AN FTI CONSULTING REPORT – PUBLISHED 9/12/2025

# Unlocking Capacity: How Health and Aged Care Must Work Together as Australia's Population Ages

## Part Two - Inside the factors contributing to delayed discharge

EXPERTS WITH IMPACT™

FTI CONSULTING

Access to aged care is the most visible element of the capacity challenge within Australia's hospital system, but the reasons why patients cannot leave hospital when clinically ready are more nuanced. Reasons vary across jurisdictions and within health services, reflecting a mix of aged care supply, workforce, approvals, family and social factors. This paper explores the contributing factors to delayed discharge and the role of hospitals.

Part One of this series explored the nature and scale of the issue and identified the state of play in relation to supply and demand now and into the future within aged care (Table 1).

In Part One, it was identified that:

— **Hospitals are feeling the strain:** Older Australians account for a disproportionate share of emergency department ('ED') presentations, admissions and long stays. Delayed access to aged care compounds these pressures.

— **Wait times are significant:** The median wait time for entry into residential aged care is 41 days from approval. Meanwhile, it takes 249-267 days to receive a home care package ('HCP'), often leading to poorer outcomes and longer hospital stays.[1]

**Table 1 — Overview of Aged Care Programs**

| PROGRAM | OVERVIEW |
|---|---|
| **Commonwealth Home Support Programme ('CHSP')** | Entry-level support to help older people live independently at home, covering basic services such as meals, transport, and domestic assistance. |
| **Support at Home (from November 2025)** | Coordinated, tailored care at four levels of need, providing in-home nursing, personal care, and allied health support. The Support at Home program replaced Home Care Packages under the new *Aged Care Act*. |
| **Transition Care Programme ('TCP')** | Short-term care (up to 12 weeks) after a hospital stay, aimed at improving recovery and independence before returning home or entering longer-term care. |
| **Residential Aged Care** | Ongoing accommodation and 24-hour care for people with higher or complex needs, including clinical care, daily living support, and social engagement. |

— **Residential aged care supply is tight:** National occupancy averages 94%, with the aged care provision ratio falling,[2] and a net bed increase of 578 beds in FY25 resulting in fewer beds available per older person.[3]

— **Commonwealth Home Support Programme ('CHSP') is carrying the load:** Over 833,670 older Australians are supported with CHSP, but it is an entry-level program, which is stretched and with big variations across states.[4]

Demographic and health trends highlight the urgency of addressing discharge delays.

The number of Australians aged 85 and over is projected to more than double between 2024 and 2042 from 420,918 to 1,117,308.[5] New South Wales ('NSW') and Victoria will see the largest absolute growth, while Queensland and Western Australia ('WA') will grow fastest in relative terms. At the same time, dementia prevalence is projected to more than double by 2054, with cases surpassing 812,500 nationally, and growth steepest in Queensland and WA.[6]

Part Two of our series examines the underlying reasons why flow for older patients within hospitals is being blocked and clarifies the role hospitals themselves play in this challenge — helping to focus collective effort on solving the right problems. Addressing these issues requires urgent, decisive and agile policy and strategy shifts at both the Australian Government and state/territory government levels, with coordinated action across short, medium and long-term horizons to deliver lasting change on this complex challenge. Our third paper will set out the solutions required to address this significant challenge facing our hospital and aged care sectors.

## Improvements to patient flow have stalled

Hospitals have made major gains over the past 15 years in improving efficiency – with shorter average length of stay ('LOS'), more procedures delivered as day surgery and streamlined discharge planning. For example, the mean LOS for multiple-day admissions in Australia declined from 6.6 days in 1993-94 to 5.4 days in 2019-20. The decline was largely driven by a 49% reduction in LOS for patients aged over 74 years. Over the same period, hospital activity rose markedly, with annual hospital separations increasing from 4.61 million to 11.33 million (a 146% increase), and separation rates increasing by 66%, particularly among people aged 75 years or more.[7,8]

Yet the pace of decline in LOS has slowed significantly in recent years, suggesting that many of the "low-hanging fruit" efficiencies may already have been claimed.[9]

In WA, excess hospital days arising from patients deemed medically fit for discharge (because of delays in aged care or disability services) were identified at 40,000 days over a year – equivalent to over $90 million in cost.[9] In Queensland, extended admissions contribute to resulting costs estimated at approximately $52,000 per older long-stay patient.[10]

This is often viewed as an aged care issue – specifically, a residential aged care ('RAC') issue. As our first paper highlighted, there are genuine supply and workforce constraints within the aged care sector. However, it is likely that there are a proportion of patients discharged to RAC who may not require residential care placement. In some cases, alternative discharge pathways such as short-term reablement/restorative care, transition care, home modifications, or Support at Home packages could be more suitable. Strengthening discharge decision-making and triage processes has the potential to reduce premature transitions into RAC and improve flow across the system. Evidence shows that patients flagged as "eligible and awaiting entry to residential aged care" spend, on average, 13 days longer in hospital than those without this flag, highlighting the downstream impact of discharge pathways on hospital flow.[11]

Rising demand for sub-acute and non-acute services suggests that pressure is being displaced rather than resolved. In 2023–24, 1 in 20 hospitalisations (5.2%) were for sub-acute and non-acute care, with these types of hospitalisations increasing by 7.3% in public hospitals and 10% in private hospitals over the previous year. Over the last five years, sub-acute and non-acute hospitalisations have grown by an annual average of 3.8% in public hospitals and 4.8% in private hospitals.[12] Rehabilitation care accounted for around 486,000 hospitalisations, 82% of which occurred in private hospitals, with NSW and Queensland together accounting for four in five of these episodes.[12]

Together, these trends indicate that despite significant efficiency gains, hospitals are increasingly accommodating patients requiring ongoing, complex, or transition care – often because the right supports are not available in the community. Evidence from recent Australian research underscores that multidisciplinary, person-centred and community-based care models can help older people remain at home longer, delaying or avoiding entry into residential aged care and in turn easing pressure on acute services.[13]

## Aged care roles and responsibilities

Funding, policy and regulation of the aged care system is overseen by the Australian Government. However, state and territory governments also play an active role within the aged care system, including delivering aged care assessment services. Transition care is jointly funded by Australian Government and state/territory governments, and administered by state/territory governments.

