From Lifespan to Healthspan

Pivoting to Lift Our Productivity

Individual Response to the Productivity Commission's *Delivering Quality Care More Efficiently Interim Report*

by Wes Morris

Contents

10 September 2025

Alison Roberts Commissioner
Martin Stokie Commissioner
Angela Jackson Commissioner

Dear Commissioners

I write to you in a personal, individual capacity. The matters which I write to you about today are matters that I have been writing to Commonwealth and State Governments about for many years- since at least April 2016. Over this time I have written a number of times since April 2016 to the following:

- Hon Sussan Ley, Commonwealth Minister for Health [Liberal]
- Hon Mark Butler, Commonwealth Minister for Health [Labor]
- Hon Anika Wells, Commonwealth Minister for Aged Care [Labor]
- Hon Shannon Fentiman, Queensland Minister for Health [Labor].

I note with particular interest the release on 04 September 2025 of the Progress Report Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety 2025. https://www.igac.gov.au/resources/2025-progress-report-implementation-recommendations-royal-commission-aged-care-quality-and-safety

In the recent report I note in particular the following:

- Supporting different backgrounds and life experiences [pages 44, 45]
- Improving health and aged care services, Care service interface – Case management [page 48]
- Reforms have largely addressed isolated issues rather than driving the systemic change required [IGAC Media Release, 04 September 2025].

The efficiency and the productivity gains that the Productivity Commission seeks to promote simply have no hope of being attained unless and until we actually see the systemic changes that the Aged Care Inspector-General is highlighting. There are a series of recent Burden of Health Reports that have been released by the WA Government, by the Queensland Government and by others. These reports show that over the next decade there will be a 34 percent increase in anticipated hospitalisations. The two main drivers of this significant increase will be:

- **Dementia:** dementia cases are modelled and forecast to increase by a staggering 87%; and,
- **Aged Care Facility Access:** The second main driver of increased hospitalisation will be patients awaiting access to inaccessible and unavailable Aged Care facilities.

I note the 27 August 2025 Media Statement from the WA Government — ***Milestone for new aged care initiative freeing up hospital beds*** https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/Milestone-for-new-aged-care-initiative-freeing-up-hospital-beds--20250827

Since that time Premier Roger Cook and Aged Care Minister Simone McGurk have travelled to Canberra to discuss how to free up the hundreds of hospital beds they say are being taken up by people who should be in aged care. And Media Reports indicate that federal Aged Care Minister

Sam Rae will later in September travel to Perth to continue those discussions. In the 27 August Media Release the WA Government states as follows:

> ***By providing dedicated 'Time to Think' beds, we are not only supporting patients in making informed decisions about their future care but also helping to alleviate pressure on our hospitals.***

> ***We are continuing to work with the Commonwealth Government on initiatives to ease the transition from hospital to aged care, to ensure the best care and support for older Western Australians.***

The same WA Government Media Release cites a number of other initiatives that the WA Government is currently taking in order to improve hospital transitions and aged care pathways in WA. Whilst I am sure that the various initiatives cited by the WA Government are all beneficial in one way or another, I am also sure that such initiatives do not represent the systemic change that the Aged Care Inspector General is currently calling for.

Former Chair of the Productivity Commission, Michael Brennan, says that addressing productivity in the Care Economy should be "the single most important priority for the government" [cited herein]. Much work remains to be done in order to develop, and then implement, an Aged Care system which integrates a cohesive and coordinated approach across both the Aged Care and Health systems. In Australia we are massively reliant on clinical downstream treatments provided in the Hospital setting. This approach is hugely expensive, inefficient and unproductive. And at the same time current approaches fail to deliver the high-quality outcomes which our elderly both need and deserve. Surely in an advanced society such as Australia we need to be aiming to not merely extend life, but to extend quality of life. In this submission I outline some practical approaches to achieving a productive, sustainable and client-centred Aged Care and Aged Health system focused on providing quality of life to the 25 percent of our population which will soon be aged 65 years or older.

As a nation we will have to respond compassionately to the hospitalisation needs of our elderly. But if this nation is serious about having a Productivity Agenda, then we need to get serious about having a Preventative Health agenda.

The suite of Burden of Health Reports all point to the same phenomena ie our hospitals will be swamped by a tsunami of aged care related cases — unless and until we do, at minimum, the following two things:

- introduce a case management approach to help people move fluidly between health, hospital and aged care systems [which I have been calling for since April 2016]
- invest in upstream, preventative, wellness approaches to aging, rather than in hugely expensive downstream, clinical, medicalised, and acute approaches to aged health [again, since 2016].

Kind Regards,

Wes Morris

[redacted], September 2025.

Recommendations

Recommendations Relating to The Broad Agenda of Promoting a Productivity and Prevention Approach to Aged Care and Health in Australia

1. Increase Investment in Preventative Health Programs, From the Current Anaemic Level of 2 Percent of Expenditure, Increasing to a Proposed Level of 5 Percent of Expenditure.

This is a variation upon the following Draft Recommendation from the Productivity Commission:

> **Draft recommendation 3.1**
>
> Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure https://www.pc.gov.au/inquiries/current/quality-care/interim

2. Commit to Reducing the Anticipated 34% Increase in Hospitalisations Over the Next Decade:

- **Make the Health Budget More Sustainable, Via Investing in the Broadscale Roll Out of a 'Healthspan' Model of Aged Care and Aged Health.**
- **Commit to a 'Healthspan' Model Trial Pilot.**

The Productivity Commission is recommending the development of a ***National Prevention Investment Framework***. Such a Framework needs, in the first instance, to focus on transformative change in the Aged Health sector, because that is where the bulk of the future cost increased hospitalisation rests. We need to proactively shift healthcare away from simply treating a patient's disease after symptoms have emerged in older age, toward a "scientific wellness" approach involving heading those diseases off earlier on, through the use of data-driven diagnostic tools, precision medicine and tailored lifestyle coaching. Technologies which are available right now, or which will be available in the next 12 months, can assist in enabling productive, efficient and effective approaches to Aged Health.

This commentary is based largely upon the following source: https://www.scientificamerican.com/custom-media/google-cloud/the-healthspan-paradigm/

3. Increase Health Productivity By Developing Actual System Integration and System Collaboration Across Health and Aging:

- **Centre Aged Health service delivery around the needs of elderly Australians by ensuring that each elderly health consumer, ie each and every Australian aged over 65, has a fully developed and functioning Health and Wellness Journey Map.**
- **Facilitate client centred, individualised Health and Wellness Journey Maps for every person over the age of 65, based on the use of smart watches or similar technologies, to provide diagnostic information around physical biomarkers, sleep, exercise, diet and social interaction.**

The Productivity Commission's Interim Report has promoted the concept of Collaborative Commissioning. This is a necessary, and much-needed, first step, but it is far from sufficient if we are to prevent a wave of increasing hospitalisations of the elderly. In a real-life recent example which I was a personal witness to, in a palliative care context, when family asked a hospital employee about communicating with a Home Care Package provider, the response received was this — "we don't seek to dictate to them." This occurred within the last 3 months. The request from family was merely for some coordination and communication. So, notwithstanding policy words, that is where the two systems are currently at ie as of today the Health and Aged Care systems remain deeply fractured, fragmented and unconnected.

