

OUR POSITION

Hospital exit block: a care economy challenge requiring coordinated transition reform

BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 80 hospitals in each Australian state and in the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care. CHA Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care services. This includes 350 aged care facilities and 53,000 older Australians cared for in their home.

CHA not-for-profit health, community and aged care providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members. A more in-depth analysis of our policy positions is available through our [government submissions](#).

POSITION

Hospital exit block — where people who no longer need acute hospital care are unable to leave hospital due to a lack of suitable downstream supports — is now a system-wide threat to hospital capacity, quality and safety. It is also a symptom of a wider care economy under strain: hospitals, aged care, disability supports and housing operate as interdependent systems, but are funded, governed and held accountable in isolation. Reform must therefore be system-wide, not hospital-bound.

These people who are medically ready for discharge occupy thousands of acute hospital beds each day while they wait for one or more of the following: residential aged care placements or appropriate home care packages; National Disability Insurance Scheme (NDIS)-funded housing and supports; short-term

transitional accommodation and step-down services; and/or home-based, community or social supports (including housing) adequate to support safe discharge.

This problem reduces inpatient capacity and drives ED overcrowding and ambulance ramping; delays elective and emergency surgery, and access to preventative care measures in appropriate care settings; and exposes these people to avoidable functional decline, hospital-acquired complications and poorer quality of life. It also displaces people from the care setting most appropriate to their needs and preferences, which is a fundamental challenge to person-centred care.

CHA urges the Australian Government to commit to a national reform package built on the following:

- Embed dedicated, cross-system discharge and transition coordination roles in hospitals, aged care, NDIS and housing, with clear authority to drive early discharge planning and match patients to the most appropriate care setting.
- Invest in time-limited, clinically appropriate transition accommodation and step-down care for patients, participants and residents awaiting permanent supports.
- Align incentives and accountability by embedding hospital transition measures into the next National Health Reform Agreement (NHRA), with shared Commonwealth–state responsibility and clear performance expectations across portfolios, including consideration of financial mechanisms that reward timely, safe transitions rather than penalising hospitals for system-wide capacity shortfalls.
- Improve data, transparency and system interoperability to make exit block visible and enable real-time, cross-system decision-making.
- Scale upstream and downstream care economy solutions, including integrated Support at Home and Hospital-in-the-Home models, Residential In-Reach, and building on the Accommodation Supplement uplift delivered in the 2026–27 Budget to create the downstream capacity needed for safe, timely discharge and to prevent avoidable hospital admissions in the first place.

What is hospital exit block and why does it matter?

Hospital exit block describes situations where older people, people with a disability, and others remain in hospital after they have been clinically assessed as "ready for discharge" due to a lack of appropriate downstream supports, or where these supports have been delayed or poorly coordinated.

Internationally, this is also referred to as "delayed transfer of care" (DTC) or "delayed discharge"; in Australia, the AMA's 2023 framing of "exit block" has become the accepted sector term.

Key drivers include:

- **Insufficient aged care and disability capacity:** limited availability of residential aged care places (with 10 aged care homes closing in 2024 and occupancy exceeding 90% in those remaining), constrained access to Support at Home packages at the appropriate level, and delays in securing NDIS-funded housing and supports all contribute to prolonged hospital stays.
- **Fragmented responsibilities:** hospitals are funded and managed by states and territories, while aged care and the NDIS are primarily Commonwealth responsibilities. This division creates blurred accountability at the point of discharge and weakens incentives for coordinated solutions. No single portfolio is accountable for the patient's transition itself, only for the system they are leaving or entering.
- **Slow assessment and approval processes:** aged care assessments under the Single Assessment System and NDIS planning processes can be complex and time-consuming, particularly for people with high or complex needs, specialised equipment requirements, or housing modifications.
- **Lack of transition options:** where transitional accommodation or step-down services exist, they are often limited in scale, narrowly targeted, or funded as short-term pilots rather than sustainable programs. State-led innovations such as South Australia's "bridging ward" at Hampstead Rehabilitation Centre and the repurposed Pullman Adelaide hotel illustrate both the urgency and the ad hoc nature of current responses.
- **Workforce and coordination challenges:** many hospitals do not have dedicated discharge staff with sufficient authority, time and cross-system relationships to resolve complex barriers spanning health, aged care, disability and housing systems.
- **Housing and social determinants:** for some patients, particularly those experiencing homelessness or precarious housing, there is simply no safe environment to return to without coordinated and sustained support.
- **Cognitive and behavioural complexity:** older people living with dementia, and particularly those experiencing behavioural and psychological symptoms of dementia (BPSD), face additional barriers to placement, contributing disproportionately to long-stay cohorts.

