Parliamentary Roundtable on Delayed Discharge

Thursday 2 July 2026
9:30am – 12:00pm AEST
Parliament House, Canberra

WHERE TO FROM HERE

The conversations in the room are not intended to end on these pages. What follows captures what we heard, where it's headed, and how we intend to carry it forward.

But first, our heartfelt thanks. Bringing together expertise from right across the care economy, inclusive of health, aged care, disability and housing, in one room can be a challenge but it matters. Too often these parts of the system are funded and run separately, and it is people who get caught in the gaps between them. Having so many perspectives in the same conversation, at the same time, is exactly the kind of connection we are calling for across the care economy. Your willingness to share your insights and lived experience is what gives this work its weight.

Insights to inform policy development on the care economy

Delayed discharge (also known as exit block) is not a hospital problem, an aged care problem or a housing problem in isolation: it's a care economy problem, and it needs a system-wide answer. The themes that follow form part of the evidence base CHA will continue to draw on as we advocate to government for a less fragmented, more person-centred and values-based care system – one where people no longer pay for the gaps in lost time, lost health and lost dignity.

These insights will also feed into how we develop future policy submissions on related matters impacting the care economy, including but not limited to workforce, health and aged care policy. They will underpin our positions on the broader integration of the care economy and adjacent sectors shaping the social determinants of health, particularly across health, aged care, disability and housing, because these issues cannot be fixed in isolation which was a point that came through strongly in the discussion.

We will advance our mission of ensuring the voices of the marginalised and vulnerable are recognised and heard through our policy and advocacy.

The best policy starts with the voices of the people living it, and we invite you to join us in shaping a better care economy: one that delivers the right care, in the right place, at the right time.

Carrying this momentum forward

To turn these conversations into genuine, cross-sector collaboration, CHA is proposing to lead a formal brief to be tabled at the Health Ministers' Meeting, focused on creating shared accountability across the care economy, informed by the themes raised on the day.

Alongside this, CHA will establish a policy working group to identify and clarify the specific short, medium and long-term actions needed to address delayed discharge. The group's task will be to translate both the outcomes of this discussion and further findings into a strategic roadmap for implementation with the aim of turning collective insight into shared accountability.

Timeline

Indicative next steps are:

- discussion themes finalised and shared back with participants;
- convene a care economy policy working group to action next steps; and
- commence drafting formal brief to the Health Ministers' Meeting.

We're committing to closing the loop and not just opening it. You'll hear from us throughout the next month with an update on where the above actions are at and how you can engage with the process.

The following pages will outline what we heard from you – the themes, priorities, and tensions that emerged, including where views differed. The positions drawn from them remain our own and have been offered as a way forward rather than a settled consensus.

Agenda	
Time	**Topic**
09:28	*Introduction & housekeeping* Led by HESTA
09:30	*Welcome and opening* Led by CHA, with opening remarks from the Hon Sam Rae MP
09:40	*Overview of key issues* Led by Dr Mike Freelander
09:50	*Facilitated discussion* Led by HESTA
10:30	*Plenary discussion* Led by Celia Street, Department of Health, Disability and Ageing and Elizabeth Wood, NSW Ministry of Health
11:15	*Wrap-up and next steps* Led by CHA
11:25	*Morning tea*

BACKGROUND

On Thursday 2 July 2026, Catholic Health Australia (CHA) convened a Parliamentary Roundtable on delayed discharge at Parliament House, Canberra.

Delayed discharge, also referred to as bed block or hospital exit block, describes situations where patients who are clinically ready to leave hospital remain in acute care because the downstream supports they need are unavailable, delayed, or poorly coordinated.

The scale of the issue is well documented. In 2023-24, an estimated 460,122 hospital patient days were used by people medically ready for discharge but waiting for residential aged care, at an associated cost of $828 million to $1.61 billion a year.

That figure has grown 60 per cent in three years. Between 8 and 10 per cent of public hospital bed days nationally are now occupied by patients awaiting discharge. Patients awaiting discharge in acute beds generate only 58 to 64 per cent of the activity of a typical acute bed day, representing a significant and growing inefficiency in the system.

