KPMG | Hassell

Demanding a digital design

What do our future health systems demand of what we build today?



November 2026

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Acknowledgement of Country

KPMG and Hassell acknowledge Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

Our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia s First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.



Recognition of lived and living experience

We recognise the individual and collective expertise of people with lived and living experience of health conditions, disability, trauma, caring responsibilities, and interactions with health and social service systems. This includes patients, consumers, families, carers, and communities whose experiences provide essential insight into how services and environments are experienced in practice.

We are committed to engaging with consumers, carers, families, communities, and staff in ways that are respectful, compassionate, and trauma informed. We value these perspectives as fundamental to designing health infrastructure, environments, and systems that better meet the needs of the people they serve.

Turning healthcare inside out.

Health systems worldwide face a value crisis: the cost of care continues to rise without commensurate improvements in outcomes or equitable access. Ageing populations, chronic disease prevalence, workforce constraints and legacy infrastructure intensify pressure on already stretched resources. Governments and health services are investing heavily in digital technologies, but many remain standalone initiatives, augmenting existing models of care locally without unlocking value across the system.

KPMG and Hassell bring together complementary expertise in care model redesign, digital transformation and health infrastructure design to tackle one of healthcare's biggest questions: What has to change in the built environment to enable digital-in-health and the future models of care it makes possible? This paper looks beyond incremental improvement to explore how digital health can drive system-wide redesign, challenging us to rethink hospital design around how and where care will be delivered in the future.

We argue that the built environment must do more than respond to healthcare capacity constraints. It should be a deliberate expression of the health system we want to create, shaping behaviours, enabling new models of care across communities, and accelerating the shift towards a more connected, sustainable and accessible health system.



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INSIGHTS SNAPSHOT

01

Our changing health needs have outgrown hospital based care.

Care complexity and rising demand make alternatives essential.

02

System design should come before hospital design.

Align digital, workforce, funding and infrastructure first, then determine whether, where and what to build.

03

Five success factors to unlocking transformation.

Place, modality, digital first care, active care partners and workforce wellbeing.

04

Hospitals belong within a broader care ecosystem

Design connected facilities that support care across settings.

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Digital first offers a different way to organise care and capacity. Health systems must align care models, digital capability and infrastructure before decisions about what to build are made.

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Principle to practice: Digital demands a different design response

Different models of care require different spatial responses, reshaping what, where and, how much we build across four key settings of care.

KPMG & Hassell care and place, planned together 36

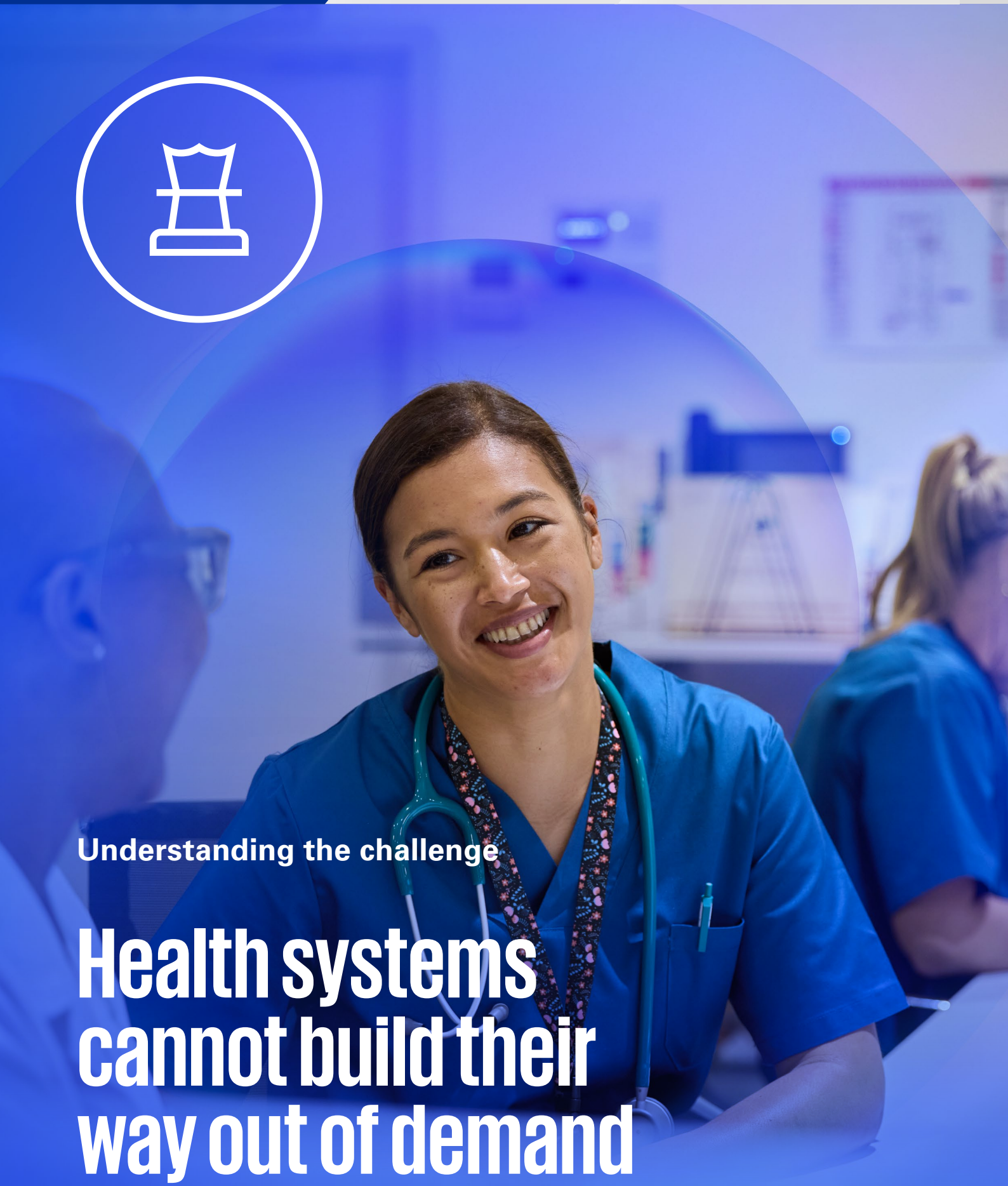
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Understanding the challenge

Health systems cannot build their way out of demand

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INSIGHTS SNAPSHOT

01

New hospital capacity cannot be built fast enough to meet growing and increasingly complex health needs, amid rising construction costs and workforce constraints.

02

Virtual care can materially reduce hospital demand and cost, with Australian models cutting admissions by 50% and saving $982 per patient per month, but capturing these benefits at scale requires coordinated funding, workforce, workflows and infrastructure.

Demand is outpacing population growth, as Australians live longer with more complex health needs.

Demand is growing faster than demographics alone would predict.

Australia's population grew by 16% in the last decade. Demand across hospital services grew by an average of 24%. Ageing explains just 0.9 of the 3.6 percentage points of annual real growth in admitted and out-of-hospital medical services. Other factors drove the remaining one-third of emergency department (ED) demand growth and over half of hospital admissions growth [2].

The nature and complexity of demand is changing.

Chronic conditions affect most Australians. Cancer, mental health and substance use disorders, musculoskeletal, cardiovascular and neurological conditions accounted for 64% of disease burden in 2024 [3]. Patients need more frequent, coordinated and prolonged care. High-acuity ED attendances have risen sharply, while lower-acuity presentations remain comparatively stable [4].

As care becomes more complex, each episode becomes more resource-intensive.

The number of hospitalisations does not capture the growing resources required to deliver each episode of care [5]. The required staff, time, diagnostics, specialist services and coordination are increasing per episode [6]. Without greater substitution of traditional care with alternative models, supply will struggle to keep pace with demand. Health systems must find better ways to meet rising demand with finite resources today, while simultaneously building for the future or, as Keynes observed: 'In the long run, we are all dead.' [10]

+700,000
Hospital admissions above predicted in 2025. [2]

+440,000
ED presentations above predicted in 2025. [7]

24%
Average growth in ED, hospital and Medicare specialist activity, 2015–2025.

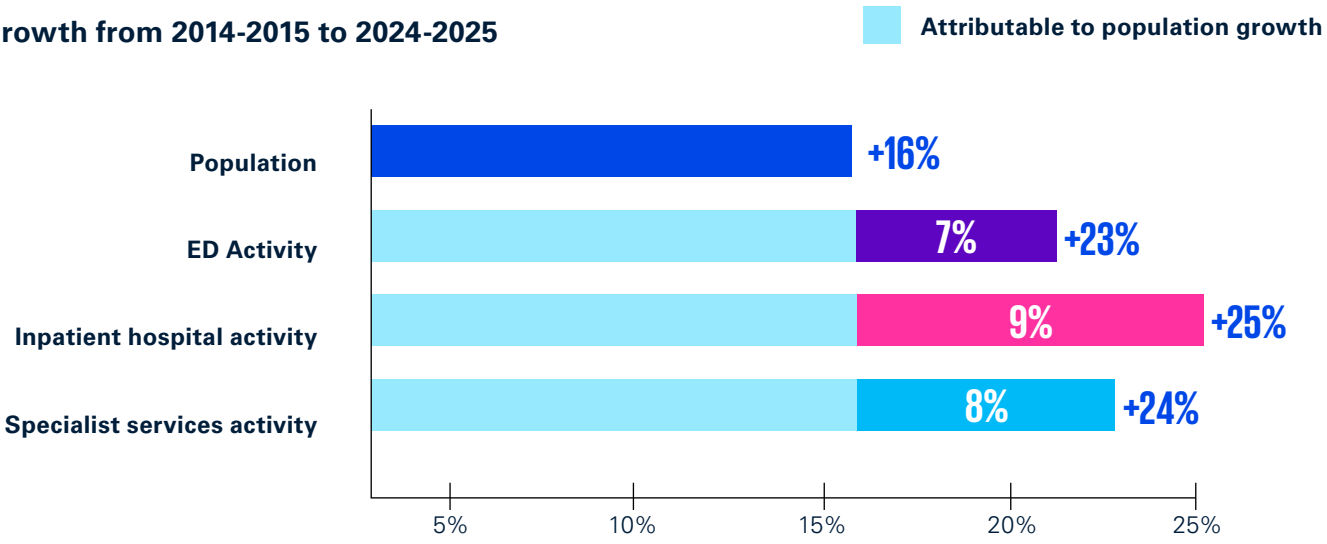
8 in 10
Australians have at least one long-term condition. [3]

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Demand for care is outpacing population growth.

Growth from 2014-2015 to 2024-2025



Source: ROGS 2026 [8]. KPMG analysis.

