



# AAG

Australian  
Association of  
Gerontology

## Legislation to action: Delivering inclusive care for all



2025



To improve the experience  
of ageing through  
**CONNECTING**  
**RESEARCH, POLICY**  
and **PRACTICE**

## Acknowledgement of Country

AAG acknowledges Traditional Owners of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures, to Elders past and present, and to all Aboriginal and Torres Strait Islander peoples, including members of the Stolen Generations.

For further information, see the AAG [Aboriginal and Torres Strait Islander Ageing Advisory Group](#).

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# Legislation to action: Delivering inclusive care for all

## Background and introduction

The Australian Association of Gerontology (AAG) is Australia's only independent, impartial membership organisation whose overarching aim is to improve the experience of ageing by connecting gerontological research, policy, and practice. AAG has 1,400 members across Australia, including ageing and aged care researchers, educators, policymakers, health professionals, service providers, advocates for older people, and community members.

This report is in response to a request from the Australian Government Department of Health, Disability and Ageing for evidence and challenges to achieving greater inclusion in Australian aged care.

Initiatives and frameworks for inclusion in care systems and services aim to promote equitable access for people in marginalised, disadvantaged, and underserved communities. However, these frameworks do not always work as intended to ensure inclusion. Some of the reasons for this include structural and systemic challenges that limit the scope of inclusive practice.

This paper explores several challenges to achieving greater inclusion in Australian aged care, including systemic barriers stemming from a market-based model that limits equitable access and the difficulty for individuals to navigate the complex system.

The paper also highlights the problem of policy and service siloing, which results in fragmented care and the exclusion of vital supports. It also addresses the detrimental impacts of ageism and ableism, leading to the homogenisation and marginalisation of older adults. Finally, the document argues for a shift towards personalised, intersectional approaches that embrace individual complexity, noting that current reform processes fall short of genuine co-design due to insufficient resources and a lack of diverse representation

## Barriers to inclusive care

### 1. Rationing and (in)equity of access

The continuation of a rationed, market-based system, rather than a service to meet the rights and needs of individuals, perpetuates inequity of access. Wait times for older people seeking aged care through the Australian Government-funded care system persist, despite increases in the number of packages made available.<sup>1</sup> This demonstrates the system's current inability to meet demand and the needs of older people.

AAG has previously recommended in several forums<sup>2</sup> that the Aged Care Statement of Rights be amended to include *the right of older people to access care that addresses their aged care service needs*. The Statement of Rights, as defined in the Aged Care Bill 2024,<sup>3</sup> will apply once a person is in receipt of aged care services, not to those who more broadly *need* services. This

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<sup>1</sup> Jones, K.L. (2025). Wait times to access care up, shows report. Australian Ageing Agenda. <https://www.australianageingagenda.com.au/research/wait-times-to-access-care-up-shows-report>

<sup>2</sup> e.g. submissions on the Exposure Draft of the Aged Care Act, to consultations run by the Department of Health, Disability and Ageing, to the Senate Community Affairs Legislation Committee for Inquiry on the Aged Care Bill, and 2025 Progress Report on Implementation of Aged Care Royal Commission Recommendations.

<sup>3</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Bills\\_Legislation/Bills\\_Search\\_Results/Result?bId=r7238](https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7238)

set of parameters around rights is tied to the continued rationing of care and is at odds with the recommendations of the Royal Commission into Aged Care Quality and Safety (hereafter, Royal Commission), which included that planning be based on need, not a rationed system, in line with international human rights principles.<sup>4</sup> The aged care approach contrasts starkly with the Australian Charter of Healthcare Rights which sets out the right to access healthcare services and treatment that meets an individual's needs.<sup>5</sup>

A second ongoing issue for equity of access is the navigability of the system. Our members continue to express concern about this issue, the complexity involved in case management, and the ability of people needing care services to understand their rights and obligations and the services available – concerns that are reflected in the literature about consumer-directed care systems, including Australia's system.<sup>6 7</sup> They report that there continues to be unmet need for simple and accessible resources and advocacy support, particularly for diverse cohorts, to help people understand eligibility and to find services.