The discussion was structured through small-group table sessions organised around three zones of the care pathway (upstream prevention, intersection and coordination, and downstream capacity). This was followed by a plenary discussion, before closing with participant polling.

Participants emphasised that there is no single solution to delayed discharge. Instead, the discussion surfaced a range of short-, medium-, and longer-term options across prevention, coordination, and capacity. This reflects the complex and multi-faceted nature of the problem, alongside the need for reform to progress on several fronts.

The session brought together over 40 participants from Commonwealth and state government, parliament, clinical practice, aged care and hospital providers, consumer groups, health economics, and regulatory bodies, making it one of the most senior cross-sector gatherings on this issue to date.

KEY DISCUSSION THEMES

Theme 1: Delayed discharge is a whole-of-system challenge

There was broad agreement that delayed discharge is not principally a hospital problem, but rather a care economy challenge arising from fragmentation across health, aged care, disability, primary care and housing. Participants consistently emphasised that responsibility for patient transitions is shared across governments, insurers and providers, and that no single intervention will resolve the issue in isolation.

Delayed discharge was perceived as a system failure rather than an individual one, with older Australians often becoming caught between services that operate under different funding, regulatory and operational arrangements.

This whole-of-system framing was the clearest point of consensus in the room, yet it also carries a tension worth highlighting as it has stalled previous reform efforts.

When responsibility is shared across the care economy, accountability is often unclear, leading to fragmented decision-making and delayed action. Several participants felt substantively challenged to propose an intervention, noting that almost any change put forward depended on conditions or changes elsewhere in the care economy. That interdependence is real and should be called out to mitigate the risk of inaction, where each actor waits for another to move first.

'Whole-of-system' framing should not equate 'no one's responsibility'. The answer to system fragmentation should be to establish shared accountability with clear, agreed points of ownership for patient transitions that hold true even as the broader system reforms around them. Robust discussions throughout the morning illustrated the specific gaps where accountability currently falls through and also surfaced innovative ideas on where accountability can be deliberately rebuilt.

Throughout these discussions, participants stressed that patients should remain at the centre of reform efforts. This principle is also the test that should be applied moving forward: not whether the solution is seemingly convenient for any one part of the system, but whether it genuinely contributes towards delivery of the right care, in the right place, at the right time.

CHA's recommendations:

- *Establish shared accountability for patient transitions, including clear agreed points of ownership that holds true even as the broader system reforms around the patient, so that shared responsibility does not become 'no one's responsibility. This should be underpinned by nationally consistent indicators for hospital transitions and shared Commonwealth and state accountability, giving the principle a concrete and measurable footing.*
- *Ensure a person-centred test is applied to all proposed reforms to prioritise the right care, in the right place, at the right time over the convenience of any single part of the system.*

Theme 2: Earlier intervention and restorative care attracted the strongest support

Throughout the discussion, participants emphasised the importance of shifting the system's focus beyond discharge itself towards prevention, early intervention and restoring functional independence.

Central to this was 'reablement', an approach that treats independence as something that can be actively rebuilt, rather than lost capacity to be managed or compensated for. Where much of the delayed-discharge conversation frames patients as a system flow problem (i.e., people waiting in beds for a destination) reablement reframes those same patients as people whose function can be restored, so that a lower-intensity destination, or none at all, becomes possible. This is a meaningful shift in that it moves the system's effort upstream, from managing dependence to preventing and reversing it, and recasts delayed discharge as a question of capability and prevention rather than throughput alone. It was this reframing, more than any single service or program, that participants consistently returned to during the day.

KEY DISCUSSION THEMES (cont.)

Participants were interested in strengthening restorative and reablement pathways, improving falls prevention, expanding access to rehabilitation, and intervening earlier to prevent unnecessary hospital admissions. One group working on reablement suggested that this could include the ability to extend support beyond an initial 12-week period where needed, alongside allied health input to address frailty, and stronger connections to assistive technology, home modifications, and end-of-life pathways.