AGEING POPULATION

3,600

Older Australians in hospital awaiting aged care. [9]

+60%

Hospital patient days used by people eligible and waiting for residential aged care. [10]

LENGTH OF STAY

+18%

Average stay: 2.7 days overall, 5.7 for overnight stays. Inpatient stay increased 18%. [2]

ACCESS

26.6%

did not access a GP when needed. [11]

WAIT TIMES

42 to 48 days

public elective surgery waits, 2019–2024. [12]

CARE ACUITY

-13.1%

Decrease in lower-urgency ED presentation rate between 2017–18 and 2024–25. [13]

125%

Rise in high-acuity ED attendances per 1,000 people, 2003–2023. [4]

EXPENDITURE

Healthcare now accounts for around **one in every ten dollars** in Australia's economy, **twice the share it did 50 years ago. [14]**

10.2%

Gross Domestic Product (GDP) on Health vs OECD Average 12.6%. [15]

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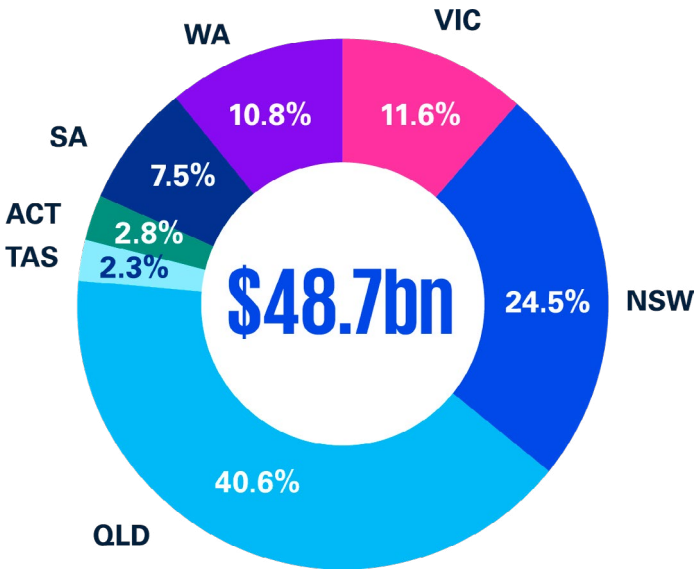
Why we can't build our way out.

Health infrastructure investment outpaces delivery capacity.

Australia is planning its largest hospital building program in a generation, amid persistent cost overruns, workforce shortages and competing infrastructure demand. [16]

With over two-thirds of the hospital infrastructure pipeline still unbuilt and competing for scarce global workforce and delivery capacity, there is a limit to how quickly new capacity can be delivered. With these pressures expected to intensify over the next five years, the need for new hospital capacity will outpace the market capacity to deliver it.

A bed is not capacity. We must challenge the conventional response of adding more beds and ask whether we are solving the right problem. More capacity cannot be the only answer; we need new ways to meet demand.



Construction market capacity constrains delivery.

+94% State and territory health infrastructure expenditure increase between 2014-2024 [17]

$242bn Five-year total public infrastructure pipeline in 2025

300k+ Projected worker shortfall by mid-2027 [16]

30k p.a Rate at which the construction workforce is growing [18]

>5% Annual building-cost escalation forecast, 2025–27 [21]

Staff shortages, skills underinvestment and rising costs constrain delivery as incomplete construction work hits record levels. [20]

Competition for finite resources. Nine public megaprojects above A$5 billion represent 64% of pipeline value. [21]

Projected global infrastructure investment above US$106 trillion by 2040 intensifies competition for workers and materials. Globally scarce skills are being drawn to larger and higher-paying infrastructure pipelines. [22]

By the 2027 construction peak, Australia's public construction pipeline will demand more workers than the market can supply, even under optimistic assumptions.

Global supply constraints limit reliability of on-time delivery. Trade disruption, supplier risk and geopolitical uncertainty increase costs and reduce certainty. [23]

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The challenge of scaling digital care.

Faced with rising demand and the limits of continued hospital expansion, health systems globally have turned to digital to enable fundamentally different models of care. Digitally enabled care offers a safe and affordable alternative, but health systems have struggled to move beyond fragmented pilots and achieve transformation at scale. [24]

Digital care has demonstrated its potential to improve access and reduce costs.

COVID-19 accelerated deployment of digital health solutions in response to immediate pressures. [25] Models vary across jurisdictions, but many have demonstrated that hospital-level acute care can be safely delivered outside hospital, with the potential to:

- Deliver safe, effective and timely care with quality and clinical outcomes at least matching hospitals.
- Improve work-life balance and job satisfaction for healthcare workers.
- Improve equitable access and reduce regional health disparities.
- Provide care at a lower cost and improve the affordability and sustainability of care.

+94% of callers diverted from ED

62m interactions with the community

29% of callers were rural/remote

66% and were after hours

Source: Healthdirect Data (2024-25)

23.5% Doubled from 11.9% in 2018-19

90% **Australians with My Health Record**

22.5% **Australians using Telehealth services**

Source: Hospital Outpatient Services via Virtual Care (2023-24)

Investment in digital is accelerating, but value at scale remains elusive.

The KPMG Global Tech Report 2026 found that 40% of healthcare organisations are committing US $50–100 million annually to digital technologies, while 83% of healthcare CEOs expect returns from AI investment within three years. Yet realising this value at scale remains challenging, with 35% identifying organisational integration as a major challenge. Research identifies persistent barriers to scaling digital care, including funding and reimbursement, infrastructure and interoperability, data governance, workforce readiness, organisational capability and public trust. However, we have limited understanding of how these factors interact to influence virtual care effectiveness, or how they can be optimised to maximise value across different health settings.

Moving from digital health to digital-in-health.

KPMG's Australian Private Health Insurance Insights 2026 declares digital health investment a strategic necessity, but digital technologies alone will not deliver transformation at scale.

The next phase is digital-in-health: [24] moving beyond a narrow focus on digitalisation to embed digital across care delivery, infrastructure, public health and health system management, and designing these elements to work together as one health system.

Embedding technology and data as integral components of the health system is critical to realising the value of digital investment at scale, enabling new models of care and more efficient use of finite capacity.

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Digitally enabled care is demonstrating tangible benefits.

Digital health spans a broad range of technologies and applications that can improve how care is delivered. Virtual hospital models use digital technologies to extend hospital-based care beyond the physical hospital, enabling services such as virtual consultations, remote monitoring, specialist care and home-based care. Evaluations of specific virtual hospital models demonstrate benefits in clinical outcomes, patient experience and resource use for selected programs and patient groups, as outlined below.

My Home Hospital

Owned and operated by Amplar Health, part of Medibank, this digital hospital service delivers acute care in patients' homes on behalf of SA Health.

0.4%
Hospital acquired complications
Compared with 1.9% in conventional hospital settings.

>97%
Patient satisfaction
Reported satisfaction consistently exceeded 97%.

23.6%
Lower cost per episode
Compared with the national average, adjusted for case mix.

KPMG modelled three scenarios for scaling Medibank's My Home Hospital, from current care models to additional clinical cohorts. Potential value comes from added capacity and productivity, with resources available for reinvestment rather than direct budget savings.

360,000–1.2m
Physical bed days replaced by current virtual hospital care in 2030.

$290m–$1.0bn
Associated modelled cost savings in 2030 for beds substituted.

$390m
Potential capital expenditure substituted under the expanded scope scenario*.

*Represents the lower end of a large modelled range of potential savings; actual savings will vary depending on the scale and extent of implementation.

MeCare, Australia

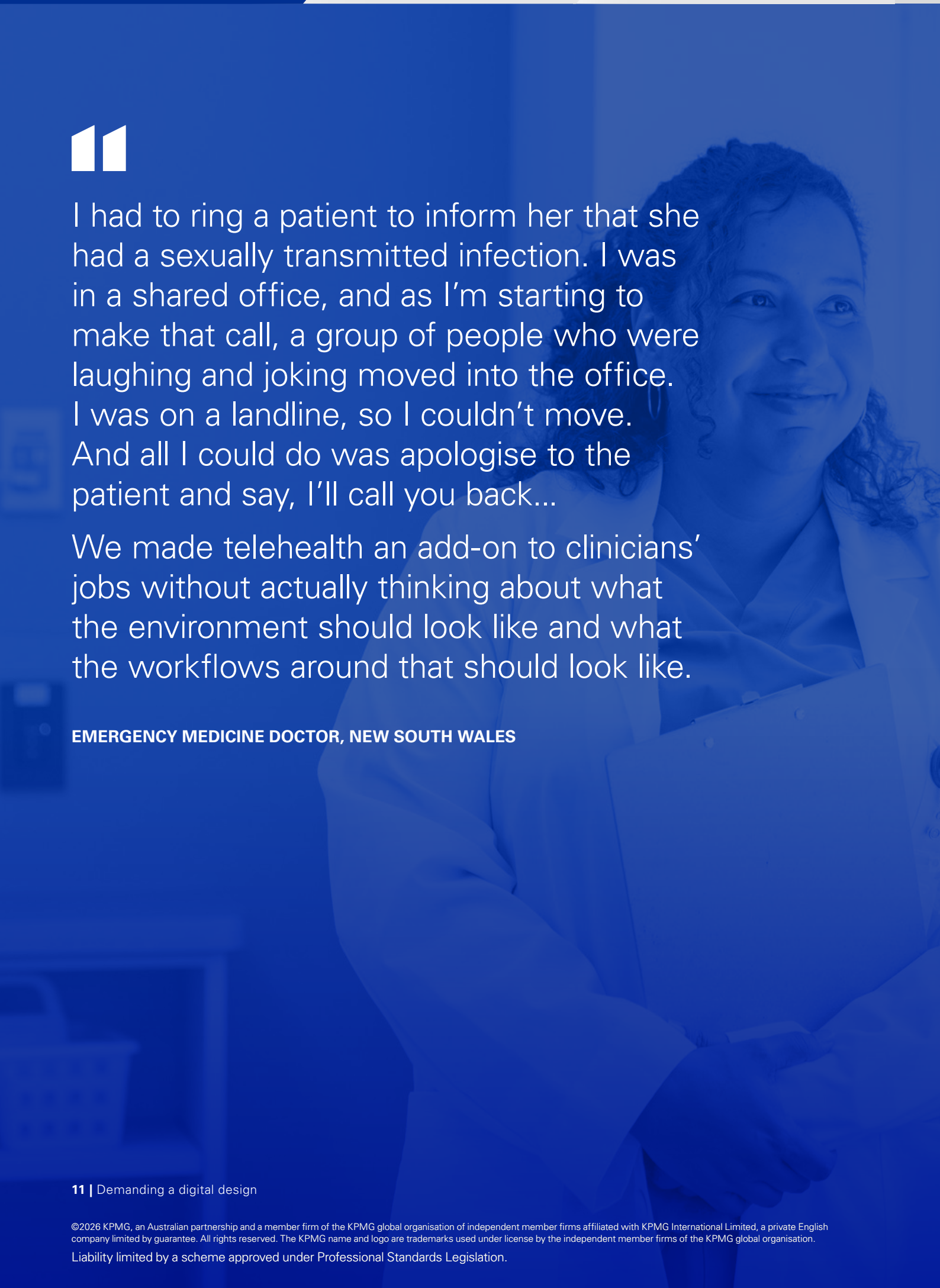
For frequent health service users with chronic illness, the evaluation reported 50% fewer hospital admissions and net savings of A$982 per participant per month. Virtual and multidisciplinary care largely substituted for existing services. [26]

Los Angeles Hospital at Home

In its first year, 876 patients avoided 3,504 inpatient bed-days. The evaluation reported US$5.6 million in net hospital savings, accounting for operating costs and foregone revenue. [27]

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I had to ring a patient to inform her that she had a sexually transmitted infection. I was in a shared office, and as I'm starting to make that call, a group of people who were laughing and joking moved into the office. I was on a landline, so I couldn't move. And all I could do was apologise to the patient and say, I'll call you back...

We made telehealth an add-on to clinicians' jobs without actually thinking about what the environment should look like and what the workflows around that should look like.

EMERGENCY MEDICINE DOCTOR, NEW SOUTH WALES

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Changing the default response

Digital by default: Reorganising the health system for future care

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INSIGHTS SNAPSHOT

01
Hospitals shape how care, resources and capacity flow across the system for generations. Plan them as part of a care ecosystem, not as standalone assets.

02
Digital first care offers a different response to future demand, but transformation requires the whole system to be designed around it.

