Delayed Discharge from Hospital: Older Australians' experiences & perspectives

2026

NSA

Contents

The issue: how can we reduce discharge delays in Australian hospitals?

In recent times the Australian media have devoted much attention to delayed discharge.

This is when people are kept in hospital longer than expected because something about their living situation is inadequate for meeting their care needs, were they to be discharged.

Such delays can negatively impact patients' physical and mental health and create stress for patients' families and friends.

They also reduce hospital bed availability, resulting in long waits in emergency, ambulance ramping, and elective surgery cancellations.

Older people, especially those aged 85+, are more likely than other Australians to experience delays.

This is partly because some can spend weeks or even months in hospital awaiting a bed in a suitable residential aged care home.

However, there is more to the delayed discharge story than a need for additional aged care.

This report presents the results of a 2026 survey module in which thousands of older Australians were asked if they had experienced delayed discharge themselves or via someone else, or if they had formed opinions about it based on media coverage or general conversation.

Based on survey participants' reported experiences and suggestions for change, and in conversation with other recent research on the topic, the report recommends several reforms to the healthcare and aged care systems that may reduce delays.

The 18 main recommendations are outlined below. Note they are not necessarily listed in order of importance, as they are thematically grouped.

Each of these, along with some additional suggestions and further contextual information, are discussed in depth in the remainder of the report.

18 main recommendations for change — overview

#1-#5 MORE AGED CARE

1. **More residential care, everywhere**
   The most widely-discussed reason for delayed discharge – waiting for a bed in residential care in an appropriate location – is indeed a big part of the picture and must be addressed with more beds, including in regional, rural, and remote parts of Australia.

2. **More home care, faster**
   Some older patients don't need residential care, but they do need some care or assistance at home – and the wait can be long. More places, shorter wait times and better availability of aged care assessment are sorely needed.

3. **More transition care and rehab facilities**
   Often patients only need 24/7 care on a temporary basis while they transition from hospital or engage in rehab, so more places to provide that sort of care are urgently needed.

4. **Timely access to social housing, equipment and home modifications**
   Older patients may require social housing if they are homeless or their home is unsafe to return to, or their current home may need modifications or equipment. Making these more readily available would reduce discharge delays.

5. **Improved care affordability**
   Disparities in older people's income and savings levels cannot be ignored because some stranded patients cannot afford the aged care that is available.

#6-#8 LESS SEPARATION BETWEEN HEALTH CARE AND AGED CARE

6. **Dementia and specialist clinical care in residences and at home**
   Even where residential or home care places are available, they do not always cater to clients with high care needs, including people with dementia. More are desperately needed.

7. **Complex and gerontological hospital care**
   Older people often have more complex health problems than younger people. Hospitals must rethink the care provided to older patients, creating new approaches informed by gerontological knowledge.

8. **Standardised cross sector communication**
   One of the solutions to getting older patients safely into residential care, respite care or rehab sooner is greater cross-sector communication with standardised procedures and tools.

#9-#11 IMPROVED QUALITY OF DISCHARGE DECISION-MAKING

9. **Discharge planning started earlier**
Thinking about a patient's likely discharge needs as soon as they are admitted may reduce the duration of delays.

10. **Person-centred decision making**
Avoiding a one-size-fits-all approach to care and discharge options would lead to more appropriate outcomes for patients.

11. **Designated aged care navigator in hospital**
Delays could be reduced if patients and families or friends were given direct assistance from a designated hospital staff member such as a social worker, when organising aged care from hospital.

#12-#15 IMPROVEMENTS TO HOSPITAL PROCESSES

12. **Avoiding early discharge as a solution**
Stretched hospital capacity can lead staff to discharge patients earlier than anticipated, but this can lead to worse outcomes including rehospitalisation, especially for older patients.

13. **Alternatives to routine overnights**
Overnight hospital stays after planned surgery are often common or mandated at present, but alternatives to this routine practice would free up beds when safe to do so.

14. **Paperwork on weekends and after hours**
Often, health care and aged care cannot wait until ordinary business hours, so expanding the days and hours worked may help.

15. **Continued work on hospital efficiencies**
While hospitals have improved efficiencies in recent times there is still work to be done on delays related to communication and administrative shortcomings.

#16-#18 BIG PICTURE CHANGES

16. **More staff and funds in these systems**
Wicked problems like delayed discharge can't be solved with money alone but money is needed, including to fund greater numbers of staff in both healthcare and aged care systems.

17. **Improved federal-state collaboration**
The delayed discharge problem is partly a jurisdictional one and requires collaboration between all levels of government.

18. **No more ignoring demographic changes**
The current crisis was foreseen decades ago when the post-war baby boom was observed, but it was insufficiently planned for. We can no longer afford to ignore the demographic realities of different generations of Australians.

Introduction

National Seniors Australia, or NSA, is a member based, not-for-profit research and advocacy organisation representing Australians aged 50 and over.

Every year we survey thousands of older people on diverse topics relevant to lifestyle and wellbeing.

This report is based on a module about delayed discharge from hospital that was presented to around 4500 older Australians in a 2026 survey.

Hospitals have always had to manage situations in which patients have completed their hospital-based treatment for a clinical condition, but their discharge has been delayed by other factors such as administrative processes or the lack of a suitable home environment to go to.

When the delay is for long periods of time, this phenomenon has been described using different terms including delayed transfer of care, stranded patients, long stay patients, exit block, bed block, and – the term preferred by the Australian Government at the time of writing, so used in this report – delayed discharge.

Delays of this kind result in patients spending unexpected extra days in hospital. This can in turn impact the availability of beds for other patients, who then spend long periods in emergency waiting for admission or have scheduled treatments cancelled.

In recent years, such situations have become more common in Australia, with chronic bed shortages, major surgery cancellations, long waits in emergency departments, and record high levels of ambulance ramping all hitting the headlines.

The problem was exacerbated during the early years of the COVID-19 pandemic, but has not gone away in the years since.

In 2025, media attention turned to the numerous older Australians stranded in hospitals waiting for suitable aged care to become available. At the time of writing in mid 2026, that number was estimated at 3300 people.

It was in this context that the Australian Government Department of Health, Disability and Ageing (DHDA) contracted NSA to survey older Australians about their experiences of delayed discharge, as part of the annual National Seniors Social Survey (NSSS).

The DHDA has been the major sponsor of the NSSS for many years. In this instance, personnel from the department collaborated with NSA researchers to design the delayed discharge module, to try and find out more about it from a grassroots perspective.

The survey provided the data for this report.

The survey module

The NSSS was open to participants for just over 2 weeks from late January to early February 2026.

Anyone aged 50 or older and living in Australia was welcome to participate, and around 4500 people did so.

The first question of the delayed discharge module gave a definition of delayed discharge, then asked participants if they had experienced it or heard about it. The definition was:

> *This is when a person is kept in hospital longer than expected because something about their living situation is inadequate for meeting their care needs, if they were to be sent home.*

Approximately 2100 participants indicated they had encountered delayed discharge in one or more ways:

- in the media (845)
- in general conversation (820)
- someone they are close to has been in the situation (476)
- they have been in the situation themselves (173)
- people they have worked with had their discharge delayed (173).

A majority of these 2100 answered further set-option or comment-based questions about delayed discharge.

Those who had experienced it themselves or via someone close were presented with multiple questions about the specific circumstances in which the delay occurred.

Those who had witnessed it in a professional capacity were invited to write a comment on any aspects of the situations they witnessed that they felt were relevant to understanding delayed discharge.

All three of these participant groups were also asked if there were any changes they would recommend that could reduce hospital discharge delays, and 428 people wrote an answer.

Participants who had encountered delayed discharge in the media or conversation were simply invited to share their thoughts or feelings on that discourse.

In addition, all NSSS participants were later presented with a hypothetical scenario in which they are unable to leave hospital unless they can access high level care at home. They were asked if there was anyone in their life who could provide that care in the short, medium, and long term. That question was answered by 3969 people.

Finally, participants were asked about their level of engagement with the residential care system via specific steps such as familiarising oneself with the financial implications of it, choosing care homes they would like to live in, or not even wanting to think about it. In total 3539 people answered this question by selecting the options that applied to them.

The report structure

The results from NSA's analysis of the responses to these questions are presented in the pages to follow.

They are contextualised in relation to a review of the delayed discharge situation published by FTI Consulting in February 2026 entitled *Unlocking Capacity: How Health and Aged Care Must Work Together.*

The review was based on nation-wide statistics, consultation with experts from the healthcare and aged care sectors, and key government and peer-reviewed literature.

Its approach took a broad view of delayed discharge which included attention to related aspects of the landscape such as general hospitalisation rates among older Australians, blocks to inter-sector collaboration, government accountability chains, and more.

Many of its themes echoed themes the NSSS participants broached in comments.

They also echoed many of the suggestions put forward in a shorter 2025 discussion paper by Dementia Australia, COTA, Ageing Australia and OPAN on delayed discharge.

It therefore made sense to present the NSSS results as a form of triangulation, with NSSS data providing additional support or nuanced addenda to FTI Consulting's conclusions about the causes of, and possible solutions to, delayed discharge.

The bulk of this report comprises a section with the title, "18+ suggestions to reduce delayed discharge", and the instances of broad agreement with FTI Consulting's findings comprise suggestions #1 through #18 of them.

However, because the NSSS collected a very different type of data, there are some additional points to be drawn from it that were not highlighted by FTI Consulting. These are presented here too.

One important type of data not covered in depth by FTI Consulting, or the 2025 paper, is the personal impacts delayed discharge has on the patients affected and their family members and friends, and also the impacts the crisis has had on older Australians' feelings about seeking hospital care. Sentiments of this kind are presented in a section towards the front of the report.

In addition, neither FTI Consulting's review nor the 2025 paper dwelt on one of the underlying causes of delayed discharge: the fact that many older people do not have someone at home who can provide post-hospital care for them. Comments highlighting this basic social reality are presented in another section.

The NSSS results can also inform our understanding by describing the key circumstantial and demographic factors surrounding hundreds of specific instances of delayed discharge experienced by NSSS participants. These are quantified next.

Characteristics of the delayed discharge instances reported in the NSSS

Key characteristics of the delayed discharge instances reported in the NSSS

Over 600 NSSS participants reported having experienced delayed discharge themselves or via someone close to them.

This section summarises the characteristics of those delays and the circumstances surrounding them.

Hundreds of NSSS participants indicated that they had experienced delayed discharge themselves or via someone close to them.

These participants were asked numerous set-response questions about those specific instances of delayed discharge, such as the calendar year of the patient's hospitalisation, how long their discharge was delayed for, if there had been concerns about their cognitive health prior to admission, and their income source at the time.

This section offers a quantitative overview of those instances based on participants' answers.

Most NSSS participants who had experienced delayed discharge themselves were aged 65-plus, with similar proportions aged under and over 75 years (Figure 1).

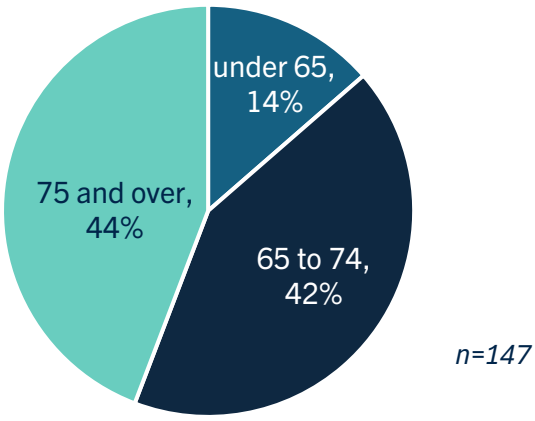


Figure 1. Age group proportions among participants who had experienced delayed discharge themselves.

Other characteristics of the delayed discharge instances reported in the survey are summarised in Tables 1 and 2. They show that the delay instances participants experienced themselves were overall different from the delays experienced by other people in their lives. For instance, most delays experienced by participants themselves were generally of shorter duration and for planned treatments compared to the longer delays and emergency care for others in their lives.

Table 1. Characteristics of the instances of delayed discharge experienced by NSSS-2026 participants, either themselves or via someone close to them.

Time period hospital entry	**self n=155**	**other n=462**
prior to 2010	4.5%	4.8%
2010-2019	16.8%	16.5%
2020-2025	78.7%	78.8%
Reason for hospitalisation	**self n=159**	**other n=475**
emergency care	53.5%	77.9%
planned treatment	37.1%	16.0%
other	6.9%	5.1%
unsure	2.5%	1.1%
Period in hospital after being ready for discharge	**self n=156**	**other n=465**
<1-week	64.1%	17.2%
1-2 weeks	12.2%	22.6%
2-4 weeks	5.1%	23.0%
1-3 months	1.3%	17.6%
> 3-months	0.6%	6.0%
unsure	5.8%	10.1%
Cognitive concern prior to hospital entry	**self n=152**	**other n=463**
very concerned	2.0%	10.6%
moderately concerned	6.6%	17.4%
a little concerned	7.9%	24.2%
not concerned	80.3%	36.5%
unsure	3.3%	11.4%
Income source at time of hospitalisation	**self n=154**	**other n=465**
Age Pension	52.0%	64.5%
Veteran Affairs pension	5.8%	7.1%
super	35.7%	20.0%
other savings or investments	19.5%	20.0%
salary	15.6%	1.5%
other or unsure	9.1%	12.5%
Engagement with the aged system prior to entering hospital	**self n=152**	**other n=462**
no prior engagement with government-funded or private aged care services	67.1%	36.2%
waiting for assessment for government-funded aged care	3.3%	7.1%
approved for government-funded home care and waiting for services to begin	6.6%	6.7%
receiving government-funded home care at the level approved for	11.2%	26.8%
receiving government-funded home care at a lower level	3.3%	12.6%
already living in residential aged care	1.3%	3.3%
making plans to move to assisted living or residential care	0.0%	5.4%
paying for care at home privately	3.3%	3.5%
unsure	9.9%	13.0%

Table 2. Reasons discharge was delayed, for instances reported by NSSS participants either for themselves or someone close to them. Participants could select more than one reason.