Most state/territory governments deliver aged care services in regional, rural and/or remote areas through multi-purpose services ('MPS'). Some state governments deliver RAC outside of MPS. This includes Victoria, which delivers approximately 5,200 public sector RAC beds, primarily in regional and rural locations. Table 2 provides an overview of the division of responsibilities and challenges between the Australian Government and states, setting out their respective roles in aged care and hospital discharge.

Historically, states and territories also played a much larger role in aged care. This was through direct control of the Home and Community Care ('HACC') programme, which transitioned into CHSP, and the Aged Care Assessment Teams who delivered complex assessments for entry into aged care. The Aged Care Assessment Teams transitioned into a single assessment workforce from December 2024, with states and territories retaining hospital-based assessments only for patients who will be discharged to residential care or transition care only. Community-based assessments are undertaken by assessment agencies on behalf and under the direction of the Commonwealth.

**Table 2 — Australian Government vs state/territory roles in aged care and hospital discharge[14,15]**

| LEVEL OF GOVERNMENT | CORE RESPONSIBILITIES | CONTRIBUTIONS TO DISCHARGE/HOSPITAL FLOW | CHALLENGES AND GAPS |
|---|---|---|---|
| **Australian Government** | — Funds and regulates aged care (residential, home care, CHSP, Support at Home from 2025).<br>— Assesses eligibility and need for services.<br>— Sets national quality standards.<br>— Subsidises care costs, with means-tested contributions from older Australians. | — CHSP, HCP, residential aged care places.<br>— Aged Care Assessment (delivered by Health assessment teams).<br>— Policy reforms (e.g. new *Aged Care Act*, Support at Home programme).<br>— Transition Care Programme ('TCP') (jointly with states/territories). | — Policy responsibility is outside of the hospital and thus outside state control.<br>— Limited accountability for discharge outcomes.<br>— Assessment occurs largely Monday to Friday during office hours, limiting discharge planning to office hours. Referral to hospital-based assessment teams occurs once discharge plan is determined. Assessment from hospital to home care can't occur – assessment can only occur once patient is home.<br>— Programme rules often complex, slow, or fragmented, and multiple departments can be involved.<br>— Funding of aged care and risk settings may act as a disincentive for post-acute support. |

| LEVEL OF GOVERNMENT | CORE RESPONSIBILITIES | CONTRIBUTIONS TO DISCHARGE/HOSPITAL FLOW | CHALLENGES AND GAPS |
|---|---|---|---|
| **States and territories** | — Operate public hospitals and emergency departments. Responsible for hospital services, flow and patient safety. | — Direct investments that support discharge (e.g. Victoria's 5,200 public RAC beds, MSPs in rural/remote areas, state-operated TCPs).<br>— Sub-acute, rehabilitation and palliative services.<br>— Delivery of assessments for residential care and transition care for patients in hospital. | — Manage discharge pressures without formal control over aged care supply.<br>— Reporting/definitions of "delayed discharge" inconsistent across states.<br>— Legacy expectations from when HACC (now CHSP) was state-run still shape service delivery profile and Australian Government funding. Uncertainty of the future of CHSP is impacting strategic consideration of the programme.<br>— Lack of investment, and/or consistency across states in sub-acute care may result in aged care being a default option. |
| **Shared/ interface** | — TCP jointly funded.<br>— Coordination during crises (e.g. COVID-19 discharge planning). | — Short-term cooperative models showed delays can be reduced when systems align. | — No permanent joint governance – accountability remains split. |

## System configuration: how differences between states shape patient flow

Analysis of hospital and aged care capacity across jurisdictions shows that while total system size varies, the way capacity is distributed between acute, sub-acute and residential aged care differs markedly between states and territories (Table 3).* Despite these differences, all states and territories report challenges with transitioning patients from hospital settings to aged care. However, these challenges are exacerbated in some jurisdictions.

Across Australia, there are approximately 65,900 available public hospital beds and 246,000 RAC places, equivalent to roughly 3.7 aged care places for every available public hospital bed. However, this ratio – and the balance between public hospital, sub-acute and aged care capacity – varies substantially across jurisdictions.

### Hospital capacity

NSW and Victoria have the largest public hospital bases, operating 21,200 and 15,900 available beds respectively, while smaller states such as South Australia ('SA') (5,180) and WA (6,871) operate significantly fewer available beds. Tasmania and the Northern Territory ('NT') have fewer than 2,000 and 1,100 beds respectively, yet Tasmania records one of the highest available beds-per-capita ratios (2.98 per 1,000 population), reflecting its smaller and older population base.

### Aged care capacity and ownership

Victoria and NSW have the highest total residential aged care places, with 65,900 and 81,100 respectively, but the public ownership profile differs sharply. Publicly-operated aged care places account for only 0.2% in NSW, 0.3% in WA and around 2-4% in Queensland and SA, compared with 8.1% in Victoria. In theory, this should mean Victoria's health system has a greater degree of direct control over aged care discharge destinations. However, these aged care places are often in rural locations, may not be available at the right time, nor align with an older person's preferred RAC provider.

**Work has been commissioned by the Australian Government to resolve this issue.*

This challenge is occurring alongside a broader system decline in RAC capacity. Nationally, the number of residential places per 1,000 people aged 70 and over has fallen from 76.1 in FY20 to 71.4 in FY24. Although policy is rightly focused on enabling people to stay at home, declining residential capacity means hospitals are increasingly caring for older adults with complex needs, including dementia, who cannot safely be supported in the community. Compounding this, access to home-based care remains limited, with long waits for Support at Home packages, meaning many older people cannot be safely supported at home even if they prefer to avoid residential care.