Hospital exit block has significant consequences:

- **Reduced hospital capacity:** beds occupied by patients who no longer need acute care cannot be used for emergency or elective admissions. In some hospitals, stranded aged-care and disability patients occupy up to one in ten beds.
- **Emergency department overcrowding and ambulance ramping:** bed block in inpatient wards slows admissions from emergency departments, leading to extended waiting times and ramping.

Continued overleaf.

What is hospital exit block and why does it matter? (cont.)

- Delays to elective and urgent surgery: when beds are unavailable for post-operative care, surgery is postponed, worsening backlogs and increasing clinical risk.
- Poorer patient outcomes: prolonged hospital stays are associated with deconditioning, hospital-acquired complications, cognitive decline and psychological distress, particularly for older people and people with disability.
- High system costs: acute hospital care is one of the most expensive forms of support. Estimates suggest that delayed discharges associated with aged care and disability supports cost public hospitals hundreds of millions, and potentially billions, of dollars annually — the AMA estimates the total cost of exit block at approximately \$2 billion per year.
- Misallocation of effort across the care economy: when hospitals absorb demand that should be met by aged care, disability or social supports, the resulting cost displacement obscures the true scale of investment needed in those downstream systems, perpetuating the cycle.

When people who are medically ready to leave hospital remain in acute care due to system fragmentation, it highlights the need for better coordination across health, aged care and disability services, and a whole-of-government view of the care economy as an interdependent system.

How big is the problem?

There is no single national data set that captures the full scale of hospital exit block across aged care, disability and social supports. However, available data indicates that the burden on hospitals is substantial and increasing.

People waiting for aged care placements account for the largest share of exit block. In 2023–24, an estimated **460,122 hospital patient days were attributed to people waiting for residential aged care despite being medically ready for discharge**. This represents a significant increase compared with earlier years (Figure 1).¹

Using estimated hospital bed-day costs,² the 2023–24 aged care waiting cohort alone is estimated to cost **between \$828 million and \$1.61 billion annually** in acute hospital resources.

Figure 1: Hospital patient days used by those eligible and waiting for residential aged care, 2017–18 to 2023–24³



How big is the problem? (cont.)

Exit block related to disability supports also contributes to hospital pressure. However, unlike aged care, there is no national reporting of hospital patient days attributed to people waiting for disability services after they are medically ready for discharge. Current reporting focuses on the number of patients awaiting discharge and the average waiting time for supports to be arranged, rather than the total hospital bed days involved.

The latest available data (31 March 2024) suggests approximately 1,125 NDIS-eligible patients are medically ready for discharge but remain in hospital,⁴ waiting an average of around 22 days for appropriate disability housing or support arrangements to be put in place.⁵ Based on these figures, this equates to approximately 24,750 hospital patient days, at an estimated cost of \$44.6 million to \$86.6 million each year.⁶

While this provides an indicative estimate of the scale of the issue, the absence of consistent national reporting on disability-related discharge delays means the full impact of exit block associated with NDIS supports is likely to be under-recognised. In addition, the lag in aged care reporting, differences in how jurisdictions record discharge delays, and the exclusion of patients waiting for other downstream supports — such as home care packages, supported disability accommodation under development, rehabilitation or step-down services, and appropriate housing — mean that available figures are likely to underestimate the true scale of the problem across Australia's care economy.

What has already been done, and what can we learn from it?