Prevention was considered beyond the point of hospital contact alone, including the role of GPs before a patient reaches hospital or aged care. One table raised the potential of social prescribing by GPs – backed by dedicated funding – as a mechanism to address falls prevention and reablement further upstream.

Participants also discussed the role of virtual models of care, including Virtual Emergency Departments and Hospital in the Home (HITH), in reducing unnecessary admissions and supporting recovery closer to home. Several noted that HITH is already established in the public system, with states looking to scale existing programs, and that Residential In-Reach models (known by various names) are also similarly well established.

Nevertheless, there was a tension underpinning this theme where participants wanted sustainable, longer-term investment in prevention and reablement, as well as immediate solutions for patients already in hospital beds today. Both of these are valid. However, these would compete for the same funding and attention, and in practice, the urgency of immediate fixes tends to crowd out the important, longer-term investments. Short-term flow measures get funded, likely to become permanent, and quietly obscure the upstream investment needed to reduced demand for scarce resources in the first place.

There should not be a choice between the two, but a question of prioritisation and conditions. Immediate measures are necessary as a bridge, and they should be recognised and funded as such. Bridging measures should be explicitly paired with a sustained transition towards investment in prevention and reablement. This approach would guard against the risk of bridging measures becoming permanent, and help to navigate this tension of protecting long-term investment while supporting the system to respond to today's pressures.

The post-event polling reflected this discussion. Improving restorative and reablement pathways was identified as both the proposal that resonated most strongly with participants and the highest implementation priority.

CHA's recommendations:

- *Strengthen restorative and reablement pathways to maximise functional recovery and reduce long-term care needs, building on interim post-acute transition programs such as the Transition Care Program. This includes the flexibility to extend support beyond an initial 12-week period where clinically needed, allied health input to address frailty, and stronger connections to assistive technology, home modifications and end-of-life pathways.*

CHA's recommendations (cont.):

- *Invest in upstream prevention pathways, including in the role of GPs, such as dedicated funding for social prescribing to address falls prevention and reablement before a patient reaches hospital or aged care.*
- *Improve early discharge planning and patient navigation across health, aged care and community services, commencing planning at the point of admission rather than at exit, and scaling face-to-face navigational supports and roles, so that likely longer-stay patients are identified and supported earlier rather than after delays occur.*
- *Scale established virtual and in-reach models of care, and pilot HITH within residential aged care settings, subject to further work on governance, scope and funding responsibilities, to reduce unnecessary admissions and support recovery closer to home.*
- *Fund immediate measures explicitly as a bridge, not a permanent solution, such as time-limited step-down and transition capacity, by pairing short-term flow measures with a sustained transition towards long-term investment in prevention and reablement, so that urgent fixes do not crowd out the upstream investment needed to reduce demand.*

Theme 3: Cost-shifting and blame-shifting are two symptoms of the same broken funding structure

Two of the strongest recurring points was the need to end blame-shifting between jurisdictions and sectors, and the frustration with cost-shifting that hinders agreed solutions to address delayed discharge.

Participants framed blame-shifting as a symptom, with cost-shifting in the funding structure as its underlying cause. Our current funding system rewards pushing costs across a boundary, leading to perverse incentives and responses. That is why these two points have been treated as one theme in this context.

A strong and recurring message throughout the roundtable – and particularly in the open feedback – was that progress depends on governments, providers and sectors working together more effectively and stepping back from attributing blame to one another.

Participants called repeatedly for a nationally consistent, cross-sectoral approach, with several using the term "finger pointing" to describe the current dynamic between the Commonwealth and the states, and between the health and aged care systems.

Beneath that behaviour sits the funding architecture that produces it. A number of participants pointed to cost-shifting – both between the Commonwealth and the jurisdictions, and between the health and aged care systems – as a core obstacle preventing solutions that are already broadly agreed upon from being effectively implemented. There was interest in exploring bundled or pooled funding models that better recognises the role of multidisciplinary teams working across acute and community settings.

KEY DISCUSSION THEMES (cont.)

There was also interest in redirecting funding currently spent managing the downstream consequences of delayed discharge towards approaches that prevent it occurring in the first place. One table added that state funding needs to sit alongside Commonwealth funding, particularly to support patients with more complex needs, rather than one level of government carrying this responsibility alone.