The Care Finder program, implemented following the Royal Commission's call for navigation support, has provided valuable support for those eligible to use it. However, limitations in what can be provided under the scheme exclude the hands-on intensive case support that some older people need, in particular those with language or cultural needs or those experiencing disadvantage. The Care Finder implementation evaluation report noted the program should be extended to include the provision for case management support where needed, and notes some Care Finder providers are doing so (despite it being outside the program guidelines).<sup>8</sup> Additional support programs, such as the Australian Government's Elder Care Support (ECS) program,<sup>9</sup> and provider-designed services such as the Brotherhood of St. Laurence's Critical Interim Support program,<sup>10</sup> provide examples of more expansive supports for older people than are available through Care Finder.

Third, inclusive care must extend beyond the care recipient to the people supporting them. Our members have emphasised that carers often feel left out, disrespected, and not recognised for their crucial role. They may also be actively excluded from appointments and care processes, even when they can provide unique support and context. However, carers continue to play a vital role, including advocacy, even after the person they care for moves into residential aged care. Carers perform numerous tasks, including complex and time-consuming case management. The support they provide is often without payment or far exceeds the allowances and supplements they may receive. The challenges faced by carers within the care system,

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<sup>4</sup> Royal Commission into Aged Care Quality and Safety (2021). Final report: Care, Dignity and Respect. Commonwealth of Australia. <https://www.royalcommission.gov.au/aged-care/final-report>.

<sup>5</sup> <https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights>

<sup>6</sup> Xie, Y., et al. (2024). Navigating Community-Based Aged Care Services From the Consumer Perspective: A Scoping Review, *The Gerontologist*, 64, 2, <https://doi.org/10.1093/geront/gnad017>

<sup>7</sup> Xie, Y., et al. (2024). Barriers Experienced by Community-Dwelling Older Adults Navigating Formal Care: Evidence From an Australian Population-Based National Survey. *Journal of Aging and Health*, 0(0). <https://doi.org/10.1177/08982643241263132>

<sup>8</sup> Department of Health, Disability and Ageing (2024). Evaluation of the care finder program. First evaluation report. <https://www.health.gov.au/sites/default/files/2024-05/first-report-on-the-implementation-of-the-care-finder-program.pdf>

<sup>9</sup> Department of Health, Disability and Ageing. (2025). Elder Care Support. <https://www.health.gov.au/our-work/elder-care-support>

<sup>10</sup> <https://www.bsl.org.au/research/publications/cis-eval/>

their own unique need for support, and the myriad of vital roles they play as direct care providers, advocates, and case managers are well-documented.<sup>11 12 13 14 15 16 17</sup> Importantly, AAG members have highlighted moves to allow family members to be paid for providing care services as an area requiring greater consideration. There is some recognition of the burden on family carers via carer payments and allowances as well as reforms to make Carer Payment's work/ study/ volunteering limits more flexible. However, legislation / policy allowing family members to be paid as carers is very restricted. Further, a lot of grey areas remain, including relating to eligibility. The practical effect for many is that unpaid family carers continue to carry a heavy load with only limited financial and policy support, often facing trade-offs (e.g. giving up work) to qualify for assistance.

## 2. Policy silo-ing and segmentation of the life course (and the community)

Different government departments and services, such as health, housing, social services, and aged care, are not well integrated. Policies relating to aged care have tended to be developed in isolation from other policies related to the broader health and social welfare system.

This siloing of services can create gaps where individuals may not be able to access comprehensive care and support or coordinate treatments effectively, leading to disjointed care. For instance, an older person might need to access both healthcare services (such as Medicare-funded services) and aged care services (such as through a Home Care Package or residential care), yet these services are often not well coordinated. Similarly, older Australians may experience difficulties in coordinating the social services they need, such as housing or financial assistance, alongside appropriate aged care. We continue to hear concerns from our members that essential services such as oral health assessments and dental referrals, sexual health services, and spiritual supports are excluded from aged care funding models, making them more difficult to access and more likely to be missed from holistic care. Despite policy

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<sup>11</sup> Fetherstonhaugh, D., et al. (2021). 'You become their advocate': The experiences of family carers as advocates for older people with dementia living in residential aged care. *J Clin Nurs*, 30: 676-686. <https://doi.org/10.1111/jocn.15589>

<sup>12</sup> Larkey, FA, Hughes, M, & Nancarrow, S. (2024). The experience of entering residential aged care: The views of residents, family members and staff: an Appreciative Inquiry. *Australasian Journal on Ageing*. 43: 52-60. doi:10.1111/ajag.13236

<sup>13</sup> Scand, J. (2021). 'I know his needs better than my own': Carers' support needs when caring for a person with dementia. *Caring Science*, 35: 586-599.