In NDIS each client has a Participant Journey information https://improvements.ndis.gov.au/participants/participant-journey Something similar should be developed and implemented in Aged Care and Aged Health. At present, the Aged Care Commissioner is recommending "a case management approach to help people move fluidly between health, hospital and aged care systems." Whilst I fully support that initiative, what I am recommending is broader and further reaching again.

The availability right now or, if not, then within the next 12 months, of wearable technologies such as smart watches, means that we already have access to technologies which can facilitate individualised Wellness Journey Maps for older Australians. Such technologies, combined with the actual implementation of a N***ational Prevention Investment Framework***, and combined with collaborative commissioning across the Health and Aged Care systems, can provide this nation with productive, efficient and effective means of ensuring quality life outcomes in their later years. And such an approach, providing better outcomes for older Australians, could be achieved at a fraction of the cost of the forecast and predicted 34 percent increase in hospitalisations due mainly to dementia and aged care cases.

In her 18 August 2025 address to the National Press Club, Productivity Chair Danielle Wood spoke of the proposed National Prevention Investment Framework, and she said that such a Framework could be applied across Health, Housing, and Early Childhood. Well, sure. If that is the path, then I would say that Justice absolutely needs to be added to that list. But irrespective of any list, then as previous Productivity Chair, Michael Brennan has said, "addressing the productivity slump in the care economy should be the single most important priority for the government." And this needs to start with addressing the 34 percent increase in hospitalisations which is predicted and which is driven mainly by Aged health needs. As Natalie Siegel-Brown says, we need case management between Aged Care and Hospitals. But to achieve major productivity gains we actually need to go even further than that and we need Case Management approaches for all of our elderly.

Recommendations Relating to the 2025 Commonwealth Government Aged Care Home Support Programme, and Future Iterations Thereof.

4. Anyone who is assessed as being eligible for support under the Support at Home Programme, should have automatic access to Healthspan Coaching.

The macro systemic need is to shift towards a 'Healthspan model' ie upstream prevention in the form of actionable, individualised *Wellness Journey Maps.* Home Care Packages are provided to a tiny fraction of the population aged over 65 years of age. The ***Support at Home Programme*** currently has provision for a Case Manager who is responsible for Care planning; Service coordination; Monitoring, review and evaluation; and Support and education. That Case Manager role, whilst welcomed, still seems fairly reactive in nature ie if a problem arises, then what is the best way of responding to that issue or problem? That is very different from the idea of 'Healthspan Coaching', which is upstream and preventative in nature, and is based on the 'Coach' or 'Coaching Team' having access to a range of medical and lifestyle information that goes far beyond the nature of a Support at Home Case Manager. How this would work in practice is described below:

> Many primary-care clinicians recognize how important these pillars are to their patients' health and well-being. But doctors are often reluctant to advocate lifestyle changes because they're considered too hard to act on. When doctors do address them, they generally give fragmented, outdated and one-size-fits all recommendations. In a rigorous healthspan medicine practice, doctors and coaches evaluate these pillars with a combination of patient-reported information, physiological biomarkers, functional assessments and wearable devices for continuous monitoring. They identify opportunities for improvement and develop a personalized health optimization program. https://www.scientificamerican.com/custom-media/google-cloud/a-practical-approach-to-healthspan-medicine/

5. Develop and Implement Realistic, Actual, and Culturally-Appropriate End of Life and Palliative Care In-Home Options for the Elderly.

This recommendation is carefully worded. The words in the recommendation have been written after reading the information contained in the ***Support at Home Programme Manual*** and further reading a range of other state – based material, including ***A guide to palliative care in Queensland*** https://resources.palassist.org.au/products/guide-to-palliative-care The present author does not accept the premise that current systems and processes facilitate ready access to appropriate, in–home, interdisciplinary palliative care options in Queensland. In a real-life recent example which I was a personal witness to, in a palliative care context, when family asked a hospital employee about communicating with a Home Care Package provider, the response received was this — [redacted] This occurred within the last 3 months. The request was merely for some coordination and communication. So,

notwithstanding policy words relating to Palliative Care Teams, that is where the two systems are currently at ie as of today the Aged Care and Health systems remain deeply fractured, fragmented and unconnected.

6. Develop Upstream, Midstream and Downstream Approaches to Dementia ie Early Prevention, Early Onset and Treatment Approaches to Dementia:

- **Tier One, Upstream, Early Prevention:** Individualised *Wellness Journey Maps,* together with 'Healthspan Coaching'
- **Tier Two, Mid -Stream, Early Onset:** Revise the *Wellness Journey Map* such that it maintains the positive, preventative elements, but is now further supported by more medical and ancillary elements ie clinicians and occupational therapists etc.
- **Tier Three, Downstream, Acute Treatment:** Ensure that all necessary legal requirements are in place ie relating to issues such as Enduring Power of Attorney and Statement of Choices documents. Empower duly nominated and appointed family members to make informed decisions within an Interdisciplinary Services Team that would typically include health providers and ancillary care providers. If the Treatment Plan cannot be centred around the express wishes of the patient, then the Treatment Plan needs to be centred around the duly and appropriately authorised wishes of the family members and next of kin, and not around issues of operational expediency for the service provider.

As previously noted, the current *Burden of Health* reports predict a 34% increase in hospitalisations over the next decade. And the single biggest driver for this increase is a predicted 81.5% increase in hospitalisations due to dementia. What is proposed is a three-tier approach, as described above. It is acknowledged that elements of the above do currently exist. But it is also clearly evident that not all three tiers currently operate. At present, Tier One is largely missing.

The word 'dementia' appears nil times in the ***Support at Home Handbook*** and it appears on 8 occasions in the ***Support at Home Manual***. The 8 times that it appears in the ***Manual*** are all references to funding issues or legacy program issues.

It appears that there are, currently, no specific guidelines around dementia — within the ***Support at Home Manual***. This is despite dementia being identified by the Queensland Government predicting an 81.5% increase in instances of hospitalisation due to dementia.

There is a range of support and guidance advice available online ie relating to dementia, including the following: https://www.dementia.org.au/get-support/home-dementia Such resources are certainly useful, helpful and valuable, especially across Tiers 2 and 3.

But are we simply happy to accept an 81.5% increase in hospitalisations due to dementia? If we don't want to see an overall increase of 34% in hospitalisations, then we have to get serious about significant investments in both Tier One and Tier Two. To do so would be to get serious about the ***National Prevention Investment Framework*** which is currently being proposed by the Productivity Commission.