Reasons for delay	self n=155	other n=471
There was no available spot in residential care	3.2%	39.9%
Care needs were too complex for residential care	1.9%	11.0%
There was a wait to get assessed (or reassessed) for aged care	3.9%	20.8%
Home care services approved, but waiting for services to begin	3.9%	9.8%
Sufficient home care services were not available	10.3%	22.3%
No one available to provide support at home	45.8%	31.2%
Staying in hospital was more affordable than alternative accommodation	1.9%	3.8%
No stable place to go after discharge	2.6%	7.4%
Awaiting respite services	5.8%	11.3%
Unsure	14.8%	6.6%
Other reason	27.1%	10.4%

For those experiencing delayed discharge through someone close to them, the relationship proportions were relatively evenly distributed across parents, relatives and friends, with a parent relationship being the most common (Figure 2). A relatively low proportion had experienced the delayed discharge of a spouse.

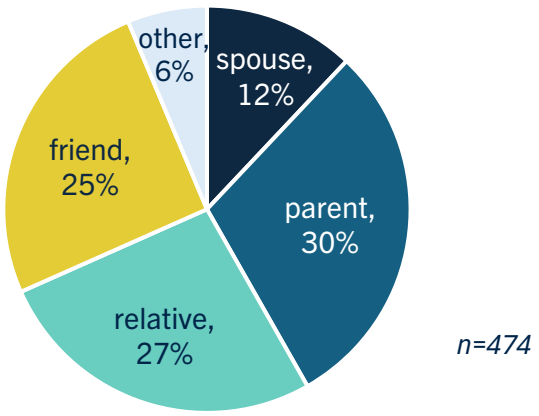


Figure 2. Relationships of the patients to the participants reporting others' delayed discharge experiences.

Personal impacts of delayed discharge on older people

Personal impacts reported by participants

Delayed discharge can have major impacts on patients' health while they are stuck in hospital and it also impacts the wellbeing of other older people.

The recent media coverage of the delayed discharge situation has been met with a collective sense of concern and outrage among the Australian public.

Two of the NSSS participants no doubt spoke for many when they wrote, *"I think something needs to be done urgently about the situation"* and *"This should not have to happen. The end!"*

But beyond such 'big picture' responses, delayed discharge also has personal impacts on older Australians in different ways. This section explores these impacts as reported by NSSS participants.

One of the set-response questions presented to participants who had experienced delays themselves or via someone close asked if any aspect of the patient's physical or mental health got worse during their hospital stay. In total, 36% indicated that it did get worse.

Perhaps unsurprisingly, there was a clear linear relationship between the length of time discharge was delayed and the proportions of those whose reported a decline in physical or mental health, with greater declines corresponding to longer delays (Figure 3).

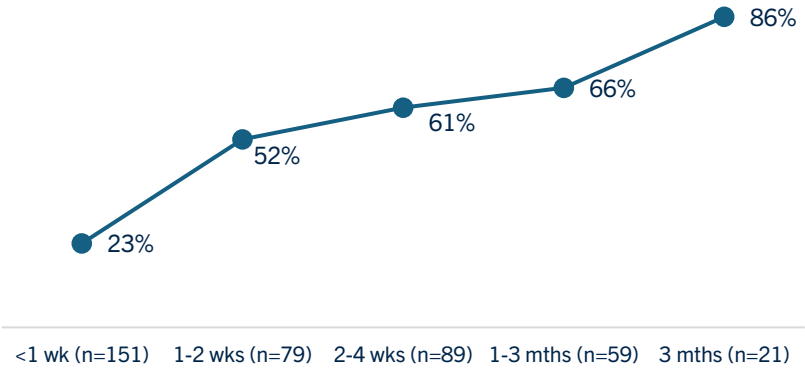


Figure 3. Percentage of patients who experienced a decline in health during their delay, charted by the duration.

Those who indicated a health impact were prompted to specify it and 183 did so. Some 'work witnesses' also described impacts on patients they had worked with.

In the following, the year and duration of a delay are noted next to a comment about it, where available.

A total of 116 participants reported declines in mental health. It was not always clear if those who used the word 'mental' were referring to emotional, psychological, or cognitive conditions, so these categories must be counted together.

The emotional and psychological impacts listed included depression, anxiety, stress, distress, frustration, anger, agitation, boredom, poor self worth, and loss of the will to live.

Cognitive impacts included confusion, delirium, hallucinations, mind wandering, paranoia, memory problems, or worsening of dementia. Behavioural impacts were mentioned by a few commenters, with patients becoming aggressive or abusive.

Sixty commenters reported declines in physical health.

- Existing conditions were exacerbated for some patients, including cancer, motor neurone disease, diverticulitis, and leg wounds.
- Some acquired infections, including UTIs, flu, COVID, norovirus, and pneumonia.
- Other physical health impacts included disruption to sleep patterns, weight loss, poor nutrition, eating issues, pressure sores, falls, and foot drop.
- Twenty commenters mentioned mobility declines, resulting from patients being in bed for long periods and/or receiving inadequate physiotherapy. Loss of muscle mass, strength, and continence resulted. Four lost the ability to walk.

Big deterioration in mental and physical condition many patients requesting to die. [work witness]

Person becomes "institutionalised" in hospital, and abilities and sense of agency decline rapidly, further reducing/impacting options for next steps. [work witness]

several older people who had come from aged residential care were unable to return to their accommodation, they were bored, frustrated and/or just slept all the time except for meals and tea/coffee. Nursing staff were kind but clearly spent less time than with actually ill patients [work witness]

Incontinence due to hospital staff insisting he wear disposable underwear, rather than requesting help to get to the toilet, and mobility (2025)

It was covid time. There were no regular physiotherapy services available. My father was in a wheelchair for the rest of his life. (2022)

They went from being quite mobile with a walker to being immobile on discharge as hospital workers including nurses didn't encourage and support her in getting out of bed and ambulating as they 'did not have time on a shift'. (2025)

They became more isolated, not going out of room and this has continued since moving into residential care. (2024, 1-3 months)

It's a neighbour and he's still in and has become confused and disoriented. (2025)

Because they had a broken wrist and because they used a walker, it was deemed unsafe to send them home initially. Then, after contracting a UTI and related confusion, they were kept longer and shuffled between four different hospitals. This led to complete disorientation and sufficient confusion to warrant an aged care institution and ultimately the dementia ward. (2024, 2-4 weeks)

Seventeen participants mentioned that the patient had sadly died in hospital while awaiting discharge. Some gave specific details of how the person close to them died due to the delay.

> Developed hospital acquired pneumonia, became untreatable leading to palliative care in hospital and subsequent death in hospital (2022)

> mental health (mid range dementia) accelerated, also aspirated for first time ingested food into lungs which became infected and my husband died of sepsis (2023)

> They had an autoimmune condition which was known but they were still put in the same room as someone with a respiratory virus. they caught the virus from sharing the room/bathroom and ultimately died from pneumonia. (2015)

> On being advised that they would be unable to return to their home, their health worsened and they passed away (pre-2010)

A few participants commented on the negative impacts delayed discharge can have on people close to the patient too.

> Unless you have had or know someone who has had a relative in this situation, it is difficult to understand the anxiety and stress placed on all family members going through this process.

> I am sure it's true as I worked within the health sector for many years. It is stressful for patients and families.

> Distressing for member & family / support welfare teams

Awareness of the delayed discharge situation through media coverage and general conversation prompted some participants to express fears about future hospitalisations, in case they themselves became stranded in hospital.

> WORRYING.

> I'm concerned that it will happen to me

> Makes people afraid to go to hospital in case they get stuck there.

> People may feel guilty about taking a hosp bed

> As all media coverage, it was alarmist. However i found it alarming that a person could be trapped without their consent

> A hospital is not a prison, so no one should be prevented from leaving or from being forced into care rather than going home.

Finally, participants also shared stories of people in their life being ramped or sent home instead of being admitted to hospital, because of bed shortages that were possibly the result of others' delayed discharge.

> the wait was to actually get a hospital bed. they were ramped up, no bath for 3 or 4 days, just a wash basin. (2025)

> they were attended to whilst sitting in the waiting room waiting to be admitted [...] They were sent home as there were no beds available to keep them (2024)

A fundamental cause: no one at home who can provide care

No one at home who can provide care

The fundamental cause of many delayed discharge situations is patients without someone in their personal life who can provide care for them at home – whether that is because of their high care needs, no available family or friends, or no able family or friends.

The fact that many older people don't have someone they can ask to care for them at home is almost a given in the delayed discharge space.

FTI Consulting acknowledge "lack of family/social support" as a 'community barrier' to timely discharge (II.08) but do not say much more about it.

Yet as a theme it figured more prominently among NSSS responses, with over 100 comments mentioning it as a standalone reason for delay and many more linking it to the need for aged care, home care, or something else.

Among those who had experienced delayed discharge themselves or via someone close, 35% selected 'I/they didn't have anyone available to support me/them at home' as a reason for the delay.

Further, when presented with a hypothetical delayed discharge scenario:

- around a fifth of participants (n=870) said they do not have someone in their life to provide high level care for them in the short term (a few days)
- a third (n=1433) do not have someone in the medium term (a few weeks)
- half (n=2028) do not have someone in the long term (a few months or indefinitely).

It is worth noting that much higher proportions of people who lived alone at the time of the survey said they had no one to provide high level care to them (Figure 4).

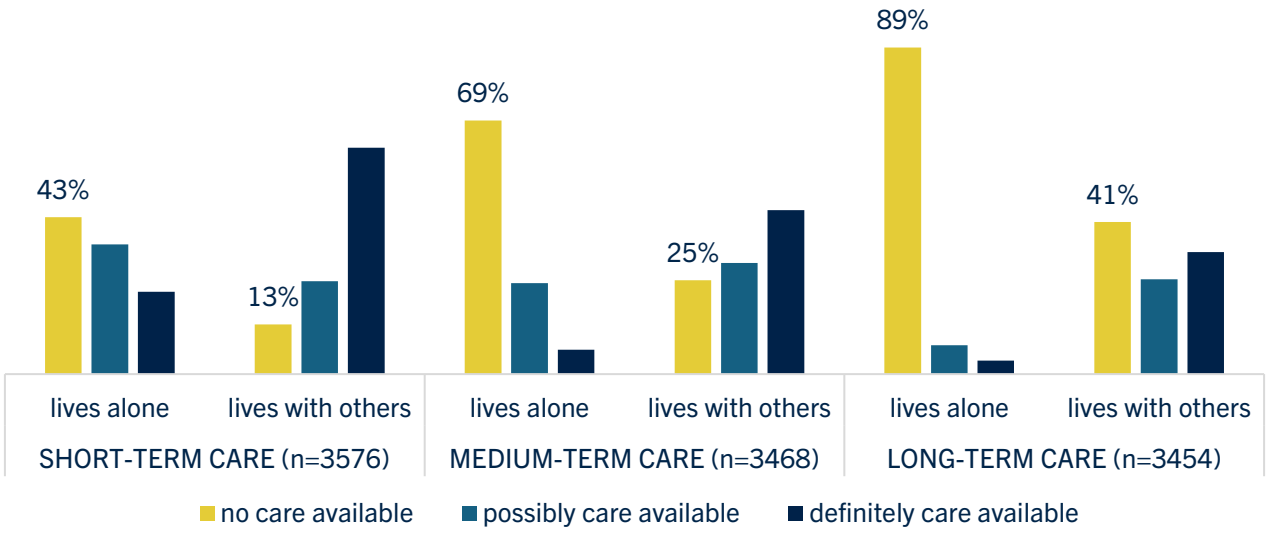


Figure 4. Availability of someone to provide high-level care, by living situation.

These numbers suggest the level of potential future need for alternative supports after hospitalisation is quite high among today's older Australians.

ABS figures show that the likelihood of a person living alone increases with age.

At the top end, a striking 41% of women aged 85+ and 25% of 85+ men lived in a lone person household at the 2016 census. A quarter of all people aged 65+ lived alone that year, compared to 10% of all Australians.

While many older people choose to live alone, a few commenters reflected on what they perceived to be changing household norms in Australia, that have contributed to this situation:

> Delayed hospital discharge is driven by lack of residential aged care places, which in itself is driven by societal expectation that both partners in a family unit, need to undertake paid work to function financially, thus requiring society/government to be responsible for the care of both elderly parents and children. This is a really sad and very poor, that the care of both elderly and children is unable to be accommodated within the extended family unit. Our society is ultimately poorer because of this.

> Conversation is mainly around elderly staying in hospital - It's very hard these days, encouraged to stay in your own homes. Once upon a time, retirement age was lower, so children could look after aging parents but children now have to work longer and look after aging parents as well as their own children who sometimes have children - so the 60 something adults are caught in the middle of trying to look after everyone and working full-time.

> The current assumption that older patients should call upon family or friends for accommodation and care seems outdated and unrealistic.

> It would also be better if people could retire to help look after their elderly relatives, give support of various kinds to younger family members (including grandparenting) and not be forced to work until they drop dead.

In terms of delayed discharge, several work witnesses documented situations in which older patients were stuck in hospital because they had no family or friends they could call on.

> Delayed discharge due to no close by family members or estrangement from family

> A patient with no family or friends.

> The patient had no home support or family at all to assist with follow up care and to do basic household chores.

Situations in which family and friends are unable to provide care were also mentioned often. More specifically, several comments highlighted the reality that in many older couples, both partners need assistance, so one cannot provide high levels of care to the other.

Ongoing situation. In hospital for 1 month to date. Partner has full blown dementia. He [partner] is unsteady on his feet, needs a cane or walker He was her sole carer with no respite for over 12 months. He was hospitalised for health reasons, she was admitted at the same time as she could not be left alone. Her health has deteriorated markedly in this time. (2025)

Patients with complex needs or deteriorating cognitive status and family no longer able to manage

family bringing them to hospital as they are unable to care for them anymore.