The main tension in this theme was around timing and sequence. Participants suggested that existing capacity and funding may not currently be used as effectively as it could be, and that progress does not need to wait for new funding through future iterations of the NHRA. Several felt that existing funding streams, combined with a shift in culture and behaviours across the sector, could support near-term progress alongside longer-term structural reform. There remains a risk of near-term workarounds that ease pressure on the system without addressing the underlying structures can entrench the very cost-shifting approach they were meant to relieve, and quietly reduce the urgency for structural reform that would address the issue.

These two approaches must be pursued together and deliberately linked, rather than being traded off. The behavioural change the room called for is unlikely to materialise unless the funding structure underpinning it stops incentivising cost-shifting. Cultural goodwill and structural reform should not be seen as alternatives, but rather as dependencies. Reform progress should not wait for the perfect funding architecture, and short-term measures should be designed as steps towards achieving shared accountability in tackling the issue.

The nature of these issues led to a number of practical proposals on the day. One that illustrates both the promise and the pitfalls was the idea that a portion of home care packages could be quarantined for states to draw on for long-stay older patients otherwise stuck in hospital, which represents a concrete way to move a person to a more appropriate setting without waiting for structural reform. However, when implemented in isolation, a measure like this cuts across the Commonwealth–state boundary in a way that could entrench cost-shifting rather than resolve it, risks disadvantaging older people already waiting in the queue for those same packages, and treats the symptom (i.e., a person in the wrong bed) rather than discrepancies in the funding structure(s) that put them there.

Innovations of this kind – several of which emerged throughout the day – have an important role to play in addressing delayed discharge, provided they are implemented as part of a broader reform agenda rather than becoming long-term substitutes for structural change.

CHA's recommendations:

- *Explore bundled or pooled funding models that recognise the role of multidisciplinary teams working across acute and community settings, and that allow state and Commonwealth funding to sit alongside one another.*

CHA's recommendations (cont.):

- *Pursue near-term progress and structural reform together as dependencies rather than alternatives. This includes leveraging existing funding and capacity more effectively without waiting for future iterations of the NHRA.*
- *Redirect funding upstream from managing delayed discharge to preventing it, and test every "bridging" measure against whether it resolves or entrenches cost-shifting rather than merely relieving short-term pressure.*

Theme 4: Coordination must work with the grain of a complex system

The clearest operational theme from the day was that coordination and accountability gaps are among the most immediate barriers to timely discharge of patients. Equally, the room stressed that the solution is rarely to add something new. Rather, these two ideas belong together. In a complex care economy, the instinct to fix a coordination problem by layering on new roles, programs, or models can itself become part of this overarching complexity, crowding the field and drawing effort away from genuine, sustainable fixes. Coordination ultimately needs to work with the grain of the existing system rather than against it.

Participants identified fragmented coordination between hospitals, aged care providers, and Commonwealth and state systems as one of the most immediate obstacles to timely discharge. The discussion focused on the absence of clearly assigned roles for managing complex discharges, and on the lack of shared data across My Health Record, My Aged Care and NDIS systems that would allow delays to be picked up as they happen rather than after the fact. Beyond data itself, participants raised the absence of a shared clinical language across the care economy. For example, a shared dataset was seen as necessary but deemed insufficient without agreed definitions to sit alongside it, with candidates including when a patient is medically ready for discharge and eligibility for transitional supports.

A specific accountability gap came up several times during the day, namely the point at which responsibility for a person's care shifts from the state health system to the Commonwealth aged care system at age 65. This was described as an artificial boundary that doesn't reflect the continuity of a person's care needs, and one that should be addressed directly rather than treated as a fixed feature of the system.

Importantly, participants were careful to note that navigation and coordination roles – whilst important – are not a substitute for capacity. For example, participants discussed how better navigation would not resolve the underlying shortage of aged care beds, nor address the lack of appropriate supports for patients with complex dementia, or other conditions warranting more specialised care. Workforce capacity was raised as a distinct constraint that is separate from bed numbers, as appropriate resourcing still needs to take place even where bed numbers are not increasing.