Key Points

A. Aged Care, Health and Budget Sustainability. Australia's Ageing Population Represents a Rapidly Increasing Burden on the Hospital System. The rate of expenditure increases in the Care Economy is financially unsustainable.

A recent [2025] report from Queensland's Chief Health Officer describes the enormous increase in systemic burden that aged care will place on the Hospital system. [See herein for details]. This is also a key focus at present for the Productivity Commission. At present Government expenditures as a percentage of GDP sit at just over 22 percent, with a forecast for that figure to rise in coming years to 27 percent. The cost of NDIS alone is growing at a staggering 10–12 percent per annum. Since the October 2022–23 Budget, total investment in aged care has increased by 30 per cent. The rate of expenditure increases in the Care Economy is financially unsustainable. Demographics cannot be changed. But patterns of expenditure can be changed. Current patterns of expenditure are hugely inefficient and unproductive.

B. 'Productivity' is a useful Prism Through Which to View These Matters– Collaboration. However, the broader goal surely has to be systems-cohesion and systems-integration between Aged Care and Health. The starting point surely has to be designing an integrated system which meets the needs of the patient journey and/or the lifestyle needs of the elderly.

One of the key dynamics that the Productivity Commission is currently inquiring in to is how to implement collaborative commissioning. Another dynamic being explored is reducing regulatory burdens and compliance and looking at efficiencies and savings through the introduction of certifications which straddle different jurisdictions and different sectors. Whilst these measures are undoubtedly worthwhile, I would like to see the Productivity Commission broaden its scope so as to examine the full gamut of issues relating to systems-cohesion and systems-integration between Aged Care and Hospitals. The starting point surely has to be designing an integrated system which meets the needs of the patient journey and/ or the lifestyle needs of the elderly.

C. 'Productivity' is a useful Prism Through Which to View These Matters-Prevention. We have improved life-expectancy but we have not equally improved quality of life. What we need is more dancing, not more doctors, for the elderly. We need to pivot from 'Lifespan' to 'Healthspan.'

Australia massively under-invests in Prevention. The Productivity Commission has identified three main barriers to increasing investment in Prevention, and has identified what it considers to be a strategy for overcoming those barriers. But as a nation we have a long history of ignoring calls for greater investment in prevention and we seem to be addicted to prioritising and privileging acute medical intervention modalities. Implementation of a ***National Prevention Investment Framework*****,** as currently recommended by the Productivity Commission, might assist us to wean ourselves off our addiction to downstream service delivery.

We are addicted to a metric called 'more hospital beds.' The AMA will always call for newer, bigger and better hospitals. But with an aging population this metric is a bottomless pit, it is hugely expensive and it doesn't address the key issue of 'quality of life'. We need more dancing, not more doctors, for the elderly. We can only realise improvements in both efficiency, and effectiveness, if the elderly dance more often and see doctors less often. We need to pivot from the current 'Lifespan' approach to a future 'Healthspan' approach.

The NDIS System Design Working Group Has Recommended the Employment of Navigators. If we are to actually achieve decreased rates of hospitalization for the elderly, then we cannot simply wish for that. If we are genuinely to pivot away from doctors, and towards dancing, from Lifespan to Healthspan, we need to plan for that. Even with access to ACAT/Support At Home packages, many elderly people don't know how to access support services which can assist them to stay at home and to live quality lives in their later years. It is recognised that the Support At Home program makes financial provision for 'management services.' But, faced with similar challenges, system navigators are being recommended in the NDIS system, with the goal of helping all people with disability and their

families to navigate the NDIS system and to access the right services for their own particular needs https://www.ndisreview.gov.au/resources/fact-sheet/finding-your-way-around-help-navigator. If we are to introduce transformative systemic and structural changes in Aged Care, and if we are to wean ourselves off our addiction to downstream service delivery, we will need 'system navigators' or, more appropriately, Healthspan coaches to assist the elderly to navigate any new systems and processes. In the 'Healthspan' model this goes beyond system navigation and extends to lifestyle and health coaching.

Narrative / Overview

If We Are to Seriously Focus on Quality of Life in the Latter Years, We Need To Pivot Aged Care Away From Doctors and Towards Dancing, From 'Lifespan' to 'Healthspan'.

The new **Home Support Programme** is the third iteration of such a program, with the earlier two iterations being:

- Health Care Homes Program, circa 2016, being a large-scale trial pilot; and
- Home Care Packages Program, running through to 2025.

My mother, Joan Morris, spent at minimum 1000 days lying in a hospital bed over the last 10 years of her life. Her longest single stay was a 5-month continuous stay in hospital. Mum received medical care and treatment of a very high standard, ranging from medical care provided by her GP; medical care provided by a number of specialists, and through to in-home nursing support funded through a Home Care Package. In addition, mum received ancillary home services, once again funded through a Home Care Package.

I started writing to the Commonwealth and State Governments, expressing my concerns about the lack of any effective interface between the Aged Care and Health systems, in 2016. The Commonwealth Minister for Health at the time was the hon Sussan Ley, who is currently the Federal Opposition Leader.

Across the 1000 days that my mum spent lying in a Hospital Bed, and across the last 10 years of her life, at no time throughout any of this was a *Wellness Plan* developed for my mother. I would often rail against specialists, who specialise, and against a system in which no one was driving the train. The overall system was hugely disjointed and unconnected. It was readily apparent that the Health system was principally predicated around sickness, not wellness.

The financial cost to mum's Private Health Insurer was well over $1.0M. This financial cost was just the cost for the Private Hospital cover. This did not include the costs of GP visits; the pharmacy costs; or the costs of nursing care and the ancillary home support provided through her Home Care Package. The Commonwealth's financial contribution to a Level 3 Home Care Package is $41,730 per annum. Thus, the full, global financial cost of my mother's medical care and home support over the last 10 years of her life would have been somewhere north of $1.5M.

Once again:

> At no time throughout any of this was a *Wellness Plan* developed for my mother. I would often rail against specialists, who specialise, and against a system in which no one was driving the train.

The Queensland Government in January 2025 advised as follows:

> Overall, hospitalisations are estimated to increase by 34.0% from 2022–23 to 2032–33. A large component of this is due to increasing population and the increasing age of the population. Results for specific conditions show that from 2022–23 to 2032–33:

- the largest increases (81.5%) will be for dementia followed by Waiting for aged care placement (74.4%) https://www.choreport.health.qld.gov.au/from-the-cho/ageing-and-future-healthcare-demand

Thus, my mother's specific case may well be regarded as being an extreme instance of the hospitalisation of the elderly, but on a broader, systemic level we are going to witness over the next 10 years a massive increase in the hospitalisation of the elderly. And the largest increase, at a staggering 81.5% increase on present levels, will be hospital admissions related to dementia. Meanwhile, hospitalisation rates for other chronic conditions which beset the elderly are actually projected to decrease:

> CHD (20.1% decline) and COPD (40.2% decline) and the group of 7-lifestyle conditions (9.9% decline).

