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

Part Three - A Path Forward

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Australia's health and aged care systems are under sustained and growing pressure, with capacity constraints increasingly limiting flow and system performance. These challenges are not new. However, they are becoming more acute as demand rises due to Australia's ageing population and the interdependencies between hospitals and aged care deepen. The *Unlocking Capacity* series outlines the scale of the challenge, its main causes and potential solutions.

Introduction and recap

The *Unlocking Capacity* series examines the mounting and increasingly interconnected capacity pressures across Australia's health and aged care systems, and the coordinated responses required to address them.

In Part One, the growing capacity pressures across Australia's health and aged care systems and the way these pressures are increasingly intersecting were explored. As the population ages, demand for both hospital and aged care services are rising faster than supply. It was identified that hospital congestion cannot be addressed in isolation, with aged care capacity and capability central to system-wide performance.

Part Two examined why older Australians who are clinically ready to leave hospital are often unable to do so. Discharge delays are driven not only by shortages in aged care places, but by fragmented pathways and administrative bottlenecks. Despite jurisdictional differences in the number of services available, timely discharge of older Australians requiring support either at home or in aged care remains a national challenge.

In Part Three, our final report in this series, we consider a range of solutions to this complex problem. It draws on research and consultations with stakeholders across the health and aged care sector and identifies where practical solutions may already be part of the health and aged care ecosystem.

Unlocking capacity across hospital and aged care is complex. There is no single fix: the solutions presented sit on a spectrum, ranging from short-term, localised actions to longer-term, system-wide reform. What is clear is that action and intervention must occur now, with the time for talking about the challenges and discussion with no action on strategies long expired. The focus needs to be on pragmatic, actionable steps that can be taken individually and collectively across the health and aged care sectors and beyond to unlock capacity and deliver sustainable improvement. Most importantly, this will ensure older Australians receive care in the most appropriate setting for their individual needs.

Overview of barriers

Throughout the *Unlocking Capacity* series, many barriers have been identified that prevent older Australians from being discharged following a hospital admission despite being clinically ready. These barriers include:

- **Aged care supply constraints**, with too few residential aged care beds relative to demand and high occupancy limiting timely transfers. Investment in new beds has also slowed and is not keeping pace with demand, due to rising construction costs.
- **Community barriers**, including increasing demand and long waits for Support at Home, which limits the availability of in-home care as a discharge pathway. A need for in-home modifications, the cost of private services and lack of family and social support can also push older people into aged care.
- **Late or delayed discharge planning**, which doesn't support the exploration of suitable alternatives to residential care, which may take time and be complex to implement.
- **Lack of or underutilised navigation support**, leaving families to coordinate complex transitions and bureaucracies alone.
- **Social delay** where families require additional time to make decisions regarding next steps.
- **Legal process issues**, including legal disputes over decision making or the need to obtain guardianship or administration orders.

— **Behavioural and psychological symptoms of dementia ('BPSD'), mental health, or challenging behaviours** which often require specialist facilities and/or expertise to manage. These are often high risk for aged care facilities to manage from a risk, funding and regulatory perspective.

— **High clinical needs** (e.g. complex wound management, dialysis, tracheostomy) which require specialist nursing or allied health to manage. Current funding often does not support the provision of appropriate levels of clinical care when care is complex in aged care settings.

Unless action is taken to address the root causes of delayed discharge, the situation will rapidly worsen over time as Australia's population ages, with continued pressure put on both the hospital and aged care systems.

Framing the solution: a whole-of-system capacity lens

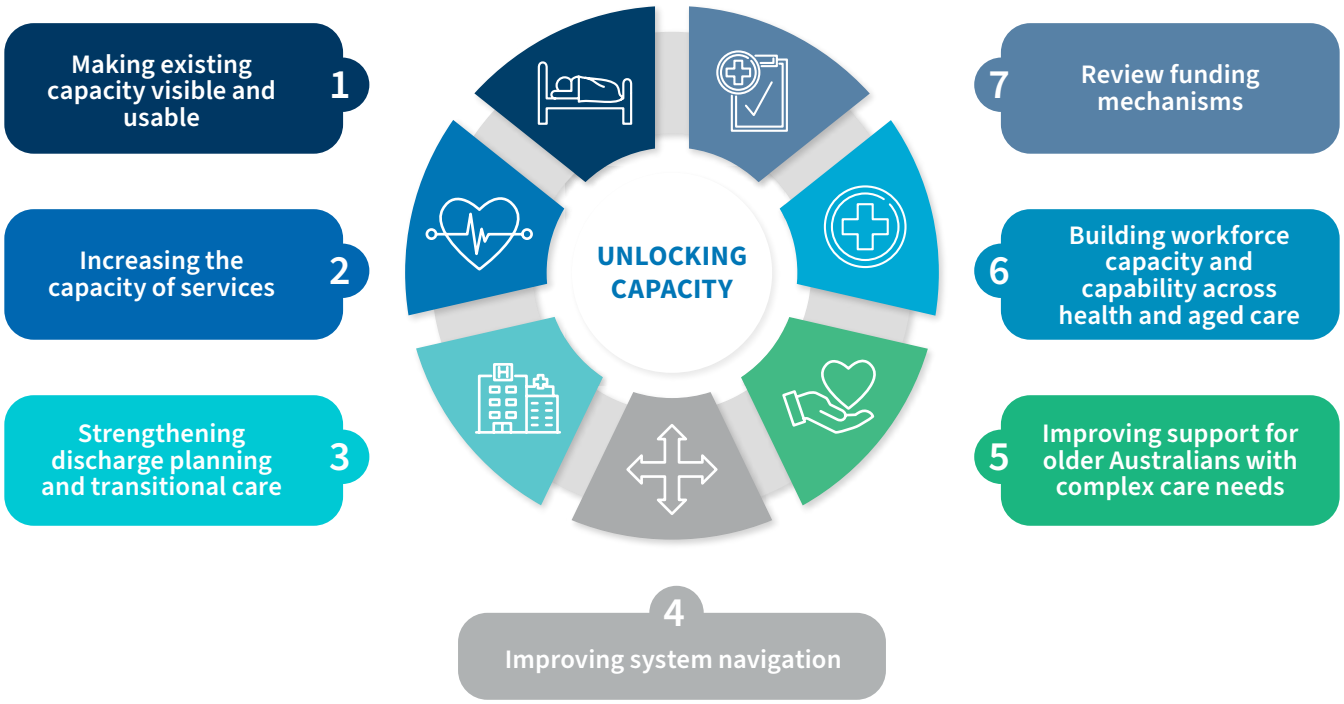
Addressing capacity pressures across health and aged care requires a shared understanding of capacity as a whole-system issue, rather than a challenge located within any single service or sector. These pressures cannot be resolved through action in one area alone as progress depends on coordinated reform across workforce, funding and service delivery settings.[1] Interventions focused on one part of the system in isolation are unlikely to deliver sustained impact unless they are supported by complementary changes elsewhere.

