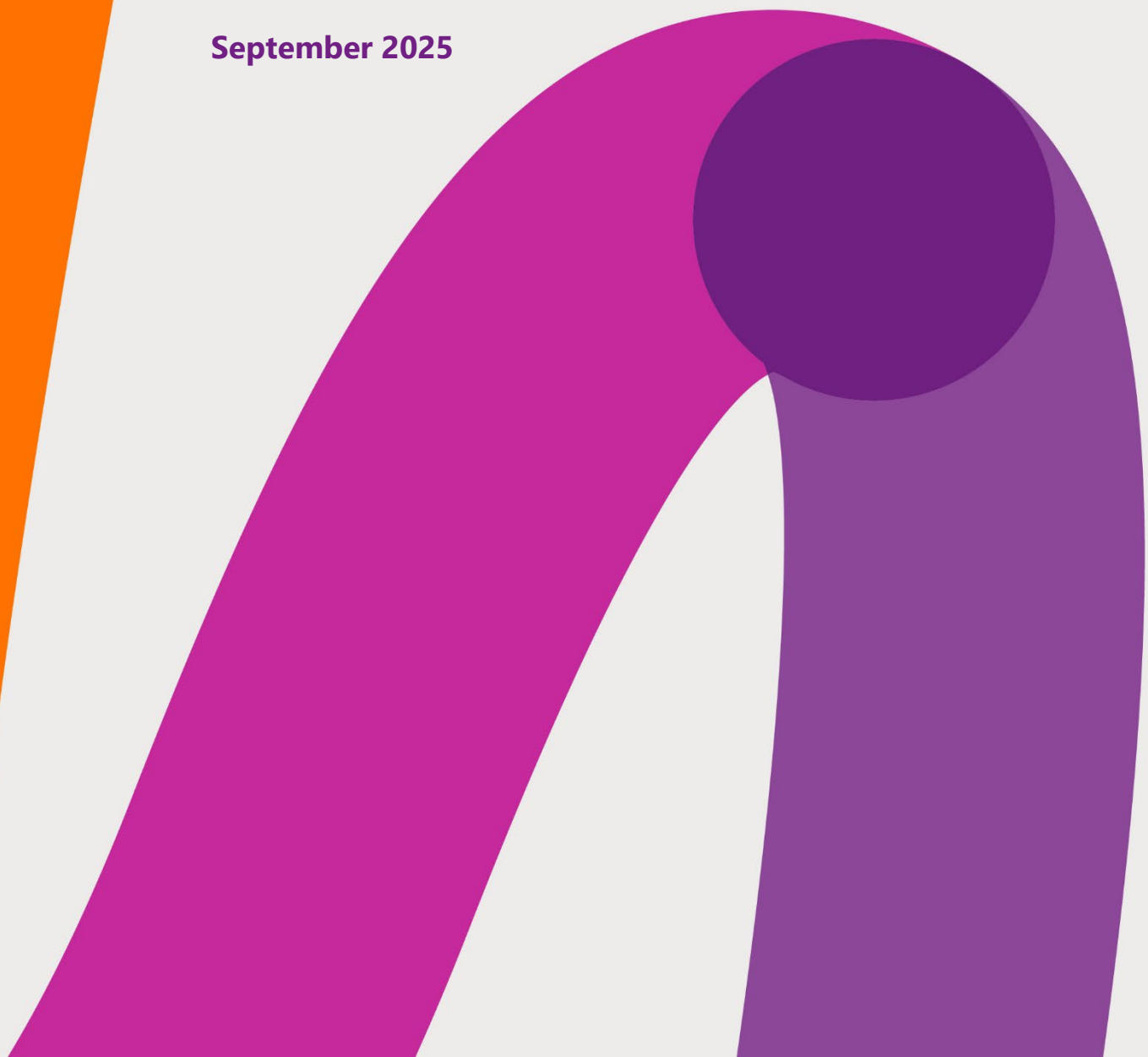
Delivering quality care more efficiently

Submission to Productivity Commission

September 2025



HammondCare response

Reform of quality and safety regulation to support a more cohesive care economy

HammondCare recommends:

1. Establish a taskforce to oversee implementation. The taskforce would be led by the federal government to run for 6 months, chaired by a federal Minister, with key personnel from the state, federal public service as well as private sector
2. The taskforce plans a nationwide regulatory approach within 6 months
3. Ensuring sector-specific expertise is maintained in a merged single regulator for the care economy.