Michael Brennan, former Chair of the Productivity Commission has recently stated as follows:

> addressing the productivity slump in the care economy should be the single most important priority for the government.
> https://www.afr.com/politics/labor-must-lift-care-economy-productivity-says-ex-pc-boss-20250728-p5miey

We have recently witnessed a three day phenomenon called the Productivity Summit. And 15th of September is the closing date for submissions to the Productivity Commission's current Delivering Quality Care More Efficiently Inquiry https://www.pc.gov.au/inquiries/current/quality-care#interim.

So, concepts such as 'productivity', 'efficiency', 'effectiveness' and 'quality care' are central to national discourses which are occurring at present in regards to Aged Care. The incoming **Support at Home Programme** is a significant advancement over, and improvement upon, earlier Aged Care programs. However, the **Support at Home Programme** fails to address some critical Aged Care and productivity elements that are being discussed within Australia at this time. Additionally, the **Support at Home Programme** was not designed to be a broadscale, mass-participation program designed specifically to address these key issues which Australia is currently grappling with. There were approximately 4.2 million people aged 65 and over as of June 30, 2020. And as of March 2024 some 280,000 people had access to a Home Care Package (HCP). Thus, it is clear that a program being delivered to around 300,000 people, out of a population of 4.2 million elderly, is clearly not going to deliver the population health outcomes and the productivity outcomes that the nation is currently striving for. **Support at Home** will be an important policy and program contribution to improving our Aged Care system. It is necessary, but far from sufficient.

I appreciate that my mother's case is an extreme example. But pointing to her case is still valid because, whilst her circumstances may have been extreme, the broader point still remains:

> Overall, hospitalisations are estimated to increase by 34.0% from 2022–23 to 2032–33. A large component of this is due to increasing population and the increasing age of the population.

If hospitalisations are estimated to increase by 34.0% over the next decade, largely due to the increasing age of the population, and largely due to dementia, then the **Support at Home Programme** can only represent one element of an appropriate strategy for mitigating and reducing those increasing rates of hospitalisation.

The Productivity Commission is currently asking as follows:

> ***Information request 3.2***
>
> How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?
> https://www.pc.gov.au/inquiries/current/quality-care/interim

The difficulties are illustrated by this very recent news story from the ABC. Whilst this particular news story is specific to Western Australia, in any given year this same news story, or versions very similar to it, are run not less than ten times across Australia:

> ***WA government defends 'world-class' health system after ramping, hospital concerns***
>
> There are many signs a lot more funding will be required in the future, including from a Health Department report released this week.
>
> The idea of its 'Burden of Disease' analysis is to track changes in not only life expectancy, but also how much of people's lives are lived in good health — meaning their impact on the health system is reduced.
>
> The latest report, which looks at data from 2023, found life expectancy was increasing faster than the proportion of people's lives considered to be lived in good health.
>
> On average, it said women under 64 and men aged under 60 could expect to have a smaller proportion of their remaining life in good health.
>
> It suggests without fundamental changes in the health system, the problems facing patients today will only get worse because of ever-increasing demand.
> https://www.abc.net.au/news/2025-08-17/wa-health-system-under-fire-analysis/105660174

What we see here is the following:

- A State Government defending its Health capital works expenditure
- A State Opposition attacking the Government for its Health expenditure
- The AMA calling for greater investments in to hospitals and for more hospital beds
- And a State Department of Health releasing a report on the Burden of Disease.

As above, in any given year one can identify at least 10 such news stories published in the media. A key theme of this present submission is that things will never improve unless and until Australia lifts its expenditures on preventable health, from the current anaemic level of 2%, and towards an identified ideal of around 5%. Not only will the situation remain bad but, given the projected 34% increase in hospitalisations over the next decade, largely driven by increasing cases of the hospitalisation of the elderly, the situation will get substantially worse. Our current approaches to Aged Care and Aged Health are hugely expensive, they are inefficient, they are ineffective — when viewed from a 'Healthspan' and not a 'Lifespan' perspective, and they are simply unsustainable for the nation. As the ABC noted in this recent news story:

> life expectancy was increasing faster than the proportion of people's lives considered to be lived in good health.

It is particularly telling that the traditional drivers of aged care hospitalisation over the last few decades, such as CHD and COPD, are both forecast to decrease markedly in coming years. Medical conditions such as CHD and COPD are preventable, and thus everything possible should be done to prevent them. But in their acute phases these conditions do require intensive, hospital – based medical care ie expensive interventions provided by specialist doctors and by hospital nursing staff. But CHD and COPD hospitalisations going forward are anticipated to decrease markedly.

The anticipated and projected 34 percent increase in overall hospitalisations over the next decade will be driven largely by enormous increases in hospitalisations due to dementia, and due to the unavailability of aged care homes. If we are to take a preventative health approach to these issues then we have to pivot away from 'Lifespan' and we need to focus instead on 'Healthspan.' 'Quantum of life' needs to be accompanied by 'Quality of life'.

If more than one quarter of the national population will soon be aged over 65, then we need to be investing in upstream early interventions that are provided on a wholesale and broadscale basis ie which are provided to the majority of people over 65. In pursuit of such transformative change, dance teachers will be as important as doctors. Pilates teachers will be as important as physiotherapists. Yes, there will be significant costs, and upstream prevention will be expensive. But the costs of such upstream programs will still be a fraction of the anticipated downstream costs ie the costs associated with the predicted 34% increase in hospitalisations over the next 10 years.

I note that every time that the Productivity Commission speaks of the proposed ***National Prevention Investment Framework*** they also speak of:

> an independent Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding and develops a standardised actuarial model and frameworks for the analysis of prevention programs.
>
> ***Delivering quality care more efficiently Interim report***

Accordingly, the proposed *Prevention Framework Advisory Board* would make rigorous assessments of the merits of any and all proposals relating to upstream prevention in the Aged Health system.

Key References

1. Ageing and future health care demand — Assessing the effects of population ageing on the health of Queenslanders and demand for health care services to 2032. https://www.choreport.health.qld.gov.au/from-the-cho/ageing-and-future-healthcare-demand
2. Labor and the Coalition have pledged billions of dollars towards health this campaign. But what will it mean for you? https://www.abc.net.au/news/2025-04-24/labor-coalition-health-policies-explained-federal-election-2025/105206970
3. Queensland Health Director-General David Rosengren identifies workforce numbers as biggest challenge https://www.abc.net.au/news/2025-01-03/queensland-health-director-general-david-rosengren-on-challenges/104764482
4. Once in a generation aged care reforms https://alp.org.au/news/once-in-a-generation-aged-care-reforms/
5. Finding your way around with help from a navigator https://www.ndisreview.gov.au/resources/fact-sheet/finding-your-way-around-help-navigator
6. The participant journey https://improvements.ndis.gov.au/participants/participant-journey
7. Progress Report Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety 2025 https://www.igac.gov.au/resources/2025-progress-report-implementation-recommendations-royal-commission-aged-care-quality-and-safety

Discussion of the Matters Flagged Above

Nine Years of Advocacy Around the Interface Between the Aged Care and Hospital Systems.