### Sub-acute and transitional care

Sub-acute care (encompassing rehabilitation, palliative and geriatric services) represents about 15% of hospital activity nationally, but this share ranges from 12% in the NT to 20% in SA and the Australian Capital Territory ('ACT').

— SA's high sub-acute share (20%) indicates deliberate investment in hospital-based step-down and rehabilitation services, providing an internal buffer for patients awaiting aged care placement.

— Queensland (17%) and Victoria (15%) also show strong sub-acute activity, reflecting efforts to expand rehabilitation and restorative care capacity.

— WA and NSW (14%) sit below the national average, suggesting fewer dedicated step-down options and potentially longer acute stays for patients awaiting discharge supports.

Transitional programmes such as the TCP and Short-Term Restorative Care ('STRC') provide further flexibility but are unevenly distributed. WA and SA record relatively high densities of MPS and TCP places per hospital bed, offering additional step-down options (particularly in rural and regional areas), while Queensland and NSW have lower transitional care capacity relative to hospital size.

**Table 3 — Comparative hospital and aged care capacity by state and territory (2023–25)[1,3,12]**

| STATE/ TERRITORY | AVAILABLE PUBLIC HOSPITAL BEDS (2023–24) | BEDS PER 1,000 POPULATION | RESIDENTIAL AGED CARE PLACES (2025) | RESIDENTIAL PLACES PER AVAILABLE PUBLIC HOSPITAL BED | % PUBLIC (STATE-OPERATED) RAC PLACES (2025) | TRANSITION CARE PROGRAMME ('TCP') | SHORT-TERM RESTORATIVE CARE ('STRC') | MULTI-PURPOSE SERVICE ('MPS') | SUB-ACUTE SHARE (% PATIENT DAYS) |
|---|---|---|---|---|---|---|---|---|---|
| NSW | 21,238 | 2.54 | 81,136 | 3.82 | 0.22% | 1,513 | 626 | 1,243 | 14% |
| VIC | 15,856 | 2.33 | 65,934 | 4.16 | 8.15% | 1,045 | 563 | 359 | 15% |
| QLD | 14,021 | 2.57 | 47,803 | 3.41 | 2.26% | 783 | 494 | 492 | 17% |
| WA | 6,871 | 2.38 | 22,946 | 3.34 | 0.28% | 576 | 262 | 636 | 14% |
| SA | 5,180 | 2.79 | 19,170 | 3.70 | 4.39% | 387 | 135 | 669 | 20% |
| TAS | 1,712 | 2.98 | 5,514 | 3.22 | 1.11% | 134 | 74 | 81 | 15% |
| ACT | n/a | n/a | 3,007 | n/a | 0.00% | 78 | 70 | 0 | 20% |
| NT | 1,057 | 4.10 | 665 | 0.63 | 0.00% | 49 | 45 | 8 | 12% |
| **Australia** | **65,935** | **2.47** | **246,175** | **3.73** | **3.12%** | **4,565** | **2,269** | **3,980** | **15%** |

### Aged care ratios and interdependencies

When comparing total aged care places to hospital beds, Victoria has the highest ratio (4.2 residential places per hospital bed), followed by SA (3.7) and NSW (3.8). The NT has the lowest ratio (0.6), underscoring its reliance on hospital infrastructure to care for older patients in the absence of aged care alternatives.

Analysis of long-stay separations shows clear differences across states and territories (Table 4). When viewed as a share of all separations coded as awaiting residential aged care or needing support at home, the proportions range from around 10% in SA to more than 50% in the NT. These differences are likely shaped by a combination of factors, including the availability of aged care and sub-acute services, local discharge and assessment practices, workforce capacity, and how jurisdictions record and manage these cases.

The NT, ACT and Tasmania record the highest population-adjusted rates, with Queensland and NSW also sitting above the national average. Victoria's very low rate may reflect the state's practice of supporting many older people awaiting RAC through alternative, non-acute pathways, resulting in fewer hospital days being captured in this dataset. Broadly, states with more developed sub-acute and transitional care options – some of which directly rely on Commonwealth capacity and investment – tend to have fewer extended stays, while those with limited downstream capacity experience higher pressure. Because each jurisdiction uses different pathways and reporting approaches, these comparisons should be seen as indicative rather than definitive.

Although these separations represent a relatively small portion of overall hospital activity, they highlight important pressure points in patient flow and signal where aged care, home support and sub-acute capacity may not be keeping pace with demand. A more complete view of system performance would also consider admissions from RAC into hospitals, to understand how well the two sectors are working together.

**Table 4 — Public hospital separations for care type 'maintenance' for people aged 50 years or over (Aboriginal and Torres Strait Islander) and people aged 65 years or over (non-Indigenous) in 2022-2023[5,16]**

| STATE/ TERRITORY | DIAGNOSIS: PERSON AWAITING ADMISSION TO RESIDENTIAL AGED CARE (Z75.11) OR NEEDS ASSISTANCE AT HOME, NO CARER AVAILABLE (Z74.2) | | | LONG STAY RATE PER 100,000 (STATE/TERRITORY POPULATION) | ANY DIAGNOSIS |
|---|---|---|---|---|---|
| | Length of stay in separation | | Total | | |
| | <35 days, n (%) | >35 days, n (%) | | | |
| NSW | 8,368 (84) | 1,643 (16) | 10,011 | 19.7 | 856,172 |
| VIC | 60 (77) | 18 (23) | 78 | 0.3 | 819,140 |
| QLD | 7,632 (85) | 1,311 (15) | 8,943 | 24.1 | 691,219 |
| WA | 2,146 (86) | 336 (14) | 2,482 | 11.6 | 275,222 |
| SA | 3,334 (90) | 362 (10) | 3,696 | 19.5 | 224,260 |
| TAS | 475 (76) | 149 (24) | 624 | 26.0 | 78,178 |
| ACT | 650 (83) | 130 (17) | 780 | 27.6 | 47,430 |
| NT | 71 (49) | 73 (51) | 144 | 28.3 | 91,306 |
| **Australia** | **22,736 (85)** | **4,022 (15)** | **26,758** | **15.1** | **3,082,927** |

## What this means for patient flow

These variations underscore the complexities in improving patient flow. While total aged care bed numbers are important, consideration should also be given to striking the appropriate balance in capacity across the entire health and aged care systems. Optimising the balance between acute, sub-acute and community-based capacity and ensuring that hospitals have practical discharge pathways – either through public aged care, MPS, or well-resourced TCPs – are a potential part of the solution.