Across Australia, a wide range of initiatives are already underway at local and jurisdictional levels to improve patient flow, discharge planning and aged care access. However, many of these efforts have developed independently, with limited coordination, shared governance or consistent evaluation. As a result, promising local solutions are generally not scaled, aligned or sustained, and system-wide capacity constraints persist.

The COVID-19 pandemic demonstrated that closer coordination between Australian and state governments, health services, aged care providers and regulators is both possible and effective when system pressures are acute. The challenge now is to move beyond isolated initiatives and translate these lessons into enduring system arrangements that enable alignment, accountability and coordinated capacity planning over the longer term.

Viewed through the whole-system lens, unlocking capacity depends on better alignment in how existing capacity is deployed, how transitions between settings are managed, and how incentives support capacity building and care in the right place at the right time. The seven key solution domains (Figure 1) set out in this paper reflect an integrated approach to address short-term actions to relieve current pressures and medium-term actions to improve sustainability.

Figure 1 – Unlocking Capacity: seven key solution domains



Effective implementation of these solutions needs to be supported by a set of cross-cutting enablers that operate across all domains. These include:

- Shared accountability and collaboration between Australian and state and territory governments, hospitals, health services, aged care providers and regulators.
- Regulatory and compliance settings that support and enable aged care services to operate safely with higher complexity.
- Data transparency and sharing to support planning and operational decision-making.
- Stakeholder engagement to ensure solutions reflect operational realities, workforce constraints, and the needs of older Australians and families.
- Funding and incentives aligned to solutions and actions to enable sustainable capacity growth over time.

We have reviewed and summarised a range of initiatives that we suggest would best assist with unlocking capacity across health and aged care, with suggested ownership and time horizons suggested for each below. We have explored selected initiatives through case studies embedded throughout this paper.

The status of the case studies we supply is indicative only and reflects FTI Consulting's understanding based on publicly available information and stakeholder consultation. Implementation and maturity vary across jurisdictions, and additional local initiatives may exist. We welcome engagement from organisations and jurisdictions delivering exemplar approaches that could inform future system-wide learning.

1. Making existing capacity visible and usable

Unlocking capacity requires a clearer understanding of what capacity is genuinely available across health and aged care. Funded capacity does not always translate into beds that can be used in practice. Differences in data, definitions, funding settings and regulatory expectations mean capacity is often fragmented and poorly visible. In many cases, it is constrained by factors beyond physical infrastructure. There is a need to improve transparency, coordination of and deployment of existing assets across the system. This could be achieved through three priority actions.

1.1 Establishing and strengthening data systems to improve visibility of capacity

— Developing a single source of truth for capacity data, with nationally consistent definitions for long-stay patients and delayed discharge.

— Improving real-time visibility of available capacity across hospitals, residential aged care, transitional care and home-based services at facility, regional and state/territory levels.

1.2 Understanding operational capacity and supply

— Clarifying operational capacity with clearer distinctions between operational, licensed and staffed beds.

— Assessing near-term supply opportunities, including brief provider surveys on current and planned capacity across residential care – including Memory Support Units ('MSU') – transition care, Support at Home and the Commonwealth Home Support Program ('CHSP').

1.3 Undertaking an asset and program review

— Conducting a cross-government stocktake of government-owned buildings and facilities that could be repurposed for aged care use with minor to moderate refurbishment.

— Reviewing existing national and state-based programs to understand what is working, where duplication exists and where resources could be better targeted.

Table 1 - Status, responsibility and urgency of reform for making existing capacity visible and usable

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON
1.1	Establishing and strengthening data systems to improve visibility of capacity	Emerging/not nationally standardised	Australian Government via the Australian Institute of Health and Wellbeing ('AIHW') with states and territories	Short-term
1.2	Understanding operational capacity and supply	Existing in parts/uneven	States and territories, health services, aged care providers	Short-term
1.3	Undertaking an asset and program review	Existing/inconsistent	States and territories, aged care providers	Short-term

2. Increasing the capacity of services

While utilising existing capacity is one aspect of the solution, addressing this does not negate the need for significant investment to increase service capacity. Analysis estimates that 10,600 new residential aged care beds are needed each year to meet growing demand for aged care services as Australia's population ages.[2] This is alongside expanded home support packages and transitional care arrangements, to meet demand and ensure older people receive care in the most appropriate setting. Without sufficient capacity in aged care, older people remain in hospital longer than necessary.