Elderly living alone or with frail [partners]

carer spouse too old themselves to fill in gaps

My friend's wife died unexpectedly while he was in hospital recovering from pneumonia and he was unable to return home because of the type of care he needed with nobody to provide it there. (2024, >3 months)

Elderly partner not able to care for him at home, no family locally (2022, 2-4 weeks)

My friend had a fall and was taken to ED. Then he transferred to a hospital ward as he was hallucinating. Eventually he was discharged and went back home but his elderly wife was unable to provide the care he required. He was admitted again to hospital and after a month he went to residential care. (2024)

Some participants, especially work witnesses, wrote about patients whose family and friends were abusive or otherwise unwilling to provide care.

it was unsafe for them to return home (due to abuse), they lived on their own and had no-one to care for them, they were mentally unstable, or they have had neighbours that have been taking advantage of them.

My sister has early onset Alzheimer disease. She had a "seizure" and was admitted to hospital. Her husband refused to have her home so she was in hospital for 3months until a care place was found for her.

A female client of mine was admitted for medical procedures, and when her discharge was coming up, her husband claimed she was mentally unable to cope outside. I was unable to convince authorities that she could cope, with my assistance.

Not safe to go home. No one wants them home eg granny dumps so family can go on holiday. Family or [patient] doesn't want to go home and expect miracles so want to stay in hospital until that miracle happens.

domestic violence clients who are unsafe

Family not willing to step in. Complicated social circumstances etc.

18+ suggestions to reduce delayed discharge problems

18+ suggestions to reduce delays

NSSS participants highlighted multiple causes of delayed discharge and also offered numerous suggestions for improvements that might reduce those delays.

This section of the report summarises the bulk of the NSSS comments about delayed discharge.

The comments have been organised into 18+ themes, each outlining a delay cause and also offering corresponding solutions that could reduce delays.

Comments are drawn from across multiple questions from the survey, including from people's personal experiences of delayed discharge, from what participants observed about other people's delays, from the solutions these commenters offered, and from participants' thoughts and feelings about the delayed discharge discourse they had encountered in the media and general conversation.

In the following pages, the specific source question from which a comment was drawn is only specified if relevant. But the source is sometimes apparent from the comment's phrasing. For comments from those who experienced delay themselves or via someone close to them, the year or time period of hospitalisation and the delay duration are indicated if the participant documented them.

Themes #1-#18 correspond to NSSS results that resonated with points raised in FTI Consulting's review. References to that review are denoted in a format that incorporates its author and its three volumes, for example "FTI III.02" means Volume III, page 2.

The "+" themes outlined at the end are additional solutions offered by NSSS commenters.

#1 – #5
More aged care

1 More residential care, everywhere

The most widely-discussed reason for delayed discharge – waiting for a bed in residential care in an appropriate location – is indeed a big part of the picture and must be addressed with more beds, including in regional, rural, and remote parts of Australia.

The very first point made in FTI Consulting's review is "residential aged care beds are not keeping up with demand" (I.02).

This fact is well known in the Australian public sphere and was reflected in the NSSS participants' experiences of delayed discharge.

Few of the participants who had experienced delayed discharge themselves mentioned a wait for residential care as the reason for their delay. This is unsurprising because the NSSS did not sample many people currently living in residential care.

However, a wait for residential care was a common reason for the delays experienced by people the NSSS participants were close to. In total, 39% of participants in that situation specified 'there was no available spot in residential care' as the reason for the patient's delay.

Many participants commented on this problem and its most obvious solution of investment in new aged care beds. Almost 300 comments across the free-text questions alluded to this proposition and solution, albeit with acknowledgement that it is a big task and expensive to tackle.

Build more facilities.

More aged care places.

Open up more care beds

While a recent cross sector forum identified a lack of suitable and available aged care facilities the challenges to rectify remain problematic.

A few commenters mentioned people they know who were still waiting for a residential care place at the time of the survey.

He is still in hospital awaiting aged care facility and assessment. (2025, 1-3 months)

They are currently in respite awaiting a residential care bed, so still essentially under the care of the hospital! (2025, 1-3 months)

Mentally incognisant after several falls resulting in skull injuries. Still awaiting care home admission after 10 months. (2025)

Some participants qualified this ask by specifying the need for *suitable* residential care, and a few gave details of what they meant by this. Others simply asserted the need for *quality* care.

> Family told that patient was unable to return to their home so the person waited for a place at the residential care where they had received good care during two respite visits. (2019, 2-4 weeks)

> A place was found and it was the first of three absolutely awful aged care places. My father's depression, sense of abandonment and hopelessness started then. (2019, 2-4 weeks)

> They were eventually able to get a couple's room in an aged care facility but had to live apart until there was availability. (2025, 1-3 months)

One commenter identified some specific properties that could be redeveloped for residential care, in line with FTI Consulting's recommendation to conduct "a cross-government stocktake of government-owned buildings and facilities that could be repurposed for aged care use with minor to moderate refurbishment" (III.05).

> Government should set up large scale public nursing homes. There are at least two C19th ex-mental asylums in Sydney set on the water, surrounded by hundreds of acres of parkland, that no longer offer residential mental care. These could be recycled, converted, and added to, to provide accommodation. Gladesville and Callan Park hospitals.

Care in regional, rural and remote locations

A more specific problem is the geographic distribution of residential care.

In particular, parts of Australia that are regional, rural, or remote often have more limited residential aged care per capita than metro locations (FTI II.08).

Consistent with this, around 45 NSSS commenters highlighted the need to redress aged care shortages in all localities, most of whom were writing about regional, rural, and remote locations. Their comments applied to residential care homes, home care providers, and aged care assessors, as well as shortages of medical equipment and expertise.

Note there were no significant differences between metro and regional/rural/remote participants' reasons for discharge being delayed, but this is unsurprising from a statistical perspective because the number of people who had experienced delays themselves was small.

> She was considered way too unwell to go home so waited over three months to find a placement in an aged care home. Eventually a place was found but an hour away from her family and friends which has been very disappointing for her and her family and friends. Now most friends can't drive the distance to see her. (2025, >3 months)

My mother was admitted to hospital due to kidney failure and was unable to return to her unit so we had to find somewhere to place her in care in the city (Rockhampton) so that she could undergo dialysis several times every week. IE: That was not possible in Gladstone due to a lack of services and driving her up to Rocky three times a week was impractical. (2012)

There are two nursing homes in the region where I live, and were generally full. Therefore when a patient was assessed as needing a nursing home placement the hospital would work to find a nursing home often 6 to 700km away that would take them. This could take a few weeks.

Build more aged care in our area which has a very high percentage of aged people living there and lots of Over 50's resorts. [regional participant]

More nursing homes or transitional centres. This experience was in Darwin which has limited opportunities for aged care.

Rural circumstances are often more difficult. I live alone and have no family in Australia. Specialist services are hours away. Finding a driver is near impossible. I nearly cancelled an operation because of it. Arranging shower and domestic help after the operation is a nightmare and so many hoops to jump through when one is vulnerable in the first place.

No delays for grab rail installation in the country. Eg my 86 year old friend waited over 2 years from first of 3 OT home visits, to rail installation, but still none in the shower.

The local availability of diagnostic equipment and specialist doctors might have averted some of the difficulties and delays. [regional participant]

2 More home care, faster

Some older patients don't need residential care, but they do need some care or assistance at home – and the wait can be long. More places, shorter wait times and better availability of aged care assessment are sorely needed.

The Australian Government's current aged care policies recognise that older people often want to stay at home longer rather than moving into residential care.

To achieve this, home care services are needed for a large number of older Australians. This includes people recently hospitalised who now need support or who were hospitalised in part because they lacked support.

Yet, as many older Australians are acutely aware, there are currently long waiting lists at each stage of the My Aged Care application process including a wait to be assessed, a wait to receive any services, and a wait to receive the level of services needed (FTI I.04, II.08).

From nine possible set responses, unavailability of sufficient home care (nominated by 20%) and the wait for aged care assessment or reassessment (nominated by 17%) were among the top four reasons preventing hospital discharge for the 614 people who had experienced delayed discharge themselves or via someone close to them and nominated a reason.

In addition, 8% said the patient had been approved for home care but was delayed because they were waiting for it to start.

Around 130 comments mentioned waiting for assessment or home care as a reason for hospital delays or argued the need for speedier provision of services and assessment and more home care services altogether (and sufficient staff to provide them), to reduce delays.

Some patients had had a relatively positive experience with home care services put in place fast, while others waited a long time. A few avoided a protracted wait by paying for services privately.

> The waiting time between being eligible for a home care package and the actual start time of the home care package is way too long. By the time the package starts the person receiving the package will often require more help than the package allows and needs to be reassessed. These wait times need to be shortened to get people off the aged care support merry go round.


At home care was arranged. Received wonderful after care when everything was sorted. (2025, 1-2 weeks)
Post rehab, hospital had to ensure adequate facilities at home and put transition care into place. Took over a week but everything went smoothly and am very grateful for how system worked. (2022, 1-2 weeks)
Mum was waiting on a higher aged care package that would assist her more with daily help. She waited 12 months (2025, hospital delay <1 week)
Went home once services were organised (2025, 1-3 months)
She discharged to village unit without care being organised through Centrelink by agreeing to pay top dollar (2025, 2-4 weeks)
There were insufficient care workers in their area to enable them to be cared for adequately at home. (2023, 1-3 months)
One of the issues for my mother was that she did not have sufficient level of coverage to receive home care that was required after her fall. Part of the problem is that someone can be entitled to a higher level of care/help but the issue is that there is no availability of providers to do the work.
My friend was waiting for care to be provided before she could go home, wheelie walker bars in bathroom frame to go over the loo and in the shower and someone to come in and help shower her - cleaner for her unit (2025, 2-4 weeks)
If home care had been available to enable him to return home earlier, I am sure his recovery would have been quickly.
Better Aged Care assessment and in home services. Contacted 25 services in local area on my mother's discharge, with no capacity for basic domestic support. Family now use user pay service.
People who have remained in hospital who could have been discharged with an appropriate care package
Lack of community service availability
I again kept on contacting service and was told they no longer provided services, had a long waiting list. I eventually paid a private person to provide me with assistance. (2022, <1 week)

3 More transition care and rehab facilities

Often patients only need 24/7 care on a temporary basis while they transition from hospital or engage in rehab, so more places to provide that sort of care are urgently needed.

One of the key themes of the FTI Consulting review was the need for more transitional care between hospital and aged care services or residences.

The review notes the rising demand for sub-acute and non-acute hospitalisations, for example for rehabilitation services, and states, "these trends indicate that [...] hospitals are increasingly accommodating patients requiring ongoing, complex, or transition care – often because the right supports are not available in the community" (II.03).

It points to practical solutions that already exist but need to be rolled out more widely throughout Australia, such as the Transition Care Program and Short-Term Restorative Care (II.06).

One of its recommendations is to "expand transitional and step-down care models to relieve acute hospital pressure" (III.08-09).

This was also one of the main recommendations of the 2025 discussion paper by Dementia Australia, COTA, Ageing Australia and OPAN (state/territory recommendation 2).

'Awaiting respite services' was a set option in the NSSS that 62 participants (10%) selected as a reason why they or someone close to them experienced delayed discharge.

Note that more than this number wrote a comment attributing their delay to their need for respite, rehab, a recovery hospital, or other post-operative care. The theme was mentioned in over 150 comments.

The discrepancy is perhaps due to some commenters counting transitional care within the period of delay and others classifying it as a post-discharge stay.

The difference between rehab and respite is also murky, so likely some of the participants alluding to the need for rehab did not consider it 'respite'.

Almost 100 participants advocated for the Australian health system to have more rehab, recovery, respite, step down, or other forms of transitional care. Some elaborated on potential options in this domain.

It seems obvious we need a large 'step down' place for people no longer needing acute care so they don't overload hospitals.

It might be good if there was some sort of staging accommodation so they didn't have to take up a hospital bed, but they were still cared for until they could find permanent accommodation.

More respite or temporary accommodation facilities need to become available

Local hotel rooms available with nursing staff supervising.

Health planning should include better provision for rehab and transition accommodation where acute medical care is not the priority, possibly in the general proximity of hospitals.

Increased access to funded respite/rehab/ convalescent care. (In my youth convalescence was a recognised stage of recovery from illness. Not so in these times I think)

not enough recuperating places, like using some of the old country hospitals for transition

More access to transitional care with rehab, reablement, health maintenance activities

More publicly funded rehab centres for people transitioning from hospital to aged care?

Provision of rehab style, short term accommodation [...] My experience is that people are prepared to pay for such a service post-op or after a hospital stay if necessary.

While more transitional care is desirable, some people's experiences revealed problems with the current offerings, including time limits, mixed accommodation, and financial disincentives for residential facilities to offer it.

Was eventually sent to respite care while I tried to obtain a full time placement. This took quite a while given the lack of vacancy and level of care deemed to be required. Moved around a couple of respite care placements as not allowed to stay in one place for a period of time (2021, 2-4 weeks)

Nursing homes that should be offering respite care beds are denying them to the public. [...] engaging in hospital dumping to get rid of respite care patients in favor of long term patients. (2025, 2-4 weeks)

He had a fall at home in the middle of the night and broke his leg. While in hospital it was discovered he had bladder cancer. He was treated for the cancer and his leg had to have pins inserted. After 3 weeks in Wollongong hospital, because lived by himself, the hospital moved him to Bulli hospital where he had to spend a further 11 weeks. The majority of the other inpatients had dementia. My friend does not have dementia and was kept awake by people screaming and calling out. He found it very distressing and he was very very depressed at his situation - he said it felt like he would never get out. (2025, >3 months)

Age eligibility is another factor limiting people's access to transitional accommodation.