## The reasons behind delayed discharge

Queensland Health identified at a high level the barriers faced by hospitals to discharge older patients.[17] We have built on these to identify the potential underlying reasons for these barriers (Table 5).

**Table 5 — Barriers to hospital discharge, potential underlying reasons and implications for hospital and aged care**

| BARRIER | UNDERLYING REASONS | IMPLICATIONS FOR HOSPITALS AND AGED CARE |
|---|---|---|
| **Awaiting assessment for aged care[1]** | — Aged care is challenging to understand and navigate, resulting in delays in referral for assessment.<br>— Workforce shortages in assessment teams.<br>— Assessments are undertaken mostly in office hours, and not on weekends or after hours.<br>— Complexity of cases requires multiple assessments.<br>— Regional areas particularly affected due to lack of access to assessment.<br>— Existing assessment process/referral restarts when patient is admitted to hospital as assessment must be done by health aligned assessors. | — Patients remain in hospital while waiting for assessments.<br>— Bottleneck slows both RAC and home care access. |
| **Community barrier** | — Shortage of packages for care at home.<br>— Limited access to suitable social housing.<br>— Barriers to accessing home modifications (e.g. tenancy restrictions, with a growing share of people over 65 living in rental housing[18]) and/or assistive technology.<br>— Lack of family/social support.<br>— Costs of private services. | — Patients fit for discharge remain in hospital awaiting services.<br>— Hospital system substitutes as social safety net. |
| **Residential aged care beds unavailable** | — Insufficient RAC supply due to limited capital investment to meet demand, both currently and in the future.<br>— Time to plan, approvals and build new RAC beds is too long to impact supply in the short to medium-term.<br>— Workforce shortages.<br>— Geographic mismatch between bed locations and patient needs.<br>— Family may not want family member to be discharged to aged care and/or may want a particular RAC facility for their family member. | — Prolonged hospital stays for people medically fit for discharge reduces bed availability, driving ED congestion, ambulance ramping and elective surgery delays.<br>— Families face heightened stress and may make rapid, unplanned decisions about long-term care placement.<br>— Older Australians face higher risk of hospital-acquired complications and functional decline due to unnecessary time in acute care.<br>— Health resources are diverted away from acute patients, lowering system-wide efficiency.<br>— Patients without strong family supports are disproportionately affected, compounding equity gaps.<br>— Lack of capacity in hospitals for acute, elective patients resulting in poorer outcomes and safety/quality compromise. |

| BARRIER | UNDERLYING REASONS | IMPLICATIONS FOR HOSPITALS AND AGED CARE |
|---|---|---|
| **Behavioural and psychological systems of dementia ('BPSD'); mental health; challenging behaviours** | — Lack of access to specialised services within health system to support behaviour management.<br>— Few psychogeriatric/step-down units.<br>— Limited specialist dementia/memory support units within RAC facilities.<br>— Providers reluctant to accept high-needs patients due to risk and staffing profile required.<br>— Residential care funding (Australian National Aged Care Classification ('AN-ACC') funding model) potentially underweights cognitive/behavioural complexity.<br>— RAC facilities lack enough staff and capability to manage psychiatric needs.<br>— Providers risk-averse due to safety and regulatory scrutiny.<br>— Disconnect between management of patients with BPSD within hospitals and aged care, particularly in relation to the use of psychotropic medication. | — Patients with dementia remain longest in hospitals.<br>— RAC facilities are perceived to "cherry pick" lower-complexity residents.<br>— Patients with psychiatric conditions remain in acute settings far longer.<br>— Added pressure to mental health wards. |
| **Legal process** | — Family disputes over decision-making.<br>— Guardianship/administration orders required before discharge.<br>— Tribunal/court backlogs.<br>— Guardianship processes often complex and difficult to navigate. | — Legal delays keep patients in hospital even when care places exist.<br>— Hospital staff tied up in administrative follow-up. |
| **Social delay** | — Families slow to choose facilities or arrange finances.<br>— Patient/family reluctance to accept available beds.<br>— Cultural and language barriers delaying decision-making. | — Occupied hospital beds not clinically required.<br>— Increased frustration for staff and families. |
| **Clinical needs** | — High-acuity requirements (e.g. dialysis, tracheostomy, complex wounds) not manageable in most RAC facilities.<br>— Specialist nursing/allied health limited in community.<br>— AN-ACC funding model does not support very high levels of care. | — Long hospital stays for complex but non-acute patients.<br>— RAC facility admission refusal for medically complex cases. |