03
Make the least reversible decisions last. Define the care model, workforce and digital capability together before locking in the physical design.

Think beyond the hospital. Design the health system.

Health systems are complex socio-technical systems: their building blocks depend on and influence each other, to collectively shape system outcomes. [28]

The built environment shapes how the health ecosystem functions, influencing both individual building blocks, and the relationships between them by enabling, or constraining, where care can be delivered and where people need to be.

The hospital has long been the organising centre of the health system, with patients, resources and services designed to flow towards it. This hardwires hospital-centricity into the system, making the hospital the central node, around which the rest of the system must organise.

The future health system is being designed in parts, not as a whole. The Australasian Health Facility Guidelines [31] increasingly require patient areas to support telehealth and remote consultation, but a dedicated Telehealth Room is non-standard component. State planning frameworks similarly acknowledge virtual care and remote monitoring without consistently translating them into mandated standards or planning requirements.

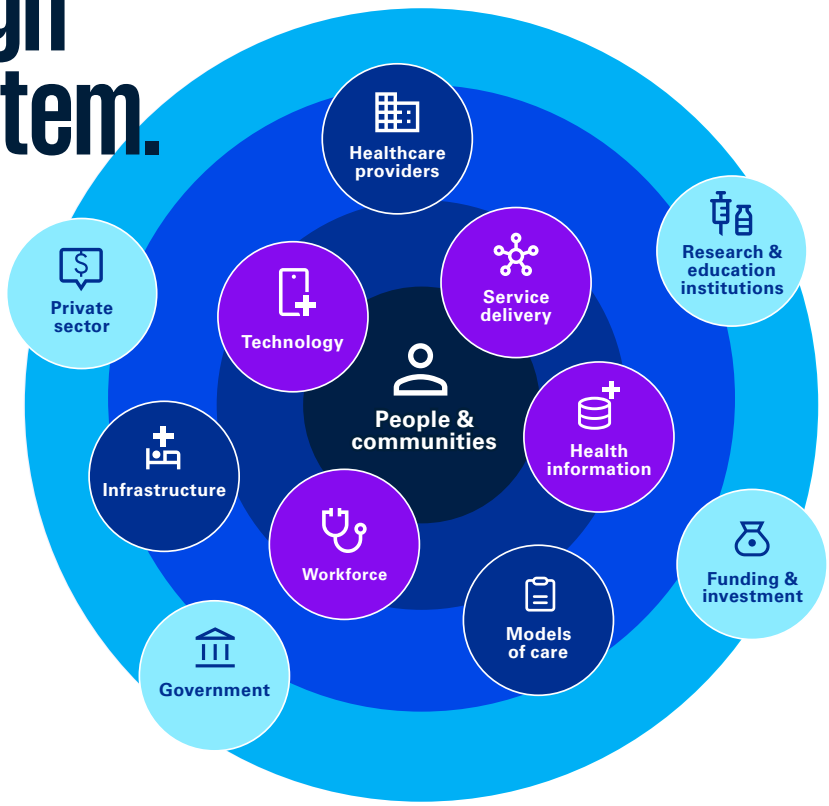


Figure 1 | An interconnected healthcare ecosystem

We fund the physical first and add on digital later. By then, the major decisions about how care will work are already locked in.

The pandemic demonstrated both how much societies depend on hospitals and how much care need not occur within them. Across OECD systems, more beds do not consistently mean better population health outcomes. [30]

Digital gives health systems new ways to create access and capacity, [29] yet the built environment remains anchored to a predominantly physical model of care.

We cannot build the future of care with the logic of the past. Whole-system planning should align population need, service models, workforce, digital, governance, funding and outcomes before capital and built-environment decisions are finalised.

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New ambitions, old building blocks.

The direction of travel is clear: care needs to move beyond the hospital. Yet Australia continues to respond to rising demand with more beds and larger facilities. This is not a failure of intent, but a system designed to reproduce these outcomes. [32] Planning, funding and governance settings make hospital-first investment the predictable choice. Breaking this cycle requires system stewards to reorient the health system's building blocks around a transformative model of care.

01 SERVICE DELIVERY

Building the answer before defining the problem.

Capital-first sequencing commits funding before demand, service models and infrastructure options are fully assessed, creating an assumption that a major project will proceed. Options assessment is often retrospective, with business cases backfilled to support the decision to build.

Once a building is assumed to be the answer, the system defaults to hospital-centric solutions. The political and institutional appeal of new infrastructure can crowd out alternatives that may deliver better outcomes, forcing service design into a pre-committed capital envelope.

02 FUNDING & LEADERSHIP

Activity-based funding rewards throughput.

Activity-based funding allocates resources according to the volume and type of services delivered, while output-based measures assess performance through those same activities. Capital investment is then informed by future demand forecast from historical utilisation. [33]

These measures make service delivery visible but emphasise what organisations do, rather than whether population health improves, which is inherently harder to measure. Together, they can optimise the system for delivering more care rather than reducing need: historical demand drives investment, hospital activity justifies capacity, and success is measured through throughput. Prevention, digitally enabled care and community-based services can therefore struggle to compete with infrastructure investment, even where they may deliver better outcomes.

03 GOVERNANCE

Optimising the parts instead of designing the whole.

Infrastructure, workforce, digital and service planning proceed through siloed decision-making pathways, separate funding processes, business cases, governance structures and investment decisions, often led by different teams or agencies. The system can assess individual investments, but not whether a different mix of interventions would deliver better outcomes overall. [24] [34]

Each organisation may make sensible decisions in isolation while the system as a whole remains inefficient because no one optimises across it. Solutions that require coordination across organisational boundaries, such as shared digital platforms, integrated workforce models and substitution mechanisms, can struggle to gain traction because their benefits accrue to the system as a whole rather than to any single organisation.

CASE STUDY

Hornsby Ku-ring-gai Hospital Redevelopment

The NSW Auditor General found that the $200 million funding envelope was set before the final business case was completed. The impact was that, when the preferred option was costed at $214.6 million, the project governance committee had to determine an "affordable version" that met the existing funding commitment. [35] This illustrates a common challenge faced by health system leaders: funding is announced publicly, locking in a capital envelope before detailed planning is complete.

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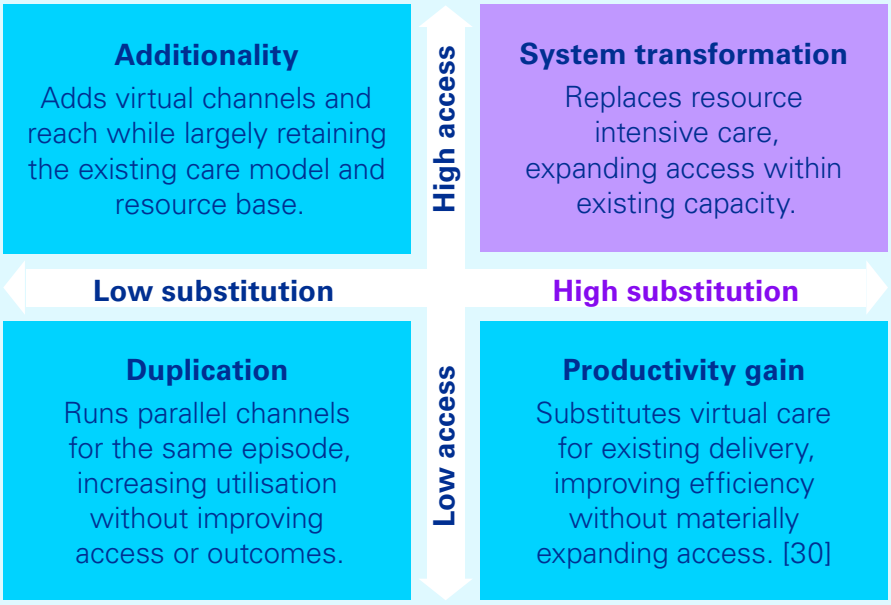
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Make digital the default through better health system design.

The potential value added of digital technologies beyond process efficiency is not yet recognised, visible, or valued. [24]

Realising digital benefits requires more than adding technology or digital channels; [36] it must relieve pressure on scarce workforce and capacity, expand access and improve how resources are used across the system. [76]

Achieving the economies of scale needed for system-wide change depends on strong leadership and governance to direct scarce investment towards the priorities that deliver the greatest value for the whole system.



Design the health system digital by default.

Digital by default changes the choice architecture of health system planning: physical care is no longer the assumed starting point, but one modality selected where it creates the greatest value. [38]

Digital is no longer planned alongside the health system; it becomes part of how the health system is planned.

The NHS uses 'digital by default' as a guiding principle for health system transformation, challenging health services to reimagine care and supporting infrastructure around patient need and outcomes, rather than traditional assumptions about place and physical capacity. [39] [40]

Digital-first models of care provide one of the few mechanisms that advance the quadruple aim: access, quality, workforce sustainability and cost, by changing how the system uses its finite capacity: [42]

- Expanding the reach of care by reducing geography as a constraint on access, to wherever the patient is
- Inverting the point of entry by making digital and remote care the default where appropriate, with physical care an escalation pathway rather than the automatic starting point.
- Redistributing demand across the care ecosystem, rather than concentrating it around the hospital.
- Freeing clinical capacity by reducing administration and returning time to care.
- Improving resource efficiency by matching the intensity of care to patient need.
- Lowering resource intensity by shifting appropriate care to lower-cost models and supporting self-management.
- Deploying clinical capability more flexibly through broader scopes of practice and across care settings.

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System design must integrate digital to transform how care is delivered.

Failures in system design cascade downward. Clinical and professional integration at the point of care is conditional on strong leadership at system-level.

System stewards are charged with setting the conditions for transformation, bringing funding, workforce, digital, services and infrastructure into alignment around a shared future model of care. [42]

THREE ACTIONS FOR SYSTEM STEWARDS:

1 Set investment priorities

Direct scarce investment to the health needs and models of care with the greatest potential for system-wide impact.

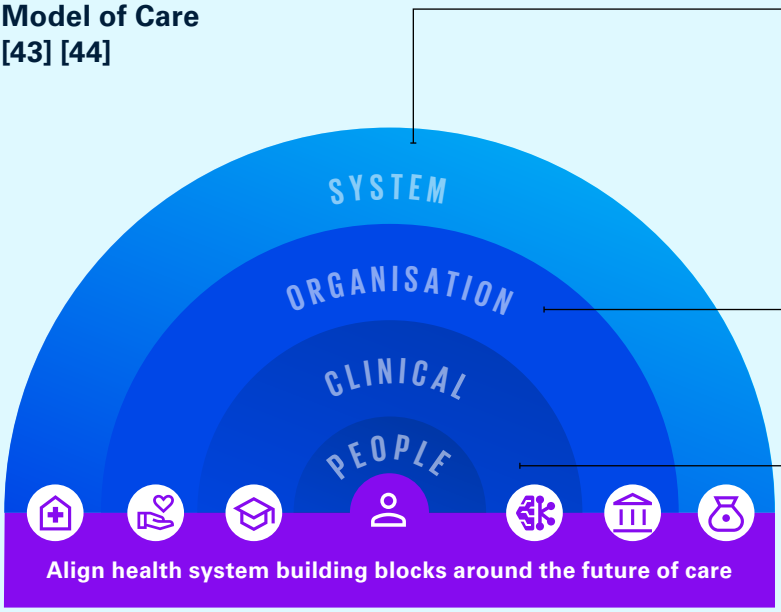
2 Connect the system

Broker knowledge across boundaries, synthesise evidence and leading practice, and establish shared mechanisms for systemwide decisions.