Person living with rare Young Onset Dementia, on NDIS, was stuck in hospital for 6 months. Insufficient support at home, ineligible for residential respite. Eventually accepted as permanent resident. [work witness]

My sister was not yet 65, was unable to go back home to live by herself. I lived remotely and was unable to look after her full time as I worked. They kept her in hospital until she turned 65 (about 3 months) and went straight into an aged care home where she could also receive palliative care as she only had a few months to live. (2021, 1-3 months)

Some participants specifically wrote of the need for better access to palliative care facilities and services, both to reduce delayed discharge and for terminally ill patients to have a more appropriate and kinder experience in their final days.

She was finally sent to residential care provided by hospital awaiting a residential aged care spot. But she only got worse and finally passed after a few weeks in this ward. As she wasn't eating or drinking I think she should have gone to palliative care but we were refused. (2023, 2-4 weeks)

Stroke down one side. Wanted the hospital bed back but there was no nursing home available. After more than a month they found a place for her to just lie in bed and fade away. Very sad. (2025)

More palliative care accommodation for end of life patients

Short term hospice beds

More place for elderly to go to when dying with cancer where they can be looked after.

doctor kept him in even though for pall care in the home (2025, <1 week)

Discharge was delayed by palliative care at home being unable to be arranged before death. (2025, 1-2 weeks)

His condition deteriorated while waiting for a palliative care place in Kew (2025, 1-2 weeks)

Decline in health, no available placement for residential or palliative care. Passed away in hospital. (2025, 1-3 months)

4 Timely access to social housing, equipment and home modifications

Older patients may require social housing if they are homeless or their home is unsafe to return to, or their current home may need modifications or equipment. Making these more readily available would reduce discharge delays.

Another reason older people may experience delayed discharge is the need for home modifications, support equipment, or even housing itself (FTI II.08).

Several NSSS participants shared comments about modifications or equipment that showed why the need for these caused delays.

> I had a stroke and was partially disabled. My place of residence needed assessment and modifications (2022, 2-4 weeks)

> The equipment needed at home was not readily available. (2024, <1 week)

> needed grab rails, a higher toilet seat, a higher chair with arms that they could sit in [. . .] they waited in hospital an extra week and when they got home it still took 4 weeks for the modifications to be done. (2023, 1-2 weeks)

One of the set options participants could select as the reason for their own delayed discharge or that of someone close to them was that the patient had no stable place to go. A few (6%) selected this.

Irrespective of the relative rarity of this reason, some of the comments showed how messy and complex the need for housing can be.

This is especially the case if a patient is dependent on a hostile family member, landlord, body corporate, retirement village management body, or even a government department to contribute to making their home a safe place to live in.

Aged care and health are not the only relevant systems with responsibility in this picture.

I suspect Elder Abuse, but no proof, loyal to her husband, but taken to hospital as she 'had enough, cannot do this anymore', still in hospital awaiting for a room in retirement place. (2025, 2-4 weeks)

Unable to return to rented house because they couldn't manage at home. We assisted other relatives to move the possessions out of the house and hand it back to the agent. They both were moved to an intermediate care place while they waited to get into residential care. (2021, 1-3 months)

I pressed the hospital to delay discharge to allow me to clean the patients home (patient is a hoarder) [work witness]

My mother's unit was flooded by an exploding hot water service in the roof. The provider moved her to a smaller cramped unit where she had a fall and required admission to hospital. When she recovered enough to go home her unit was not repaired by the provider. They took over 6 months to do this. My mother was temporarily housed in a nursing home that she funded. Eventually my mother was able to go back to her own unit. She was never the same after experiencing the fall. The complete incompetence of the provider [business name] in getting the unit refurbished was totally unsatisfactory. I would be consistently told that things were happening, only to find nothing had been done. The hot water service exploded in the roof due to the provider's poor maintenance practises. As a result, may residents had their hot water service replaced to be housed outside the unit, rather than in the roof. [Provider] took no responsibility. (2020, 1-3 months)

She had an infection in her toe that went untreated. The infection spread up her leg and lodge in her recent hip replacement. The infection didn't respond to antibiotics. The doctors had to source a very rare antibiotic and had it imported to Australia for her. That got her infection under control but it led to 2 subsequent hip replacement. She lives in a small unit in a retirement village and there wasn't room for the equipment she would need. She went into respite care from the hospital a number of times. Eventually, when she was discharged after 10-11months, the hospital arranged the care she needed at home. She is now recovered but hasn't regained her previous level of fitness nor mobility. (2024)

The house they were living in was housing commission - the house required modification and the housing commission would not come to the party - I had to do the mods myself, then remove them all (after my mother died), with no help or support. (2022, 1-2 weeks)

5 Improved care affordability

Disparities in older people's income and savings levels cannot be ignored because some stranded patients cannot afford the aged care that is available.

More aged care is essential, but it also needs to be affordable for all patients to be able to access it.

That often necessitates increasing government funding and broadening eligibility criteria.

Several NSSS participants commented on this point.

This theme did not feature prominently in the FTI Consulting review, though the review did mention the cost of aged care (specifically private services) as a barrier to being discharged from hospital and a factor that may result in patients being pushed into residential care prematurely (II.08 and III.02).

One of the set reasons participants could choose from to explain the delayed discharge they experienced was 'staying hospital was more affordable than alternative accommodation'. Selecting this may indicate a financial barrier to paying for residential aged care or home care, but only 3% selected it.

Most comments on this topic were written by participants who were asked for their suggested solutions to delayed discharge or who heard about delayed discharge via the media or general conversation.

Some of these made some claims about care costs that, if true, must be addressed urgently.

> More government funded aged care places. My Neighbour was told by [provider name] that they wouldn't talk to her about a place for her husband who had rapidly advancing dementia that they wouldn't talk to her unless she had $750k cash

> it appeared that the bed blocking is related to people on pensions waiting for supported aged care beds. There is no delay for people paying a RAD. Many providers appear to ONLY accept RAD payers

> Yes they don't have a house to give to the nursing home, or their spouse is still living in the house. I took care of my mother and mother in law and I was surprised how very very quickly my mother was approved to live in a nursing home very close to me, while others I know of waited.

Nursing homes in the private sector are expensive and people have to sell their homes to pay for the bond. More Government owned aged care facilities would help.

We were lucky to find caring staff eventually to look after my parent. We saw patients who had been waiting for over 9 months for placement in a Nursing care facility - families who didn't have sufficient funds to pay for private care

An easy progression to aged care residential services that do not require an ingoing RAD would assist.

We need many more public, government funded retirement homes and nursing homes.

It is frequently caused by the exhaustion of the carer, and sometimes by the high costs of care which favours more well-off patients and their families.

provide more quality aged care places at an affordable cost. Prices are currently ridiculous

The health system is not working for elderly people, resulting in delayed discharge. My Aged Care has become too expensive for many people and they are cancelling services they need, ending up in hospital and not being able to return home due to having no in home care! The whole system needs a rethink

On the other hand, some comments revealed some people may be unwilling to pay for care even if they have the means to do so.

Yes, the Government has allowed the Nursing Homes to gouge people needing admission excessively. Just because you worked hard all your life and weren't a burden on the Government, why should you then have to pay hundreds of thousands of dollars to be admitted to a home when people who were a drain on taxpayers got the same conditions for basically nothing

I think it's wrong for wealthy people who take advantage of the public system to leave older family members in hospital to [save] age care costs.

#6 – #8

Less separation between health care and aged care

6 Dementia and specialist clinical care in residences and at home

Even where residential or home care places are available, they do not always cater to clients with high care needs, including people with dementia. More are desperately needed.

A major barrier to delayed discharge identified by NSSS participants is finding appropriate post-hospital care for patients who have high needs.

Many mentioned the need for more care for people with dementia. Others wrote about the needs of people who need ongoing support with physical illness or injuries after discharge from hospital.

FTI Consulting document the limited prevalence of aged care providers or community nursing services with specialist dementia/memory units, capability to support people with psychiatric needs, or capability to care for people with high clinical needs including dialysis and complex wounds.

They also note the perception that aged care residences are 'cherry picking' lower complexity residents (II.09).

Accordingly, they recommend expanding the use of hospital in the home type services, dementia-specific facilities and services, and memory support units (III.12).

When NSSS participants were asked to nominate a reason for the delayed discharge they or someone close to them experienced, one of the set options they could select was that the patient's care needs were too complex for a residential care home to accept them. Overall, 9% selected this option.

Awareness of this as a widespread problem appears to be greater than just those it has personally affected, with around 80 comments referencing issues in this domain.

Some of the more informative comments came from people who witnessed delayed discharge at work, though they differed in their historical experiences of aged care and healthcare systems.

Comments included numerous stories of people being unable to find a place in an aged care residence because of dementia, mental ill health, or antisocial behaviours such as violence.

Because of becoming aggressive, nursing home would not allow him to return (2025, 2-4 weeks)

In some cases I know of some care homes are refusing to take those with behavioural issues - such as dementia.

The ward I was in was full of dementia patients who should have been in nursing homes. [work witness]

I was working as under a govt funded program (Demetia Behavior Management Advisory Service (DBMAS). Almost every case I saw in the regional major hospital or in a nursing home where the client had recently returned from the hospital, the recent history was a massive escalation in confusion, aggression and inappropriate behaviors that coincided with the hospital admission of more than a few days.

Before I retired 18 months ago from 51 years of nursing delayed discharge was very normal & has been for about the last 20 years. Patients unable to get a bed in a nursing home due to their violent behaviours [was one reason]

There is a shortage of qualified staff who understand the complex needs of patients.

Some participants argued that there is a need for staff qualified in healthcare professions to work in residential aged care to provide much needed clinical support.

More skilled nursing capacity in aged care would allow quicker transfers.

Aged care facilities need additional nursing support at residence

In the 1970- and 1980ties patients could stay in hospital for a whole year, simply because the system of aged care and nursing homes was not set up properly to provide the required care.

better care services provided in aged care, so for some things they do not have to be disrupted, removed, transported, re-located and then await treatment, especially in the case where they have impaired cognitive abilities and may only need to be placed in palliative care.

When I was Director of Nursing of several large aged care facilities, we were staffed appropriately to care for people who required significant sub-acute care. However, in 1997 significant staffing requirements were changed, supposedly in the interest of creating a 'homelike' environment (according to the PM of the time). This then has resulted in untrained staff employed to deliver very basic care needs with only one Registered Nurse required for 24hr. cover for clinical care!!!! This has resulted in aged care facilities being unequipped to cope with any resident who may require more than very basic care.....hence people unable to be discharged from an acute hospital who may require ongoing specialised care.

A few people shared experiences of patients who could not find a placement within residential aged care because of high care needs that were not necessarily related to dementia.

Due to weight issues and other health issues most 'residential care' homes wouldn't and won't take her so she remains in a rehabilitation centre. (2025, >3 months)

Located spot in major care home but had to wait for larger bed. (2018, 2-4 weeks)

He was treated as a mental patient even after test's proved he had severe brain damage leading to a diagnosis of Alzheimer's Dementia. For seven months their reports to nursing homes denied him access because they said he had severe depression. After seven months of awful treatment (even after writing to the health minister) he was at last accepted into a nursing home after the intervention of a patient help group. He only lived another three months. In that time he was cared for with love and respect. (2024)

Still in hospital and would require bariatric facilities to be discharged to a care facility and these are mostly unavailable 200+kg. (2025, >3 months)

The person had cognitive issues, depression and beginning of MND. Needed constant assistance but only 2 Nursing home in town would accept person in his condition. Waiting list dictate his remaining into 'hospital accommodation' for aprox. 6 months (2025)

Participants also wrote about clinical healthcare services in the home that patients would benefit from, including two participants who had received such services.

the hospital organised home visits from physio [...] also a home visit from a nurse (2025, <1 week)

Poor follow up services eg physio, rehabilitation and properly skilled nursing services. [work witness]

more hospital at home programs

more nursing services for home care with wounds

Physio support in the home, helping the person to be mobile and use new equipment.

Funding for in-home nursing care to administer injectable medications and to take bloods at home for pathology testing

More funding for home nursing care, especially for those living alone.

Falls led to fractures, bed rest led to clots and pneumonia. Very unwell, close to death. Many shifts to different healthcare facilities as main centres too busy [for] parent to stay there long. This occurred x 3 times in 2025, tough year. On discharge all family had to cope until District nursing available in area and nurses are brilliant very thorough and caring in home (2025, 2-4 weeks)

Funding for more community based services. Evidence reveals many health conditions can be managed in community based settings yet our funders keep pouring resources into inpatient services. Community based services not only keep inpatient hospital settings reserved for those who really need them, but it is also often more conducive to better health outcomes if managed at home.

7 Complex and gerontological hospital care

Older people often have more complex health problems than younger people. Hospitals must rethink the care provided to older patients, creating new approaches informed by gerontological knowledge.

A less widely documented cause of delayed discharge is older patients' need for more extensive or more complex medical care than hospitals generally provide.

Hospitals have traditionally been designed to treat one condition, disease, or organ at a time.

But Australians increasingly live with multiple health conditions and this is more common with age.

Age usually brings more health problems and more complex health situations, with multiple conditions, and often interactions between them.

In addition, frail older people are more susceptible to acquiring new medical problems in hospital, such as infections, delirium, or complications of being bedridden.

Older people also make up "a disproportionately high share of emergency department presentations and hospital admissions" (FTI I.07). Australians aged 65+ generally have a higher admission rate and longer average lengths of stay than the national figures (FTI I.07 and II.10).

Again, this increases with age, with women aged 85+ presenting to hospital at a rate more than double the national average, and men aged 85+ presenting at almost triple the rate (FTI I.07).

It stands to reason that hospitals need to make a major adjustment in response to this reality so that they can better care for older patients.

This means bringing gerontological expertise into the mainstream of hospital care. It also means training hospital staff more in dementia care, given the significant numbers of people who have dementia now and the bigger projected numbers (FTI I.06, III.14).