## The reasons behind delayed discharge

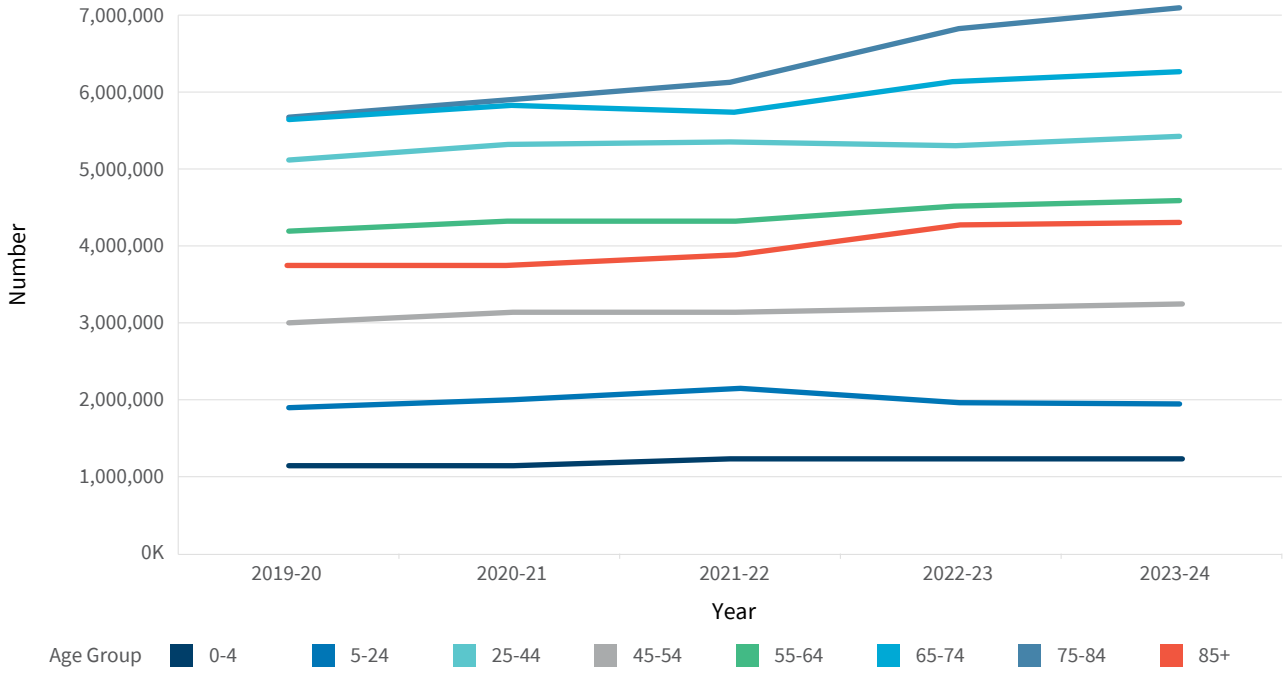
To properly understand and compare discharge delays, a broader set of perspectives is needed. Exit block varies by age, diagnosis, geography and socioeconomic status.

### Time in system

Length of stay differs depending on discharge destination. Patients transferred to RAC typically remain longer in hospital, as placement availability, assessment and family agreement must all be secured (as outlined above).

Australian Institute of Health and Welfare ('AIHW') data shows that patient days rise steeply with age. Between 2019-20 and 2023-24, Australians aged 75-84 and 85+ accounted for the largest and fastest-growing share of hospital bed-days (Figure 1).

**Figure 1 — Patient days by age group, public and private hospitals, Australia, 2019-20 to 2023-24[19]**

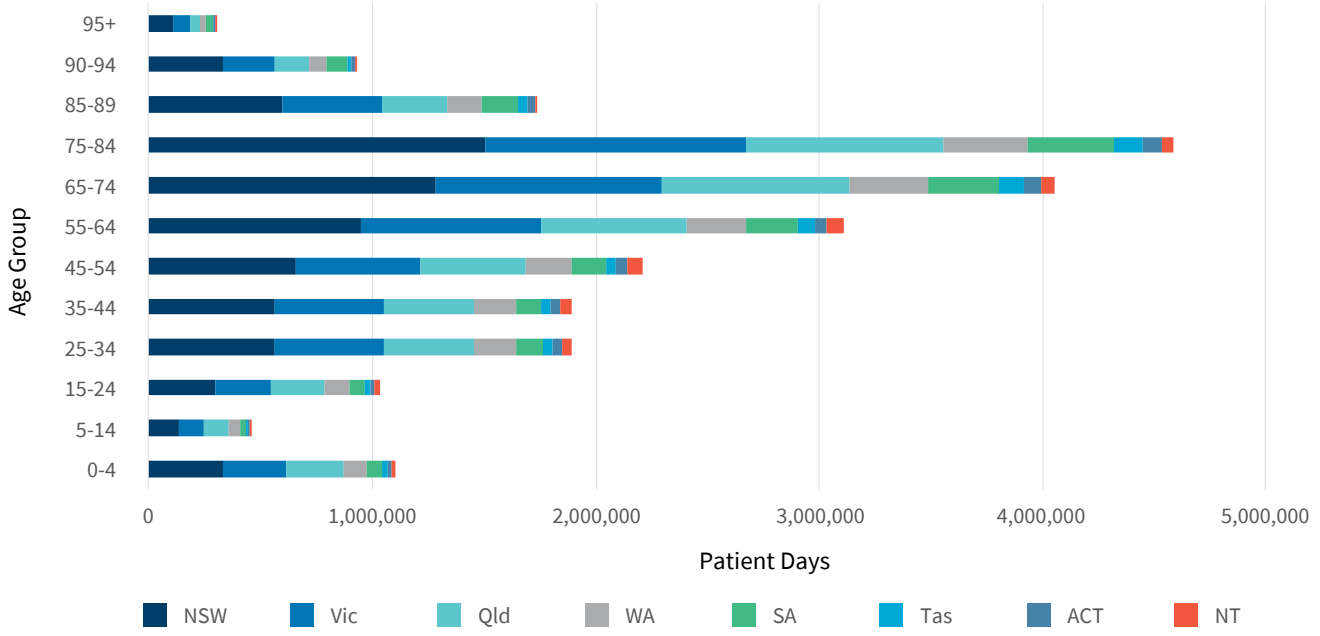



Note: There may be minor differences with previously published data due to revisions of historical data. This visualisation excludes hospitalisations for 'newborns with unqualified days only'.