KEY DISCUSSION THEMES (cont.)

One table working on improving system navigation reinforced this point, noting that several similar programs already exist, and that the priority should be streamlining and improving visibility of what's already there within the system, rather than adding new roles.

This relates to an earlier point, namely that practical reforms should work within the system as it exists today, whilst avoiding changes that make longer-term reform more difficult. Immediate action to relieve pressure on hospitals should support, rather than constrain, future improvements to funding, governance, and accountability.

Participants also cautioned against standardised national models that do not account for variation in local needs, cohorts and service environments. There was support for funding and governance arrangements flexible enough to allow solutions to be adapted to local circumstances, rather than a single uniform model applied consistently across the country. This flexibility is precisely what's required to develop solutions that address the issue in the shorter- and longer-term.

A practical example raised by participants was enhancing the supply of residential aged care beds. By embedding relevant design principles now, such as building beds to be dementia-friendly from the outset, and then prioritising system coordination around those same principles, the system would collectively increase its near-term capacity in a way that anticipates tomorrow's needs rather than merely meeting the present care needs.

This was reinforced by the existing models of care that many participants shared with CHA prior to the discussions. A common lesson drawn from these models was a core need for flexibility across funding, governance, workforce, and other design elements, rather than a fixed approach applied uniformly.

Underneath this theme sits a tension between two things that should be valued equally: the appetite for innovation and the discipline of stewardship. The system needs new thinking, but every new role, program or model also adds a layer to an already crowded and fragmented environment, and enough well-intentioned additions can compound the very complexity they set out to solve.

The room's caution against 'one-size-fits-all' national models is the same caution in another form: a uniform fix imposed from the centre can be just as disruptive as an unnecessary new layer, because it overrides the local design that makes coordination work.

In practice that means a strong default towards streamlining, connecting and giving visibility to what already exists before creating anything new; designing for place rather than for uniformity, so solutions flex to local needs, cohorts and service environments; and reserving genuine innovation for the gaps that existing capacity cannot fill, which leans towards addressing the structural boundaries, like the artificial cut-off at age 65, that no amount of coordination can navigate around. Innovation and stewardship are not opposites here; stewardship is what keeps innovation honest and sustainable.

CHA's recommendations:

- *Streamline and connect what already exists to improve visibility and coordination of current programs and roles. Where new cross-system roles are proposed, such as dedicated hospital liaison or discharge planning roles, these should be justified as filling a specific coordination gap that existing capacity cannot, rather than added by default.*
- *Develop a national minimum dataset on delayed discharge and a shared clinical language across the care economy. Supported by improved interoperability, this should span My Health Record, My Aged Care, and NDIS information systems so that delays can be flagged as they occur.*
- *Design for place, not uniformity to ensure funding and governance arrangements remain flexible enough to adapt to local needs, cohorts, and service environments.*

Theme 5: Practical work is needed in design, execution and rebuilding trust

This final theme captures what participants took away as the practical work still to be done to achieve the strategic direction set out in previous themes. There was strong alignment across sectors when it came to the nature of the problem and the general direction of solutions required. This consensus is real and valuable but participants were candid in flagging that agreement on direction is not the same as readiness to implement, and that detailed design of care models, how the proposals would function in practice, and the trust required to make them work all remains underdeveloped.

Design principles are clearer than delivery detail. The reablement discussion was a case in point. Participants noted that patients who were more likely to move into residential aged care may need a dedicated step-down or transition setting to reach a point where they can safely do so, rather than assuming reablement occurs within the hospital stay itself. One table took this further, suggesting that any reablement program should avoid being positioned as long-term or permanent, and should have the ability to extend beyond an initial 12-week period where clinically necessary. The principle is agreed but the delivery model to make it reality requires further work.

Execution relies on getting operational details right. On discharge coordination, participants pointed to the value of risk stratification at the point of admission to identify likely longer-stay patients earlier. Others highlighted how discharge planners play an important role in driving cultural change around coordinated discharge within hospitals. This was a good reminder that execution is as much about people and behaviour as it is about the design process.