HammondCare agrees with the interim recommendation 1.1 that Australian Government should pursue **greater alignment** in quality and safety regulation of the care economy. To best solve the issue of siloed regulatory practices, we propose that a broader view is taken whereby **state-level regulation is also included**. Focusing on reducing inefficiencies, duplications, and burdensome administration whilst improving information sharing throughout multiple tiers of government would provide a more holistic solution.

There are currently regulatory compliance overlaps, resulting in aged care providers being asked for duplicate information from multiple government agencies and departments. For example:

- **Key personnel notification** (called 'responsible person' in the incoming new Aged Care Act 2024). The Aged Care Quality and Safety Commission requires aged care providers to supply this information and keep it up-to-date. This information could be obtained from other agencies, such as:
  - Aged Care Financing Authority (AFCA) – Insolvency check / National Disability Insurance Scheme worker screening
  - Australian Securities and Investments Commission (ASIC) – Banned or disqualification notices
  - Australian Health Practitioner Regulation Agency (APHRA) – Registration and qualification confirmation
  - Nursing and Midwifery Board (state-based) – Conditions, suspensions.
- **Whistleblower notifications** were part of the 2017 Senate Committee looking into improving protections. The committee found there were 20 different statutes of law with varying degrees of difference across federal, state and territory governments. The new Aged Care Act 2024, commencing 1 November 2025, adds another layer of whistleblowing obligations to aged care providers.

There is no doubt that regulation is an important factor in increasing safety, quality and transparency. However, the increasingly complex duplication of regulation is not achieving this, instead it is making access and quality care more difficult for older people to obtain. Under a more streamlined system, a compliance item such as 'key personnel notification' would change from being a reactive process to an automatic notification, where the regulatory body accesses the relevant information from both federal and state agencies – this would be an action that protects the public proactively while requiring less time and resources from both aged care providers and government agencies.

Exploring a single regulator for the care sector

Merging care regulatory authorities is a potential mechanism to deliver quality care more efficiently. The success of the idea hinges on harmonisation and ensuring administrative and financial benefits are realised. Ways to ensure positive outcomes from a single regulator include:

- **Maintaining specialisations within the regulator**. A merged regulatory body must ensure it has teams that have a capability, focus and understanding of each specific area within the regulator's scope. The sectors that comprise the care economy still have unique profiles requiring tailored expertise.
- **Improving information sharing from state and territory agencies from the start**. The interim recommendation to carry this out in stages risks creating a clunky and convoluted process that will likely delay issues instead of solving them.

Investing in a robust strategy that addresses the inefficiency problems from commencement would lead to greater benefits and costs savings.

Investing in prevention

HammondCare recommends:

4. Improve the MRFF by enabling funding access to provider-led research and non-pharma clinical trials on dementia
5. Implement a National Framework for care services that outlines an agreed responsibility and removes duplicated services at a federal and state level
6. Mandate timely and high quality data for health, disability and aged care, to provide insight on critical performance areas such as waiting lists, delayed discharge and care assessment times.

There is an opportunity to address critical care economy efficiency issues by implementing **legislative and funding changes** that will improve preventative capabilities. An example is the issue of older people who are stuck in hospital waiting for an aged care service (see Appendix A). Often, they are experiencing behaviours and psychological symptoms of complex dementia and other comorbidities such as mental health. The lack of available aged care stems from a legislative and funding approach which means a provider's quality ratings suffer if they are supporting an older person with complex behaviours and funding is inadequate for the level and intensity of care needed. Apart from the costs to primary care and reduction in hospital beds people that need medical attention, the impact on the older people in hospitals escalates their needs:

- Delays in leaving hospital can lead to a 50% chance of developing delirium, which in turn increases length of stay with a 60-100% increase in risk of death.
- Functional decline occurs when staying in a hospital bed, including loss of mobility, strength, or independence. This increases the likelihood that older people will need higher-level care, making it exponentially harder to find an aged care place.
- People living with dementia experience distress and heightened symptoms when stuck in hospital and are far more likely to face restrictions which can lead to injury and decline.