Source: AIHW National Hospital Morbidity Database

Looking at state-level patterns, NSW, Victoria and Queensland dominate hospital use among older cohorts, with people aged 75-84 and 85+ in these states representing the bulk of long-stay patient days (Figure 2). Smaller jurisdictions such as Tasmania and SA also show significant proportions relative to their population base, indicating that discharge delays are not confined to the eastern seaboard.

**Figure 2 — Patient days by age group and state/territory, public and private hospitals, Australia, 2023-24[19]**

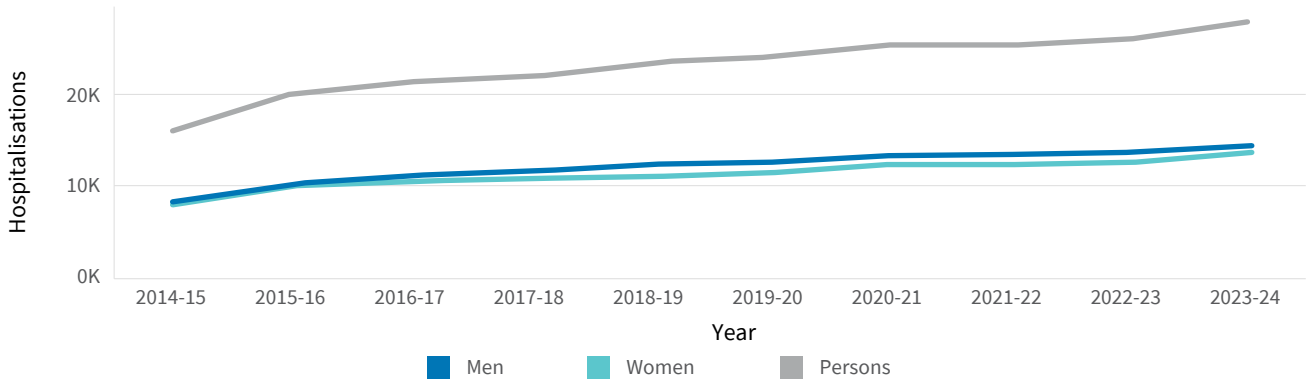



These patterns suggest that while efficiency gains have reduced average overall stays in hospitals, the absolute volume of older patients is driving prolonged occupancy and highlighting the importance of regional planning.

## Patient cohorts

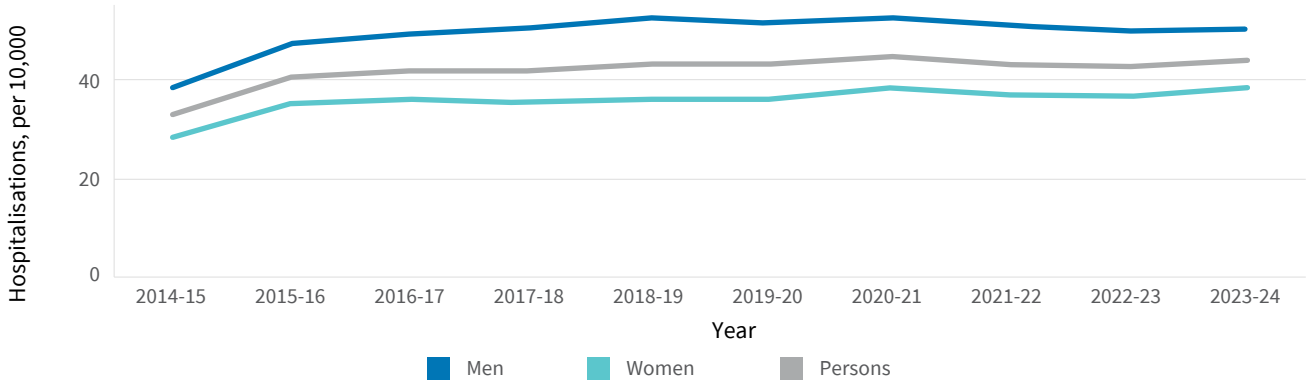
Dementia is a leading driver of prolonged hospital stays. The number of hospitalisations due to dementia increased steadily from 2014–15 to 2023–24, rising to more than 35,000 cases annually (Figure 3).

**Figure 3 — Number of hospitalisations due to dementia, Australia, 2014–15 to 2023–24[20]**



Age-standardised rates also grew, particularly for women, reaching almost 50 per 10,000 people aged 60+ (Figure 4).

**Figure 4 — Age-standardised rates of hospitalisation due to dementia per 10,000 people aged 60+, Australia, 2014–15 to 2023–24[20]**



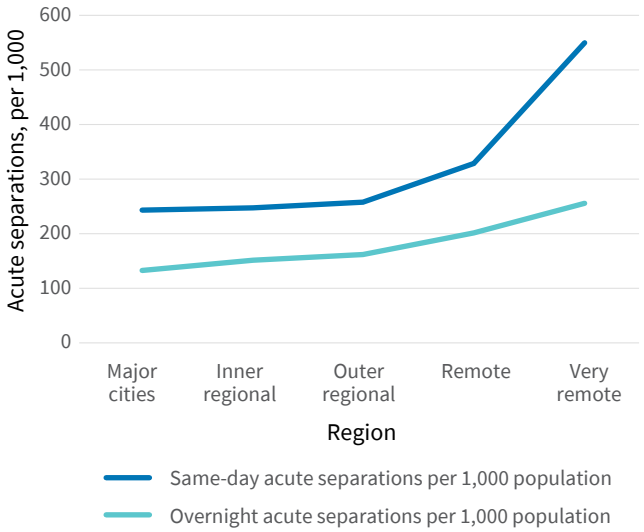

These patients often require specialist RAC facility units or behavioural supports that are in short supply, leaving them as some of the longest-stay patients in hospitals.

## Regional differences

Overnight acute separations per 1,000 people are significantly higher in very remote areas compared with major cities, while same-day separations are more concentrated in metropolitan settings (Figure 5).