The matters which I write to you about today I have been writing to Commonwealth and State Governments about for many years- since at least April 2016. Over this time I have written a number of times, since April 2016 to the following:

- Hon Sussan Ley, Commonwealth Minister for Health [Liberal]
- Hon Mark Butler, Commonwealth Minister for Health [Labor]
- Hon Anika Wells, Commonwealth Minister for Aged Care [Labor]
- Hon Shannon Fentiman, Queensland Minister for Health [Labor]

On 01 April 2016 I wrote to the then Commonwealth Health Minister, the Hon Sussan Ley, with the subject line of ***'How Does the Health Care Home Initiative Interface With Hospital Services?'*** It is extremely disappointing that nine years later there has been such very little progress towards developing a coherent and integrated interface between hospital health care, in home aged care and the broader suite of aged care services.

The new **Support at Home Program** is a refinement on, and improvement upon, earlier endeavours over the last decade to provide high quality aged care, and to do so in a sustainable manner. However, by way of analogy and comparison, one looks at the stasis and lack of progress in the Mental Health system and one quickly comes to realise that systemic and structural change is exceedingly difficult to achieve. A number of the same factors which lead to structural stasis and policy quagmire in the Mental Health System are also prevalent in the Aged Care and Hospitals system.

Australia, when measured by international standards, performs very poorly when it comes to investing in prevention. We are addicted to costly downstream, clinical interventions whilst failing to support modalities which could serve to provide better life outcomes.

In light of the very significant barriers to change, it would be difficult to be optimistic about the prospects for change going forward. But there is in Australia in 2025 a national discussion at present around productivity. It may be that the current productivity dialogue and discourse is able to lead to meaningful and significant advances in Aged Care and that it may lead to the **Support At Home Program** achieving all, or most, of what it was designed to achieve.

Beyond that, as noted earlier in this present document, the **Support at Home Program** is only accessed by around 300,000 Australians, whereas it will soon be the case that over one quarter of the entire Australian population will be aged over 65. In such a context, we need to develop and implement policy settings and program offerings that assist in providing older Australians with an improved quality of life en– masse. In the face of a projected 34% increase in hospitalisations over the next decade, largely driven by massive increases in dementia hospitalisations and huge inabilities to access aged care facilities, if we are to achieve systemic transformation, and if we are to seriously invest in prevention, we will need to think much more about employing dance teachers. We need to focus less on employing doctors and developing endlessly more hospital beds, all at massive financial costs to the States.

The Growing Costs of the Care Economy, Especially In Regards to the Hospitalisation of Elderly Patients.

Continuing to Prioritise Downstream Hospital Treatment, and Continuing to Neglect Upstream Prevention, Is Simply Unsustainable.

I draw your attention to the January 2025 Report from Queensland Health: Ageing and future health care demand — Assessing the effects of population ageing on the health of Queenslanders and demand for health care services to 2032. https://www.choreport.health.qld.gov.au/from-the-cho/ageing-and-future-healthcare-demand And in this report from Queensland's Chief Health Officer, released in early January this year, I particularly note the following:

> *"Overall, hospitalisations are estimated to increase by 34.0% from 2022–23 to 2032–33. A large component of this is due to increasing population and the increasing age of the population. Results*

for specific conditions show that from 2022–23 to 2032–33:

- the largest increases (81.5%) will be for dementia followed by Waiting for aged care placement (74.4%)
- conditions estimated to decrease over time are CHD (20.1% decline) and COPD (40.2% decline) and the group of 7-lifestyle conditions (9.9% decline).....

If we then broaden this out to consideration of the wider Care Economy, the Productivity Commission tells us as follows:

> The care economy is growing fast, having more than doubled its workforce over the 20 years to 2020 (NSC 2021a). It contributed 8% of Australia's GDP, and an estimated 12% of the workforce in 2022-23 (Commonwealth of Australia 2023a, p. 16). Both shares are expected to grow over the next 40 years (figure 2).

The Productivity Summit ran from 19th of August to 21st of August, and on 20th August Mark Butler, Minister for Health, spoke at the National Press Club. At the outset of the week the ABC ran with this following news story: ***Productivity summit begins with a warning on NDIS spending:***

> The National Disability Insurance Scheme (NDIS) is set to loom large over the summit, with Thursday's session on budget sustainability and tax reform expected to examine its rapidly escalating cost.
>
> That conversation will come a day after Health Minister Mark Butler is expected to make a significant policy announcement aimed at tightening elements of the disability insurance scheme amid reports that 16 per cent of six-year-old boys are now recipients.
>
> Prime Minister Anthony Albanese on Monday flagged the need for reform, citing concerns about its growth trajectory.
>
> "We need to make sure the system's sustainable," he told Sky News.
>
> "The NDIS was never envisaged that 40 per cent of the population would be on it. It's about giving people support who need it."
>
> Currently about 2.8 per cent of the population, or 740,000 Australians, utilise the NDIS.
>
> Mr Albanese added that reforms passed last year to rein in NDIS spending growth to 8 per cent was an "interim target", with that growth rate still well outpacing broader GDP growth.
>
> With annual costs projected to surpass $64 billion by 2029, the NDIS is on track to become the third-most expensive item in the budget, behind only health and aged pensions.
>
> The Coalition has signalled it is open to further savings, with Shadow Treasurer Ted O'Brien saying in July the scheme must be made sustainable.
>
> The NDIS, as well as defence, debt costs, health and aged care, will be among the structural issues up for discussion.
> https://www.abc.net.au/news/2025-08-19/productivity-summit-begins-ndis-spotlight/105668816

In this context it is worth noting the title of the current Productivity Commission Inquiry in to this space ie ***Delivering quality care more efficiently***. What we see in the title to this inquiry are two competing interests:

- Quality Care
- Efficiency.

And whilst the rate of increase in NDIS expenses is the main focus for much of the current discourse and discussion, it is worth noting once again that hospitalisations are projected to increase by 34.0% from 2022–23 to 2032–33, with the two largest cost drivers being:

- the largest increases (81.5%) will be for dementia;
- Waiting for aged care placement (74.4%)

In recent weeks the Premiers of, or Health Ministers of, four states [WA, SA, NSW and Qld] have all called on Canberra to do more in regards to the provision of Aged Care beds in their respective states, as described in this following news article — ***WA Premier to Canberra: "Do better on aged care" as hospitals overflow with older patients***
https://www.theweeklysource.com.au/news-issues/wa-premier-to-canberra-do-better-on-aged-care-as-hospitals-overflow-with-older-patients

As serious, and as properly and appropriately concerning as that is, the dialogue and the discussion is all about downstream service delivery. Whilst Australia remains locked in to discussions about downstream service delivery, and as long as Australia fails to invest appropriately and sufficiently in upstream preventative approaches to Aged Care, then the need for additional hospital beds, or aged care beds, will remain an ever-growing, bottomless pit and will represent a huge burden on the national budget.

