Evolution of the Care Economy Summit 2026

Transitions in the care economy – how to approach reform and regulation

THE UNIVERSITY OF SYDNEY
Leeder Centre

Sponsored by IHACPA

Thursday 6 August 2026

The Refectory, Holme Building, University of Sydney

Leeder Centre for Health Policy, Economics and Data, University of Sydney, proudly supported by the Independent Health and Aged Care Pricing Authority

Transitions in the Care Economy: From a Collection of Care Systems to a System of Care

The Leeder Centre for Health Policy, Economics and Data at the University of Sydney, with the support of the Independent Health and Aged Care Pricing Authority (IHACPA), convened a national summit to consider how to improve the transitions that people make between services, settings and stages of life.

The summit brought together researchers, policy makers, clinicians, and system leaders from Australia and overseas. Discussions ranged from hospital capacity and long-stay older patients to aged care, primary care, virtual care, workforce, information systems, funding and payment reform, regulation and research. Despite this breadth, common messages emerged.

People experience a journey through care. They do not experience hospitals, primary care, aged care, disability and community services as separate systems. Yet our systems are organised, funded and governed largely along these boundaries. Transitions between and across care services are not a new phenomenon. They have existed for as long as care has been organised through separate institutions and professional domains. What has changed is the complexity of people's needs and the growing consequences of systems that remain organised around those institutional boundaries.

The challenge is therefore not simply to improve individual services. It is to understand where the boundaries between services create problems for people, and to find practical ways of making those transitions work better.

Hospitals have historically dominated both the delivery of care and the way we think about care. This remains evident in the way system performance is often framed around hospital access, capacity, activity and flow, even when the underlying problem lies elsewhere in the care journey. The summit brought the focus back to what happens when people move between services and, importantly, when they become stuck.

This is particularly important in Australia. Our federated system means that responsibility for funding, policy, regulation and service delivery is distributed across different levels of government and across sectors.

These arrangements are deeply embedded and are unlikely to change fundamentally in the near term. Reform therefore needs to work with the system we have, while finding ways to overcome the friction that its boundaries can create.

The summit identified key issues that can guide this next phase of reform

From separate systems to connected care

The Australian health and care system is not one system. Commonwealth, state and territory governments, local providers and different sectors have distinct responsibilities, funding arrangements and accountability structures. These boundaries are not simply administrative details: they shape incentives, decision-making, information flows and the services available to people.

Many of the problems experienced in one part of the system are consequently symptoms of problems somewhere else. A hospital may struggle with capacity because appropriate care is unavailable elsewhere. A person may remain in hospital because there is no suitable aged-care placement or community support. Primary care may struggle to access information generated in hospital. Families and carers may be left to coordinate services across multiple systems that were never designed to connect. Furthermore, where they commence their care may impact on how people's care trajectories and treatment.

The answer to those problems is unlikely to be a wholesale redesign of Australia's federation. Nor is integration an end in itself. A more pragmatic approach is to identify where the consequences of fragmentation are most visible and consequential, and focus reform there.

Long-stay older patients provide a particularly clear example. A person may no longer require acute hospital care but remain in hospital because the next appropriate service is unavailable. This is not simply a hospital efficiency problem. It is a problem arising at the interface between hospital care and the services, workforce, funding and supports required to enable a person to move to the next stage of their care journey.

The experience of long-stay older patients therefore provides an important opportunity to understand where the boundaries between sectors are failing people and where targeted reforms could make a material difference. It therefore provides a powerful indicator of whether health and aged care systems are working effectively together.

Evidence presented at the summit showed growing pressure at this interface in Australia, with long-stay patients spending longer in hospital. Both the United Kingdom and Canada are confronting similar pressures, despite differences in their health systems. In England, around 14,000 people on an average winter day were reported to be medically ready for discharge but waiting for a suitable care placement, representing around 10 per cent of the acute hospital bed base. Canadian experience was presented as an even stronger warning of the consequences that can arise when these system interfaces fail.

Virtual care can be part of the response to fragmentation. Well-designed virtual models have the potential to connect people with care across geographic and organisational boundaries, bring services closer to home, support earlier intervention and reduce unnecessary reliance on hospital-based care. The important question is not whether virtual care is inherently better. It is where and under what circumstances virtual models can improve transitions and outcomes, and what funding, workforce and governance arrangements are required to support them.

Make it possible for systems to talk to each other

Different countries, with very different health systems, face remarkably similar challenges in getting information to move between services. This suggests that information fragmentation is not simply an Australian peculiarity, it is a structural challenge.

In a federated system, where organisations and governments have different responsibilities, the ability to communicate and exchange information becomes a form of essential infrastructure for integration. The priority should therefore be interoperability, appropriate information sharing and the ability to build on existing systems.

Put people and their journeys at the centre

The case for better transitions is about people's experiences. The summit heard how families and carers frequently absorb the costs of gaps between services. They coordinate appointments, transport, information and support, and often step in when the formal system cannot provide what is needed. For people with complex needs, the boundaries between hospital, aged care, primary care, disability and community services can become particularly difficult to navigate.

The needs of Australians accessing care are also becoming increasingly complex, particularly as people live longer with dementia, chronic conditions and multiple, interacting health and care needs. These changing patterns of need make the quality of transitions increasingly important.