<sup>14</sup> Temple, J., Dow, B., & Kosowicz, L. (2021). Carers of older Australians: Unmet support needs and carer well-being. *Australian Journal of Primary Health*, 27, 178-185.

<sup>15</sup> Heath, A., Carey, L.B., & Chong, S. (2018). Helping carers care: An exploratory study of factors impacting informal family carers and their use of aged care services. *Journal of Religion and Health*, 57, 1146-1167. <https://doi.org/10.1007/s10943-018-0593-3>

<sup>16</sup> Monro, C., et al. (2023). 'I could no longer cope at home': Experiences of clients and families in residential aged care within the context of Australia's aged care reforms. *Australasian Journal on Ageing*. 42: 344-354. doi: 10.1111/ajag.13159

<sup>17</sup> Hamilton, M., et al. (2024). The importance of recognition: predictors and outcomes of carer recognition among working carers of ageing relatives. *Community, Work & Family*, 1-26. <https://doi.org/10.1080/13668803.2024.2413874>

attempts to integrate care, the burden of coordination, or “integration”, is left to individuals and carers.<sup>18</sup>

This contrasts with recommendations from the Royal Commission that aged care be better integrated into the health and other support systems for older people (e.g. *Recommendation 4: Integrated long-term support and care for older people; Recommendation 13: Embedding high quality aged care; Recommendation 38: Residential aged care to include allied health care; and several others*).<sup>19</sup>

In particular, our members highlight that difficulties in accessing allied health services (e.g., physiotherapy, psychology, occupational therapy) abound in residential aged care. The allied health workforce has only recently been considered, described by one of our members as a “sidestep” after other professions were addressed. Indeed, analysis of Australian data has indicated that the lack of regulatory requirements around allied health services, combined with the introduction of requirements around nursing and personal care, provided an incentive for allied health use to be reduced.<sup>20</sup> While a quality indicator regarding allied health minutes has been introduced, there is no guidance around how allied health can be involved, or how it could be embedded within care services. AAG members express concern that the aged care sector has limited capacity to understand the roles of allied health professionals and why they should be involved.

One specific example of the negative impacts of disjointed systems is the issue of psychological support for older adults, particularly those in residential care or receiving home care who are living with dementia. Our members report that the Better Access scheme does not work effectively in aged care settings and does not cover dementia as a primary presenting issue, creating “needless roadblocks” and requiring workarounds. Older Persons’ Mental Health Services may refuse clients if they are seeing a private psychologist, hindering collaborative care. Therefore, our members tell us that even though mental illness often precedes or co-occurs with a dementia diagnosis, the fragmented and siloed approach to care significantly delays diagnosis and appropriate support.

One particularly persistent example of segmentation based on both category of ‘need’ and of ‘age’ is the separation between aged care and disability services. This is a significant area of concern for AAG members. Some older people with disabilities may have care and support needs that don’t fit neatly into one category. Aged care services may not be equipped to support people with lifelong disabilities, and appropriate disability services may not be available to older people, creating care gaps.<sup>21</sup> As Hussain et al. (2021) summarise:

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<sup>18</sup> Ludlow, K., et al. (2021). Policy Delusions and Dutiful Daughters: Imagined Versus Real Care Integration for Older People. In: Kislou, R., Burns, D., Mørk, B.E., Montgomery, K. (eds) *Managing Healthcare Organisations in Challenging Policy Contexts. Organizational Behaviour in Healthcare*. Palgrave Macmillan, Cham. [https://doi.org/10.1007/978-3-030-81093-1\\_4](https://doi.org/10.1007/978-3-030-81093-1_4)

<sup>19</sup> Royal Commission into Aged Care Quality and Safety (2021). *Final report: Care, Dignity and Respect*. Commonwealth of Australia.