This reflects thinner service markets and limited access to home care or rehabilitation in regional areas, resulting in longer hospital stays and fewer alternatives to inpatient care.

**Figure 5 — Same-day and overnight acute separations per 1,000 population, by remoteness of residence, Australia, 2023–24[21]**

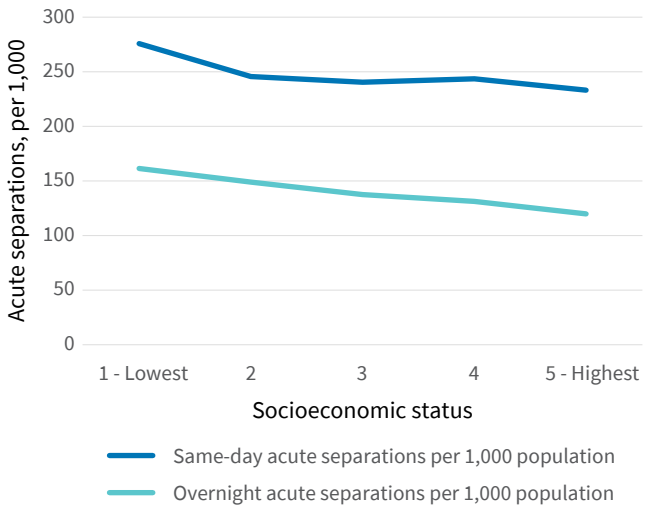



## Equity differences

Patients from lower socioeconomic areas are more likely to be admitted overnight and remain longer in hospital. Overnight acute separations per 1,000 population are highest in the lowest socioeconomic status ('SES') quintile and decline steadily with higher SES (Figure 6).

This pattern reflects the impact of affordability barriers, weaker informal supports and provider reluctance to admit higher-complexity or lower-income residents. Socioeconomic status therefore emerges as a structural determinant of delayed discharge.

**Figure 6 — Same-day and overnight acute separations per 1,000 population, by socioeconomic status of residence, Australia, 2023–24[22]**



### System integration and navigation

Families, hospitals and providers often struggle to navigate and coordinate safe transitions out of hospital. Key barriers include:

— **Housing and home modifications:** Access to appropriate social housing is limited and tenancy rules frequently prevent modifications to state-owned properties, as well as privately owned rental properties. With more older Australians renting, this issue is growing.[23]

— **Fragmented navigation support:** Programs such as Care Finders were intended to guide vulnerable older people into aged care, yet utilisation remains low. Hospitals rarely refer patients, leaving many without support.[24]

— **Role mismatch:** Care Finders are formally positioned as facilitators, but in practice they often act as case managers, connecting health professionals, government services and community supports because no one else fills the gap. This creates inconsistent service delivery and further delays.[15]

— **Limited integration with hospitals:** Navigation roles generally sit outside hospital systems. In states like Queensland and Victoria, attempts to link housing and navigation supports to discharge planning remain small-scale, leaving most hospitals without structured pathways.

The impact:

— Discharge is stalled while patients wait for housing, home modifications or service coordination.

— Families and clinicians face duplicated assessments and unclear responsibilities.

— Patients without strong informal supports are most affected, often remaining in hospital longer than clinically necessary.

### State/territory vs Australian Government roles

While aged care is an Australian Government responsibility, states and territories manage the immediate consequences of delayed discharge. This tension is longstanding but is now more visible as hospitals operate at or above capacity.

— **Fragmented accountability:** Because the Australian Government funds aged care and state/territory governments run hospitals, neither level of government has full visibility or responsibility for discharge outcomes. Older people and families experience this as fragmentation – multiple assessments, duplicated paperwork and long waits for approvals.

— **Comparability of reporting:** States and territories report and measure access block, ramping and long-stay patients differently, making it difficult to compare performance nationally. Developing consistent national definitions of delayed discharge, like the UK's National Health Service "criteria to reside" model, would allow better benchmarking and accountability.[25]

— **Lessons from COVID-19:** During the pandemic, the Australian Government, states and territories and providers coordinated more closely in all areas across the health system, especially in moving patients out of hospitals and addressing aged care workforce shortages. While more informal, these mechanisms showed that when governments act in tandem, discharge delays can be reduced. Permanently embedding this level of joint-planning is critical.[26]

— **Future governance questions:** If integrated care is the goal, should stewardship of aged care remain solely with the Australian Government? Options such as pooled budgets, joint commissioning of services, or shared state/territory-Australian Government accountability for transition care could strengthen alignment between the systems.

## Where to from here?

Hospitals are not inefficient – they are blocked. Over the past two decades, states and territories have invested heavily in improving hospital efficiency: average length of stay has fallen, more procedures are delivered as day surgery and discharge planning has been streamlined. These gains mean hospitals are, in many ways, already doing more with less.

Yet patients remain in acute beds not because they require acute care, but for a range of complex reasons which are often intertwined. These include situations where the aged care, housing and community supports required after discharge are unavailable, inaccessible or where transition arrangements are too slow. The key reasons for these challenges are summarised in Figure 7.

Figure 7 — Key themes and contributing factors

Hospitals cannot solve this alone. Whilst further hospital efficiency gains exist; the greater prize lies in strengthening the interface between hospital and aged care. To start to shift the dial, it will be critical to address the root causes of the challenges. This will require leadership, resourcing and intervention from the Australian Government over a protracted period, along with joint action across the Australian Government, states and territories and aged care providers.