The FTI Consulting review notes there is a "lack of access to specialised services within [the] health system to support behaviour management" of hospitalised people with dementia or mental ill health (FTI II.09, see also II.11-12).

The NSSS comments reflect these realities.

Some participants attributed patients' discharge delay to the need for further medical care in hospital.

Golden staph in blood stream on antibiotic drip pre and post op. As i had a metal pacemaker implanted preop. Also had collapsed lung and was rehabilitating. Preparing for treatment for prostate cancer which was postponed due to heart condition. Have diabetes and low kidney function (42 percent). Could not be discharged until my anti-biotic treatment had been completed. Along with rehabilitation well enough to go home (2024, 1-2 weeks)

Clinical concerns over speed of recovery from acute pneumonia (2018)

My condition needed extra days to stabilise (2025, <1 week)

Complications with surgery [...] It was purely a medical issue, nothing to do with waiting for someone, something or some place. (2019, <1 week)

I Took a down turn and stayed a little longer. (2016, <1 week)

After a fall in which resulted in multiple broken ribs, the medical authorities determined that she should stay in hospital for several days to recuperate. (2025, <1 week)

Delayed discharge due to not healing as quickly as expected. (2025, <1 week)

Leg problem with blocked veins plus removal of large toe but operation was too dangerous to do (2025, >3 months)

In some cases, patients needed to stay longer because of a serious hospital-acquired infection. Some patients tragically died with this.

Knee replacement operation went wrong and caused infection and ultimately amputation after some 8 months [work witness]

He got the flu after being admitted for a stroke which led to his decline. (2025, <1 week)

Knee replacement followed by lung infection and struggled with walking due to reduced body strength (2025, 2-4 weeks)

My father had a fall at home. He fractured his hip. He had surgery and was recovering well until he developed a hospital acquired infection. He had CRF [chronic renal failure] and the infection affected his kidneys and his blood pressure. In short he could not overcome the infection. Luckily he had private health insurance so he was transferred to a private hospital. Within a few weeks he was made palliative. He spent his last 4 months of life in hospital and died 2 days before he would transfer to an aged care facility (2023, 2-4 weeks)

A pacemaker insertion caused infection which required administration of heavy anti-biotics, extending their overnight stay to about three weeks. (2025, 2-4 weeks)

In & out of hospital for over 12 months. Had a fracture to her replacement hip which was fixed but it needed reopening to clear out infection 3 times. Had some dementia problems & became angry. When this settled, she couldn't walk properly for some time. (2024)

Commenters also recounted examples of older patients not receiving the allied care, rehabilitation, or dementia support they needed while stuck in hospital. They therefore declined in fitness, mobility, and/or cognitive health. This is both a cause and an impact of delays.

They became more intolerant and bad tempered as the days wore on. It was obvious that staff found my friend difficult to deal with so were avoiding them which made the situation worse. (2024, <1 week)

Her anxiety levels worsened. Leg ulcers worsened - I expect due to less exercise in hospital than what she had at home. (2022, <1 week)

she then went to rehab where she declined further and it was deemed by physio that she was too tired to do any rehab so she declined over 2 3 weeks and then we were told she was near death and to have family visit. We visited when able and brought food from home that she liked and she started improving. We could see that she needed to get out of rehab/hospital. Even the dr said that hospital was not doing her any good. We pushed for respite and this happened and upon arriving at a nursing home, the physio started working with her and she improved and came home. We were amazed and very disappointed with the physio offered at the rehab. (2021, 2-4 weeks)

they were admitted after having a fall. Nothing was broken but the person was initially told that they could not leave the bed unaccompanied. The person then lost some of their ability to walk and was then told they needed rehab. (2015, 1-3 months)

Lack of treatment and care and no Physio weakened her and mental state deteriorated [...] If I had not gone in every day from 11am till 7pm she would have died. When I decided they were no longer treating or helping her I took her home. We used TCC program which we were encouraged to use which delayed her discharge due to wrong information and no treatment. I have to fight for her the whole time and do much of the care myself. Since being home and with me giving her Physio etc she is now walking small distances and eating almost normal food. (2025)

Three people reported medical error as the cause of a patient's delayed discharge, including hospital staff narrowly focusing on one medical issue not the patient's whole health situation.

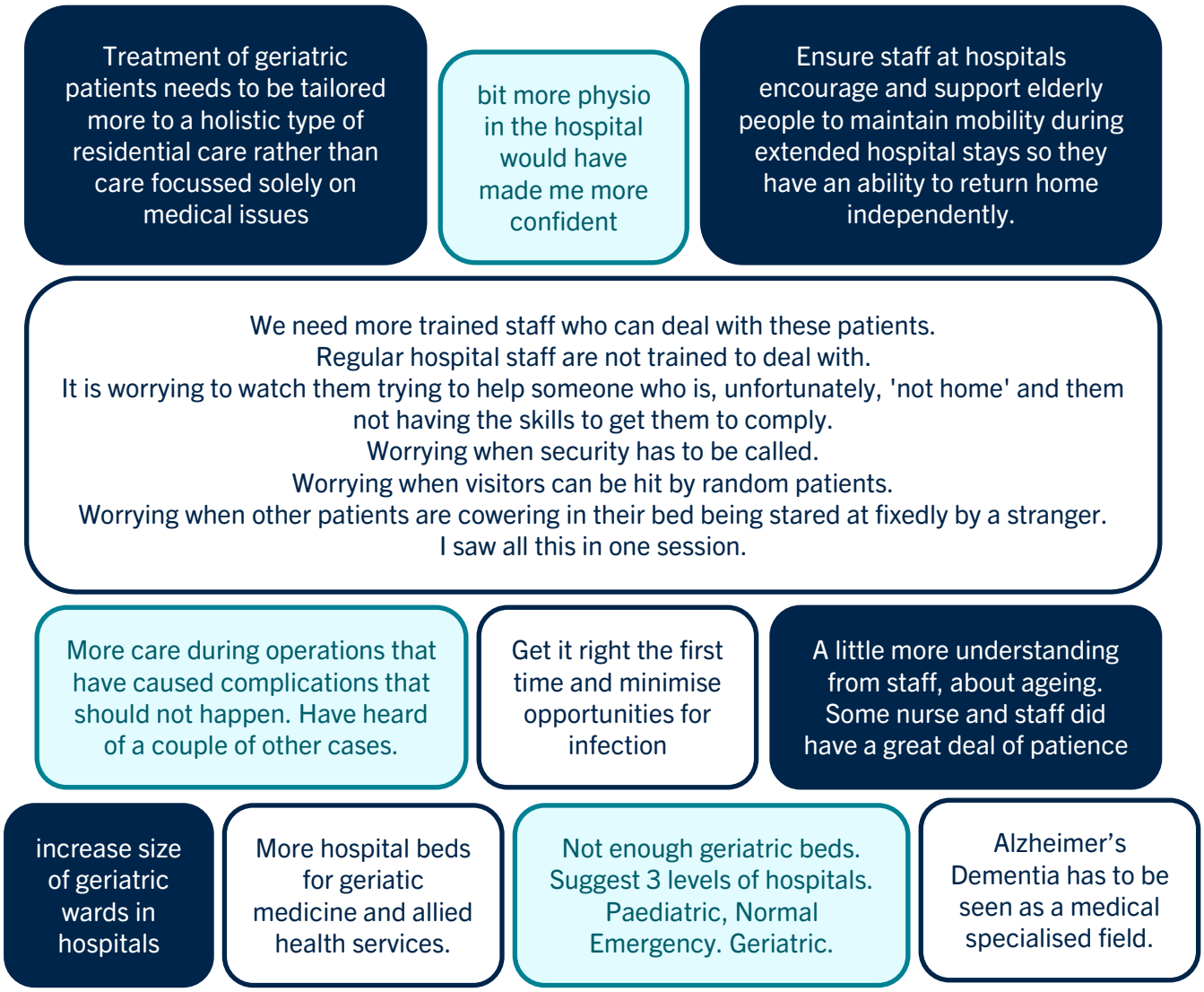
Keyhole op turned into 5 hours and caused numerous problems - mental and physical. One year later still needs assistance showering, now uses walker. Avid reader no longer picks up a book - very sad situation. Previously very active helping other people (2024, 1-3 months)

A dietician stopped a 'medication' he needed. Exercise and discharge delayed several weeks [...] I queried medications - discovered what had been stopped - had it reintroduced - he was discharged three days later (2025)

When a person enters hospital they are told that they will only be treated for the ailment they presented on initially. I personally was admitted for a blocked bowel and while in hospital developed gout. Doctors refused to even look at the gout aspect even though it prevented me from getting to the toilet and was extremely painful to the point I was struggling desperately to walk. I believed this was taking an instruction, which I did understand, far beyond the realms intended and was effectively being extremely abusive to patients.

Participants' suggestions for improvement emphasised the need for hospitals to adjust their healthcare approaches to better suit older or frail patients, and integrate geriatric medicine approaches, dementia training, and aged-care-like supports.

These responses suggest many NSSS participants had a holistic view of delayed discharge, connecting it to the bigger picture of ensuring older people can stay as healthy and independent as possible at all times.



8 Standardised cross-sector communication

One of the solutions to getting older patients safely into residential care, respite care or rehab sooner is greater cross-sector communication with standardised procedures and tools.

A systemic change suggested by a small number of NSSS participants to reduce instances of delayed discharge is better communication between healthcare and aged care sectors in general.

> It seems that there is a disconnect between the hospital system and the aged care system, which isn't assisting timely discharge.

> Compulsory co-ordination between hospital staff and ACAT staff.

One of FTI Consulting's proposed solutions to delayed discharge is "improving real-time visibility of available capacity across hospitals, residential aged care, transitional care and home-based services at facility, regional and state/territory levels" (III.05, see also III.07).

This suggestion was also made by four commenters.

> A central register of support accommodation beds?

> It would be good if there was a list of nursing homes and beds available.

> a data base of available respite beds in aged care places

Participants also said there was a need for better communication between hospital teams, and between different hospitals, to prevent patients from falling through the cracks.

> Better communication between hospital doctors and specialists.

> Less waiting on professionals for decision making. More cohesion/communication between health professionals to prevent confusion and conflicting information

> Better communication between systems in place at hospitals. By this I mean not having to start again with explanations each time a new representative comes in to provide information to families.

> Better communication between major and smaller local hospitals with major hospitals understanding limitations available in small towns and remote areas

#9 – #11

Improved quality of discharge decision-making

9 Discharge planning started earlier

Thinking about a patient's likely discharge needs as soon as they are admitted may reduce the duration of delays.

A logical approach to reducing delays in discharge is to start planning the discharge process earlier.

Six NSSS participants made suggestions along this line of thinking.

Discharge should be thought about at admission, so that assessments can occur and arrangements made before the day of discharge.

They need to ask at intake whether you have services that can help

Explain to family earlier that they would not be able to come home.

The FTI Consulting review similarly observes "Discharge planning is absent or begins too late in the hospital stay" (I.08). It recommends "care teams commence discharge planning from the moment an older person is admitted to hospital", so that proper consideration can be given to the options available (III.07).

This should entail "Strengthening discharge coordination through earlier involvement of dedicated discharge planners and aged care liaison roles, while also embedding discharge planning as core business for all relevant health professionals" (III.10).

Twelve commenters made suggestions for Services Australia that could help expedite this: (1) fast-track aged care access for stranded patients, and (2) provide a temporary carer's payment or other financial incentives to individuals who will care for the patient at home.

Service Australia and Assessment teams working in hospitals to assess and move the most urgent cases.

Quick placement in high-level residential care

immediate accelerated home nursing

More community-based care by volunteers that could be rewarded via the taxation system.

More financial support for people that were prepared to care for me at home

Numerous people commented on patients' lack of engagement with the aged care system as a contributor to delayed discharge, or they suggested older people be encouraged to plan for aged care prior to hospitalisation. Some referenced existing programs in this space or proposed innovations, including both carrot and stick approaches.

Their general physical health was poor but they were refusing help of any kind. Their carer was frustrated by this. (2025, >3 months)

She had been resisting respite care, insisting on staying at home and barely moving, losing sight and mobility. (2025, 1-2 weeks)

refused to apply for aged care prior to being acutely unwell, despite being quite frail. then became unwell and there were no services available so ended up in aged care, probably could have coped at home with supports if they had been available quicker. It was a pride thing. You can lead a horse to water but cannot make them drink (2021, 2-4 weeks)

The Anglicare clients I am mentioning were so determined to die at home that they made no moves for Residential Aged Care. Then they had to be taken by ambulance to the Base Hospital and could not go home. Very sad.

My mother was also difficult about going to a residential home. She 'escaped' with help from my dad before a week was up. She then fell out of bed at home, had multiple fractures and died in hospital on an Anzac Day, just as the Last Post was echoing through the wards. This was both beautiful and sad. (pre-2010, 1-3 months)

Encourage families to check out nursing homes before they need them. Nursing homes to provide look and see tours.

Our GP has organised a representative to come to our clinic once a week, and see patients (that our doctors have recommended), to help them with organising MyAged care/ACAT etc. Doing this has helped quite a few of our patients.

Have assessment in place with Aged Care Respite code applicable for admission to a facility

Not allow people to decline multiple offered placements

People should be more educated about their financial options prior to entering hospital and should have their wishes lodged with a solicitor.

Making aged care more attractive e.g. more functional like practical activities like dementia villages in Holland?

I feel that all Australians should be given the knowledge or educated on aging and the costs involved in living in a cared residence and the various differences. We had no knowledge of the system and bureaucracy. It is such a huge transition in one's life that it needs to be done respectfully and with dignity, listening to the needs of the patient.

Have all residents assessed for my aged care at 65 even if there is no requirement so they are already in the system and then if a situation arises where they need immediate assistance there could be an emergency review.

if local councils had regular welfare checks on people living alone without family support over the age of 65 - this is a vulnerable age group and still need checking and that includes their pets being ok too.