<sup>20</sup> Gibson, D., & Isbel, S. (2024). Reform and reverberation: Australian aged care policy changes and the unintended consequences for allied health. *Australian Occupational Therapy Journal*, 71(3), 392–407. <https://doi.org/10.1111/1440-1630.12953>

<sup>21</sup> Hussain, R., et al. (2021). Mitigating the impact of the ‘silos’ between the disability and aged-care sectors in Australia: Development of a Best Practice Framework. *Journal of Applied Research in Intellectual Disabilities*, 34: 1477-1488. <https://doi.org/10.1111/jar.12890>

*A seamless service system requires a care model with the capacity to respond to the needs of people as they age, including both ongoing and emerging needs. The current service system, with an arbitrary delineation based on chronological age or disability type, does not accommodate those that do not 'fit' into the government's tightly defined boxes (p. 1485).*

There are also differences in funding arrangements between the two schemes, resulting in different requirements to contribute to the costs of care. These inequities are at odds with Royal Commission Recommendations that older people living with disability should be able to access the same level of support available to them under the National Disability Insurance Scheme (NDIS) if they are aged under 65.<sup>22</sup> Thus, in practice, an arbitrary hard line can be drawn between systems that serve younger and older people, creating gaps through which the more nuanced real needs of individuals can fall. This segmentation of ageing can also lead to a narrowed focus on older people as recipients of care and support, rather than as active participants in society, with ambitions and ongoing contributions.

There is an opportunity for recent changes to the structure of the Department of Health, Disability and Ageing, and responsibilities within the Australian Government, to go some way in addressing the silo-ing and segmentation of policy and services. It is encouraging to see “ageing”, rather than “aged care”, once again explicitly the focus of a major Cabinet portfolio, with aged care remaining an explicit portfolio in the outer ministry. Disability services and aged care services are also now combined within this single department, which may offer an opportunity for greater integration of policy and system approaches.

It will be important that, in taking advantage of this opportunity, the way ageing is conceptualised and addressed in policy does not default back to a traditional, medical model of ageing. The medical model tends to treat ageing as a primarily health-related issue, attempting to “standardise” the ageing experience and treating individuals as though they are the same. Rather, ageing is a multi-faceted, complex phenomenon impacting and impacted by broad and diverse areas of policy and community functioning. The “bundling” of ageing broadly within health and disability presents a risk of reinforcing, in perception and in practice, the view of ageing as a health-focused experience of decline.

Recent changes to the care system have attempted to address this in practical terms. For example, there has been considerable criticism of the reliance on clinical measures of care quality and effectiveness. This is a limiting approach for care that fails to address the actual experiences and preferences of older people regarding care quality.<sup>23</sup> The inclusion of consumer experience and quality of life as quality indicators in aged care is a significant step towards embedding a broader model of the ageing experience into the design of the aged care system. There have been calls for more comprehensive, interdisciplinary, and more rigorous measures to adequately understand the needs, met and unmet, of older people and carers in

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<sup>22</sup> Royal Commission into Aged Care Quality and Safety (2021). Final report: Care, Dignity and Respect. Commonwealth of Australia.

<sup>23</sup> Cleland, J., et al. (2021). What defines quality of care for older people in aged care? A comprehensive literature review. *Geriatrics and Gerontology International*, 21: 765–778. <https://doi.org/10.1111/ggi.14231>

the aged care system.<sup>24</sup> Nevertheless, the persistence of policy approaches and systems that conflate ageing with deficit-based aged care services, decline, and dependency has severely limited the scope of opportunities to support healthy ageing. Instead, there is an opportunity to treat ageing as an ongoing, dynamic experience that encompasses opportunities for growth and continued agency across diverse domains of life.

### 3. Ageism and ableism

Both ageism and ableism in aged care represent significant barriers to inclusive practice. One of the ways these are evident in care and policy impacting older people more broadly is in the oversimplification and homogenisation of older adults as a group. While there is broad recognition that older people represent a large, diverse, and dynamic cohort, these nuances are frequently lost in practice. This can have significant and damaging effects.

For example, it can appear in assumptions about interests and aspirations, available resources, capability, adaptability, and capacity, or about health and functioning. The result of ageist attitudes may include patronising or negative communication, exclusion from decision-making and loss of autonomy, under-treatment or inappropriate interventions, or, at its worst, neglect or abuse.<sup>25 26 27</sup> This tendency to treat all older adults as if they are the same, often defined by presumed vulnerability, physical frailty, or cognitive impairment, overlooks the reality that ageing is a complex, multifaceted process that varies widely from person to person.