A 'Healthspan' Approach to Aging in Australia

Improving Productivity Through Focusing on Prevention ie Prioritising Upstream Approaches Over Downstream Approaches.

There are many historical and structural reasons why the Aged Care and Health Care systems in Australia fail to deliver outcomes for elderly people which enable them to live their lives to the fullest, without having to excessively access expensive, downstream, hospital-based services. A range of Commonwealth and State agencies, including the Productivity Commission, are currently giving consideration as to how to increase the productivity and efficiency of our Care Sector. This focus on the Care Sector is not simply about economic savings. It is also about delivering better life outcomes. Amongst the factors impeding quality outcomes for our elderly is:

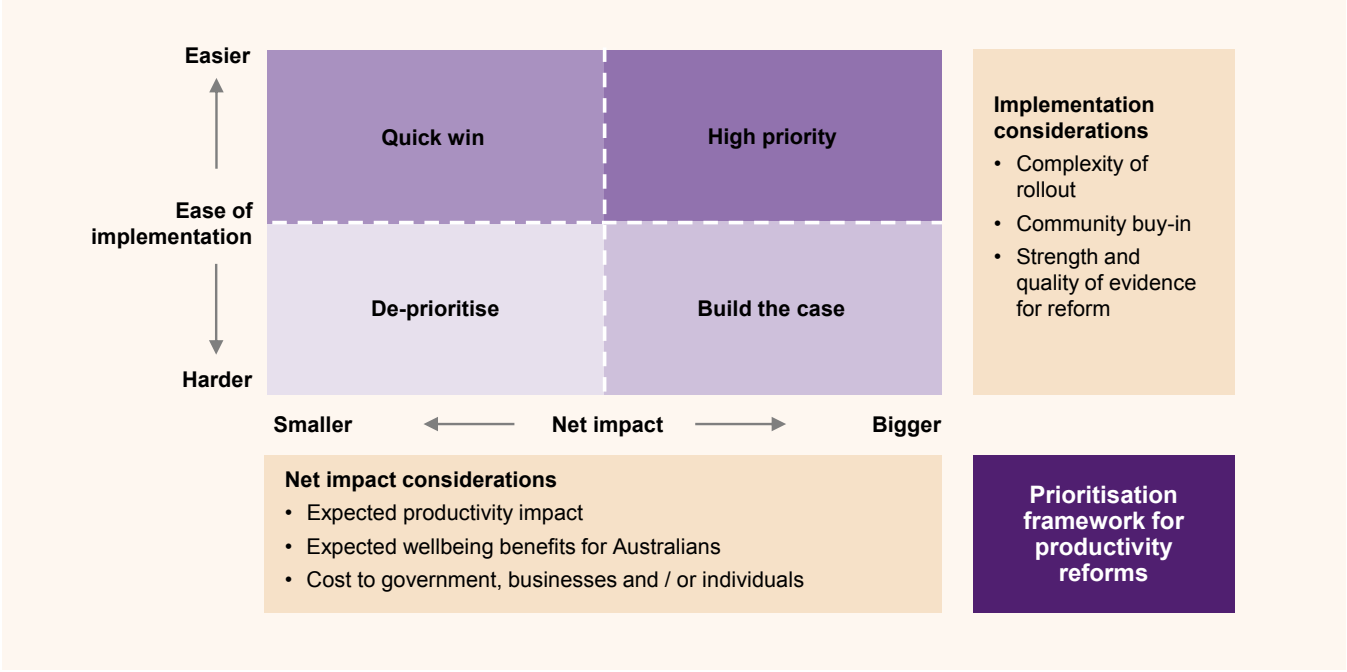
1). our federated system, with different levels of Government having different responsibilities for different aspects of both Health and Aged Care; and

2). our national failure to invest in preventative programs and our addiction to downstream, acute modalities.

As a nation we are addicted to costly downstream, clinical interventions, whilst failing to support modalities which could serve to provide better life outcomes.

There are very few easy fixes. In looking for productivity improvements, and being realistic about what is achievable in the near term and in the medium term, the Productivity Commission presents us with a four-quadrant diagram to assist us to assess where best to focus our efforts:

The PCs Prioritisation Framework



Growth mindset: how to boost Australia's productivity 5 productivity inquiries
https://www.pc.gov.au/inquiries/current/five-productivity-inquiries

If we look at the Productivity Commission's four quadrant diagram, addressing the issues of integrating Aged Care and Health sits not in the top left corner, because it is not a Quick and Easy Win. But these issues do clearly sit within the top right corner of the diagram ie it is, as Michael Brennan puts it, the single most important priority for the Government. As such, even though it is not a Quick Win, it is nonetheless a High Priority — the single highest priority that Government should have at this time.

The introduction of the new **Support At Home Programme**, if done well, will move us forward considerably along the *'Ease of Implementation'* axis in the four-quadrant diagram. Productivity is not merely about saving money. It is also about providing Quality Care. And in the ***Support at Home Programme Manual*** we can see the following features which augur well for an improvement in the quality of care going forward:

The Statement of Rights includes the right for every older person to have:

- independence, autonomy, empowerment and freedom of choice
- equitable access to care
- quality and safe funded aged care services
- respect for privacy and information
- person-centred communication and ability to raise issues without reprisal
- access and support from advocates, significant persons and social connections.

Providers delivering funded aged care services must take all reasonable and proportionate steps to act compatibly with these rights. [Page 21]

The Statement of Principles includes:

- putting older people first
- treating older people as unique individuals
- recognising the rights of participants under the Statement of Rights. [Page 21]

These Rights and these Principles are then enshrined within a new set of **Strengthened Aged Care Quality Standards** and these Standards are represented in the following diagram, as presented on page 25:

On the basis of the documentation that we see in the ***Support at Home Programme Manual*** we have reasonable grounds for having confidence that an enhanced and improved quality of service will be provided to those older Australians who are deemed eligible for assistance under the **Support at Home Program**. However, we can have little, if any, confidence that the new **Support at Home Program** will materially limit or curtail the anticipated 34% increase in anticipated hospitalisations over the next 10 years.

The reason for this is twofold:

- **Small cohort for the Support at Home Program:** In the near future over one quarter of the entire Australian population will be aged over 65, but only around 300,000 Australians have access to the Support at Home Program at any time.
- **The Program Logic for the Support at Home Program Remains Service Focused, Not Truly Person Focused:** The diagram above locates 'the Person' at the centre of the circle. However, in reading over the documentation, I can find patient or client pathways/ journey maps in the NDIS documents and in Mental Health documents, but I cannot find equivalents in the Aged Care and Aged Health documents. The model remains, seemingly, quite static. And real-life experience, as recent as three months ago, shows just how terribly, terribly disjointed and unconnected the Aged Health system remains. What we witnessed firsthand over some months earlier this year was a system in which elements of the same institution were utterly incapable of talking with one another, much less holding out any prospect of engaging meaningfully, in a coordinated and cohesive manner, with outside service providers.