Establishing and rebuilding trust between parts of the system is a crucial component. A recurring, practical concern was the confidence of aged care providers in accepting patients from hospital. Providers need to be confident in being given an accurate picture of the person that they will be caring for, and this trust is not always there in practice.

Participants suggested that there should be a guarantee of return to hospital where a patient's needs turn out to exceed what a facility can safely provide, describing an agreed fallback that lowers the risk of saying "yes". The willingness of a provider to accept a transferred patient depends on having confidence in the information they are acting on, and on an agreed pathway if that information proves incorrect.

They also pointed to the value of an agreed minimum dataset: a shared, standardised set of information that travels with a patient across the hospital-aged care interface, so that a receiving provider knows what to expect before they accept a transfer. This connects directly to the shared clinical language raised earlier (Theme 4) where a common dataset is only as useful as the agreed definitions beneath it.

Faster, safer transitions into aged care rest on exactly this: reliable information, and a shared commitment to the right care at the right time for each patient.

CHA's recommendations:

- *Progress detailed design of care models by translating agree principles into delivery models. This includes embedding reablement supports in the design of step-down or transition settings for patients moving into permanent aged care, building on the proposed national pool of time-limited transition beds.*
- *Embed operational tools to support earlier, coordinated discharge, including risk stratification at the point of admission to identify likely longer-stay patients sooner, and recognising the role of discharge planners in driving cultural change within hospitals.*
- *Build provider confidence at the point of transfer by pairing the national minimum dataset and agreed definitions recommended under Theme 4 with a guaranteed return-to-hospital pathway where a patient's needs turn out to exceed what a facility can safely provide.*

POLICY RECOMMENDATIONS

Across every discussion theme, the same shape emerged. Delayed discharge is a whole-of-system challenge that no single actor can resolve alone (Theme 1); the durable answer lies upstream, in reablement and prevention, provided immediate fixes are built as bridges rather than destinations (Theme 2); behavioural goodwill will not hold unless the funding structures that reward cost-shifting are reformed alongside it (Theme 3); new ideas must be disciplined by stewardship of the complex system we already have, designed for place and for tomorrow as well as today (Theme 4); and consensus on direction, real as it is, still has to be earned into delivery through design, execution and trust (Theme 5).

The through-line connecting all five is shared accountability: clear, agreed ownership for patient transitions that holds even as the wider system reforms around it.

POLICY RECOMMENDATIONS (cont.)

While recognising that delayed discharge requires action across multiple parts of the care economy, discussion and participant polling identified several proposals that emerged as priorities for further policy development, alongside areas where views diverged and questions the day did not resolve.

Where support was strongest

The clearest convergence, reinforced by participant polling, centred on:

1. Strengthening restorative and reablement pathways to maximise functional recovery and reduce long-term care needs.
2. Piloting HITH models within residential aged care settings, subject to further work on governance, scope and funding responsibilities.
3. Improving early discharge planning and patient navigation across health, aged care and community services.

Where views diverged

Several proposals attracted genuine support and genuine caution in equal measure. Some of these have been outlined below.

- **Cross-system coordination roles.** There was support for dedicated discharge and liaison roles, set against caution that new roles can add complexity to the existing system. These roles should therefore only be introduced where they fill a gap that existing capacity cannot, and paired with conditions to streamline what already exists.
- **Acting now versus investing in upstream.** Participants were split between addressing patients stuck in hospital today and strategically investing in prevention. This could be addressed by funding immediate measures as a bridge, not a destination.
- **Capacity and funding commitments.** There was support for accelerating Support at Home, transition care and residential beds, tempered by the risk of entrenching cost-shifting if pursued in isolation. These should be advanced as part of structural funding reform, not in place of it.

WHAT THE ROOM TOLD US: POLLING RESULTS

Participant polling captured on the day provides a direct, quantifiable record of where the room landed, independent of how CHA has characterised the discussion.