These stereotypes are particularly pervasive when applied to individuals living with cognitive impairment or dementia, often seen as incapable of participating meaningfully in decision-making, enacting their own agency, or developing and strengthening capacities. Such views, rooted in ageism and ableism, not only undermine the dignity of older individuals but also perpetuate a cycle where their potential contributions to society, as well as their preferences and desires for their own care, are ignored. Ultimately, these attitudes limit the possibilities for inclusive, person-centred care that respects the diverse needs and aspirations of older adults.

The impacts of this can perhaps be most clearly seen in risk-averse systems of oversight and regulation, which prioritise risk avoidance and safeguarding. In this type of system, providers can be more focused on compliance and avoiding repercussions than on shaping care to the individual. This often results in a paternalistic approach to decision-making and can inadvertently limit access to services, activities, or choices that could enhance quality of life. This has particularly negative consequences for those experiencing severe or persistent disadvantage, as well as individuals living with cognitive impairment or dementia, facing multiple, intersecting barriers that are compounded by systemic limitations on their agency. As a

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<sup>24</sup> Hill, T., et al. (2025). From rationing to rights: measuring unmet care needs to transform aged care systems. *Care Poverty and Unmet Needs*, 43. [https://www.researchgate.net/publication/392019149\\_From\\_rationing\\_to\\_rights\\_measuring\\_unmet\\_care\\_needs\\_to\\_transform\\_aged\\_care\\_systems](https://www.researchgate.net/publication/392019149_From_rationing_to_rights_measuring_unmet_care_needs_to_transform_aged_care_systems).

<sup>25</sup> Chhetri, A., & Kanawati, N. (2021). "What can you expect at your age?!" an investigation of recent experiences of age discrimination by older adults accessing health care. *Ageism in Health Care Final Report*. Older Women's Network NSW and Health Consumers NSW. <https://hcnsw.org.au/projects-campaigns/ageism-what-can-you-expect-at-your-age/>

<sup>26</sup> Australian Human Rights Commission (2021). What's age got to do with it? A snapshot of ageism across the Australian lifespan. <https://humanrights.gov.au/our-work/age-discrimination/publications/whats-age-got-do-it-2021>

<sup>27</sup> Henry, J.D., Coundouris, S.P., & Nangle, M.R. (2024). Breaking the links between ageism and health: An integrated perspective. *Ageing Research Reviews*. 95. <https://doi.org/10.1016/j.arr.2024.102212>.

result, those most in need of personalised and flexible care are most likely to be excluded, or to have their rights, autonomy, and individuality curtailed. Safeguarding and risk management are essential in a system where individuals can be extremely vulnerable. However, inclusive aged care, and care that aligns with the Australian Aged Care Standards, requires flexibility and personalisation, supporting individual agency through responsive and respectful relationships at the point of care.<sup>28</sup>

While strides have been made in challenging ageism and ableism, including through Australian Government frameworks and standards, there are some significant areas where the impacts persist. This manifests at all levels of the policy and service development process, including in research where risk-averse research and ethics approaches have limited the participation of individuals with cognitive impairment in research, effectively silencing their voices in the evidence base.<sup>29</sup> It also manifests at the point of care, where, as just two examples, people with dementia can be excluded from referral to or provision of reablement services,<sup>30 31</sup> as well as in policy development and reform processes.<sup>32</sup>

Indeed, our members have highlighted that despite the prevalence of dementia in aged care the direct voices of people living with dementia are significantly underrepresented in both feedback and reform processes. Concerns around legal capacity often lead to perspectives being sought solely from legal proxies (e.g., power of attorney), bypassing the person with dementia themselves, even in the case of resident surveys and quality of life measures. This conflates legal capacity with the capability to participate and effectively limits the ability of people living with dementia to participate actively in their own care.

Finally, assumptions about the capability of older people to contribute are reflective of a broader “gatekeeping” of knowledge and expertise and a lack of recognition of diverse knowledge systems that limit the agency of older people. As highlighted by an AAG member, there is value in initiatives that support communities to co-create resources for reablement, health and wellbeing, rather than this being the domain of providers and professionals alone. This is one example of the wide range of co-design initiatives across the health and aged care sectors that demonstrate the impact of an inclusive and respectful process.