3 Scale what works

Create the funding, capability and partnerships needed to take proven models from isolated initiatives to system-wide delivery.

Integrated Model of Care [43] [44]



Population-level health outcomes
How the system is designed to achieve outcomes: policy, regulation, funding and governance aligned to whole-of-system strategy, standards, requirements and digital interoperability.

Service-level integration for target population groups
How care is organised: services configured around digital, workforce readiness, digital care pathways, patient flow optimisation, integrated workflows, designing care settings and supporting infrastructure.

Individual-level care coordination
How care is experienced: workforce and people interactions, technology day to day, accessibility of health information, usability and continuity across care settings.

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Design from the outside in.

The built environment is the health system's most enduring, least reversible decision.

Models of care are evolving faster than the infrastructure built to support them. At Australia s current pipeline scale, today s assumptions about demand, workforce and models of care become embedded in infrastructure that shapes future service delivery for decades — potentially locking tens of billions of dollars into a model of care the system is seeking to leave behind. [45] [46]



Decisions	Horizon before revision & consequence	
Primary structure and site	100 years	Commits future clinicians and patients to a configuration of care set before the model of care exists.
Capital envelope	Fixed at commitment	Where cost exceeds envelope, scope is reduced to fit funding rather than funding adjusted to fit need.
Secondary systems	20 50 years	Developed against a capacity envelope already fixed, so the model adapts to the asset.
Model of care	5 10 years	Reversible, and treated as such. Appropriately sequenced.
Tertiary systems	5 10 years	Reversible, and treated as such. Appropriately sequenced.
Digital architecture	3 7 years	The most revisable decision is made last, so it cannot constrain the least revisable one
Workforce model and scope	Continuous	Resolved after estate and platform are fixed, so both constrain roles that should have shaped them.

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Make the least reversible decisions last

Better delivery cannot compensate for the wrong strategic choice: a project can be delivered on time and on budget, and still be the wrong project. A global study of more than 16,000 major projects found that fewer than one in ten were delivered both on budget and on time, and only around one in 200 also delivered the promised benefits. [47]

A more effective planning sequence would define the future model of care before capital and space are fixed. Care pathways, service requirements, workforce design and digital architecture would be developed together, with AI, simulation and digital twins used to test alternatives and operational implications. Evidence from established models, pilots and evaluations should inform common standards and repeatable approaches that can be adapted across settings, reducing duplication while preserving local flexibility and allowing physical design to respond to the model of care, rather than define it.

CASE STUDY

Children's Healthcare of Atlanta

Simulation based design testing before construction of a new 400 bed paediatric hospital exposed 722 latent design conditions before construction, allowing costly issues to be resolved through design and generating substantial avoided cost from a relatively modest upfront investment. [48]

The leverage came from co specifying the operating model and spatial design before the floor plate was fixed. Australia s hospital pipeline risks forgoing this benefit when clinical, digital and workforce requirements are resolved after the brief.

Early design testing avoids costly rework

722 latent design conditions identified

57% mitigated through design changes

$90m estimated cost avoided

CASE STUDY

UK Hospital 2.0

Standardise the core. Adapt to place.

Hospital 2.0 demonstrates a more integrated approach to hospital planning, in which clinical, digital and operational needs are translated into codified requirements and integrated design rules. Up to 80% of each hospital is standardised around modular clinical clusters, with around 20% reserved for local needs. [49]

Repeatable design modules and Modern Methods of Construction bring greater standardisation to design and delivery, with some applications reporting potential cost reductions of up to 25% and programme reductions of up to 20% compared with traditional approaches. [50]

Standardising what can be repeated can reduce infrastructure costs and redirect investment towards care design and innovation.





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THE HOSPITAL 2.0 FRAMEWORK

A systemwide blueprint for hospitals of the future.

NHS England guidance explicitly requires infrastructure planning to consider how estate, digital and workforce models support clinical pathways and system strategy. [49] [51] [52]

Changing the default response

More than a hospital

We are not simply replacing a building. We are designing for the future, transforming how care and services are provided across the community and wider health system.

Set the default, then adapt

Standardise by default and embed digital from the outset. Adapt only where need demands it, focusing infrastructure and investment on what is genuinely required.

Transformational model of care

Set the future operating intent for care and require capital programs to respond to it. Define where care happens, how patients experience it, how clinicians and services work together, and how digital enables delivery.

CLINICAL BRIEFS | **DIGITAL BRIEFS** | **TECHNICAL REQUIREMENTS** | **WHOLE-SYSTEM STRATEGIES**

↓

THE STANDARDISED BLUEPRINT

Repeatable templates for wards, theatres and treatment rooms and recommended layout for services, setting out which services should be close together.

↓

THE OPERATING SYSTEM

Driving this blueprint is a system of key principles, standards and guidelines for how the hospital should operate and be delivered.

↓

WHOLE HOSPITAL DESIGN

BENEFITS

FASTER DELIVERY	REPEATABLE BUILD	LOWER COST	FUTURE-READY
Compressed design and approvals	MMC, procurement and manufacturing	Shared supply chains and scale	Digitally mature, integrated and adaptable over time.

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It is vitally important that specific digital investments… are designed and implemented with an overall digital ecosystem master plan in mind…The overall puzzle matters, as do the pieces that fit into it and the order in which they are put in place. Value can be either created or diminished depending on these decisions.

WORLD BANK (2023) [24]

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Designing future-ready infrastructure

From principle to practice: Digital demands a different response

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INSIGHTS SNAPSHOT

01
Design one connected care ecosystem. Patients should experience continuity across home, community, virtual and acute settings.

02
Match each setting to the care need. Technology, workforce, workflow and governance must be designed with the place.

03
Shift appropriate care outward so the acute core can focus on complex, high-acuity and procedural work.

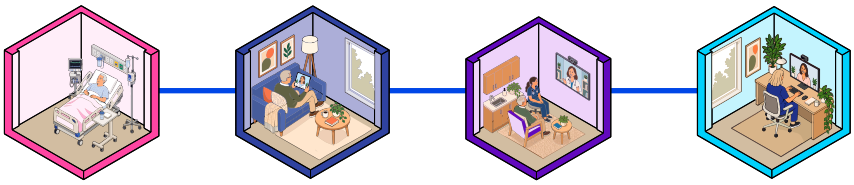
Digital by default: designing infrastructure around the future of care.

Health infrastructure has traditionally been planned from the building outwards, starting with beds, departments and facilities. Reversing that logic means first determining how and where care should be delivered, then designing the built environment to support it. [53]

This section translates the building blocks of the future health system ecosystem into practical infrastructure and design choices across four connected care settings. Future-ready infrastructure requires a system-level framework: standardising what benefits from consistency and scale, while allowing the built response to adapt to local models of care, population needs and place.

Reimagining the care of the future: four settings working as one

Shared information, coordinated workflows and clear clinical responsibility create a connected care ecosystem, enabling expertise to move between settings.



Acute core

Complex, high-acuity and procedural care

Home

Connected care in the home

Community node

Local access and coordinated care

Virtual clinical workplace

Remote care and clinical collaboration

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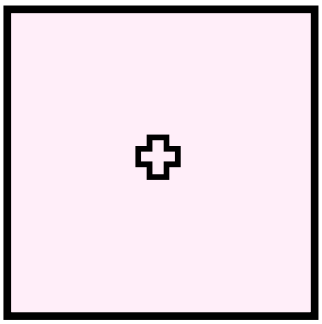
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Moving beyond hospital walls

A growing range of care can be delivered at home, but this setting is not suitable in every case. A network of environments is therefore needed to meet different clinical needs.

Where it is safe, effective, and equitable, care can be delivered in the home, supported by virtual consultations, monitoring, equipment, carers, and mobile clinical teams. Some care must still be delivered physically, requiring access to diagnostic equipment, clinical support and environments that cannot be replicated efficiently in every home. A community node fills this gap, offering a place closer to home where patients can receive in-person care or help accessing virtual services. The most complex and acute work remains in the hospital, where specialist staff, technology, and controlled clinical environments can be concentrated in a more focused acute core.

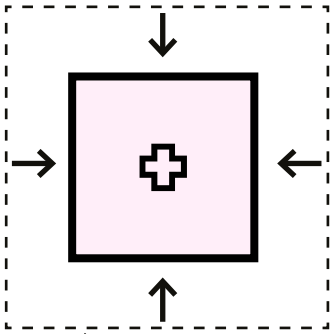
CURRENT STATE
Existing centralised hospital infrastructure



Connecting these patient settings is the virtual clinical workplace. It gives clinicians a place to deliver remote care, monitor patients, coordinate mobile teams, and manage transitions between settings.

Together, the four settings form the spatial framework for a health ecosystem. Their scale and configuration will differ between health systems. The aim is to distribute what can move, retain what cannot, and connect the whole care ecosystem so patients experience it as one service. [54]

FUTURE STATE
Decrease physical footprint by moving non-acute services closer to patient homes



ACUTE CORE
Services that can't be distributed are retained in a streamlined acute core.

+

HOME
When safe, effective, and equitable, care is moved from the hospital to the home.

COMMUNITY NODE
Care requiring physical interaction or supported access is delivered closer to patient in community setting.

VIRTUAL CLINICAL WORKPLACE
A dedicated workplace for clinicians delivering care remotely supports the care ecosystem.

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Four settings, one experience

Although the services are spatially distributed, a patient still experiences a unified service, with continuity between settings.

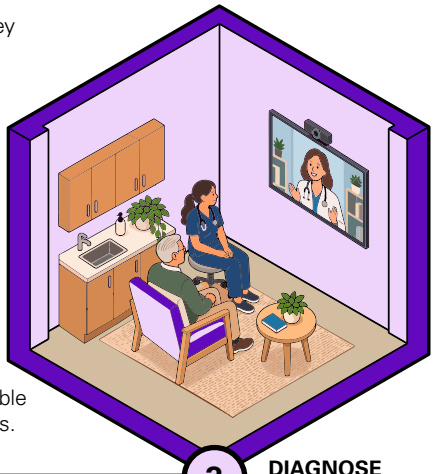


Meet John

To understand how the care ecosystem works, it is helpful to look at it from the patient's perspective. This is John's journey with a chronic heart condition, from early symptoms to acute care and recovery.

1 DETECT
At home, John contacts the service with increasing breathlessness. A clinician reviews his history and confirms next steps.

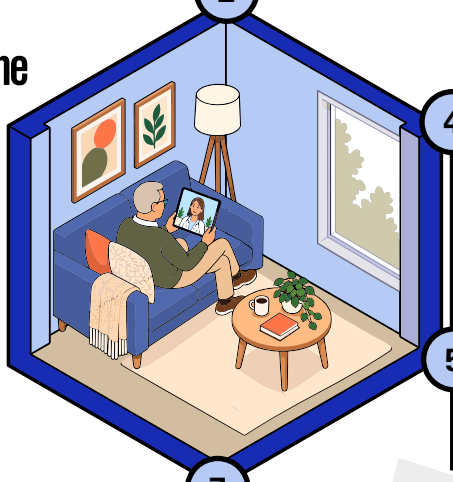
2 TRIAGE
A GP assesses John remotely and finds him stable enough for local diagnostics.



Community node

3 DIAGNOSE
A local clinician examines John. A remote cardiac specialist reviews the results, speaks with John, and agrees on the plan.