Existing funding mechanisms, such as the Capital Assistance Grant, are limited and primarily target rural and remote areas, leaving metropolitan and high-growth regions underserved.[3] Some states, including Western Australia ('WA') through its Aged Care Low Interest Loan Scheme (see Case Study 1), have introduced measures to encourage investment, but these remain small, fragmented, and insufficient to address system-wide pressures on both aged care and hospitals.

Case Study 1: Aged Care Low Interest Loan Scheme – Western Australia[4]

In January 2026, the WA Government introduced the $100 million Aged Care Low Interest Loan Scheme to support the expansion and modernisation of residential aged care infrastructure. The Scheme provides eligible aged care providers with access to concessional loans of up to $20 million, with terms of up to 15 years, to fund new builds, extensions and major refurbishments. The primary objective of the Scheme is to increase the supply of aged care places across WA, including in regional and high-demand areas.

By enabling providers to proceed with projects that may not be feasible under standard commercial lending, the initiative is expected to accelerate the delivery of additional capacity and support longer-term sector sustainability. This targeted investment reflects a deliberate policy choice to incentivise providers to expand residential aged care capacity as demand continues to rise.

A more flexible suite of capital and financing mechanisms is needed to rapidly translate investment into operational beds and services that relieve hospital congestion. In the short term, capacity constraints could be alleviated through targeted investment and policy measures.

2.1 Incentivising and facilitating rapid investment in new aged care beds

Deploying fast-acting capital mechanisms to rapidly bring new beds online in priority locations. This could be achieved through a mix of concessional finance for expansions, refurbishments, modular builds and conversions to reduce costs and accelerate delivery. Other financial mechanisms could include:

- Co-investment and time-limited grants to attract private capital in high-need regions.
- Capital partnerships and sale–leasebacks to unlock provider balance sheets.
- Support for modular or prefabricated builds, enabling rapid deployment on existing aged care or hospital-adjacent sites.
- Targeted repurposing and rapid commissioning of existing assets and services, including under-utilised hospitals, closed facilities, retirement living communities, and commissioning home care providers to deliver additional short-term capacity in high-pressure locations.

2.2 Establishing the right planning and policy settings to increase capacity

Over the medium term, planning for sustainable capacity growth is critical to protect hospital flow and ensure timely care transitions. This may include:

- Developing a National Aged Care Infrastructure Plan and pipeline to coordinate approvals, land, and build timelines.
- Aligning federal and state funding and incentives to accelerate priority builds and expand residential, transition, and home-based services in high demand areas.
- Ensuring consistent investment by states/territories in sub-acute and rehabilitation capacity.
- Considering alternative delivery models in thin or high-pressure markets, including public delivery or public–private partnerships, where private investment alone may not deliver sufficient capacity.

Table 2 - Status, responsibility and urgency of reform for increasing the capacity of services

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
2.1	Incentivising and facilitating rapid investment in new aged care beds	Limited/jurisdiction-specific	Australian Government with states and territories	Short-term	Low Interest Loan Scheme for Residential Aged Care Infrastructure (WA)
2.2	Establishing the right planning and policy settings to increase capacity	Not currently coordinated nationally	Australian Government with states and territories	Medium-term	-

3. Strengthening discharge planning and transitional care

The Royal Commission into Aged Care Quality and Safety ('the Commission') explicitly considered the importance of the relationship between the hospital system and the aged care sector, particularly proper discharge planning and handover.[5] The report notes that:

> *'Any breakdown in the relationship or 'interface' between the aged care and health care systems is likely to have significant, and adverse, impacts on the health of people receiving aged care'.*[6]

The Commission made two recommendations to:

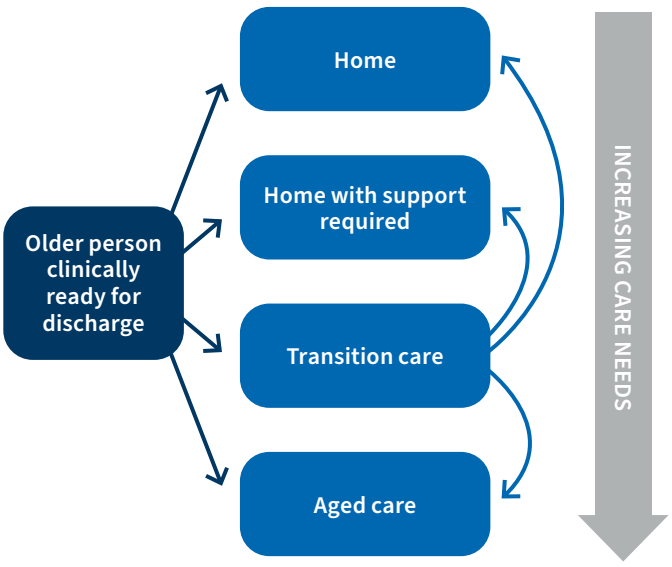
- Improve the transition from hospital to aged care through the development of standardised discharge protocols and compliance reporting (Recommendation 66); and
- Establish data on the interaction of the aged care system and hospital care through the development of a national minimum data set, data linkage and publishing of relevant data sets by the AIHW (Recommendation 67).[7]

Although the recommendations on standardised discharge practices and enhanced data collection have yet to be progressed, their implementation continues to hold merit. Delivering on these measures would generate insights and consistency that will assist in unlocking additional aged care capacity.