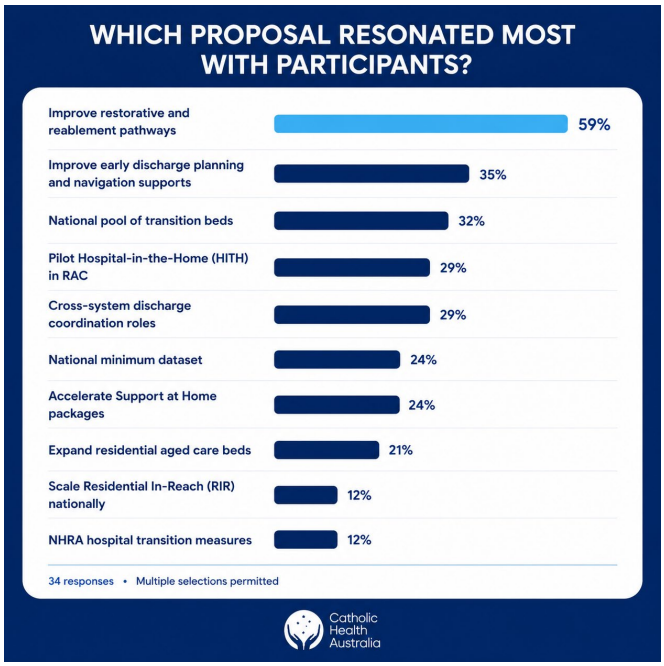

Figure 1. *When asked which proposal resonated most, participants (n = 34) most strongly backed improving restorative and reablement pathways, chosen by 59%, clear of the next group of proposals (early discharge planning and navigation, 35%; and, a national pool of transition beds, 32%). As a multiple-select question, participants could endorse more than one proposal, so responses sum to more than 100%.*

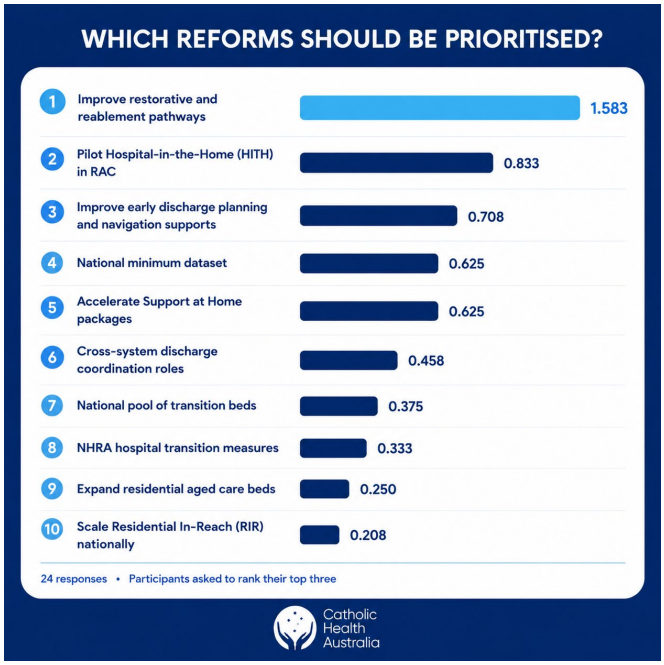

Figure 2. *Participants were asked to prioritise their top three proposals for implementation, participants (n = 24) again placed improving restorative and reablement pathways well ahead of the field, with a weighted score of 1.58, nearly double the next-ranked proposal (piloting HITH in residential aged care, 0.83), followed by improving early discharge planning and navigation supports (0.71). Scores are weighted by how often and how highly each proposal was ranked; the list numbers at left denote items, not final order.*

Figure 3. (below) *When asked for their biggest takeaway, participants (34 responses from 28 participants) returned open-text answers that closely mirror the five themes of this summary.*

WHAT HAS BEEN YOUR BIGGEST TAKEAWAY FROM TODAY'S DISCUSSION?

Open text responses • 34 responses • 28 participants

1 Consensus on direction but the delivery detail is unfinished (7)

- Broad agreement on the problem and direction of solutions.
- Alignment on the problem and solutions across the system.
- "We know the solutions" the task now is good data and appropriate funding.
- Strong support for change, but major gaps remain in care model design.
- Specific design questions remain (e.g. defining HITH within residential aged care).
- Time to commit to a way forward no more admiring of the problem."
- "We must stop having an escalating commitment to a failing course of action."