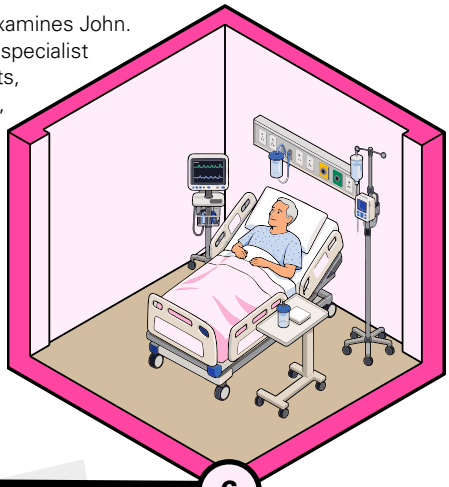
Home



4 MANAGE
John follows the plan for medicines, rehabilitation, and review. The team monitors him remotely with hands-on care as needed.

5 ESCALATE
John develops severe chest pain. His partner activates the urgent pathway; transport takes him directly to the acute core.

Acute core



6 TREAT
Emergency, cardiology, imaging, and procedural teams stabilise John. Discharge planning begins early.

7 RECOVER
John is accepted into hospital-in-the-home. Equipment is set up, and virtual ward rounds and mobile visits continue hospital-level care.

8 STEP DOWN
The virtual bed closes, equipment is collected, and handover occurs with John's GP. John visits the community node for regular check-ups and review.

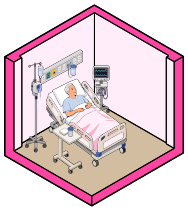


Virtual clinical workplace

At many points in John's journey, clinicians support or monitor his condition remotely. They may work from their own homes, clinical settings, or a dedicated virtual workplace.

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Setting	Role in the system	What it is
Home	Patient environment 	Where possible, the home should be the default location of care. This is made possible by remote monitoring, mobile clinicians, diagnostics, medicines and a defined escalation pathway. The service retains clinical responsibility throughout, while suitability depends on the patient, the condition, the home environment and available support.
Community node	Patient access environment 	The community node is a local access point that provides capabilities beyond the home without requiring the full infrastructure of an acute hospital. It brings together local clinical support, examination, diagnostics and access to remote expertise. Its form may vary from an existing primary care facility to a dedicated neighbourhood health hub, but its role remains consistent: bringing care closer to where people live. Depending on local need, the node may sit alongside short-stay accommodation for patients travelling for care or clinically supported step-down care.
Virtual clinical workplace	Clinician environment 	The virtual clinical workplace supports care across the home, community node, and acute core, with clinicians and patients often in different settings during the same encounter. It involves activities such as remote consultation, virtual ward rounds, monitoring, multidisciplinary review and escalation across the care ecosystem. It is a distinct clinical environment that enables clinicians to provide care beyond a single physical location.
Acute core	Clinical care environment 	The acute core accommodates care where timely physical co-presence, specialist infrastructure and concentrated capability remain essential. It provides emergency care, surgery, critical care, complex in-patient care and the diagnostic and support services these require. In a distributed care ecosystem, its role is not eliminated but refocused around the care that genuinely benefits from being concentrated in one place.

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Home

The home is a key place of care in the ecosystem. Supported by virtual care and in-home visits, it allows more people to receive care where they live, while remaining connected to the expertise and support of the wider health system.



The home is one care setting that healthcare providers cannot design. Instead, they must assess whether each home is suitable, then build the right support around it: equipment and connectivity, mobile care and monitoring, carer support, logistics, and escalation. As clinical risk and treatment intensity rise, so do the demands for clinical oversight, diagnostic access, mobile response, and logistical support.

Building block	How it shapes the setting	Spatial implications for the brief
Patient need	Home-based care is appropriate only where the patient and usual residence can support the episode without transferring unreasonable risk or burden to the household.	→ Set the minimum conditions to be assessed, including safe access, privacy, space for care and equipment, power and connectivity, and workable conditions for visiting staff. → Provide an alternative access setting where these conditions cannot be met.
Model of care	The home stage may include set-up, remote review, agreed patient or carer tasks, mobile visits, escalation and offboarding.	→ Plan the movement of staff, equipment, medicines, specimens and information to and from the home, with defined set-up, retrieval and transfer points.
Clinical services	The commissioned service scope determines the temporary clinical footprint introduced into the home and the capabilities retained in community or acute settings.	→ Use portable equipment and supplies matched to the pathway, with provision for safe placement, use and removal.
Workforce	The home becomes a temporary workplace for visiting clinicians, supported by a remote team and an external operations base.	→ Provide a compact staff base and, where relevant, staging for mobile and home-visiting teams. → Provide adaptable space for staff training and for carer onboarding to digital and home-based care.
Information systems	The patient, monitoring devices and visiting team remain connected to the responsible service and the authoritative clinical record.	→ Provide supported devices, reliable power and connectivity, charging and suitable positioning, with technical support and a risk-based fallback when the digital link is unavailable.
Financing	The funding and asset model specifies which equipment and support are provided by the service, and who is responsible for their ownership, maintenance, replacement and retrieval.	→ Treat equipment fleets, connectivity support, temporary set-up, logistics and the mobile-service base as funded service assets, with clear ownership, maintenance and replacement responsibilities.

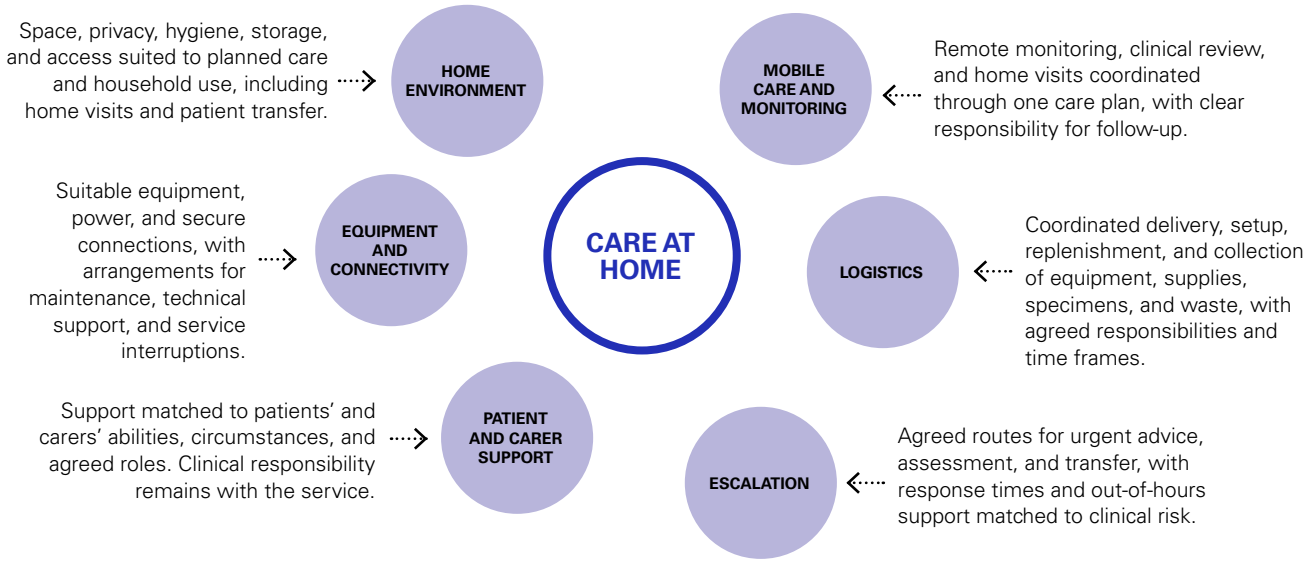
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PERFORMANCE CRITERIA

Conditions for care at home

Informed by guidance on virtual and home-based care, these performance criteria offer a starting point for assessing the home environment and supporting services. Applying them helps ensure a consistent standard of care at home, while accommodating each patient's needs and care plan. [55]



IN PRACTICE

Sydney Virtual Hospital (formerly RPA Virtual Hospital)

Sydney, Australia

Sydney Virtual connects a 24/7 Virtual Care Centre with district nursing and chronic care services to support people at home.

Virtual clinical support

- → Video and telephone consultations connect patients with clinicians, with remote monitoring used where appropriate.
- → In virtual rehabilitation, regular reviews are supported by coordinated home visits and equipment deliveries when needed.

Care delivered at home

- → Nurses work with the Virtual Care Centre, hospitals, GPs, and allied health teams to connect patients with ongoing support.


1.


2.

Left: Virtual consultation at Sydney Virtual Care Centre
Right: Sydney District Nursing home visit, Haberfield

Images:

1. 2. Sydney Local Health District/SydneyConnect

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Community node

A hybrid local care setting that combines hands-on care, selected diagnostics and remote expertise to resolve more care needs closer to home.

The key briefing decision is which capabilities can be provided locally, at what scale, and when care must move to the acute core. For suitable patients, virtual assessment can lead to examination, diagnostics, or treatment at the node without a visit to the acute emergency department. The node may include urgent care, but its scope must match its commissioned pathways, workforce, facilities, and escalation arrangements.



Building block	How it shapes the setting	Spatial implications for the brief
Patient need	Provides supported local access when care cannot be completed at home but does not require an acute hospital.	→ Locate around catchment access, with a legible arrival and appropriate privacy, accessibility and support.
Model of care	Coordinates local assessment, remote expertise and escalation as one pathway.	→ Organise clinical spaces around linked activities, with remote participation and a clear route for escalation.
Clinical services	Provides only the diagnostic and treatment capability needed to complete the local stage of commissioned pathways.	→ Use shared, adaptable clinical rooms where possible. → Add specialist spaces and support only where the capability requires them.
Workforce	A local multidisciplinary team provides hands-on care, supported by remote specialists and coordination roles.	→ Provide a compact staff base and, where relevant, staging for mobile and home-visiting teams. → Provide adaptable space for staff training and for carer onboarding to digital and home-based care.
Information systems	Records, results and care plans are available across local, remote and acute services.	→ Embed secure connectivity. → Enable shared information access. → Embed telehealth capability in clinical spaces.
Funding	The business case links recurrent service funding, pathway-level value and an asset strategy that can scale as demand is demonstrated.	→ Match tenure, co-location and staging to service maturity and demand certainty. → Plan for third-party ownership and shared asset responsibilities.

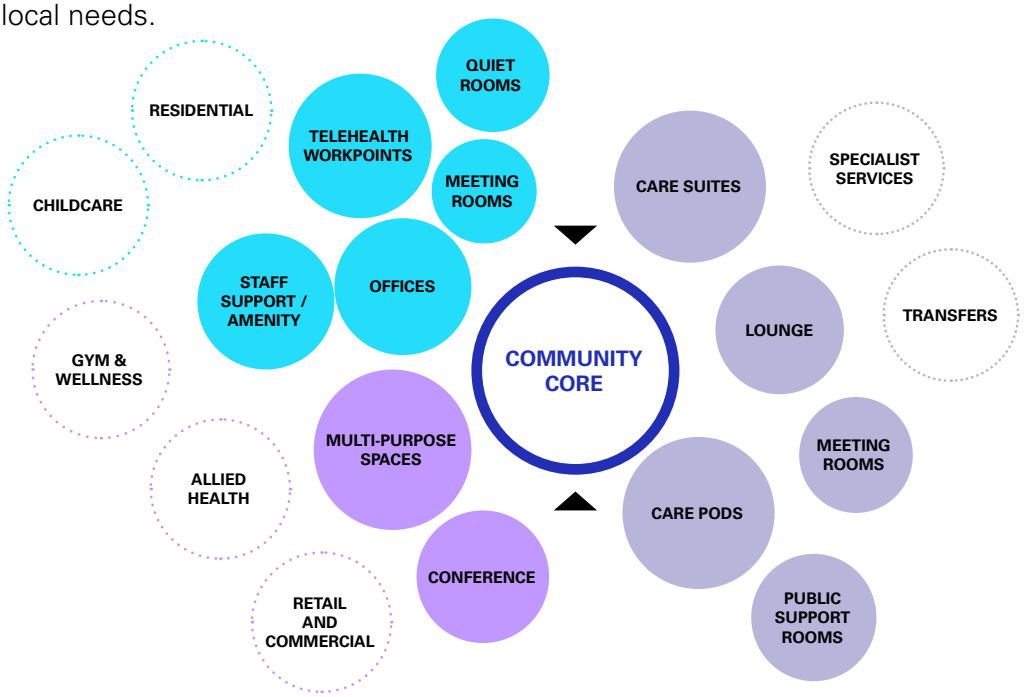
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CONCEPT PROTOTYPE

Community node and clinical workplace

The aim is to bring more care within easy reach of the community. Clinical services, remote expertise, and community facilities come together around a shared arrival space, with the mix shaped by local needs.