The survey question about level of engagement with the residential care system is also informative on this topic. It reveals a general low level of engagement among the older Australians surveyed (Figure 5). More than half had taken no action in this area.

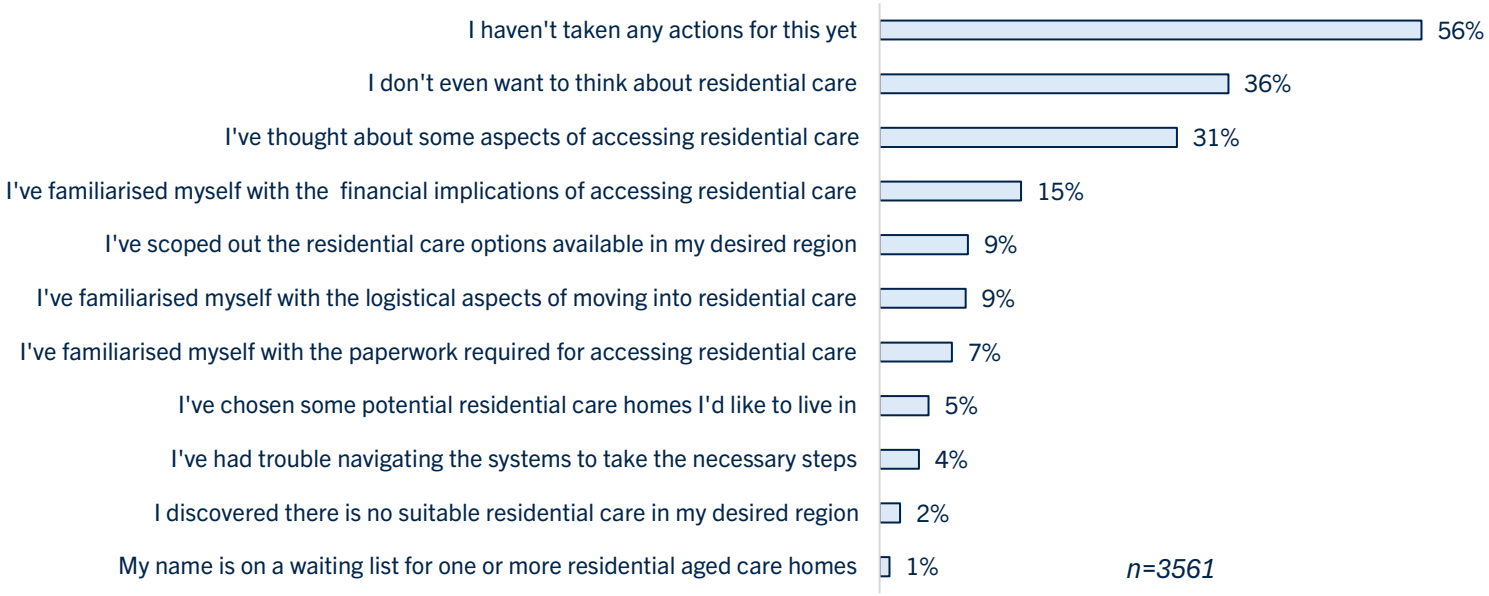


Figure 5. NSSS participants' engagement with the residential aged care system. Limited to participants aged 65 and over (aged care eligibility age).

Figure 6 shows further results of the same residential care engagement question but limited to statements for which there were significant differences between participants who had experienced delayed discharge and those who had not. In all cases, a higher percentage of people who had experienced delayed discharge had taken action to prepare for residential care.

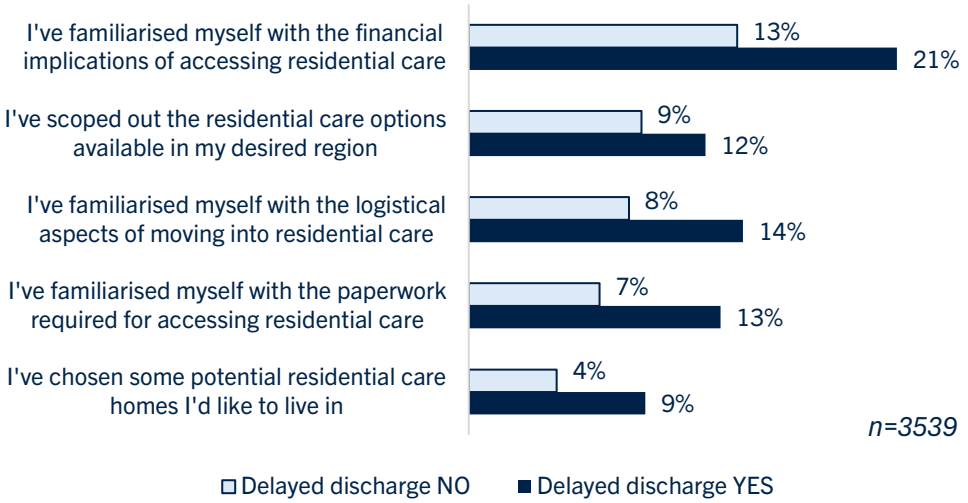


Figure 6. The subset of statements from Figure 5 for which there were significant differences between participants who had experienced delayed discharge and those who had not.

Despite these differences, recall from Table 1 that 67% of delayed participants and 36% of other delayed patients had not engaged with the aged care system prior to hospitalisation.

10 Person-centred decision making

Avoiding a one-size-fits-all approach to care and discharge options would lead to more appropriate outcomes for patients.

Person-centred aged care is a foundation principle of the Australian Government's current aged care system. It constitutes Outcome 1.1 of the Strengthened Quality Standards for aged care.

A person-centred approach to any care is part of the delayed discharge solution according to some NSSS participants, and the lack of it is part of the problem.

The FTI Consulting review identifies a suite of problems related to having to make aged care decisions under duress and with time pressure, such as patients or their families not wanting the patient to enter residential care at all, having a particular care home in mind, or being reluctant to accept a care option offered (II.08-09).

While it is common for people to feel reluctant to enter residential care and to resist it, some NSSS commenters recounted stories of patients being forced into care, distressing them as well as adding delays to their time in hospital. Participants often attributed their family or friends' declines and even premature deaths to the lack of control they had over their own living situations.

> Forcibly hospitalized by Home Care provider [. . .] Home Care provider + family attempted unsuccessfully to put her under Public Guardianship orders. She was eventually discharged to permanent residential care. (2022, 1-3 months)

> After hospital & overbearing authorities ordered him be in nursing home he became seriously distressed and that forced my aunt to go into aged care with in and forced selling of home. The family were very distressed about how this all evolved. In the end he deteriorated so badly and this impacted extremely badly on my aunt that neither would leave their room (2022)

> My mother was wanting to go to her own home when ready for discharge, however [there] were no packages available for her level of care. The doctor said she couldn't go home without care so she was forced to go into a nursing home (the first one available, which she was not happy with). Her emotional well being deteriorated from that time until her death. (2012)

following a fall at home, my friend was admitted to hospital for observation as she had nobody at home to assist her. She was already receiving daily nurse visits to assist with medication and some shopping visits and cleaning. Her cognitive function had been steadily declining and it was recommended that she be moved into residential care immediately rather than more home care assistance. While we waited for the final assessment to be completed whilst she was in hospital, she suffered a heart attack which meant she needed to stay in hospital longer while we organised a permanent place which took a couple of weeks to finalise and set up her room at the home. Unfortunately she suffered a fall from her bed in the home which meant another hospital stay. Her health continued to decline on return to the home and she passed away within six months of the original fall. Her not having a say in the original decisions from the medical professionals about being able to go home weighed heavily on her mentally. (2022, 1-2 weeks)

Mum was fully cognitive and did not want to go into care but stay in her own home. However, she could not be mobile enough to go to the toilet etc. [. . .] She was put into residential care against her wishes and died nine days later. I believe if she had been able to go home and live with her pet dog, and I could care for her during the day, and just have relief at night she would have lived much longer. (2014, 1-2 weeks)

Patient was wanting to return to their home before the appropriate alterations had been completed. Patient kept saying the hospital was keeping them prisoner; actually reported it to the police. Patient was transferred to a secure ward till house alterations were finished and then discharged. Patient was subsequently diagnosed with dementia, which explained their anxiety. [work witness]

A friend had nowhere to go, and I took him to many different retirement villages and homes. He eventually got discharged to a home, after we worked together through all the applications etc. It wasn't in the area he wanted to live, nor was it the type of accommodation that he wanted. He eventually shifted out and became homeless. He ended up committing suicide.

Conversely, a few commenters shared positive stories about patients asserting their wishes and ultimately getting a good outcome.

Father fell at home [. . .] Went to rehab from hospital and then aged care but got out after a few months as wanted to be at home. Incident led to greater entity aged care and improved home support. (2023, 1-3 months)

[No suggestions for change], as husband came home and not aged care. Am grateful rehab hospital let me watch and learn, then let me take care of husband myself, when possible, in hospital. I was prepared as much as possible. (2022, 1-2 weeks)

I found the occupational therapists to be too picky with their home assessment visits. My husband's physical condition improved a lot once he was home where I took care of him. He wanted to come home. I believe that not letting him come home earlier was detrimental to his mental and physical health. (2023, 1-3 months)

One participant wrote at length about a patient not being listened to or being treated as a fool when trying to find out the power requirements of a piece of medical equipment because her home was off grid. This story also had a positive ending for the patient but only because of the solar power company's actions, not the actions of healthcare or aged care staff.

> most distressing was the ignorant and intransient response from the social worker and hospital staff when my mother sought to discuss the power requirements of the oxygen concentrator required for her safe return home. Her home was 'off-grid', powered solely by an array of solar panels and batteries with a finite capacity both in overall quantity of power available and individual appliance wattage that could be supported by the system's inverter. It was essential for her to know the details of the concentrator's likely power requirements, but her questions were brushed off with simplistic comments to the effect that the equipment would run on solar power - which was not the issue. She had been living with the system for 30 years, and fully responsible for it for 15 of those years since my father's death, but was treated by staff as if she was being childish and stupid when in fact she was attempting to engage cooperatively in planning for her safe return home. I endeavoured to ask hospital the same questions and was told I would need to speak with the supplier [who similarly ignored the questions, as did the technician, who assured her it would work]. What happened was that overnight the concentrator drained the batteries to a riskily low level requiring urgent running of the emergency generator to recharge batteries (not something my mother could do without assistance), and an urgent call to the solar power company (not based in the same city) which responded magnificently with urgent installation of extra panels and batteries, a major upgrade to the system which cost thousands more than outright purchase of a more suitable concentrator would have done - all because the health and aged care system apparently considered an elderly infirm person could not possibly know what she was talking about. [...] Such disrespect seems both wide-spread (not universal, thankfully) and deep-seated in practice notwithstanding PR efforts and documentation about entitlement of aged persons to be treated with respect that have been much on show in recent years. With the upgraded system, my mother managed to continue living at home for few more years before her health became too precarious, and the local rep for the oxygen support service became a valued part of her helpful and friendly support network. (2021)

The FTI Consulting review highlights Western Australia's 'Time to Think' program as a good model to alleviate the problem of too-hasty or one-size-fits-all discharge plans:

> Patients stay in dedicated aged care beds where clinical and allied health teams work with them and their families to explore options, address questions, and make informed decisions about the next stage of care. This approach ensures that transitions are person-centred and that decisions are made with time and support (III.09)

Providing transitional accommodation is clearly a key part of this program and is addressed under solution #3 above. But the program's emphasis on a person-centred approach is equally valuable. If people can take stock of their situation, think through who or what is available to assist them, identify what they need in the short and long term and also what they want both individually and culturally, they are more likely to make better decisions.

In addition, if healthcare staff treat patients as people, they are perhaps more likely to listen to what they have to say. Patients are then less likely to be placed in residential care unnecessarily, which can occur if discharge planners assume residential care will be required without adequately evaluating options on a case-by-case basis (I.08 and III.03).

Numerous commenters asserted the need to enshrine person-centred care into the system to avoid poor outcomes and empower the patient to negotiate the best outcome for themselves.

Desirable actions they mentioned include avoiding one-size-fits-all approaches, listening to patients and their family or friend advocates, and ensuring information is available in their language.

more consideration for the emotional well being of people

Well for one keep the patient informed

Better consultation with family the medical team and social worker.

Listen to the patient.

appropriate arrangements rather than using a 'one shoe fits all' kind of approach

A more in depth of a person's needs, such as an in depth investigation as to living conditions and suitability before release and professional advice.

Information about the person involved should be all in one place and everyone should join together in a meeting to make an informed decision, include the family as well with the necessary advice and possibilities.

Instead of the hospitals box ticking on their forms, that they actually discuss with the patient what their options are should they need support upon discharge. My friend would have been difficult to deal with but surely there are staff trained to deal with the elderly who are frightened of losing their independence. I had tried to get my friend to look into respite care but they dismissed it.

Listen to family members and their concerns. Don't have preconceived ideas and run with your own opinion without adequate medical interventions to see what is needed. Doctors who talk over family members and make snap judgements without having done any research are a danger to a persons future health and well-being.

Listen to the family of patient. The team meetings occurred but we felt that we were not listened to. We felt helpless.

thorough assessment of patient and their situation at home rather than tick and flick

The requirements for discharge were too rigid to accommodate someone with a manageable chronic condition. The individual circumstances of the case should bear more weight.

Social worker liaising with family promptly. Medical team working with family. Interpreters to be available 24/7 and able to assist.

the over 95 yr old mother of friend had an accident & hurt her head [...] She doesn't want to go home & definitely didn't like the idea to go to a nursing home (which is a bad word, in her vocabulary). [...] For many months on the hospital (where she said she preferred to die), she was finally transferred to a nursing home. In the nursing home, she continues to be angry & refuses to be bathe, changed nappy, eat much [...] Not sure if it's the hospital's fault or just too complex a case on the above issue. I personally think it could have been handled better by having a Chinese speaking psychologist, doctor/nurse or social worker to discuss/explain or clarify what's the next thing to do for the patient. (2023, 1-3 months)

11 Designated aged care navigator in hospital

Delays could be reduced if patients and families or friends were given direct assistance from a designated hospital staff member such as a social worker, when organising aged care from hospital.