3.1 Commence discharge planning at admission

To minimise delays, it is critical that care teams commence discharge planning from the moment an older person is admitted to hospital. This ensures that proper consideration is given to the range of discharge options available, including residential aged care among several options to be considered (see Figure 2). There is also an opportunity to strengthen discharge planning through clearer education and information for families, such as standardised information packs, early conversations about care options, and access to specialist navigation support.

Figure 2 – Discharge pathways from hospital for older people



3.2 Expand transitional and step-down care models to relieve acute hospital pressure

Even where families are actively engaged in care discussions and an older person's wishes are known, time is often required to consider and agree on next steps. Time and potentially rehabilitation also support recovery after a post-acute illness, enabling functional improvement that may allow an older person to return home. This decision-making period can delay discharge, particularly when complex clinical, social, or end-of-life considerations are involved, and where families have limited understanding of aged care pathways, eligibility or available supports.

In response, some hospitals and jurisdictions have implemented targeted programs or established dedicated transition or step-down beds to support people during this interim period and reduce pressure on acute services. Short-term transitional care arrangements can play an important role in supporting system flow at the interface between hospitals, aged care and the community. These arrangements should be considered as part of discharge planning. They provide temporary care for older people who are not yet able to return home or move into long-term care, allowing time for recovery, assessment, care planning and placement decisions to occur outside the acute hospital setting. By creating structured alternatives to prolonged hospital stays, transitional models help reduce delayed discharges, manage demand across settings and support more appropriate care pathways, including through programs such as the *Transition Care Service* and *Time to Think* programs (see Case Studies 2 and 3).

Case Study 2: Transition Care Service at the Pullman Hotel – South Australia[8,9]

South Australia ('SA') established a hotel-based Transition Care Service to support older South Australians who were clinically ready to leave hospital but unable to do so due to delays in accessing aged care or community services. The Service was a collaboration between SA Health, Amplar Health Home Hospital and the Pullman Hotel. It started with 24 beds, which were later expanded to 48. The model enabled eligible patients to be transferred from acute hospitals to a non-hospital setting with appropriate clinical governance, nursing oversight and access to allied health. The approach was designed to provide care in a setting better matched to patients' needs, while reducing reliance on acute hospital infrastructure for non-acute care.

The program reduced acute bed occupancy by patients awaiting discharge, contributing to improved patient flow across the hospital system. It increased available hospital capacity during periods of demand and reduced the length of stay associated with delayed discharges. While not a long-term solution to aged care capacity shortages, the program demonstrates how intermediate care models can quickly improve system flow, reduce congestion, and deliver better outcomes for both patients and hospitals when the system is under strain.

Case Study 3: Time to Think – WA[10]

The *Time to Think* program in WA provides a short-term placement for older people who are medically ready to leave hospital but require extra support to plan their long-term care or wait for a permanent aged care placement. Patients stay in dedicated aged care beds where clinical and allied health teams work with them and their families to explore options, address questions, and make informed decisions about the next stage of care. This approach ensures that transitions are person-centred and that decisions are made with time and support, rather than in the pressure of an acute hospital setting.

Stays in the program generally last 2 to 4 weeks, though patients can move on sooner if ready. By offering this structured planning period, the program not only supports smoother transitions for older people but also eases pressure on hospital beds, helping the system manage acute demand more effectively while reducing the risks associated with rushed or unsupported aged care placements. The program has been expanded since its launch, with additional beds added across metropolitan and regional WA.

WA Health secures the beds and the associated care and services on behalf of eligible patients, so they can leave hospital. Beds allocated to the *Time to Think* program are paid for irrespective of whether they are occupied. This gives the provider greater financial security, unlocking their ability to make decisions on investing in more beds and infrastructure, and the state certainty around capacity.

Table 3 - Status, responsibility and urgency of reform in strengthening discharge planning and transitional care

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
3.1	Commence discharge planning at admission	Existing/variable practice	Health services	Short-term	-
3.2	Expand transitional and step-down care models to relieve acute hospital pressure	Existing/limited scale	States and territories with the Australian Government	Short to medium-term	Transition Care Service at the Pullman Hotel (SA) *Time to Think* Program (WA)

4. Improving system navigation

Improving how older people and their carers navigate the system and transition between hospital, home and residential aged care represents one of the most immediate opportunities to unlock capacity across health and aged care. As outlined previously, delays frequently arise because pathways are unclear, assessments are fragmented, and coordination responsibilities are diffused across jurisdictions. Addressing these issues requires strengthening navigation, assessment and discharge functions as core system capabilities rather than adjunct processes.

In the short term, capacity can be unlocked by embedding stronger navigation and coordination functions within hospital.

4.1 Expanding cross-sector aged care navigator roles within hospitals

— Expanding the use of dedicated aged care navigators within health services to support older Australians, families and clinicians to navigate health, aged care, housing and community systems. These roles require specialist cross-agency capability and should operate seven days a week to support timely discharge.

4.2 Strengthening clinical workforce capability in discharge planning and aged care navigation

— Upskilling frontline clinical and support staff in aged care pathways, eligibility, funding arrangements and referral processes.

— Strengthening discharge coordination through earlier involvement of dedicated discharge planners and aged care liaison roles, while also embedding discharge planning as core business for all relevant health professionals, including social workers, occupational therapists and allied health staff who already play a critical role in planning safe and timely transitions.

4.3 Improving access to aged care assessments

— Improving access to timely aged care assessments supported through better alignment between hospitals and the Single Assessment System, including clearer referral pathways, earlier initiation of assessments during hospital stays, and improved information sharing to reduce delays and duplication.