Clinical Care Spaces

Community Core
- → Public space for entry with contactless booking, AI wellness screening and check-in touchpoints that create an intuitive and efficient arrival experience that minimises wait times
- → Waiting lounge with comfortable furnishings and a healthy food and beverage offering
- → Interactive AI health check-up stations provide pre-consult triage, live support, physiological and wellness monitoring of vital signs, health indices, and body composition, including blood pressure, weight, heart rate, BMI, and body fat %.

Care Pods
- → Combination of beds and chairs to support user comfort and a range of AI-assisted medical screening, diagnostic tests and day treatments, including full-body scans, heart health, thyroid testing, blood pressure, weight management, diabetes screening, COVID-19 testing, and HIV screening.

Care Suites
- → Equipped with video-conferencing and remote monitoring capabilities to support low- to mid-acuity procedures under remote specialist guidance

Meeting Rooms
- → Mix of small, medium, and large meeting rooms equipped with video-conferencing, remote monitoring capabilities, and EMR

Clinical Workplace Spaces

Telehealth Workpoints
- → Mix of more open and private office spaces for remote consults

Offices and Quiet Rooms
- → Mix of open and private office spaces for private and collaborative work

Meeting Rooms
- → Mix of small, medium, and large meeting rooms equipped with video-conferencing, remote monitoring capabilities, and EMR

Staff Support/Amenity
- → Staff lounges and breakout spaces with beverage bays

Service Expansion Opportunities
- → Potential to include additional spaces such as residential/worker housing and childcare to support the clinical workforce

*All clinical workspaces are equipped with high speed internet and provide secure monitoring and access to EMR (i.e. Citrix cards).

Community Support Spaces

Multi-purpose and conference spaces
- → Flexible events spaces to accommodate health seminars, digital literacy training and other community cultural gatherings that promote health and well-being

Service Expansion Opportunities
- → Potential to integrate various allied health and retail/commercial offerings, such as gyms, community-based therapies and treatments, to enhance the holistic wellness offering

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PLANNING PRINCIPLES

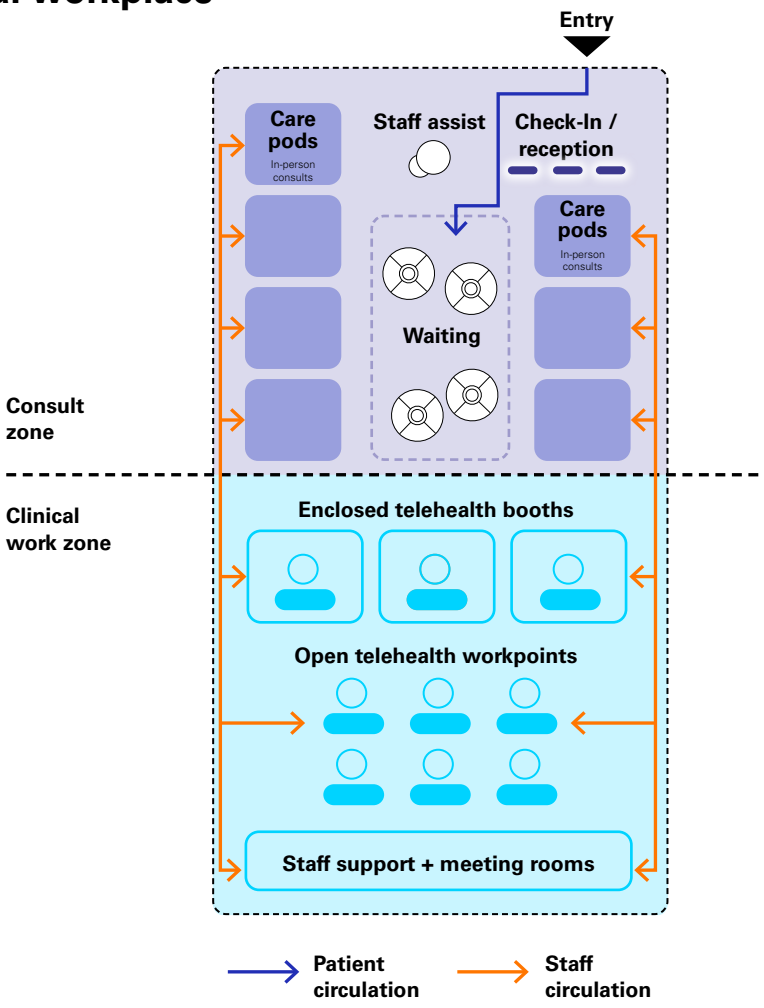
Community node and clinical workplace

Co-Location with Urban Infrastructure:
→ New facilities, like the planned Integrated Health Hub in Wilton, are explicitly designed to sit near commercial zones, retail centres, and public transport. Healthcare is being woven directly into high streets and suburbs.

Bridging the Tech Gap:
→ Community hubs act as physical anchors for virtual care. They provide diagnostic imaging, blood collection, high-speed internet booths for virtual specialist consults, and digital literacy training for patients who lack reliable technology at home.

Modular and Adaptive Layouts:
→ To insulate communities against future pandemics or shifting local demographics, these hubs rely on modular grids and flexible furniture. A physical exam room can be rapidly converted into a virtual mental health broadcast booth or an emergency triage zone.

Ambient and Automated Patient Rooms:
→ The internal design of standard rooms now integrates computer vision, contactless vital sign sensors, and ambient listening devices. Rooms are built around data flows rather than static medical carts, automating charting tasks so on-site staff can focus purely on tactile patient interaction.



IN PRACTICE

CareZen Virtual Care Pod: A deployable, supported access point at its smallest scale

Australia

The CareZen Virtual Care Pod, made in Australia by Modvale, is a modular, deployable, soundproof pod that patients step into for a private video consultation. Each pod carries TGA (Therapeutic Goods Administration)-approved devices for basic vitals — blood pressure, SpO2 (peripheral capillary oxygen saturation), temperature and single-lead ECG — and connects via dedicated satellite for reliable bandwidth.

WHERE IT ADDS VALUE

Built to replace the '*telehealth cart behind a curtain*', the pod is most valuable where care at home is not viable — such as aged-care homes and rural towns, where lack of privacy, patchy connectivity, missing devices or low confidence in virtual care otherwise blocks access, with a secondary role sorting demand in urban EDs.

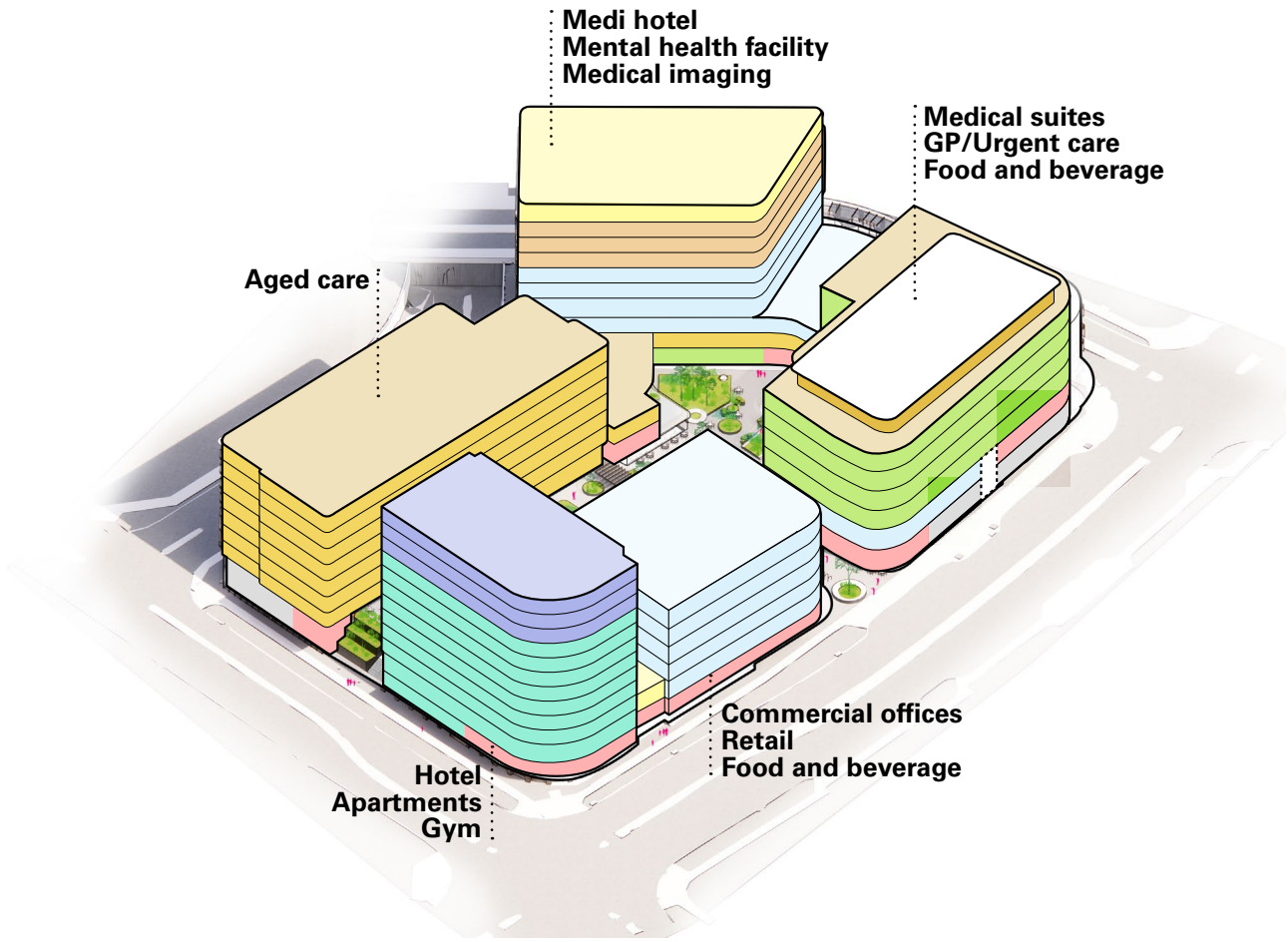


Full pod within its surroundings

Images: Modvale's Health Services.

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1.

CASE STUDY

Murdoch Square: A precinct-scale health node

Perth, Australia

Murdoch Square brings healthcare into the daily life of a mixed-use precinct. Consulting suites, treatment facilities, and aged care sit alongside homes, workplaces, shops, and places to eat, arranged around a landscaped public plaza. Connections to nearby hospitals and public transport link the precinct to the wider city. Patients, staff, residents, and visitors share places to meet, pause, and spend time. For community care nodes, the project offers a spatial reference for bringing clinical services together with the amenities and infrastructure people use every day.