A person does not cease to need care simply because they have been discharged from hospital. A more integrated care economy puts the person, their family and their carers at the centre of system design. The individual journey should become an increasingly important unit of analysis for health and care reform. For some older complex and frail patients we need to move from phased/staged care across sectors to mutualised care. This requires a shift in perspective: from asking whether individual services are performing well to asking whether the transition between them is working for the person.

Use funding and payment reform to support better transitions

The way services are funded influences what providers do, what they measure, what they invest in and where they assume responsibility. Funding arrangements can reinforce boundaries between sectors, or they can help overcome them.

The new 2026–32 National Health Reform Agreement (NHRA) creates an important opportunity to reconsider these arrangements. It provides a framework for pursuing better outcomes and experiences, greater value and stronger shared stewardship. It also creates opportunities to develop and test new approaches to service models and funding.

This is an opportunity to move the discussion beyond the question of how individual services are paid. This does not mean that every service should be bundled, integrated or subject to a new payment model. Different problems will require different approaches.

Payment reform should instead be targeted towards circumstances where existing funding arrangements contribute to identifiable problems in care, where there is sufficient opportunity to influence behaviour, and where outcomes can be meaningfully measured.

The summit reinforced that even if financial barriers between sectors were reduced, integration would still require investment, information, governance, workforce capability and the involvement of the right decision makers.

The opportunity presented by the NHRA is therefore to use funding reform selectively and strategically, while developing the other capabilities needed to make those reforms work.

Build the capability to reform

The summit also raised a broader question about why improvement can remain difficult despite substantial innovation and demonstrated capacity to develop new ways of working. The problem is not necessarily a lack of ideas or an unwillingness to innovate. It is often the difficulty of escaping established ways of working, assumptions and organisational cultures that have developed around the existing system.

This is an important distinction. Reform does not simply require generating new solutions. It requires creating the conditions in which those solutions can displace or reshape established practices when the evidence shows that change is warranted. The challenge for the next phase is to ensure that new initiatives build on what has already been learned rather than repeatedly starting again.

New payment approaches require organisations to understand new incentives, manage risk, collect and use better information, measure outcomes. It also requires providers. governments and system managers to work together differently to design and oversee new models of care.

The next phase should be viewed as an opportunity to invest in the infrastructure of reform itself: data and analytical capability, evaluation expertise, implementation capability, workforce skills, governance arrangements and the institutional capacity to learn.

This is particularly important where reforms involve new payment models. Payment reform changes incentives, and the responses of providers and patients may not always be predictable. Evidence needs to be generated as reforms are implemented, not simply after they have concluded.

The NHRA creates an opportunity for a series of reforms, pilots and experiments across different settings. Each has the potential to generate valuable information about what works, what does not, for whom, and under what circumstances.

The value of this activity will be limited, however, if each pilot is treated as a stand-alone exercise. A successful reform program needs a mechanism through which knowledge can accumulate. The experience of one pilot should inform the design of the next, lessons about implementation should be available to those designing subsequent reforms, and evidence about unintended consequences should become part of the institutional knowledge of the system.

Without institutional backing, alternative mechanisms for such endeavours are needed. These could include shared research and evaluation frameworks, common outcome measures, consistent approaches to documenting implementation, cross-program learning networks, linked data and repositories of evidence, and deliberate partnerships between governments, system agencies, providers and universities.

Making research a driver of health system reform

Research should not sit outside reform, evaluating it only after the policy has been implemented. Nor should policy development proceed without mechanisms for generating evidence about what is working.

The scale and complexity of the reforms envisaged under the NHRA create an opportunity for a much closer relationship between research and policy.

Researchers can help identify the problems that matter, design and test interventions, develop measures of outcomes and value, examine distributional consequences and identify unintended effects. Policy makers and system leaders bring the operational knowledge, institutional context and ability to translate evidence into action. These capabilities are complementary.

The reform agenda should therefore be accompanied by an explicit learning agenda. This includes the need for sustained investment in research. Dedicated funding for health and funding reform could help build the critical mass and institutional capability needed to support this work, while enabling each reform to generate evidence that informs the next.

The Medical Research Future Fund provides an existing mechanism through which research related to reform activities could be supported, creating an opportunity to strengthen the connection between research investment and the implementation of the new NHRA.

Key conclusions

The discussions at the summit point to 6 priorities for the next phase of Australia's care economy reform:

Focus on the transitions that matter most. Identify the points where fragmented responsibilities create the greatest consequences for people, carers and the system, and use these as practical priorities for reform.

Use the NHRA as an opportunity to test and learn. The new NHRA provides an important platform for developing and testing new approaches to models of care and payment. Reform should be targeted at identifiable problems and designed to generate evidence that can inform future policy.

Build the infrastructure for connected care. Better transitions require systems that can communicate. Interoperable information and communication technology, appropriate information sharing and common approaches to data are foundational infrastructure for a more connected care economy.

Build institutional capability alongside reform. Payment and service reform require capability in policy design, implementation, data, evaluation, risk management, workforce and governance.

Create a collective memory for reform. Every pilot should contribute to the next. Australia needs mechanisms to capture, synthesise and share lessons across reforms so that knowledge accumulates rather than being lost between programs and institutions.

Strengthen the partnership between research and policy. Research and policy should work together throughout the reform cycle. The evidence base for the care economy needs to be built alongside reform, enabling policy makers and system leaders to learn, adapt and scale what works and be supported by dedicated research funding opportunities.