*In Part Three of this series, we will explore practical solutions - from funding reforms and operating models to new governance structures – to unlock and increase capacity to support better outcomes for older Australians.*

**NATHAN SCHLESINGER**
Head of FTI Consulting Health
nathan.schlesinger@fticonsulting.com

**NICKI DOYLE**
Head of FTI Consulting Aged Care
nicki.doyle@fticonsulting.com

**DR DAVID (RUSS) RUSSELL-WEISZ**
Senior Advisor
david.russell-weisz@fticonsulting.com

Endnotes

[1] Australian Institute of Health and Welfare, *Timeliness of access to aged care services in Australia* (2024), https://www.aihw.gov.au/getmedia/dbd62ec5-f7b9-4bf1-815b-5cac8609a96b/timeliness-of-access-to-aged-care-services-in-australia.pdf

[2] StewartBrown, *Aged Care Financial Performance Survey Sector Report* (2023), https://www.stewartbrown.com.au/

[3] Colliers and Boxwell & Co, *Aged care supply shortfall is now a crisis …. and will get worse: Residential Aged Care Places: Summary Trends FY18-FY25* (2025), https://www.colliers.com.au/en-au/research/residential-aged-care-places-fy18-fy25-trends

[4] Australian Government Department of Health, Disability and Ageing, *Commonwealth Home Support Programme aged care services* (2025), https://www.gen-agedcaredata.gov.au/resources/dashboards/commonwealth-home-support-programme-aged-care-services

[5] Australian Bureau of Statistics, *Population Projections, Australia (Medium Series), ABS Catalogue No. 3222.0* (2023), https://www.abs.gov.au/statistics/people/population/population-projections-australia/latest-release

[6] Dementia Australia, *Dementia prevalence data 2024–2054* (2024), https://www.dementia.org.au/sites/default/files/2024-03/Prevalence-Data-2024-Updates-All-forms-of-dementia.pdf

[7] Gray, L.C., Yeo, M.A. and Duckett, S.J., *Trends in the use of hospital beds by older people in Australia: 1993–2002. Medical Journal of Australia*, 181: 478-481 (2004). https://doi.org/10.5694/j.1326-5377.2004.tb06403.x

[8] Reid, N., Gamage, T., Duckett, S.J. and Gray, L.C., *Hospital utilisation in Australia, 1993–2020, with a focus on use by people over 75 years of age: a review of AIHW data, Medical Journal of Australia*, 219: 113-119 (2023), https://doi.org/10.5694/mja2.52026

[9] Office of the Auditor General Western Australia, *Management of Long Stay Patients in Public Hospitals* (2022), https://audit.wa.gov.au/reports-and-publications/reports/management-of-long-stay-patients-in-public-hospitals/

[10] Create Health Advisory and Duckett, S.J., *The Growth Drivers of Australian Public Hospital Costs and Prices* (2025), https://www.treasury.sa.gov.au/__data/assets/pdf_file/0006/1191165/Duckett-Report-Growth-Drivers-Australian-Public-Hospital-Costs-Prices.pdf

[11] Australian Institute of Health and Welfare, *Transitions to residential aged care after hospital for people living with dementia,* AIHW, Canberra (2023), https://www.aihw.gov.au/reports/dementia/transitions-to-aged-care-after-hospital-dementia

[12] Australian Institute of Health and Welfare, *Admitted patient care 2023–24: Types of care provided*, AIHW, Canberra (2024), https://www.aihw.gov.au/hospitals/topics/admitted-patient-care/types-of-care-provided-types-of-services-provided

[13] Inacio, M.C., Harrison, S., Schwabe, J., Crotty, M., & Caughey, G.E., *Models of care across settings supporting ageing in place: a narrative review, Medical Journal of Australia* 223(4), 218–225 (2025), https://doi.org/10.5694/mja2.70003

[14] Australian Government Department of Health, Disability and Ageing, *Aged care – overview* (2024), https://www.health.gov.au/topics/aged-care

[15] Productivity Commission, *Report on Government Services 2025 – Public hospitals* (2025), https://www.pc.gov.au/ongoing/report-on-government-services/2025/health/public-hospitals

[16] Productivity Commission, *Report on Government Services 2025 – Aged Care Services* (2025), https://www.pc.gov.au/ongoing/report-on-government-services/2025/community-services/aged-care-services/

[17] Caroline Egan, *More than 500 aged care patients in Queensland hospital beds – how many nationally?* The Weekly Source (2025), https://www.theweeklysource.com.au/aged-care/more-than-500-aged-care-patients-in-queensland-hospital-beds-how-many-nationally

[18] Australian Institute of Health and Welfare, *Older Australians: housing and living arrangements* (2024), https://www.aihw.gov.au/reports/older-people/older-australians/contents/housing-and-living-arrangements

[19] Australian Institute of Health and Welfare, *Hospitalisations and patient days* (2025), https://www.aihw.gov.au/hospitals/topics/admitted-patient-care/hospitalisations-and-patient-days. CC-BY 4.0.

[20] Australian Institute of Health and Welfare, *Dementia in Australia – hospital care* (2025), https://www.aihw.gov.au/reports/dementia/dementia-in-aus. CC-BY 4.0.

[21] PHIDU (Torrens University), *Remoteness in Australia – Social Health Atlases* (2024), https://phidu.torrens.edu.au/social-health-atlases/graphs/113-remoteness-in-australia

[22] PHIDU (Torrens University), *Social Health Atlases – socioeconomic status* (2024), https://phidu.torrens.edu.au/

[23] Productivity Commission, *Report on Government Services – Housing and homelessness* (2025), https://www.pc.gov.au/ongoing/report-on-government-services/2025/housing-homelessness/

[24] Australian Government Department of Health, Disability and Ageing, *Care finder program* (2025), https://www.health.gov.au/our-work/care-finder-program

[25] Sapey, E., Gallier, S., Evison, F., McNulty, D., Reeves, K., & Ball, S. (2022). *Variability and performance of NHS England's 'reason to reside' criteria in predicting hospital discharge in acute hospitals in England: a retrospective, observational cohort study.* BMJ open, 12(12), e065862. https://doi.org/10.1136/bmjopen-2022-065862

[26] Blecher, G. E., Blashki, G. A., & Judkins, S.. *Crisis as opportunity: how COVID-19 can reshape the Australian health system*. The Medical journal of Australia, 213(5), 196–198.e1 (2020). https://doi.org/10.5694/mja2.50730