2.

Above: Healthcare, residential, commercial, and hospitality uses arranged around Murdoch Square's landscaped public plaza. Below: Murdoch Square within the wider health precinct, showing how integrated planning brings community care and everyday amenities into neighbourhood life. Images: 2. Murdoch Square precinct and context diagrams. Hassell project team.

TAKEAWAY

Plan community care nodes as part of their urban setting. Bringing care together with public transport, everyday amenities, and shared public spaces can connect a clinical visit with the wider life of a neighbourhood.

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Virtual clinical workplace

A purpose-built setting for clinicians to deliver care remotely. It could be integrated into other healthcare settings or operated as a stand-alone centralised hub.

A virtual clinical workplace is purpose-built to help clinicians deliver care remotely. It has the technology, acoustics, privacy, ergonomic support, and operational reliability required for sustained clinical work.



Building block	How it shapes the setting	Spatial implications for the brief
Patient need	Virtual encounters must protect confidentiality and allow patients, carers and interpreters to communicate clearly.	→ Provide acoustic and visual containment, controlled backgrounds and clinically usable audio and video.
Model of care	Work combines scheduled consultations, continuous triage and monitoring, asynchronous review and team coordination, with scheduled virtual activity grouped into dedicated sessions where possible.	→ Use a mix of enclosed stations, shared team settings and telehealth-enabled rooms matched to each work mode. → Match the distribution and capacity of virtual work settings to scheduling patterns and concurrent demand.
Clinical services	The service portfolio and acuity determine response times, senior support and how continuously the workplace must operate.	→ Configure higher-acuity services around dedicated coordination and direct access to senior clinical support.
Workforce	Whole-shift virtual work requires concentration, team connection, supervision and recovery.	→ Provide ergonomic workpoints, access to peers and senior support, and staff support spaces appropriate to operating hours.
Information systems	Records, monitoring, images and orders need to operate as one clinical workflow.	→ Integrate task-appropriate displays, secure audio, video and resilient power and network access.
Funding	The workplace may be capital-light relative to the acute estate, but its business case depends on committed service volumes, workforce design and technology renewal.	→ Select a shell and fitout that support clinical privacy, operational reliability and future reconfiguration.

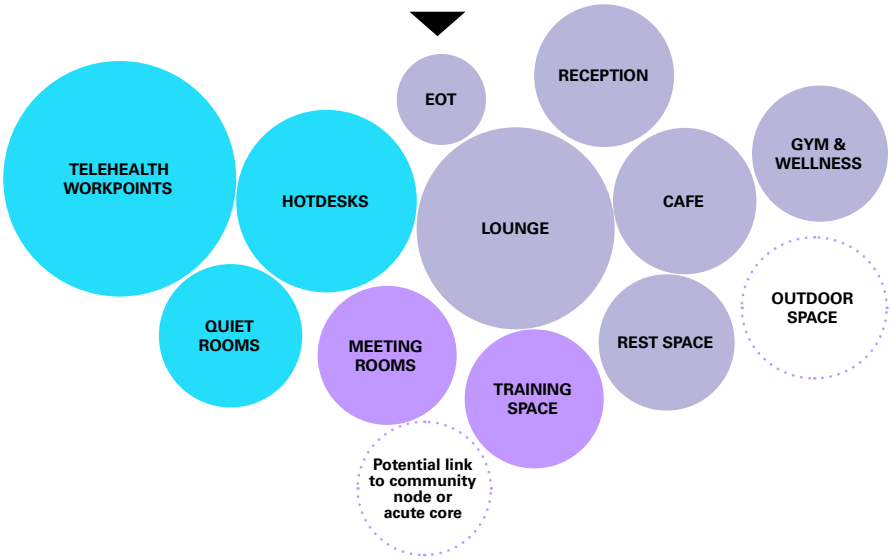
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CONCEPT PROTOTYPE

Virtual clinical workplace

This prototype supports the full working day of a remote clinical team. Private workspaces protect concentration and confidentiality, while shared spaces allow clinicians to collaborate, learn, and decompress between demanding sessions.



Clinical Workplace Spaces

Telehealth Workpoints
→ Private office spaces for remote consults. Acoustically isolated and designed around the consultation camera, with considered lighting and a calm, professional backdrop.

Hotdesks
→ Touchdown points for interstitial work.

Quiet Rooms
→ Enclosed booths for focused work.

*All clinical workspaces are equipped with high-speed internet and provide secure monitoring and access to EMR (i.e. Citrix cards).

Wellness Spaces

Reception/lounge
→ Entrance designed to transition the clinician into the workspace.

Cafe
→ Space for clinicians to gather during breaks. Provides an area to eat and relax away from the main workspaces while also developing a sense of community among the staff.

Wellness spaces
→ Places for clinicians to decompress during breaks or before/after work.

Group Spaces

Meeting Rooms
→ Small meeting rooms equipped with video-conferencing, remote monitoring capabilities, and EMR. Used for both team meetings and clinical work.

Training space
→ Large, flexible space for training events. AV design to accommodate remote or hybrid learning.



CASE STUDY

Mercy Virtual

Missouri, United States

The world's first purpose-built virtual clinical command centre in the US. Now about a decade into operation at scale — around 600,000 patients across seven states. One floorplate runs a tele-ICU covering more than 30 hospitals, tele-stroke and a mature home-monitoring program.

TAKEAWAY

Mercy Virtual Care Center organises screen-based clinical work within an open, refittable floorplate, using daylight, landscape views and natural materials to support staff working long shifts.

Images:

1. Image courtesy of Sam Fentress.

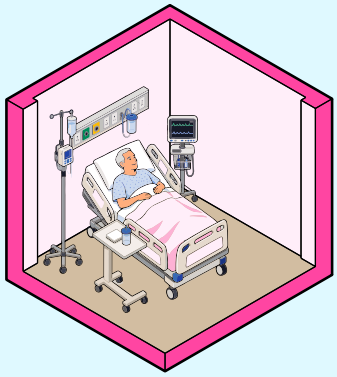
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Acute core

A more focused hospital environment shaped by the needs of complex care.

The acute core is planned around the care that needs to remain within the hospital once home, community, and virtual pathways are defined, funded, and tested. This allows space, workforce capacity, and investment to be concentrated on complex and specialised treatment.



Building block	How it shapes the setting	Spatial implications for the brief
Patient need	Retains care requiring continuous observation, rapid intervention, specialist infrastructure or immediate clinical co-presence.	→ Plan public, ambulance and planned-transfer access to match the residual demand profile.
Model of care	Patients enter through the pathway matched to risk. Treatment, stabilisation and onward planning are managed as one episode.	→ Use short, direct and non-public links between emergency care, imaging, operating theatres, interventional suites and critical care. → Support safe handover to downstream care.
Clinical services	Concentrates high-acuity capabilities that are unsafe or inefficient to distribute.	→ Use shared, adaptable clinical rooms where possible. → Add specialist spaces and support only where the capability requires them.
Workforce	Multidisciplinary teams require rapid access to senior decision makers and specialist support.	→ Provide a compact staff base and, where relevant, staging for mobile and home-visiting teams. → Provide adaptable space for staff training and for carer onboarding to digital and home-based care.
Information systems	Pre-arrival, point-of-care and capacity information connect the core to the wider care network.	→ Embed secure connectivity. → Enable shared information access. → Embed telehealth capability in clinical spaces.
Funding	The business case sizes the core against evidenced residual demand and concentrates capital in capabilities that cannot be distributed.	→ Match tenure, co-location and staging to service maturity and demand certainty. → Plan for third-party ownership and shared asset responsibilities.

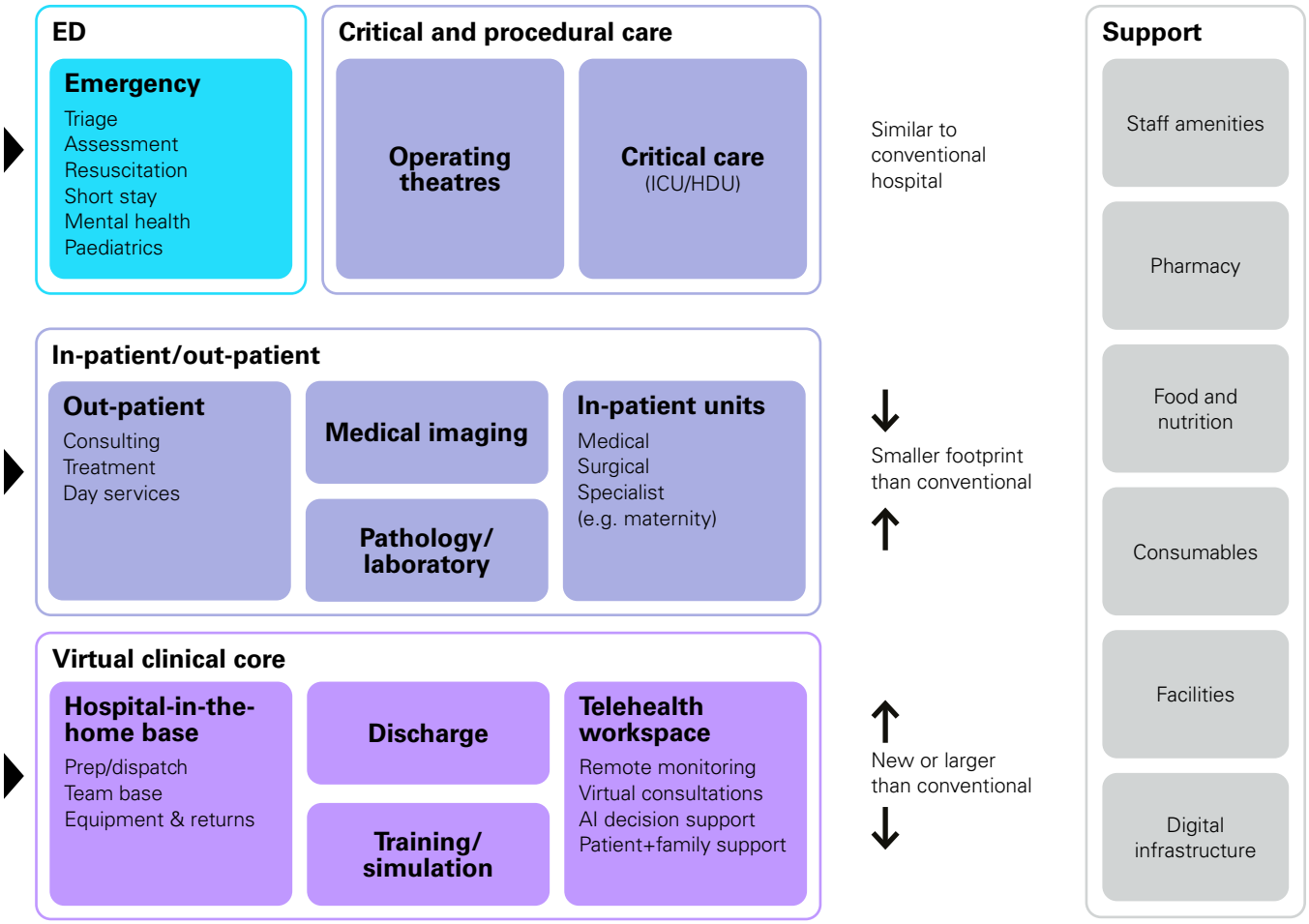
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CONCEPT PROTOTYPE

Acute core

The aim is to focus specialist expertise and equipment on complex care, while also creating a setting where junior doctors can learn alongside experienced clinicians. Telehealth is built into clinical spaces as standard, enabling teams to draw on specialist advice from across the wider care network.