4.4 Establishing and embedding system-level infrastructure and processes to support navigation

Medium term, these gains need to be supported by more consistent system-level navigation infrastructure.

— Establish a dedicated My Aged Care support line for health professionals, operating seven days per week with extended hours.

— Formalise aged care navigation as a core system function, with clear roles, sustainable funding and consistent triggers (including during hospital admissions) to ensure proactive linkage across health, aged care, housing and community services.

— Improve visibility and reuse of hospital-based assessments (functional, cognitive and social) within aged care processes to reduce duplication during transitions of care.

— Strengthen structured transition pathways for people living with dementia, with shared protocols across hospitals, aged care and primary care to support safe handover, continuity of care and reduced readmissions.

Programs such as Services Australia's Aged Care Specialist Officers and *Care Finders* (see Case Study 4), provide in-person assistance to older people and their families to understand and navigate aged care pathways. These programs demonstrate how targeted navigation support can assist people at key transition points within a complex system. Consideration should also be given to providing appropriate support to First Nations people and people from culturally and linguistically diverse ('CALD') backgrounds.

Table 4 - Status, responsibility and urgency of reform in improving system navigation

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
4.1	Expanding cross-sector aged care navigator roles within hospitals	Existing/patchy coverage	States and territories with the Australian Government	Short-term	Aged Care Specialist Officers (Services Australia)
4.2	Strengthening clinical workforce capability in discharge planning and aged care navigation	Not consistently formalised	Australian Government with states and territories	Medium-term	*Care Finders*
4.3	Improving access to aged care assessments	Limited/ad hoc	Australian Government, states and territories	Medium-term	-
4.4	Establishing and embedding system-level infrastructure and processes to support navigation	Not consistently in place/ fragmented	Australian Government with states and territories	Medium-term	-

Case Study 4: Targeted navigation support for aged care access[11,12]

Targeted navigation support programs such as Aged Care Specialist Officers ('ACSOs') and the *Care Finders* program provide practical, person-centred assistance to help older people access government-funded aged care. Both initiatives are delivered at no cost and are designed to complement the My Aged Care system by supporting people who prefer, or require, additional guidance to understand eligibility, assessments and available care options. Together, they respond to the complexity of the aged care system by providing tailored support at key decision points.

ACSOs are embedded within selected Services Australia service centres, with approximately 80 officers nationally, offering face-to-face assistance to older people, families and carers. Their role focuses on helping individuals navigate eligibility requirements, register with My Aged Care, arrange aged care assessments and understand care pathways and associated fees. By providing specialist expertise within existing service centres, the model improves accessibility and confidence for people engaging with aged care for the first time or managing more complex circumstances, without changing underlying program settings.

The *Care Finders* program extends this approach by targeting older people who are particularly vulnerable or at risk of missing out on care, including those with limited social supports, language or cultural barriers, housing insecurity, or difficulty using digital or phone-based systems. Delivered by local organisations, care finders provide hands-on, personalised support to help individuals progress through assessments and connect with appropriate services once approved. Together, these models demonstrate how targeted, non-clinical support can reduce access barriers, improve user experience and help people move more efficiently through the aged care system.

5. Improving support for older Australians with complex care needs

Increasing acuity and misaligned service models at the hospital and aged care interface continue to drive avoidable hospital use and constrain capacity across health and aged care. In response, redesigning services is critical to ensuring older people receive care in the most appropriate setting, particularly those living with dementia. In the short term, this includes strengthening the capability and capacity of residential aged care and community-based services.

Achieving this will require alignment between service models and workforce capacity, including targeted funding to address workforce gaps within residential aged care and support the safe care of people with higher or more complex needs (see Section 6).

5.1 Improving hospital to aged care clinical integration and BPSD management

- Improving hospital-based supports to reduce BPSD, including building staff capability in dementia-informed care and behaviour management, and improving understanding of aged care regulatory and practice requirements so care approaches initiated in hospital are clinically appropriate and able to be safely sustained in residential aged care following discharge. This is particularly relevant for behavioural management, psychotropic use and discharge planning.
- Strengthening clinical alignment between hospital and aged care settings and consistency in care practices to support ongoing management. This includes greater alignment in approaches to psychotropic medication use.

5.2 Leveraging existing MSU and SDCP capacity and other models of care such as Hospital in the Home

- Stocktaking existing MSU and Specialist Dementia Care Program ('SDCP') capacity to identify current and emerging gaps.
- Expanding the use of Hospital in the Home ('HITH') and in-reach models to deliver acute and sub-acute care in home and residential care settings.

Over the medium term, service redesign should be guided by clearer needs analysis and stronger alignment between planning, funding and delivery.

5.3 Expand capacity to care for patients with BPSD

- Expansion of dementia-specific services based on needs analysis in metropolitan and adjacent growth areas where dementia care exceeds supply.
- Supporting greenfield development of MSU and services in areas of projected need, particularly in metropolitan growth corridors and regions with limited access to dementia-specific residential care.
- Undertaking updated demand projections for SDCP to assess whether the current national rollout is sufficient, and to inform decisions about whether additional SDCP services are required and where.

5.4 Evaluating current programs – Support at Home and CHSP

- Evaluating Support at Home and CHSP to identify which service elements most effectively reduce hospital admissions and/or delay or avoid entry to residential care.