Any Australians who have engaged with it know the aged care system is very difficult to understand and navigate.

Making aged care decisions under duress for a patient stuck in hospital can result in family disputes, a need for guardianship orders, and even court cases (FTI II.09).

Families may be slow to find suitable care and arrange finances, adding to discharge delays (II.09).

The situation is rendered more difficult by the fact that aged care navigation roles do not generally operate within hospitals (II.13).

To address these issues, one of FTI Consulting's recommendations is "to strengthen discharge planning through clearer education and information for families, such as standardised information packs [and] access to specialist navigation support" (III.07).

They further recommend "expanding the use of dedicated aged care navigators within health services to support older Australians, families and clinicians" and "upskilling frontline clinical and support staff in aged care pathways" (III.10).

Twenty participants made similar recommendations, often with hospital social workers in mind.

Possibly more help to negotiate the aged care system

help the poor people who cannot navigate My Age Care or don't have the schooling. Not all of us know how to use computers or phones. Also a lot more help in hospital by social worker. If you knew the things I went through. (2024)

More social workers available to help patients and to follow through on plans

Hospital social workers offer no expertise and have no ability to intervene in the process, so they become an information hub really. An "action hub" would be much more useful.

A dedicated team that would be able to activate an option and funding that took the strain off the hospital social worker/s.

My relative was in a private hospital and I got a lot of help from the 'discharge' team who helped me with lists of care homes and giving me reports to accompany the applications. Not sure if you get this service in a public hospital.

#12 – #15
Improvements to hospital processes

12 Avoiding early discharge as a solution

Stretched hospital capacity can lead staff to discharge patients earlier than anticipated, but this can lead to worse outcomes including rehospitalisation, especially for older patients.

While delays in discharge were the focus of the survey module, numerous NSSS participants noted that early discharge is also a problem and cannot be part of the solution to delays.

FTI Consulting attribute early discharges in part to a lack of integration between hospitals and aged care (I.08).

A few survey participants wrote about their experiences with older people who were discharged early, were unable to manage outside hospital, and were readmitted.

> This is a two way question because sometimes some people need extra care to stay longer because sadly without the right support they could come back several times to keep them safe at home.

> They discharge patients too quickly now without full assessment and physically checking clients. Have seen it many times. I have sent many a patient back into hospital due to quick discharges.

> Continuously being discharged to home then being readmitted as unable to care for themselves (2023, 1-3 months)

> Medical condition was slow to heal. Had 3 admissions overall as he was discharged early. (2025, 1-2 weeks)

> They were discharged, then ended back in hospital again, went to rehab, then home again, then back in hospital, and now finally in respite care. (2025, 2-4 weeks)

Many other participants simply stated it is beneficial to err on the side of caution, so some delays are welcome.

> Get it right - better to delay than rush and regret it. People living on their own to be ready to go home/get a care plan set up. Better safe than sorry.

> I feel delayed discharge is important especially if the patient feels unwell and would be better cared for by having an extended stay in hospital

> I think it's really good, and very enlightened. It's doing what's best for the patient, which is really important.

13 Alternatives to routine overnights

Overnight hospital stays after planned surgery are often common or mandated at present, but alternatives to this routine practice would free up beds when safe to do so.

While the delayed discharge focus is usually long-stay patients, short delays also impact bed availability.

Approximately 19% of the people who identified as having experienced delayed discharge themselves specified (or suggested) that it was for a routine post-procedure overnight stay because they had no one to pick them up or stay with them. Others resisted this by discharging themselves against medical advice.

> I had an operation that required anaesthetic and was not allowed to go home as there was no-one else in the home. I had to stay overnight and then caught a taxi home.

> I live alone and the treatment I had required me to stay overnight as I wasn't allowed to drive for 24 hours and I had no other support.

> Not in my case. Self discharged as my dog was at home on my deck.

If safe alternatives are available, making use of them would likely benefit both hospitals and patients.

This may also redress some inequities because routine overnights are not equitably distributed. The FTI Consulting review shows lower socioeconomic status and geographical remoteness are both associated with overnight hospitalisations as opposed to same-day acute separations (II.12).

A few participants suggested alternatives, signalling an appetite for them.

> Allowing discharge with taxi transport for relatively minor day procedures

> Ambulances/Bus with a cot, for going home should be FREE.

> Person from country kept in hospital longer than necessary when many of the tests and treatments could have been done as outpatient, places available for country people close to hospital to use but under utilized

14 Paperwork on weekends and after hours

Often, health care and aged care cannot wait until ordinary business hours, so expanding the days and hours worked may help.

One of the underlying reasons patients experience long waits in hospital is the fact that some clinical procedures or personnel are unavailable outside office hours.

Similarly, aged care assessments are mostly undertaken in office hours (FTI II.08) and aged care workers may not work on weekends or public holidays.

Some NSSS participants had observed that this was a problem in the delayed discharge instances they or someone they knew experienced, implying delays could be reduced by expanding working hours in key areas.

Mum was unsteady on her feet and needed OT assessment of her house. She was in hospital over Christmas and a lot of support services were closed down for the holiday period. She eventually got assistance she needed. (2023, 1-2 weeks)

Friend had a fall and was hospitalised. My wife was her only carer at home and we were in Sydney with her recovering from an operation. My friend had no one at home to care for her and it was a weekend and her aged care providers don't work on weekends. (2025, <1 week)

Lots of elderly fall fracture their spines and we don't have Orthotists on the premises on weekends for the specialist braces and cervical collars so they remain in Emergency until Monday in an incorrect cervical collar that aggravates the patient and distresses them. [work witness]

My relative was to be discharged after 5 weeks in hospital after major spinal surgery. She was told she could have help showering on Monday, Wednesday and Friday, not on public holidays. They insisted on discharging her on the day before Good Friday, so it would be the following Wednesday - 6 full days, before anyone visited her home. I refused to take her home and the nurse-in-charge hissed at me 'We're not a hotel, you know.' And I said, 'It's medically negligent to send home an 80 year old in her condition to an empty house, so you work it out.' My relative stayed in hospital til Easter Tuesday, but without my advocacy, would have been put in a taxi and sent home (1-2 weeks, 2023)

Public Holidays and Weekends resulted in delays with specialists (2025, <1 week)

15 Continued work on hospital efficiencies

While hospitals have improved efficiencies in recent times there is still work to be done on delays related to communication and administrative shortcomings.

The review by FTI Consulting praises the efficiency gains hospitals have made in the past 15 years (II.03) and offers solid evidence of this. These gains have been shown to reduce unnecessary delays to some extent.

However, some NSSS participants attributed patients' delayed discharge to hospital inefficiencies that should be avoidable with improved processes. In other words, more work still needs to be done in this area.

Comments relevant to this included participants' stories of lost paperwork, staff lacking power to discharge, slow dispensing of medication or facilitation of scans, staff miscommunication, staff unavailability, a poor staff work ethic, and poor management.

Paper work was not completed to finalise discharge. Eventually I was sent home without discharge papers. (2023)

The staff were waiting on doctors and reports to be finished before they would allow me to go home! (2023, <1 week)

I was moved to a private hospital which had greater expertise but was delayed in discharge as the appropriate medical specialist went on leave (2025, 1-2 weeks)

The Orthopaedic Surgeon was on holiday and after my replaced hip had displaced for the fourth time, because they had placed a replacement that was not the right size, it was considered that I should stay in hospital until he returned. (2024, 1-2 weeks)

patients held up by pharmacy medications [work witness]

Allow a qualified nurse to sign them out having verbal permission to release them.

I believe we are dealing with delays fairly well in some areas but we have little control on waits for X-rays, CT scans and reports, long waits for Neurology Consultants responses and recommendations.

A doctor wasn't available to sign her discharge papers. (2025, <1 week)

I think that delayed discharge is because of what is happening in the hospital management

The "system" was bogged down by staff with poor work culture habits

#16 – #18
Big picture changes

16 More staff and funds in these systems

Wicked problems like delayed discharge can't be solved with money alone but money is needed, including to fund greater numbers of staff in both healthcare and aged care systems.

FTI Consulting acknowledges the current situation requires increasing both capacity and capability of health care and aged care workforces (III.14).

Their final recommendation is to review funding mechanisms, with a view to committing to further large-scale investment in aged care (III.16-17).

Numerous NSSS participants also made comments to this effect, often advocating more staff and funding for both healthcare and aged care systems. Some made suggestions for how this could be achieved.

Most of these comments were written by those who had heard about delayed discharge through the media or general conversation, plus a few who had experienced delays firsthand.

17 Improved federal-state collaboration

The delayed discharge problem is partly a jurisdictional one and requires collaboration between all levels of government.

One of the themes commonly broached in media coverage of delayed discharge is the relationship between the Commonwealth Government and state and territory governments, and questions of which government is accountable for the problem.

FTI Consulting also named this tension as one of the broader factors behind delayed discharge (II.13).

Around 50 NSSS participants agreed or simply expressed general frustration with government inaction.

State and commonwealth governments need to work together rather than against each other. The patient becomes stuck in the middle and outcomes suffer

Better management & accountability of Government (Federal & State) funding to provide services and facilities to mitigate the delays in hospital discharge.

due to division of health responsibilities between State and Federal governments

This appears to be caused where different levels of government (state and federal) are not working cohesively to provide a seamless transition.

The problem is the constant attempts by States and the Commonwealth to shift costs onto each other.

In general, most of those with 'the levers of power' don't really give a Tinker's cuss about community facilities or the problems with and from hospitals. They talk so but don't walk so.

Opposition politicians [playing] politics always, rather than doing anything constructive.

no-one cares. Certainly not the Government. People are terrified of the rising costs they have to pay for aged care now. THIS IS NOT A REAL LABOR GOVERNMENT.

the Feds do barely anything, re funding, After all we are in an Ageist Australia mentality system of govt, and that includes all the parties. Gough would be turning in his grave, is all I can say

18 No more ignoring demographic changes

The current crisis was foreseen decades ago when the post-war baby boom was observed, but it was insufficiently planned for. We can no longer afford to ignore the demographic realities of different generations of Australians.

FTI Consulting conclude the first volume of their review with the assertion: "As Baby Boomers reach their mid-80s, the hospital and aged care sectors must prepare for higher complex care demands" (I.09).

A few NSSS participants offered remarks on this state of affairs too, often observing that governments have known this problem was coming for decades but did not respond appropriately to head it off at the pass.

Commenters variously mentioned the demographic trends that have made the current crisis possible, and the historical state of hospitals and aged care that saw the first signs of what was ahead.

> The govt knew the baby boomers were aging and have just not prepared for them! My lady friend is a silent gen in her mid 80's but she has suffered too.

> This will only increase as more people especially baby boomers age.

> No government has undertaken enough senior needs even though the census and other information has indicated these needs for at least 3 or more decades.

> With the rapidly aging population, the planning and supply of nursing home beds is far too inadequate.

> A typical situation caused by governments concentrating on short term popularity and not planning for the long term.

> Since the beginning of my nursing training (1963) this has been a continuous problem experienced by many older people.

> Clogging of hospital beds waiting for nursing home placement has been an issue for 30+ years as I have witnessed in my practice.

> All Governments have known since 1946 about the coming numbers of Baby Boomers who would retire and eventually need Nursing Home care unless they've died earlier. [...] I know many families of that time had 5 or more children. Some living near us had 9 or 10 children. Most Baby Boomer children were born from the late 1940s (I was born in January 1947) that was 80 years ago. Naturally, you didn't need to be Einstein to understand that 80 years later, very large numbers of Older people would take up beds in hospitals

+

Further suggestions for change

+ Further suggestions for change

NSSS participants made other suggestions for changes that might help reduce delayed discharge – changes not mentioned in the FTI Consulting review.

As noted in the Introduction, the previous 18 themes all correspond to points raised in the review by FTI Consulting. But NSSS participants made some additional suggestions for change to reduce instances or durations of delayed discharge.

Improve access to primary care and invest in health promotion

One solution is to keep people out of hospital in the first place. Nine participants made the point that better access to non-hospital-based healthcare, or better health in the first place, will reduce admissions and therefore delays. The 2025 discussion paper by Dementia Australia, COTA, Ageing Australia and OPAN also made this point.

> I feel so much more could be done in primary health/health promotion so over the long term less demand is made on services. Investment in primary health means people can remain healthier over their lifetime with fewer crises. It's like a toothpaste tube that gets choked at the exit point. Hospital beds filled with people who don't need to be there blocks discharge of patients banked up in ambulances. More accessible primary health ($$) would mean fewer calls to ambos for non emergency situations.

> Some people go to the emergency department, for minor events. These clog the system for more urgent cases.

> Give access to bulk billing to everyone vis their local GP - who can afford to go to a GP these days. My last visit cost $180! It is out of control.

> Look after your bones so you don't develop osteoporosis to not need this admission.

> not to forget funding for programs that help people better manage e.g. chronic conditions such as diabetes, heart conditions, chronic respiratory conditions, fracture prevention due to osteoporosis, arthritis, and others.

Mental health care improvements

Eight survey participants looked beyond older patients to write about patients of any age with poor mental health being stuck in hospital. They advocated more resourcing for people with mental ill health or related wellness barriers to get them out of hospital or stop them going in.

People stuck in Mental health units due to not having a home, or due to paternalistic attitudes and risk averse attitudes of mental health professionals and family. [work witness]

Residential Support Accommodation with Mental Health staff specifically for the thousands around Australia in this situation. Current SRS residences are privately owned and are not 'supplied' with these vital services that are desperately needed.