2 A whole-of-system challenge, not an individual failure (3)

- The fault is not on the individual in the bed.
- This is a system challenge, not simply a hospital challenge.
- No single solution exists, but immediate action is still required.

3 Prevention and reablement balanced against acting now (5)

- Distinct funding for prevention and reablement.
- Sub-acute reablement services are critical to safe discharge.
- Greater focus is needed upstream, not only downstream.
- "Two streams needed": solve today's block while preventing tomorrow's.
- Prevention ambitions should not delay action for people currently in hospital.

4 End cost-shifting and blame-shifting; fix the funding structure (7)

- "Cost shifting is the elephant in the room stopping action.
- Work together no more finger pointing.
- Nationally consistent bundled funding recognising multidisciplinary care.
- Redirect downstream spending toward whole-pathway solutions.
- Invest in models that can scale.
- Make existing funding streams work now rather than waiting for the next NHRA.

5 Steward and coordinate what already exists; design for place (5)

- Existing capacity is likely not being used optimally.
- Flexible solutions tailored to local needs.
- Better coordination and understanding of patient experience.
- Agreed datasets and stronger transition pathways.
- Solutions driven from each stakeholder's sphere of influence.

6 Keep the older person at the centre; collaborate (7)

- Keep older people at the centre of every decision.
- Cross-sector collaboration is essential.
- Better engage older people and their supporters in designing solutions.
- Design with older people, not just for them.
- Collaborative action is possible now.
- Improve awareness of available care options.

OPEN QUESTIONS

The day did not resolve everything. Further work is needed on the artificial age-65 boundary, the detailed design of care models, and development of a national minimum dataset to underpin accountability and performance measures. Some of these questions are captured below.

Co-design with older people and community

Participants raised the need for co-design with older people and community, placing older people at the centre and allowing their perspectives to guide future directions, rather than assumptions from across the sector about what is best for them. This raises an open question on how to ensure the principle of co-design is put into practice so that older people's needs shape the solutions to delayed discharge.

Addressing the complexity and acuity of patients

The rising complexity and acuity of patients was identified as a key challenge, with implications for how care is planned and delivered. An open question remains on how services and pathways can be adapted to address this complexity.

Common understanding, dataset and language

A further area still to be resolved was the need for a shared understanding, a common dataset, and consistent language when talking about individuals who become stuck in hospital, such as those who remain in emergency departments for longer than medically necessary.

Going forward, there is a need to establish shared definitions and terminology across the sector to ensure that data and discussion about these individuals are consistent and comparable. Participants also pointed to the importance of tackling ageism and being deliberate about the language used to describe these issues, which can itself reflect and reinforce assumptions about older people.

CONCLUDING REMARKS

The Parliamentary Roundtable reaffirmed that delayed discharge is a whole-of-system challenge, growing in scale, that no single level of government or sector can solve alone. It demands a coordinated, system-wide response. Participants were broadly aligned on the nature of the problem and key solutions required, although views varied on what should be immediately prioritised.

There was strong support across the room for a greater focus on prevention, earlier intervention, restorative care and reablement, reflecting shared understanding that upstream investment in these areas can ease pressure on hospitals and reduce delays further down the system.

Alongside this, participants pointed to the need for a common dataset, full use of existing capacity within the system, and an end to cost- and blame-shifting between governments and sectors.

The conditions raised for policy proposals to succeed in practice provided a valuable roadmap, sharpening future directions to address delayed discharge. There was a sense that the time to act is now, with multiple participants calling for this work to be progressed under the current NHRA. With the ideas and the will to act clearly in place, turning these shared solutions into action now ultimately depends on sustained, cross-sector collaboration and commitment.

NOTE FROM CHA

Catholic Health Australia was able to design and facilitate this Roundtable with the support of HESTA as our corporate sponsor, the generosity of our speakers and facilitators, and the high level of engagement from participants in the room. We extend our sincere thanks to all who contributed.