Case Study 5: Grampians Local Health Service Network Residential in Reach ('RIR') Program – Victoria[13]

The Grampians RIR model provides an example of service design that delivers hospital-level clinical expertise directly into residential aged care homes to manage acute and complex needs in place. The nurse-led multidisciplinary service operates across multiple facilities using a centralised hub and a telehealth-enabled approach. Care is delivered collaboratively with aged care staff, general practitioners ('GPs'), emergency and urgent care services and specialist teams. This supports aged care staff, reduces avoidable hospital presentations, and improves continuity of care for residents.

Dedicated Victoria Department of Health funding, supported by an activity-based funding mechanism, enables clinicians to provide outreach beyond traditional hospital settings. The Grampians RIR model illustrates how targeted service redesign may help unlock capacity across health and aged care systems, while supporting care in the most appropriate settings.

Case Study 6: Aged Care Emergency service – New South Wales ('NSW')[14]

The Aged Care Emergency ('ACE') service is a nurse-led, multi-agency model operating across the Hunter New England and Central Coast regions of NSW. The program aims to manage acute deterioration in place and avoid unnecessary transfers to hospital where clinically appropriate.

The service provides 24-hour clinical advice and decision support to residential aged care facilities ('RACFs') and GPs on recognising deterioration and effective clinical handover. When hospital transfer is required, ACE helps clarify the reason and goals of care with proactive case management in the emergency department.

ACE has demonstrated reduced emergency department presentations and hospital admissions by approximately 20% with a significant proportion of acute episodes safely managed within RACFs.[15] The model has also strengthened collaboration between aged care, primary care and hospital services.[16]

Case Study 7: Hospital to Aged Care Dementia Support Program[17]

The Hospital to Aged Care Dementia Support Program ('HACDSP') is an Australian government-funded initiative to support older people living with dementia who are at risk of delayed hospital discharge. The program supports the wellbeing of at-risk older people during hospital stays and enables timely transition into appropriate aged care settings.

Delivered by Dementia Support Australia, the program has multidisciplinary teams comprising Dementia Consultants, Dementia Support Coaches and Family Liaison Officers who work with hospital staff to provide dementia-informed care, behavioural support and practical advice. Following discharge, the program offers intensive transition support for up to three months, helping aged care providers and families manage behavioural needs and reduce the risk of failed placements or readmissions.

"Our experience of this program [Hospital to Aged Care Dementia Support Program] is really positive. A good case study is our home in Eastern Shore Tasmania, where we are effectively the provider of last resort for residents with complex dementia and behaviours".

— DR LINDA MELLORS
CEO, Regis Healthcare

Table 5 - Status, responsibility and urgency of reform in improving support for older people with complex needs

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
5.1	Improving hospital to aged care clinical integration and BPSD management	Existing/variable capability	Health services	Short-term	Hospital to Aged Care Dementia Support Program ('HACDSP')
5.2	Leveraging existing MSU and SCDP capacity and other models of care such as HITH	Existing/jurisdiction-specific	States and territories	Short to medium-term	Residential In-Reach ('RIR') program (Victoria) Aged Care Emergency ('ACE') Service (NSW)
5.3	Expand capacity to care for patients with BPSD	Combination of existing programs and future planning	Australian Government with states and territories	Medium-term	-
5.4	Evaluating current programs – Support at Home and CHSP	Existing programs/ impact on hospital demand not consistently assessed	Australian Government	Medium-term	-

6. Building workforce capacity and capability across health and aged care

Building a workforce that meets the growing demand and increasing clinical and social complexity requires action on both capacity and capability.* Workforce responses must address both dimensions and recognise that health and aged care function as an interconnected workforce system, rather than separate sectors.

In the short term, stabilising workforce capacity and addressing critical capability gaps will require targeted action.

6.1 Undertaking workforce gap analysis and capability assessment

- Building on existing workforce analyses to identify and address priority capacity and skills gaps across health and aged care, with a specific focus on roles and capabilities that support hospital discharge and care for older people with complex needs.
- Identifying gaps in health workforce capability (knowledge of the aged care system/capability around BPSD in older people living with dementia).

6.2 Targeted workforce recruitment and funding

- Limited and targeted over-recruitment in priority roles, including registered nurses, personal care workers and key allied health roles (such as occupational therapy and social work), supported by the Australian Government and state co-funding to address immediate shortages.
- Targeted funding to address workforce gaps within aged care providers, enabling them to accept and safely care for people with higher or more complex needs (for example, behavioural or cognitive issues), where physical capacity exists, but workforce capability is the binding constraint.
- Identify how under-utilised or alternative health workforce can be leveraged to support delivery of care or transition programs (for example, allied health or para-medical professionals).

Over the medium term, workforce sustainability depends on clearer career pathways and stronger cross-sector capability building. This includes:

6.3 Long-term workforce planning and capability development

- Developing long-term workforce plans that reflect the full range of roles needed to support older people across hospital, aged care and community settings.
- Embedding dementia-specific capability development within acute and community settings.
- Strengthening training pipelines that enable progression from entry-level roles (e.g. personal care workers, enrolled nurses) through to advanced clinical and leadership roles (e.g. registered nurses, nurse practitioners, clinical nurse consultants).
- Trialling rotational employment arrangements that enable staff to work across hospitals, residential aged care and community services.

Capacity refers to having sufficient numbers of staff in the right roles and locations to meet demand. Capability refers to the skills, knowledge and confidence required to care for older people with complex needs, particularly across the hospital–aged care interface.

Case Study 8: Regional, Rural and Remote Home Care Workforce Support Program[18]

The Regional, Rural and Remote Home Care Workforce Support Program is an Australian Government initiative to strengthen the home care workforce in areas of acute shortage. It will support engagement of an additional 4,000 personal care workers across regional, rural and remote locations (MMM 3-7) over three years (2024-25 to 2026-27).