Adoption by mental health services of best practice care provision for frequent presenters to Emergency Departments instead of admitting these people

have more dedicated treatment centres for drug abuse

Disability support and housing improvements

Similarly, 10 participants wrote about the need for people with disabilities to receive more support or more appropriate housing, so that they are neither stuck in hospital nor placed in residential aged care when they are in younger years.

better disability service housing

I think it happens because there's no place for those with disabilities

Get the young (disabled) out of aged care and properly fund their care. If there is money for submarines there is money for aged care. Want to fix delayed discharge FIX aged care and all ages disability services.

Transport assistance

Five participants recounted examples of people being stuck in hospital because they were waiting for transport home, over and above those who had no one to drive them home after a minor procedure (discussed in theme #13). Timely transport support, whether to the next suburb or hundreds of kilometres away, could reduce delays.

Most common delayed discharge I witnessed was people who lived remotely being not being discharged due to transport issues back to remote communities

Long way from home needed to fly family member to come and drive us home (10 hours) as husband no longer drives and I had significant leg injury (2024, <1 week)

at the time of the incident i lived in a remote area and had been flown to hospital with the flying doctor to perth [. . .] during the emergency treatment the nerves in my right hand were damaged so i could not manage to use public transport to return to Cue where my wife and i lived at the time and my wife was unable to drive down and back to pick me up. Arrangements were made to return me home via ambulance patient transfer. (2014, <1 week)

Subsidies for private services

Three participants suggested the government subsidise private care services at home or in private hospitals if public-funded care is stretched.

> Increase the funding so that there is enough money to pay for private care when home care workers are in short supply.

> The Government could provide a Rebate for going to a Private Hospital Emergency Department. It costs $500 to $600 with no Rebate available.

Fight ageist attitudes and language

Twelve participants linked delayed discharge to ageism or the ageist attitudes encapsulated in terms like 'bed blockers', contending such attitudes contribute to the neglect of older people and blame the victims rather than tackling the underlying problems.

> From the way it is presented in the media, I get the impression that it is 'old people' who are blocking the system [. . .] And this is true, but they have no choice in the matter. [. . .] It gives the impression that these 'old people' are having a lovely time just waiting around to be given a place.

> Use of the term "bed blockers" is dehumanising and deeply disrespectful to people, who have not chosen to be there but are being let down by a system that has closed its eyes to the need for alternate care design.

> When one is in old age, people tend to Ignore one.

> I can't think of anything other than a complete change in Australian society of our attitude to our aged.

Broaden access to VAD

Finally, three participants wrote about their desire for all of us to be able to die with dignity at a time of our choosing by accessing voluntary assisted dying (VAD). While it would be entering an ethical minefield for NSA to advocate for wider access to VAD to free up hospital beds, the theme is included here to fully reflect NSSS participants' legitimate views on this topic.

> VAD, only place in Australia doesn't have this. Would free up most hospitals and retirement places. [NT resident]

> older people needing aged care environments are being kept alive with 'drugs' when they would be better off being able to die with dignity. People with dementia are the worst cared for and kept alive with drugs when all they want to do is die. My mother was one of these people. The aged care facility found her a burden and treated her like a piece of garbage. Nothing was done about this. I am fearful that I will be the same and would prefer to commit suicide rather than suffer like her.

Conclusions

Conclusions

The time to act is now, but the frame of reference must be broad

Delayed discharge has become an issue worthy of media attention in recent times because of the large number of people who have been stuck in hospital long term while awaiting residential aged care.

As of May 2026, at the time of writing, health ministers across the country have committed to a joint taskforce to address that situation.

As part of this, the NSW Productivity and Equality Commission has announced it will undertake a review into stranded hospital patients. The review launch materials note that the number of patients stranded in NSW public hospitals because they are waiting for aged care placement has surged from 300 in 2023 to 776 in 2025.

NSA welcomes these government actions.

However, this report – like FTI Consulting's review and the 2025 discussion paper by Dementia Australia, COTA, Ageing Australia and OPAN – has shown that the circumstances leading to discharge delays, and its potential solutions, extend well beyond a shortage of residential care places.

NSA urges those charged with addressing the problem to take a wider perspective that considers the underlying causes, and to make change at a deep systemic level.

Delayed discharge should not be framed as a singular aged care capacity issue, but as a broader system design failure spanning hospital discharge planning, community access, transitional care infrastructure, dementia capacity, and consumer decision support.

While urgent interventions are required for the thousands of patients currently stranded in hospital, sustainable reform must focus equally on preventing future discharge delays through earlier planning, stronger community supports, and redesigned transition pathways.

The number and duration of delays will only be reduced in years and decades to come if action is taken on multiple fronts.

This report identifies 18 suggestions for change that emerged from NSSS participants' experiences and opinions and that also reflected FTI Consulting's recommendations.

The survey participants also put forward a few other suggestions to address the delayed discharge problem that were not highlighted by FTI Consulting.

These suggestions can be seen as, in some sense, both validating the conclusions of FTI Consulting and the 2025 discussion paper and also co-designing potential solutions to discharge delays.

The alignment between consumer experiences and existing system reviews strengthens confidence that these findings reflect genuine system pressures, while the additional lived experiences of older Australians provide practical insights for reform design.

All the suggestions merit attention. However, in this report, they have been sequenced thematically not presented in order of importance.

Some of the recommendations are fairly obvious and go to issues that require immediate attention. Clearly there is a need for more residential aged care places across the country, and faster access to home care, as the NSSS participants noted and experienced. These needs are well

established and are the primary focus of current public discussion on the issue.

The same is true of the need for more dementia care capacity, in residential aged care homes, hospitals, and elsewhere in the community, especially with the increasing numbers of people living with dementia as FTI Consulting and the 2025 discussion paper have noted.

This increasing prevalence of dementia adds urgency to reform, given the specialised care needs of this cohort and limited system capacity across hospitals, aged care, and community settings.

In general, the similarities between the NSSS data, FTI Consulting's review and the 2025 discussion paper leads NSA to endorse these two other reports and their recommendations.

But other important points have emerged from this NSSS data too and are worth drawing attention to here.

Many older Australians lack personal support networks

A critical structural issue emerging from this research is that discharge systems continue to rely heavily on informal care assumptions that do not reflect the reality of many older Australians, particularly those living alone.

The current healthcare system is built on the assumption that family or friends will be able to provide care and support for a patient after discharge, including staying with them after a routine procedure.

However, many older people do not have the care and support of family or friends available to them. The NSSS comments showed this is a common reason older patients' discharge was delayed.

The percentage of older people living alone is much higher than the percentage of younger age groups, with 25% of those aged 65+ living alone in 2016.

This is a much higher percentage than the all-ages average (10%), suggesting a greater proportion of older people are at risk of having no one to care for them after discharge from hospital.

This sociodemographic shift should be a key consideration in any response to the delayed discharge crisis.

NSSS commenters noted that policy makers have known about the likely impact of the post-war baby boom for decades.

However, the large number of older people living alone at this time without support from family or friends may not have been anticipated in past government planning.

Future health and aged care policy must be designed around changing demographic realities, not outdated assumptions about family care availability.

More transitional care could add considerable value

This report, the review by FTI Consulting, and the 2025 discussion paper all suggest there is an urgent need for more clinically supported transitional care.

Investment in transitional care, including step down care, rehabilitation, respite, palliative transition pathways, and short term recover services may offer one of the most practical system-wide opportunities to reduce avoidable hospital occupancy while improving patient outcomes.

There may be several benefits to older people of investing in transitional care.

A large proportion of the NSSS participants whose own discharge was delayed were stuck in hospital for less than one week, often only for a routine overnight stay. For many this overnight was needed because they had no one at home or no transport to get home after a procedure.

Transitional facilities could be used for these routine overnights – for patients of any age – to make more hospital beds available on a daily basis.

Older people often take longer to recover from medical conditions or treatments and are more susceptible to hospital-acquired infections and complications, so are more likely to need a longer duration of supervised recovery time. A transitional facility could be a suitable place for some patients in these situations, particularly if they included attention to mobility assistance and rehabilitation for patients readying to be discharged.

Transitional facilities are sometimes also better places for patients to consider their care options after hospital treatment, without feeling time pressured.

The examples documented by the FTI Consulting review show that transitional facilities are crucial for delivering person-centred care in such decision-making periods. The review argues that enabling people to have more time to take stock of the assistance available to them and make better decisions would likely lead to fewer premature entries to residential care. This would in turn reserve residential care beds for those who need them most.

Earlier preparation may reduce discharge delays

The FTI Consulting review recommends commencing discharge planning at the time of hospital admission.

It also recommends a suite of other changes to support such planning, including having a designated aged care navigator within health services and having real time information about residential bed occupancy available to hospital staff.

These recommendations were all reflected in NSSS comments.

But another aspect of discharge planning could assist as well.

The comments showed that patient fear or hesitancy about aged care options is a reason why some face delays, and family disputes about options can also add delay.

Improving public information about aged care pathways and making future care planning easier before crisis points may reduce avoidable delays and improve decision making outcomes for older Australians and their families.

Few NSSS participants had taken steps to plan for the possibility of needing residential care, but a greater proportion of those who had experienced delayed discharge had taken such steps.

Finding out exactly what older people need to feel able to take these planning steps would be a useful avenue for future research.

In short

Delayed discharge is not simply a hospital flow issue, nor solely a residential aged care capacity problem. It is a symptom of deeper fragmentation across health, aged care, and community support systems.

While immediate action is needed for older Australians currently stranded in hospital, long term reform must focus on preventing recurrence through better discharge planning, stronger transitional care infrastructure, faster access to community supports, improved dementia capability, and policy settings that reflect the reality that many older Australians do not have informal carers to rely on.

The lived experiences captured in this report provide an important consumer-informed foundation for practical reform.

Methods

The information in this report comes from the iteration of the National Seniors Social Survey (NSSS) conducted in January-February 2026.

Anyone aged 50 or older who resides in Australia is welcome to participate in the NSSS.

The survey received ethics approval from Bellberry Ltd prior to implementation (approval 2025-11-1852).

The survey included a module about delayed discharge. For a more detailed quantitative overview of the results of each survey question in this module, see the NSSS-26 summary report to the Department of Health, Disability and Ageing.

The software package Stata v18 was used for all quantitative analysis. Statistical tests took the form of chi-square analysis. P-values <.05 were considered significant.

Comments were analysed for this report using the thematic analysis framework described by Braun and Clarke. We identified themes via inductive analysis guided by a critical realist approach that aimed for accuracy and objectivity in interpreting participants' views.

The number of comments comprising any given theme was estimated to give a sense of its prominence. The data were not cross-coded so numbers should be treated as estimates only.

Quotes from survey participants were selected to illustrate some of the variety and prevalence of ideas expressed.

Where possible, quotes were reproduced verbatim, occasionally omitting or altering parts for clarity or anonymity (indicated with square brackets []). Minor typos were corrected for readability (no brackets). We retained all other phrasing idiosyncrasies.

When inviting people to participate in the NSSS, we strive for greater inclusivity and maximising participation, rather than numerical representativeness. This is especially relevant to open-ended questions because people's unique experiences are the focus, not statistical patterns, and some groups are more likely than others to write a comment.

For this reason, we summarise key demographic traits of the sample for readers' information (over page).

Sample

The percentages below characterise the demographic traits of the 2111 participants who indicated they had experienced or heard of delayed discharge in any capacity. Note that this number includes participants who skipped some (or in a few cases all) subsequent questions about delayed discharge.

No question was compulsory, and unsure responses are not shown, so some rows do not add up to 100%.

Age group	50-64 years 8%	65-74 years 45%	75-84 years 40%	85+ years 5% (oldest 100)
Self-rated health	Excellent 13%	Good 58%	Fair 24%	Poor/very poor 5%
Savings including super	<$200k 27%	$200k-$500k 17%	$500k-$750k 10%	>$750k 25%
State or territory	ACT 4% SA 11%	NSW 23% TAS 3%	NT 1% VIC 16%	QLD 32% WA 10%
Not metro	Regional 25%	Rural 10%		Remote 1%
Gender	Female 63%	Male 37%		Non-binary 3 people
Partner status	Single 14%	Live with partner 55%		Divorced/widowed 27%
Education	School up to Year 10 13%	Year 12 or cert/dip 39%		Degree or higher 47%
Diversity groups	First Nations 1% Living with disability 6%	CALD background 3% Veteran 4%		LGBTI 2%
Other	Live alone 37%			

The percentages were slightly different for the 3979 participants who answered the hypothetical scenario question of whether there was anyone in their life who could provide high level care to them at home in the short, medium, and long term and/or the question about level of engagement with residential care.

Age group	50-64 years 9%	65-74 years 44%	75-84 years 40%	85+ years 6% (oldest 100)
Self-rated health	Excellent 13%	Good 57%	Fair 24%	Poor/very poor 5%
Savings including super	<$200k 29%	$200k-$500k 16%	$500k-$750k 9%	>$750k 25%
State or territory	ACT 3% SA 9%	NSW 25% TAS 2%	NT 1% VIC 18%	QLD 31% WA 10%
Not metro	Regional 27%	Rural 10%		Remote 1%
Gender	Female 57%	Male 43%		Non-binary 4 people
Partner status	Single 13%	Live with partner 58%		Divorced/widowed 25%
Education	School up to Year 10 16%	Year 12 or cert/dip 41%		Degree or higher 41%
Diversity groups	First Nations 1% Living with disability 6%	CALD background 3% Veteran 5%		LGBTI 2%
Other	Live alone 34%			

**Survey data unweighted.*

The head office of National Seniors Australia is located in Brisbane/Meanjin but we represent older people from across this great continent.

We acknowledge the traditional custodians of the land and waters in which we operate, the Turrbul People, and all other First Nations, Aboriginal, and Torres Strait Islander people.

We honour and value their continuing cultures, contributions, and connections to Country, and pay our respects to Elders, past and present.

We extend our warmest thanks to the thousands of older people who participated in the 2026 National Seniors Social Survey, who so generously gave their time, thoughts, stories, and personal information. Without them this report would not be possible.

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