A Proposed Fourth Iteration of Aged Care in Australia — a Healthspan Model Available and Accessible to All Australians Aged 65 years and Older.

In Australia we have successfully managed to increase our average life expectancy, so that it currently sits at 81.1 years for males and 85.1 years for females. But we have had much less success in ensuring ongoing quality of life across these increasing number of 'golden years.' As such, the situation we have now created is a situation in which the elderly have extended lifespans, ie they now live additional years of life, compared with previous generations. But this additional lifespan consists in large part of additional years in which the elderly suffer from a range of chronic diseases–lives in which they frequently oscillate backwards and forwards between stints in hospital and stints at home.

In contrast to the current, less than satisfactory situation, a counter narrative is that of the 'extended Healthspan'. The goal of the 'extended Healthspan' is to create a future in which a 'longer life' is synonymous with a 'better life'. The four pillars of the 'extended Healthspan' are as follows:

Eat:	Having a healthy diet
Move:	Participating in sufficient, age- appropriate physical activity
Sleep:	Receiving sufficient, age- appropriate sleep
Connect:	Maintaining and extending social interactions and not becoming socially isolated.

Critical to this kind of Aged-care service modality is a role known as the 'Healthspan coach', an individual whose responsibility it is to act as a life coach to assist the elderly to make informed and wise decisions about their lifestyles. The goal of such approaches is to give people in Western industrialised countries an additional 10–20 years of high-quality life.

The Science of Aging Well: "A Practical Approach to HealthSpan Medicine"
https://www.youtube.com/watch?v=t5FPJ3P3hao

A new measure of health is revolutionising how we think about ageing
https://www.newscientist.com/article/2489666-a-new-measure-of-health-is-revolutionising-how-we-think-about-ageing/

The introduction of such 'Healthspan coaches' would represent a financial cost. However, the savings to the Hospital system would be enormous. Additionally, I note that funding roles such as 'Healthspan coaches' do not have to be borne solely by the taxpayer. In regards to superannuation, I note this recent comment from Anne Fuchs, General Manager for advocacy and impact, Australian Retirement Trust:

> *"There are millions of Australians around the country that aren't taking up an income stream in retirement, and that's a squandered economic opportunity for the country because it's just tied up in savings – it's just sitting there in an accumulation environment."*

https://www.investmentmagazine.com.au/2025/08/art-pushes-soft-default-for-retirement-ahead-of-productivity-summit/

Superannuation should be contributing to increasing productivity. And whilst taking overseas holidays may be worthwhile and enjoyable, I would suggest that a more urgent and a higher priority would be allocating some of these significant superannuation balances [which largely go unspent in later years] towards funding 'Healthspan models of wellbeing' for all Australians.

If we are to seriously focus on quality of life in the latter years, we need to pivot Aged Care away from doctors and towards dancing; away from mere 'Lifespan' and towards 'Healthspan'. Yes, there are currently 7 identifiable preventable chronic conditions which currently represent an enormous burden on our hospital system. These 7 conditions are Coronary heart disease [CHD], stroke, lung cancer, colorectal cancer, breast cancer, Chronic obstructive pulmonary disease [COPD] and diabetes. And, yes, each of these conditions requires clinical treatment, using the very best available medical science and technology. But the point here is that each of these 7 conditions is – Preventable. If we wean ourselves off our addiction to downstream modalities, and if we start investing seriously in prevention, then we can reduce the financial and lifestyle burdens of the acute phases of these preventable diseases. And future cases of these very same 7 conditions are predicted to fall significantly in future, at the same time as dementia cases see a massive increase.

Introducing a Healthspan approach to Aged Care and Aged Health will be a massive win for elderly Australians. They will live much better lives and they will enjoy a much higher quality of life. But it will also be a massive win for the sustainability of the Health and Aged Care systems. Achieving this transformative systemic change will be anything but easy. However, through the introduction of the incoming **Support At Home Programme** the Government is already taking important steps in the right direction. In this context, the employment of *Aged Care System Navigators* [akin to NDIS Navigators] and/or the employment of *'Lifespan Coaches'* can be viewed as being a near–term objective that could be truly classified as both a Quick Win and a High Priority on the Productivity Commission's four-quadrant productivity diagram.

'Productivity' is a useful Prism Through Which to View Prevention in the Aged Care and Aged Health Systems

Upstream Prevention and A Strong Focus on Quality of Life, Not Just Extending Life

Australia, when measured by international standards, performs very poorly when it comes to investing in prevention. The Productivity Commission is recommending three courses of action, these being:

- reform quality and safety regulation to support a more cohesive care economy
- embed collaborative commissioning to create more integrated care services
- establish a national framework to support investment in prevention.
  https://www.pc.gov.au/inquiries/current/quality-care/interim

All three recommended courses of action have considerable merit. But as important and as worthwhile as the first two are, unless and until we fix our problem with significant under–investment in prevention, then the Aged Care and Hospital systems will remain under considerable sustainability pressures. And older Australians won't receive the support-at home — that they both want and they deserve.

The Productivity Commission identifies three main barriers to investment in prevention:

- Misalignment between who benefits and who funds prevention
- Short-term thinking
- Limited evaluations

Delivering quality care more efficiently Interim report

In response to Australia's chronic under- investment in prevention, the Productivity Commission is currently recommending the development of a ***National Framework to Support Government Investment in Prevention***. On page 70 of the ***Delivering quality care more efficiently Interim report*** one finds the following:

Information Request 3.2:

How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board?

Should alternative approaches be considered for governance of the framework, including institutional setting, processes for arriving at co-funding arrangements, decisions and evidence requirements? What considerations would ensure that the framework works together with existing prevention programs funded by states and territories? How can the framework encourage governments to keep supporting existing effective prevention programs?

And this is really the crux of the matter. As the Productivity Commission notes a few pages earlier in its ***Interim Report:***

"Governments are under constant financial pressure, and securing new funding for prevention may be a challenge".

So, Governments can indeed **"remain mindful of the high value of prevention investment"** but when the Australian Medical Association is calling for funding for more hospital beds, who is going to say no to them? And, consequently, inevitably, we remain stuck at spending 2% on Prevention. And then in 5 or 10 years' time we will need yet more hospital beds, and the result is a self–perpetuating, never-ending and ever-growing need for more, and more, and still more hospital beds.

Australia massively under- invests in Prevention. The Productivity Commission has identified three main barriers to increasing investment in Prevention and has identified what it considers to be a strategy for overcoming those barriers. But as a nation we have a long history of prioritising and privileging acute medical intervention modalities. It will be exceedingly difficult for us as a nation to kick our habit and change our behaviours.

A recent article on quality aging identifies four key factors in later life, these being:

Grow: They continue to expand and explore.