The program focuses on both growing the workforce and building provider capability to recruit, train and retain staff locally. Activities supported by the program grants include:

- Recruiting and retaining new personal care workers to the home sector in MMM 3-7 regions.
- Supporting high quality training for new personal care workers.
- Improving retention of new personal care workers in the sector.
- Enhancing the capability of providers to attract, retain, train and support workers.
- Evaluation and continuous improvement activities.

By increasing home care capacity in thin markets, the program supports earlier hospital discharge, reduces avoidable admissions and eases pressure on residential aged care and acute beds.

This program builds on the Home Care Workforce Support Program (2021-2024), which attracted approximately 13,000 new personal care workers nationally. An evaluation of the program highlighted that, while additional funding was effective in increasing workforce numbers, sustainable growth depended on strengthening providers' capability in recruitment, workforce planning, HR processes and responsiveness to local labour market conditions.[19]

These capabilities were critical because workforce shortages in home care are highly localised, time-sensitive and influenced by competition from other sectors, particularly in regional and thin markets. Grant recipients, primarily peak bodies and training providers, were most effective where they had a strong local presence and established relationships with aged care providers and registered training organisations, enabling faster recruitment, better retention and more durable workforce outcomes.

Table 6 - Status, responsibility and urgency of reform in building workforce capacity and capability across health and aged care

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
6.1	Undertaking workforce gap analysis and capability assessment	Emerging/limited pilots	Australian Government and states and territories	Short-term	Regional, Rural and Remote Home Care Workforce Program
6.2	Targeted workforce recruitment and funding	Existing/uneven	Australian Government, states, providers	Medium-term	-
6.3	Long-term workforce planning and capability development	Limited/early stage	States and territories, providers	Medium-term	-

7. Reviewing funding mechanisms

Mechanisms are required to support integrated planning, capacity growth, and sustainable service delivery across health and aged care. While funding model design matters, the current capacity crisis reflects both misaligned funding settings and a lack of coordinated planning and accountability at the national level, with downstream impacts increasingly borne by states and health systems.

7.1 Dedicated aged care bilateral agreements

In the short term, there is a need to clarify roles, rebalance responsibilities and introduce more flexible funding arrangements across health and aged care. This could be achieved through dedicated aged care bilateral agreements between the Australian Government and individual states and territories, designed to provide additional, time-limited and flexible funding to address immediate capacity and discharge pressures. Selected jurisdictions could pilot these arrangements ahead of broader rollout. Under such a model:

- The Australian Government would provide additional, time-limited funding on top of existing aged care programs, delivered through pooled funding envelopes governed via bilateral agreements with states and territories.
- States and territories have flexibility to deploy funding locally in response to capacity constraints, workforce availability and hospital discharge pressures.
- Funding could be used across priority services, including residential aged care, transitional care, and services that sit between residential and in-home care such as the CHSP and Support at Home.
- Australian Government funding would subsidise state delivery, recognising national responsibility for aged care while enabling locally responsive implementation.
- Governance and accountability arrangements would support transparency and evaluation, ensuring funding is targeted to areas of highest need and delivers measurable reductions in hospital pressure.

This approach would build on and expand the intent of the Transitional Care Program ('TCP'), increasing both the scale and flexibility of funding to support a broader range of discharge and step-down pathways.

7.2 Targeted refinements to the Australian National Aged Care Classification to support post-hospital transitions and dementia care

Targeted refinements to existing aged care funding models are required, rather than a complete overhaul. In residential aged care, this includes reviewing aspects of the Australian National Aged Care Classification ('AN-ACC') to ensure funding better reflects periods of heightened clinical and staffing intensity following hospital discharge.

Priority areas for refinement include:

- Temporary transition funding following hospital discharge, scaled to length and acuity of hospital stay (for example, higher short-term supplements for residents returning after longer or more complex admissions), to support safe stabilisation in the initial post-discharge period.
- Improved recognition of the care intensity associated with people living with dementia and severe BPSD, particularly where behaviours such as exit-seeking and high supervision needs materially increase staffing and environmental requirements.
- Short-term alignment between hospital care inputs and aged care funding, ensuring that increased staffing, clinical oversight or environmental supports required immediately post-discharge are reflected in aged care funding for a defined period.

These refinements would reduce placement refusals, support safer transitions and remain significantly lower cost than prolonged hospital stays, while avoiding disruption associated with wholesale funding reform.

7.3 Undertake a comprehensive review of aged care funding arrangements

Over the medium term, a more comprehensive review of aged care funding arrangements should be undertaken to assess whether current settings adequately support system capacity, workforce sustainability and integrated care. This should consider whether a new or strengthened funding agreement with states is required to provide greater certainty for providers and governments, supporting long-term investment and coordinated planning across jurisdictions.

7.4 Large-scale investment in aged care capacity, workforce and enabling infrastructure

Critically, funding reform must proceed in parallel with major investment in capacity. There is a risk that calls for reform delay necessary capital and workforce investment; this must be avoided. Urgent, large-scale investment in residential aged care, home-based services, workforce growth and enabling infrastructure is required now, alongside targeted funding refinements, to address existing shortages and prevent further deterioration in system performance.