The NDIS hospital discharge operational plan

In June 2022, the former Minister for the NDIS Bill Shorten announced an operational agreement between the Commonwealth and state and territory governments to improve discharge for NDIS participants. Key components included:

- increasing the number of dedicated Hospital Liaison Officers (HLOs) and special discharge planners working with hospitals
- streamlining delegations so staff could approve higher-value plans more quickly
- commitments for the National Disability Insurance Agency (NDIA) to contact participants within four days of hospital notification
- a target to have a discharge plan approved within 30 days
- enhanced monitoring and reporting on discharge timeliness.

Within months of implementation, the average time NDIS-eligible patients spent waiting in hospital fell markedly, with the operational plan estimated to have saved the health system between \$205 million and \$548.8 million since implementation. Modelling by the AMA suggests that if the plan continues to reduce waiting days to zero, annual savings could range \$495 million to \$1.32 billion. When contrasted against program costs of \$5.3 – 6.6 million, this represents a return on investment of between 30:1 and over 100:1, demonstrating the strongest evidence available on the value of intentionally coordinated, cross-system reform.

What has already been done, and what can we learn from it?

State transition and step-down programs

Several state-based models provide further evidence:

- Victoria's Pathways to Home, a \$39 million program that supports patients with disability to leave hospital once medically fit and move to home or home-like accommodation while longer-term NDIS arrangements are finalised. A successful Melbourne metropolitan pilot freed up more than 3,000 hospital bed days before the program was expanded into regional Victoria. It has been promoted as a key response to bed block and has demonstrably freed up hospital bed days.
- Western Australian transition initiatives, including "From Hospital 2 Home" and similar programs, provide time-limited accommodation and support for NDIS-eligible patients awaiting permanent housing and supports, facilitating earlier discharge.
- The national Transition Care Program (TCP), now reformed and integrated under the Support at Home program as TACPAS, provides up to 12 weeks of short-term support for older people after a hospital stay, aiming to restore function and prevent premature entry into residential aged care. Evaluation evidence shows TCP can reduce length of stay and support returns home, although study designs vary.
- HammondCare's Hospital to Aged Care Dementia Specialist Program (HACDSP), delivered through Dementia Support Australia, supports older people living with dementia — a cohort with particularly complex transition needs — to move from hospital into appropriate aged care. Recent evaluation indicates patients spend an average of 92 days from hospital admission to aged care placement, with only 3 per cent returning to hospital due to placement failure. The program also provides three months of post-discharge follow-up.
- The national Care Finder Program provides intensive face-to-face navigation support for vulnerable older people accessing My Aged Care, helping prevent the disconnection from community supports that often leads to avoidable hospital presentations and delayed discharge. Evaluation findings showed promising short-term outcomes, though growing client complexity and limited downstream service availability constrain its impact on the sector.

In the research literature, multicomponent interventions that combine early discharge planning, patient and carer education, and coordinated follow-up have been shown to improve transitions and reduce potentially preventable readmissions among older adults. International evidence — particularly from England's "Discharge to Assess" model and from reablement programs — also suggests that assessing long-term care needs in a non-acute environment leads to better placement decisions, lower rates of premature entry to residential care, and reduced functional decline. The UK's experience with financial reimbursement mechanisms between health and social care systems (which reduced delayed bed-days by 22 per cent between 2017 and 2020) is also instructive for Australian incentive design.

These initiatives show what is possible, but remain fragmented in their implementation, uneven in coverage and frequently time-limited due to funding constraints.

What has already been done, and what can we learn from it? (cont.)

What is the solution?

Residential-In-Reach: preventing avoidable admissions

Residential In-Reach (RIR) programs send hospital-based clinical teams into aged care homes to treat aged care residents on-site, preventing avoidable admissions of older people who are disproportionately represented among long-stay patients. Queensland's "Hospital in the Nursing Home" program, for example, reduced ED presentations by 22 per cent and hospital admissions by 38 per cent from participating residential aged care facilities.

Outcomes from Victoria's RIR programs and equivalent programs in other jurisdictions are comparable: effective, evaluated models exist but remain state-branded, state-funded and unevenly available. Emerging research is now also examining the application of RIR in rural and regional settings, where evidence has historically been limited.