Connect: They put time into new and existing relationships.

Adapt: They adjust to changing and challenging situations.

Give: They share themselves.

https://www.theguardian.com/commentisfree/ng-interactive/2025/jul/18/best-ageing-advice-expert-tips

The same article, dated 19th July 2025 describes the shift from Lifespan to Healthspan as follows:

When it comes to longevity, the primary focus has been lifespan, the length of life. More recently though, the scope has expanded beyond years of life to years of life in good health, or healthspan. This is a welcome shift, because we all want to live as healthily as possible for as long as possible. But there's a catch. A long life, even a long life in good health, doesn't mean much if you don't like your life. As geriatrician Dr Louise Aronson observes: "We've added a couple of decades, essentially an entire generation, on to our lives, and we haven't figured out how to handle that."

To thrive in old age means to live a fulfilling, purposeful and satisfying life despite the challenges that accompany ageing. It involves maximizing physical health, cognitive function, emotional wellbeing, social connections, and a sense of meaning. Thriving doesn't mean being free of all health problems or challenges; rather, it emphasizes resilience, adaptability and the ability to find joy and value in life. People don't thrive in longevity by mistake or luck. People who thrive in longevity actively maximize the quality of their lives.

A significant element of the Productivity Summit relates to the contribution that technology can make to driving the nation's Productivity Agenda. What I am advocating here is an approach to Aged Care that is focused on a client's journey or map. Using traditional/ current technologies and medical approaches, this would entail older Australians trudging off to a dozen or more trips to GPs, specialists, pathology laps and chemists. And on top of those costs I am advocating for the employment of case managers/navigators/health coaches. The whole thing could be hugely labour–intensive, and hideously expensive.

Except, it need not be hugely labour–intensive, and it need to be hideously expensive. Quite the opposite. The Productivity Commission's current Harnessing data and digital technology Interim report

https://www.pc.gov.au/inquiries/current/data-digital/interim

includes the following:

> **Draft recommendation 2.1 Establish lower-cost and more flexible regulatory pathways to expand basic data access for individuals and businesses**
>
> The Australian Government should support new pathways to allow individuals and businesses to access and share data that relates to them. These regulatory pathways will differ by sector recognising that the benefits (and the implementation costs) from data access and sharing are different by sector. This could include approaches such as:
>
> - industry-led data access codes that support basic use cases by enabling consumers to export relatively non-sensitive data on a periodic (snapshot) basis
> - standardised data transfers with government helping to formalise minimum technical standards to support use cases requiring high-frequency data transfers and interoperability.

We live in a world where we either currently have, or in the very near future [ie September 2025] will have, the veritable "lab on your wrist." This article puts things thus:

> The data-driven, preventive-care approach to healthspan is getting a big boost from the availability of sophisticated wearable devices capable of continuously measuring a wide array of biological and behavioral details. That includes heart-rate variability, respiration rate, blood oxygen saturation, body temperature, stress levels, sleep stages, energy expenditure, and much more. Devices that continuously monitor blood-sugar levels are particularly helpful. "People can see in real time what's happening in their blood an hour after eating garlic bread or ice cream," Kaeberlein says. "It helps them adopt much healthier diets."
>
> The data from wearables can typically be uploaded to a patient's clinical care team, so that it can be added to lab data and medical history to provide a clearer picture of what might need tweaking for maximum healthspan benefits. "We know how to interpret this data to optimize personal health," says Kaeberlein. https://www.scientificamerican.com/custom-media/google-cloud/the-healthspan-paradigm/

All of the research says the same thing ie there are four critical elements in preventable Aged Care Health. These four elements are:

- Diet
- Sleep
- Exercise
- Socialisation, family, community and connection.

All four of these elements can be in large part accurately measured via a smartwatch and that same device can increasingly provide information around additional biomarkers. This includes Blood Pressure [as of September 2025] and in the very near future blood analysis.

Conclusion

If we are genuinely serious about productivity, then we need to get serious about prevention. And if we are to get serious about prevention then we need to develop Patient Health Maps for each and every Australian over the age of 65. The Productivity Commission is urging us to embrace technology so as to lift productivity. The Productivity Commission is urging us to lift investments in to evidence-based preventative strategies. The Productivity Commission is urging us to lift productivity in the Care Economy. And we are currently faced with a projected 34 percent increase in hospitalisations, driven by massive increases in dementia cases and elderly people awaiting access to aged care facilities. We cannot continue with hugely unproductive, and massively expensive, downstream approaches to Aged Care and Aged Health. We need to undertake transformative systemic change. We need to shift from a Lifespan model of aging to a Healthspan model of aging.

Appendix: Extracts from the *Progress Report Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety 2025*

Media Release 04 September 2025

More Action Needed to Deliver Transformational Aged Care Reform

'There has been furious activity to make progress, but reforms have largely addressed isolated issues rather than driving the systemic change required.
There is no doubt that the new aged care law largely promises the Royal Commission's vision. But the community is still waiting on the actions needed to make this more than just a vision.
https://www.igac.gov.au/collections/2025-progress-report-inspector-general-aged-care#media-release

Progress Report Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety 2025

https://www.igac.gov.au/resources/2025-progress-report-implementation-recommendations-royal-commission-aged-care-quality-and-safety

Supporting different backgrounds and life experiences

The Royal Commission envisaged an aged care system where diversity is embraced, care is individualised, and peoples' diverse backgrounds and life experiences are welcomed and accommodated. People approaching the aged care system may have had a largely happy and comfortable life, but equally they could have had lives characterised by trauma, prejudice or expectations of exclusion. From the very first contact, the aged care system needs to be welcoming and accessible for all. Care needs to be trauma-aware and healing focused. It also needs to be culturally sensitive, for both Aboriginal and Torres Strait Islander people and people from diverse cultural backgrounds. The Royal Commission called for mandatory training in culturally sensitive, trauma-informed care. This should have been included in the Act: a requirement for 'regular competency-based training' in the Quality Standards is not the equivalent. 44 | 2025 Progress Report The department should participate in genuine co-design with people from diverse backgrounds to support the development of care models and environments that cater for a true breadth of needs.
[Pages 44, 45]

Improving health and aged care services

Care service interface

Stakeholders are increasingly calling for the introduction of a case management approach to help people move fluidly between health, hospital and aged care systems. Greater access to personalised support that helps older people navigate the complexities and transition points in these systems is urgently needed. Such support would be a significant stride towards delivering the transformation that the Royal Commission sought in this dimension of care. In the short term, as mentioned above, the department should determine the feasibility of reversing the cap on care management fees. Care managers assist people to navigate the complexities of moving between health systems, hospitals and aged care. Beyond this, the department should pursue options for delivering greater face-to-face support for older people who are navigating complex care arrangements across the aged care and other health and hospital settings. In that context, the department should commission a cost-benefit analysis to determine whether funding a case management program could save the Australian Government money when looking at aged care and health system funding combined.
[Page 48]