Table 7 - Status, responsibility and urgency of reform in reviewing funding mechanisms

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
Reviewing funding mechanisms					
7.1	Dedicated aged care bilateral agreements	Proposed/limited precedents	Australian Government with states and territories	Short-term	Transitional Care Program ('TCP')
7.2	Targeted refine-ments to the AN-ACC to support post-hospital transitions and dementia care	Existing/refinement required	Australian Government	Short-term	-
7.3	Undertake a comprehensive review of aged care funding arrangements	Required/scale-up needed	Australian Government with states and territories	Short to medium-term	-
7.4	Large-scale investment in aged care capacity, workforce and enabling infrastructure	Required/insufficient at current levels	Australian Government with states and territories	Short to medium-term	-

Conclusion

This series has shown that improving capacity across health and aged care is not limited by a lack of ideas, but by how effectively the system operates. Practical solutions already exist to improve patient flow, reduce delays and strengthen service connections, particularly where care pathways are clear and systems are designed around consumer needs. When applied consistently, these approaches can deliver meaningful improvements in performance and outcomes.

However, reform within existing settings will not be sufficient to meet the scale of demand now facing the system. Australia's ageing population means substantial new investment is required across the aged care sector, alongside reform, to expand service capacity, stabilise the workforce and support integrated models of care at scale. This includes significantly increased investment in residential aged care, home-based services and supporting infrastructure.

Decisions made now by the Australian Government and the states and territories will shape whether the health and aged care systems can keep pace with rising demand. Timely investment and coordinated reform will be critical to maintaining access to appropriate care and avoiding escalating pressure on hospitals in the years ahead.

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Appendix – Summary of initiatives to unlock capacity across health and aged care

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
1.	**Making existing capacity visible and usable**				
1.1	Establishing and strengthening data systems to improve visibility of capacity	Emerging/not nationally standardised	Australian Government via the Australian Institute of Health and Wellbeing ('AIHW') with states and territories	Short-term	-
1.2	Understanding operational capacity and supply	Existing in parts/ uneven	States and territories, health services, aged care providers	Short-term	-
1.3	Undertaking an asset and program review	Existing/inconsistent	States and territories, aged care providers	Short-term	-
2.	**Increasing the capacity of services**				
2.1	Incentivising and facilitating rapid investment in new aged care beds	Limited/jurisdiction-specific	Australian Government with states and territories	Short-term	Low Interest Loan Scheme for Residential Aged Care Infrastructure (WA)
2.2	Establishing the right planning and policy settings to increase capacity	Not currently coordinated nationally	Australian Government with states and territories	Medium-term	-
3.	**Strengthening discharge planning and transitional care**				
3.1	Commence discharge planning at admission	Existing/variable practice	Health services	Short-term	-
3.2	Expand transitional and step-down care models to relieve acute hospital pressure	Existing/limited scale	States and territories with the Australian Government	Short to medium-term	Transition Care Service at the Pullman Hotel (SA) *Time to Think* Program (WA)
4.	**Improving system navigation**				
4.1	Expanding cross-sector aged care navigator roles within hospitals	Existing/patchy coverage	States and territories with the Australian Government	Short-term	Aged Care Specialist Officers (Services Australia)
4.2	Strengthening clinical work-force capability in discharge planning and aged care navigation	Not consistently formalised	Australian Government with states and territories	Medium-term	*Care Finders*
4.3	Improving access to aged care assessments	Limited/ad hoc	Australian Government, states and territories	Medium-term	-
4.4	Establishing and embedding system-level infrastructure and processes to support navigation	Not consistently in place/fragmented	Australian Government with states and territories	Medium-term	-

#	INITIATIVE	STATUS (INDICATIVE)	LOGICAL OWNER	TIME HORIZON	CASE STUDIES
5.	**Improving support for older Australians with complex needs**				
5.1	Improving hospital to aged care clinical integration and BPSD management	Existing/variable capability	Health services	Short-term	Hospital to Aged Care Dementia Support Program ('HACDSP')
5.2	Leveraging existing MSU and SCDP capacity and other models of care such as HITH	Existing/jurisdiction-specific	States and territories	Short to medium-term	Residential In-Reach ('RIR') program (Victoria) Aged Care Emergency ('ACE') Service (NSW)
5.3	Expand capacity to care for patients with BPSD	Combination of existing programs and future planning	Australian Government with states and territories	Medium-term	-
5.4	Evaluating current programs – Support at Home and CHSP	Existing programs/ impact on hospital demand not consistently assessed	Australian Government	Medium-term	-
6.	**Building workforce capacity and capability across health and aged care**				
6.1	Undertaking workforce gap analysis and capability assessment	Emerging/limited pilots	Australian Government and states and territories	Short-term	Regional, Rural and Remote Home Care Work-force Program
6.2	Targeted workforce recruitment and funding	Existing/uneven	Australian Government, states, providers	Medium-term	-
6.3	Long-term workforce planning and capability development	Limited/early stage	States and territories, providers	Medium-term	-
7.	**Reviewing funding mechanisms**				
7.1	Dedicated aged care bilateral agreements	Proposed/limited precedents	Australian Government with states and territories	Short-term	Transitional Care Program ('TCP')
7.2	Targeted refinements to the AN-ACC to support post-hospital transitions and dementia care	Existing/refinement required	Australian Government	Short-term	-
7.3	Undertake a comprehensive review of aged care funding arrangements	Required/scale-up needed	Australian Government with states and territories	Short to medium-term	-
7.4	Large-scale investment in aged care capacity, workforce and enabling infrastructure	Required/insufficient at current levels	Australian Government with states and territories	Short to medium-term	-

**Status is indicative only and reflects FTI Consulting's understanding based on publicly available information and stakeholder consultation. Implementation and maturity varies across jurisdictions, and additional local initiatives may exist. We welcome engagement from organisations and jurisdictions delivering exemplar approaches that could inform future system-wide learning.*

Endnotes

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