Recommendation 3.1 in the interim report regarding an intergovernmental agreement is a great step forward. This can be strengthened by implementing a taskforce led by a federal Minister to provide strong direction and leadership, and the onus to achieve tangible outcomes. Alignment of the care economy needs federal and state governments to collaborate. A robust national framework, developed by a taskforce, is needed to address the inefficiencies causes by gaps and problems in legislation and funding.

Refining how the **Medical Research Future Fund (MRFF)** operates also provides a clear investment opportunity for the care economy, which could include:

- **Research** treatments and early prevention for dementia while understanding the health and fiscal budget disadvantages of not taking action. Australian Institute of Health and Welfare research shows the current number of people living with dementia (433,350) is projected to double by 2058, with two thirds being female[1].
- Improve funding access for **non-pharma clinical trials** through provider-led innovative models of care. Creating a dedicated aged care research stream that allows provider-led research and trials focused on addressing solutions to patient journeys through the health and aged care systems could offer solutions to address bed blocking and enhance hospital performance nationally.

Health and aged care data maturity could be developed to give government and providers more relevant information to guide practice improvements. Health data metrics in the aged care sector is consistently released 12 to 18 months after occurrence and in many instances is provided over inconsistent time periods.

It is hard to understand or tackle issues in the sector when data is scarce on specific topics, some examples of this include:

- Home care waiting lists
- Home care assessment times
- Aged care funding levels
- Home care packages numbers
- AN-ACC class assessments

[1] https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/summary

- Prevalence of dementia, mental health, behaviours and psychological symptoms of dementia, and other comorbidities in aged care
- Residential aged care placement and admission timeframes.

This is further complicated in the primary health system where delayed discharge is a problem for state governments. Figures released by state health departments and Ministers usually only occur when the issue escalates or is under media or parliamentary review, and is rarely consistently released.

Improving the timeliness and quality of data would enable the care sector to pivot and solve issues quickly. Furthermore, real time indictors would enable the sector to strive for improvement, which would lead to better quality care.

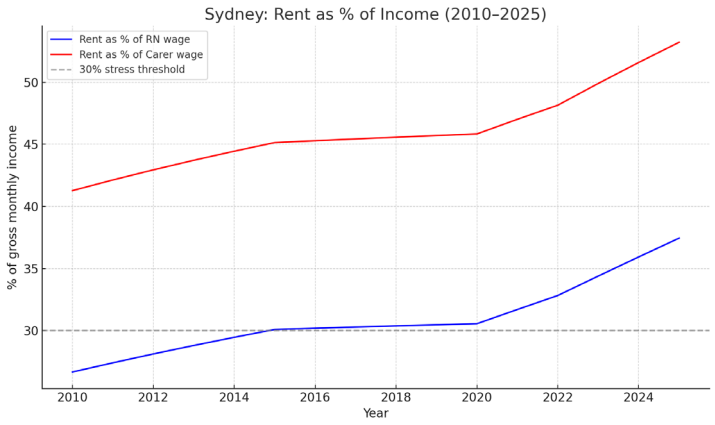
Essential workforce attraction and housing reform

HammondCare recommends

7. Improve government Help to Buy scheme by targeting it towards the essential workforce, while ensuring clear policy boundaries to prevent 'gaming' (see Appendix B)
8. Review government requirements around staffing to ensure they are not inadvertently creating shortages or hardships (such as the methodology used to count mandatory care minutes in aged care).

Over the past two decades, the cost of housing has outpaced the earnings of essential workers such as Registered Nurses (RNs) and care workers in the aged care sector. For example, in Sydney (NSW):

- **Mortgage costs are not sustainable for essential workers**. In 2005, repayments on a median dwelling (90% LVR, 30-year loan) were within reach of a RN. By 2025, monthly repayments are around **$6,500** – equal to **83% of an RN's salary** and **well over 100% of what a care worker is paid**. Both are far above the 30–35% affordability benchmark.[2]



- **Deposit barriers**. Saving a 10% deposit now takes 15–20 years, locking younger workers out of ownership.
    - **RN:** After paying median Sydney rent of $3,030/month, only $5,000 remains. Saving 15% of that disposable income means it would take **13.7 years to save a 10% deposit**.
    - **Care Workers:** After rent, disposable income is just $2,700/month. Saving 15% means it would take **26 years to reach a 10% deposit**.
- **Rents are unaffordable.** A typical Sydney rent ($700/week in 2025) consumes **38–43% of an aged-care RN's income** and **55–60% of a care worker's income**, putting these groups in housing stress.[3]
- **Wage–cost mismatch**. RNs now earn around $8000/month, care workers around $5,700/month, but median dwelling values have risen from $500k in 2005 to $1.25m in 2025, severing the historic link between local salaries and local housing costs.[4]

Australia is projected to face a **shortage of at least 110,000 direct aged care workers by 2030**.