Specialist emergency services

- → Dedicated entries, emergency assessment and treatment areas to facilitate direct admission and fast-track pathways that overcome treatment barriers and inefficiencies of single ED entry points
- → Integrated EMR for streamlined information flow across entry and handover points

Shared acute services

- → All spaces are tech-enabled for hybrid delivery of in-person and remote treatment
- → Dedicated discharge and transition spaces for final clinical reviews, patient education, and coordinated handover to home, community, or virtual care

Virtual clinical core

- → Open and private workspace for clinicians to perform remote consults
- → Base for hospital-in-the-home, including space for equipment storage and patient preparation
- → Teaching, simulation, and case review spaces close to clinical work areas, supporting learning alongside clinicians
- → Adaptability to co-locate clinical research and conferencing facilities, supporting the translation of research into practice

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KPMG & Hassell:

Care and place, planned together

Transformation will not follow a single roadmap. Every health system starts from a different place, but every project creates an opportunity to move towards digital-first care. The actions that follow are practical prompts for where to start.

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While your journey will be unique, five principles for success should shape every decision along the way.

1. **Use evidence to define need, and place to determine the solution.**
2. **Right care, right place, right delivery modality.**
3. **Digital as the default, and make every human interaction count.**
4. **Put people in the driver's seat of their care journey.**
5. **Well designed digital workplaces enable clinicians to deliver great care.**

From principle to practice: Three key entry points for action

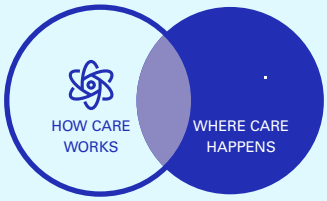
SYSTEM	Establish a population needs baseline and forecasting methodology to inform system planning.	Embed value-based investment criteria into capital allocation frameworks.	Establish a national 'digital-first' policy, and national standards for digital care delivery.	Link funding and KPIs to enablement of patient self-management wherever possible and their experiences of care.	Mature a system-wide workforce intelligence platform to guide infrastructure, training and workforce planning.
ORGANISATION	Invest in and embed digital twins and simulation modelling into infrastructure and service planning.	Identify priority cohorts and develop locally tailored models of care, workforce approaches and service responses.	Establish a statewide digital health delivery hub to redesign digital models of care, iterate standards, and drive implementation.	Redesign care pathways so digital monitoring and follow-up become the norm, with specialist input focused on exceptions and escalation.	Masterplan facilities to support workforce flexibility, team-based care, shared resources and clinical productivity.
PROFESSIONAL	Design and simulate real-world clinical scenarios to support validation of room layouts, patient journeys and clinical workflows.	Review all specialties' model of care and identify opportunities to safely shift care closer to home, supported by clear credentialling and escalation arrangements.	Time-in-motion studies of how clinicians spend their time and target high-burden administrative tasks and friction points for automation or digital enablement.	Act as an early adopter of self-management technologies.	Audit local facilities and assets for readiness to support digitally enabled models of care.

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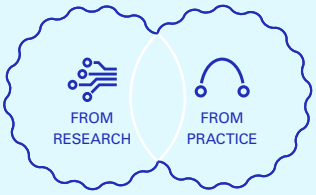
KPMG & Hassell bring health system strategy, digital expertise, and healthcare design into one team.

Combining complementary expertise to bridge the gap between strategy and delivery, we are helping clients transform healthcare ambitions into future-ready services, places, and experiences.



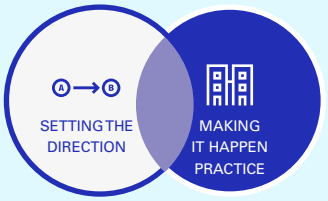
An integrated brief

We develop the future operating model and physical environment together, aligning how care is delivered with the spaces and digital systems it needs from the outset.



Decisions grounded in evidence

Our approach draws on joint research, data analysis, and international experience designing and transforming healthcare. These inform investment and design decisions as technologies, models of care, and community needs evolve.



Support from strategy to delivery

Our combined team supports clients through business cases, planning, design, and implementation, connecting early strategic decisions with the practical work of changing services and places.

KPMG

KPMG Australia's national Health, Ageing and Human Services team combines deep sector expertise with insights from our global health network spanning 46 countries. We work across the health ecosystem, partnering with government, providers and funders to navigate change, offering specialist strategies and innovative solutions to navigate this evolving environment.

We work with clients to improve how health systems and services are planned, delivered and sustained. Our capabilities span health strategy and service design, hospital performance, commissioning, workforce and organisational transformation, digital health and data, infrastructure, commercial and financial advisory, and governance and risk.

Hassell

Hassell is a leading international architecture and design practice with studios in Asia, Australia, the United Kingdom and the United States.

Our purpose is to create a better future by designing the world's best places – places people love. We do this by combining our creative design expertise with capabilities in research, strategy and technology to unlock the social, cultural and economic value of places.

We collaborate with the best minds in research, industry and design worldwide and we're committed to making a positive impact on communities and our environment.

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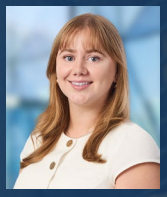
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Glossary

Term	Working definition
Digital health	The use of digital technologies, data and connectivity to support health, wellbeing and care delivery.
Digitally enabled care	Application of digital health tools and technologies in clinical settings to deliver, coordinate or enhance patient care.
Digital-in-health	The integration of digital technology and data into every aspect of health system management and health service delivery to improve health outcomes.
Digital by default	A system design principle in which digital and remote care are considered the starting point where appropriate, with physical care selected where it creates greater clinical or system value.
Virtual care	A form of digitally enabled care in which patients and clinicians are in different locations, including virtual consultations, remote monitoring and remote clinical support.
Model of care	Framework that determines how services should be delivered, including the processes of care, the organisation of providers and the management of services.
Care setting	The physical or virtual environment in which care is delivered, such as the home, a community node, the acute core or a virtual clinical workplace.
Care pathway	The sequence of services, decisions and transitions a person experiences for a defined condition or care need.
Care ecosystem	The connected groups of people, services, settings, organisations and technologies through which care is delivered and coordinated.
People-centred care	Care organised around the needs, preferences and goals of individuals, families and communities, with continuity across providers and settings.
Health system building blocks	The interdependent components that shape health system performance, including service delivery, workforce, information, technologies, funding, and leadership and governance.
System stewardship	The responsibility for guiding and shaping a system as a whole to achieve long-term outcomes in the public interest.
Quadruple aim	Four connected goals for health system improvement: better population health, better experiences of care, a sustainable workforce and greater value from finite resources.
Built environment	The human-made physical surroundings in which people live, work and interact, including buildings, spaces and supporting infrastructure.
Health infrastructure	The buildings where health services are delivered, supporting facilities and underlying systems, including utilities, equipment and digital technologies.
Node	A physical or virtual point within a distributed care network, with a defined role and capability through which care is delivered, coordinated or accessed.

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Examples of virtual care across Australia

Existing services show the breadth of delivery models. The challenge is consistent integration and scale.

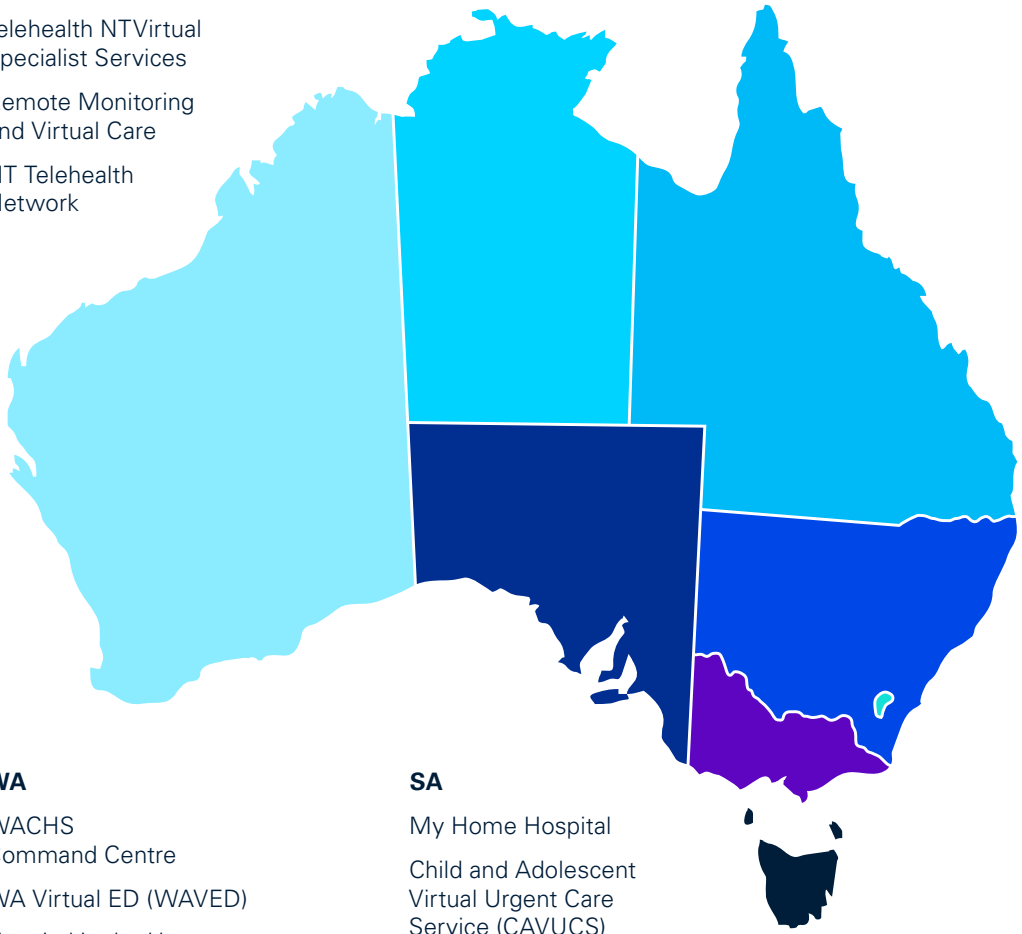
NT

NT Virtual Care Centre

Telehealth NTVirtual Specialist Services

Remote Monitoring and Virtual Care

NT Telehealth Network



WA

WACHS Command Centre

WA Virtual ED (WAVED)

Hospital in the Home (HiTH)

Ramsay Connect

SA

My Home Hospital

Child and Adolescent Virtual Urgent Care Service (CAVUCS)

SA Virtual ED (SAVES)

SA Virtual Care Service

TAS

Hospital@Home Tasmania

Tasmanian Virtual Care Service

QLD

Mackay COVID-19 Virtual Ward

Gold Coast Health COVID-19 Virtual Ward

Metro North Virtual ED & COVID Virtual Ward

Hospital in the Home

Metro North Virtual Emergency Care Service

NSW

RPA Virtual Hospital

NSW Virtual Care Service

Sydney Local Health District Virtual Hospital

Ramsay Connect

Healthscope Virtual Care Programs

ACT

Virtual Care Remote Patient Monitoring

Virtually Enhanced Community Care

VirtualKIDS

Virtual Rural Generalist Service

VIC

Virtual Emergency Department (VED)

Virtual Hospital in the Home

Austin and RMH Virtual Hospital Pilot

Ramsay Connect

St Vincent's Hospital in the Home

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