This points to a broader lesson: recognising prevention as a critical part of the older person's care journey, and embedding it upstream as part of an integrated care economy approach, is essential to addressing exit block, not just managing it once it occurs. The policy question is no longer whether these models work, but why they have not been scaled nationally.

CHA advocates for a national reform package to address exit block that builds on these lessons and is grounded in the mission and values of Catholic health care. This package is deliberately cross-system in scope: it recognises that hospital flow cannot be restored through hospital-only interventions, and that the care economy must be reformed as an interconnected whole.

Embed dedicated, cross-system discharge coordination roles in relevant care settings

Establish a national network of cross-system discharge coordination roles in relevant care settings, including hospitals, aged care, NDIS, and housing, who have clear authority to:

- commence discharge planning early in the admission process (particularly within the hospital context)
- coordinate assessments and approvals across aged care, the NDIS and housing
- actively problem-solve complex cross-system barriers
- ensure patients are matched to the most appropriate care setting (not defaulting to residential care where home-based supports are viable or aligned with patient need)
- monitor time from "ready for discharge" to actual discharge, leveraging insights from predictive analytics tools (i.e., the Adelaide Score) to support faster actual discharge.⁷

CHA modelling suggests that implementing 150 liaison officers and 150 discharge planners across relevant care settings nationally would cost around \$124 million over the forward estimates, with roles indexed to reflect growth in hospital activity and wages.⁸

Invest in transition accommodation and step-down care

Develop a national pool of transition accommodation beds, for example, around 600 beds operating at high occupancy across the country, to provide short-term, non-acute step-down care for patients awaiting permanent supports.

Continued overleaf.

What is the solution? (cont.)

These services should:

- be time-limited, clinically appropriate and embedded in clear pathways to aged care, disability or community supports
- include wraparound services such as case management, allied health, transport, and support for complex needs
- be designed in partnership with consumers, carers and providers to avoid institutionalisation and respect dignity
- be available in rural and regional locations, not concentrated in metropolitan centres, to ensure equity of access.

CHA estimates the cost of national transition accommodation capacity at approximately \$429.7 million over the forward estimates, including an uplift to cover program infrastructure and wraparound supports.

Embed hospital transition measures in the next NHRA

To overcome siloed responsibilities, CHA proposes that hospital transition reforms be incorporated into the next National Health Reform Agreement. This would:

- establish shared Commonwealth–state accountability for timely and safe transitions
- align hospital funding with downstream aged care, disability and housing capacity
- support nationally consistent performance indicators, such as avoidable bed days, time from “ready for discharge” to discharge, and readmission rates
- reduce the need for new regulatory structures by using existing NHRA governance mechanisms.
- explore the design of carefully calibrated financial mechanisms, informed by international evidence, that incentivise downstream systems to absorb demand promptly, while avoiding the perverse incentive of unsafe early discharge.

Improve data, transparency and evaluation

A national minimum data set on exit block should be developed, including:

- the number of people medically ready for discharge but awaiting aged care, disability or housing supports
- associated bed days and costs
- patient characteristics, including age, disability, dementia status, housing status and rural/remote location.

Improved interoperability between hospital systems, My Health Record, My Aged Care and NDIS information systems is essential to equip cross-system discharge coordinators with accurate, real-time information and enable timely decisions for people who are medically ready for discharge but awaiting downstream supports.

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What is the solution? (cont.)

Scale aged care solutions that create downstream capacity

Exit block cannot be resolved by acting on hospitals alone as it is fundamentally a care economy problem. The largest gains will come from scaling proven aged care and community-based models that both create discharge capacity downstream and prevent avoidable admissions upstream. Three reforms that should be considered are:

- Accelerating the expansion of Support at Home packages. CHA has called for 60,000 additional packages annually to clear the wait list and prevent 200,000 older Australians being left without care by mid-2027. The 2026–27 Budget's commitment to an additional 40,000 packages is a welcome start but falls short of what is required to materially reduce exit block driven by older Australians waiting for home-based care.
- Piloting integrated Support at Home and Hospital-in-the-Home (HITH) models, beginning with HITH delivery in residential aged care using an approach similar to Residential In-Reach. Building on the strengths of the reformed Transition Care Program (TACPAS) under the Support at Home program, this would create faster, clinically appropriate discharge pathways and reduce avoidable admissions and readmissions.
- Building on the Accommodation Supplement uplift delivered in the 2026–27 Budget (\$1.1bn) to ensure ongoing, targeted support for services most exposed to structural underfunding. While CHA welcomes the Government's response to our call for this uplift, broader pricing reform remains essential to incentivise construction of new aged care beds at the scale needed and to stabilise services at greatest risk of closure. The Commonwealth's commitment to incentivising construction of up to 5,000 aged care beds per year from 2029 must be brought forward where possible, given that current bed shortages are already driving exit block today.

What must be considered in implementing public-private and cross-system solutions?

CHA members provide public and private hospital services, aged care and community supports. Any reform must:

- Ensure person-centred care: discharge and transition arrangements must be clinically appropriate, culturally safe and consistent with patient and family preferences. The most appropriate care setting, not the most available one, must drive decisions.
- Avoid simply shifting the problem: transition accommodation must not become a long-term holding arrangement; it must be tightly linked to permanent supports with clear time limits and accountability mechanisms in place to safeguard continuity of care.
- Preserve clinical expertise in assessments: aged care and disability assessments for complex patients should retain strong involvement from hospital clinicians to prevent fragmentation of care.
- Address equity and access: reforms must consider the needs of people in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people living with dementia, and communities with limited local aged care or disability providers.
- Monitor unintended consequences: including readmission rates, prolonged transition stays, premature entry into residential aged care from hospital, and substitution of health funding for gaps elsewhere in the system.

References

¹Australian Government Productivity Commission. *Report on Government Services 2026 – 14 Aged care services*. Retrieved 09/03/20256 from: <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/aged-care-services/>

² Estimated hospital bed-day costs were derived using data from the Independent Health and Aged Care Pricing Authority (IHACPA) National Hospital Cost Data Collection (NHCDC) Public Hospitals Report (retrieved 09/03/2026 from: <https://www.ihacpa.gov.au/health-care/costing/national-hospital-cost-data-collection/national-hospital-cost-data-collection-public-sector/>). The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) category maintenance care (non-acute care) was used as a proxy for patients who remain in hospital despite no longer requiring acute treatment, including those waiting for aged care or disability services. The NHCDC reports average cost per separation and average length of stay for each maintenance care class. An estimated cost per hospital bed-day was calculated by dividing the average cost per separation by the average length of stay for each class. The minimum and maximum values across relevant maintenance care classes were used to derive an indicative national range. Based on the most recent NHCDC data, the estimated cost of a hospital bed-day for patients awaiting aged care or disability services is approximately \$1,800–\$3,500 per day (2022–23 dollars). This range was applied to the total number of patient-days attributed to delayed discharge to estimate associated hospital system costs.

³ Australian Government Productivity Commission. *Report on Government Services 2026 – 14 Aged care services*. Retrieved 09/03/20256 from: <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/aged-care-services/>

⁴ Lyons K. (2025, October 30). *I'm being punished: Emily is health enough to leave hospital but her NDIS plan isn't enough to support her at home*. Retrieved 09/03/2026 from: <https://www.theguardian.com/australia-news/2025/oct/29/ndis-funding-cuts-leave-disabled-australians-stuck-in-hospital>

⁵ Australian Government Productivity Commission. *Report on Government Services 2026 – 15 Services for people with disability*. Retrieved 09/03/20256 from: <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/services-for-people-with-disability/>

⁶ Estimated using the methodology in Reference 2.

⁷ Koor et al. (2025). The Adelaide Score: prospective implementation of an artificial intelligence system to improve hospital and cost efficiency. *ANZ Journey of Surgery*. Retrieved 19/05/2026 from: <https://onlinelibrary.wiley.com/doi/full/10.1111/ans.19383?msocid=0924a545f7e5602f1cdfb3f0f6e86143>

⁸Base salaries were assumed to be \$115,272 per annum for HLOs and \$83,031 per annum for HDPs, reflecting current public-sector salary ranges.