[2] Jobs & Skills Australia, Occupational Profiles – Registered Nurses (2544), Aged & Disabled Carers (4231) (median weekly earnings, ABS EEH May 2023)
[3] PropTrack, *Rental Report 2024–25* (Sydney median advertised rents)
[4] ABS *Total Value of Dwellings, Mar Qtr 2025* (mean dwelling prices)

Appendices

Appendix A – Case study bed blocking

Leonard lived independently in his home with Home Care Package support since he was 71. When he turned 79, Leonard's care workers and family identified significant behaviour and mood changes. Leonard began to have physical and verbal outbursts. During one of these episodes, Leonard fell and required treatment in hospital. Given Leonard's behaviour changes and new injury, he was assessed as requiring residential care.

Whilst Leonard was in hospital, his family tried every avenue to secure him a suitable residential care place. The low vacancy rates made finding a place difficult, but then residential care homes with available beds were turning him away. In hindsight, Leonard's family has realised it was likely that providers were unwilling and unable to support Leonard's complex needs and behaviours.

As a result, Leonard remained in hospital for just short of 140 days before his death. This was much longer than medically necessary and meant that during Leonard's last days, he experienced distress and declined quality of life. Earlier access to residential care would have meant Leonard having suitable care in an appropriate environment, and that the hospital bed would have been used for acute patients.

Appendix B – Proposed Help to Buy policy principles

Parameters that would ensure a strengthened Health to Buy program addresses care economy needs:

Targeted eligibility

- Restrict eligibility to **registered nurses, enrolled nurses, aged care workers, disability support workers, and personal care assistants** (the lower-paid health and aged care workforce)
- Require **evidence** of current employment with audit processes
- Introduce a **service period** (such as a minimum 5 years of employment in health/aged care)
- If the worker exits the sector before this period, they would need to **repay the government equity share or grant**.

Enhanced equity contribution

- For this cohort, **government equity share could be higher** than the standard scheme (for example, up to 40% instead of 30%), lowering mortgage repayments
- Consider **waiving stamp duty** (state cooperation required) to further reduce barriers.

Target localities

- Extra support for **rural and regional health workers**, where shortages are most acute (for example, higher equity share, relocation subsidy).

Protection from 'gaming'

- Purchase must be for **owner occupiers only**, grant must be paid back in full if this is contravened, penalties should also be considered to deter wrongdoing
- Tie eligibility to a **registered provider list** of aged care homes, disability providers, and hospitals – ensuring the worker is employed in the sector.

Integration with Workforce Strategy

- Link the scheme to **national aged-care and health workforce plans**, positioning it as a retention and attraction lever, with an annual data report showing need and impacts
- Pilot in high-shortage areas (regional NSW, outer Melbourne, outer Perth, etc) before scaling nationally.

About HammondCare

HammondCare is an independent Christian not-for-profit aged care provider that is passionate about caring for those with complex care needs, specialising in dementia and palliative care. Our integrated services extend across the country and include residential care, home care, healthcare and hospitals, and advisory services. We also deliver older persons mental health and homelessness supports. Since 1932 we have been committed to supporting people who others can't or won't and **have a mission to improve quality of life for people in need, regardless of their circumstances.**

In 2024 we provided care and support for:

- 2,797 people in 19 residential care sites pioneering the small household model
- 21,214 people accessing specialist care through our advisory services
- 9,796 people living in their own home through 626,061 visits
- 4,795 people requiring health and palliative care.

HammondCare's services are delivered by 5,792 dedicated staff and 861 committed volunteers across 91 locations. Through our relationship-focused approach and embedded principles of care, HammondCare teams are **motivated by mission**; we strongly believe in the intrinsic value of every person that we care for. Our position is informed by our mission to improve quality of life for people in need and our commitment to compassionate, person-centred care.