maternity and paediatrics, cancer services, renal and dialysis, mental health, rehabilitation, palliative care, outpatient services and allied health.
- A smaller Private Hospital Building of approximately 6,000-8,000 square metres, proceeding only after market testing and on terms requiring private fit-out, equipment, rent and full-cost payment for shared services.
- Parking beneath the public and private buildings where geotechnical, access and cost analysis supports it.
- A protected expansion zone and an optional education hub funded through confirmed Commonwealth, UTAS or other partner contributions.

16.2 Services and population need

The Burnie business case should test cardiac catheterisation and other specialist capability against regional cardiovascular burden, transfer times, clinical volumes, workforce sustainability and network arrangements. The decision should be evidence-led and should consider both planned procedures and time-critical access.

16.3 Pilot questions

- Does the GP and urgent-care front door reduce avoidable emergency demand without creating delay or confusion?
- Do shared theatres, diagnostics and critical care improve utilisation while preserving public priority?
- Are private charges sufficient to prevent public subsidy and recover whole-of-life costs?
- Can shared specialist practice improve recruitment and retention without weakening public rosters?
- Do the classification and transfer rules reduce routine cost shifting into public beds?
- Does the design improve emergency access, patient flow, clinical outcomes and regional confidence?

17. Implementation Roadmap

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

- Establish an empowered national taskforce supported by Health, Treasury, Finance and infrastructure expertise.
- Complete service planning, site assessment and reference design for Burnie and two comparison pilots.
- Draft classification, shared-service charging, public-priority and transfer-accountability rules.
- Negotiate heads of agreement with participating jurisdictions and education partners.
- Begin workforce, digital interoperability and procurement design.

17.2 Phase Two - Public core and pilot delivery (Years 2-5)

Construct or redevelop the central and public buildings first. Commission services in stages, test the urgent-care front door, introduce national reporting and evaluate patient flow, access, workforce and operating costs.

17.3 Phase Three - Private and education components (Years 3-6)

Following open market testing, proceed with the private building only when financing and full-cost service agreements are demonstrably sustainable. Proceed with the education hub only when partner funding and placement commitments are secured.

17.4 Phase Four - Expansion and standardisation (Years 5-10)

Use independently evaluated pilot evidence to issue national design, contracting and service standards. Scale first where regional access and health outcomes show the greatest need.

18. Planning Suggestions for Ministerial Consideration

The proposal is most credible when framed around visible operational problems: emergency congestion, regional access, delayed diagnosis, workforce instability and private cost shifting. The three-building model offers a concrete way to add capacity while protecting the public system.

Government can separate the political decision to test the model from the later decision to fund national rollout. Early commitments should be limited to detailed design, independent costing, legislative preparation and a small number of pilots.

Communication should be clear that the public and private buildings are not equal claimants on public resources. The central building is public infrastructure. Private access is conditional, secondary to clinical priority and paid for at full cost.

19. Risks and Mitigation

State resistance to national control: Use long-term agreements, shared capital commitments and retained local operation, with transparent dispute resolution.

Private use displaces public patients: Set minimum public allocations, real-time escalation rules, independent scheduling oversight and published performance.

Hidden public subsidy: Apply metered usage, whole-of-life pricing, open-book audit and periodic market testing.

Private operator failure: Require financial security, step-in rights, continuity plans and separation of core public utilities and systems.

Workforce cannibalisation: Commission additional training and positions, protect public rosters and monitor movement between the buildings.

Capital cost overruns: Use reference designs, staged approvals, independent assurance and scope control.

Clinical fragmentation: Adopt one campus-wide safety framework, shared credentialing and clear responsibility for each episode.

Digital and cyber risk: Use staged migration, common standards, security testing and offline continuity capability.

Pilot selected for politics rather than need: Publish selection criteria and require independent evaluation against a pre-agreed baseline.

20. Measures of Success

- Emergency department waiting time, ambulance offload time and admission delay.
- Elective surgery waiting time, theatre utilisation and cancellation rates.
- Time to diagnostic imaging, pathology and clinically indicated specialist treatment.
- Regional transfer rates, transfer time and potentially avoidable transfers.
- Public versus private use of central services and compliance with public-priority thresholds.
- Full-cost recovery from private activity, verified by independent audit.
- Complication, readmission and transfer rates by originating facility and payer.
- Staff vacancies, turnover, agency expenditure and regional training-to-employment conversion.
- Patient experience, informed choice and complaint resolution.
- Capital delivery, operating cost and whole-of-life maintenance performance.
- Emergency preparedness, cyber resilience and supply availability.

Measures should be published at campus, regional and national level, with privacy protection and risk adjustment where appropriate. Pilot evaluation should compare results with a pre-construction baseline and suitable comparison regions.

21. Actions Requested

1. Commission a detailed feasibility and service-planning study for the three-building hospital model.

2. Select Burnie and two comparison regions for preliminary pilot design using published operational criteria.

3. Request Treasury, Finance and independent infrastructure advice on capital, operating and shared-service pricing models.

4. Develop national definitions for hospitals and procedural facilities, including transfer and funding responsibility.

5. Prepare model rules protecting public priority and preventing cross-subsidy within shared campuses.

6. Begin negotiations on workforce portability, regional training partnerships and public staffing pools.

7. Commission the national patient-record interoperability and procurement work programs.

8. Prepare legislative safeguards for public ownership of core clinical assets and transparent private participation.

9. Publish pilot baselines, evaluation measures and decision gates before construction commitment.

These actions move the proposal from concept to disciplined assessment without committing government to an uncosted national rollout.

Appendix A - Indicative Funding and Reform Structure

The table summarises the revised architecture. All financial settings require formal modelling and negotiation.

Component	Indicative approach	Primary purpose
Universal public system	Strengthened Medicare-based funding plus pooled Commonwealth and state contributions	Hospitals, primary care, emergency services, public clinical infrastructure and core administration
Central clinical building	Public capital with transparent operating budgets	Emergency, theatres, critical care, cardiac and stroke services, diagnostics, sterilisation, pharmacy and helipad access
Public hospital building	Public capital and activity funding	Public wards, maternity, paediatrics, cancer, renal, mental health, rehabilitation, palliative and outpatient care
Private hospital building	Investor or operator finance after open market testing	Private inpatient capacity; operator funds fit-out, equipment, rent and operating costs
Private use of shared services	Metered full-cost charges	Recovery of clinical, staffing, consumable, maintenance, digital, overhead and capital costs
Education hub	Commonwealth, UTAS or other partner funding	Training, placements and research without diverting the core hospital capital budget
National enablers	Commonwealth-led implementation agreements	Workforce portability, patient records, procurement, standards and emergency coordination