#### 4. Lack of personalisation and embracing complexity

A focus on diversity and the use of diversity frameworks are important strategies in promoting awareness while building the structural supports needed for critical aspects of inclusion, such as culturally safe and trauma-informed care. These frameworks cement in care policy and standards the expectations that the differences among people using care services are

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<sup>28</sup> Aged Care Quality and Safety Commission (2023). Standard 1: The individual – Person-centred care. Retrieved from <https://www.agedcarequality.gov.au/strengthened-quality-standards/individual/person-centred-care>

<sup>29</sup> O'Connor, C.M.C., et al. (2022). Advocating the rights of people with dementia to contribute to research: Considerations for researchers and ethics committees. *Australasian Journal on Ageing*. 41: 309–313. doi:10.1111/ajag.13023

<sup>30</sup> Laver, K., et al. (2020). Improving adherence to guideline recommendations in dementia care through establishing a quality improvement collaborative of agents of change: an interrupted time series study. *Implementation Science Communications*, 1, 80. <https://doi.org/10.1186/s43058-020-00073-x>

<sup>31</sup> O'Connor, C.M.C., et al. (2020). Understanding in the Australian aged care sector of reablement interventions for people living with dementia: a qualitative content analysis. *BMC Health Serv Res* 20, 140. <https://doi.org/10.1186/s12913-020-4977-1>

<sup>32</sup> Chelberg, K., & Swaffer, K. (2023). ‘Missing persons’: Absent voices of people with dementia in the Australian Royal Commission into Aged Care. *J Law Med*. 30(3):761-776. <https://pubmed.ncbi.nlm.nih.gov/38332606/>.

acknowledged and understood, and that systems and services are designed to promote equity. Further, the new *Aged Care Act 2024* includes rights provisions that require care to not only be non-discriminatory, but that individual identity, culture, spirituality, and diversity are *valued and supported*. This is an important step in promoting the recognition and active support of differences in care services. However, the ways that diversity frameworks and other diversity-focused policy initiatives are integrated into the aged care system are not always sufficient to promote an inclusive approach to care.

## Safety, dignity, and respect

One issue raised by AAG members is that of cultural safety. It is important and positive that cultural safety inclusions are embedded within the new Aged Care Act. However, AAG members highlight that inclusion in the legislation does not ensure an implementation plan, with details lacking on how culturally safe, trauma-aware and healing-informed care should be delivered, including best practice standards for delivering such care.<sup>33</sup> In the context of providing aged care services for Aboriginal and Torres Strait Islander Elders and communities, all members of the Stolen Generations are now eligible for aged care, making culturally safe, trauma-aware, and healing-informed care practices crucial for every provider.<sup>34</sup>

However, as highlighted by AAG members, rather than transforming or adapting the aged care system to the needs of Elders and older Aboriginal and Torres Strait Islander people, current Indigenous-specific programs are being adapted to fit within the mainstream system. In addition, there is great concern that incoming changes to NATSIFACP and the development of the new Support at Home Program were designed from an individualist and mainstream perspective. Inflexibility regarding funding and the presumption of “choice” as a mechanism for quality control in aged care “markets” do not meet the needs or reflect the reality of Aboriginal and Torres Strait Islander people.

AAG members involved in Aboriginal Community-Controlled Organisations (ACCOs) have repeatedly noted that during the COVID-19 pandemic emergency response, ACCOs benefited from the flexibility and support for local decision-making that was provided.<sup>35</sup> Therefore, there is an opportunity for the new system to look at ways to replicate these efficiencies and authority structures. Currently, many in the sector (workers and care recipients) are confused by the changes and unsure where to go to get up-to-date, reliable, and easy-to-understand information. This is also reflective of similar concerns published in the report by the Interim First Nations Aged Care Commissioner, Andrea Kelly.<sup>36</sup>

Some progress in respectful and inclusive practice is also yet to be made in the language of policy itself. For example, an analysis of the Australian National Aged Care Classification (AN-ACC) funding instrument found that the language used within the Behaviour Resources

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<sup>33</sup> Australian Association of Gerontology (2025). AAG Discussion Paper. The new Aged Care Act & Aboriginal and Torres Strait Islander Care Organisations: Preparations and considerations of Aboriginal and Torres Strait Islander community-controlled organisations. <https://aag.asn.au/libraryviewer?ResourceID=372>

<sup>34</sup> Healing Foundation (2025). 'Are you waiting for us to die?' The unfinished business of Bringing them home <https://healingfoundation.org.au/resources/are-you-waiting-for-us-to-die/>

<sup>35</sup> Australian Association of Gerontology (2025). <https://aag.asn.au/libraryviewer?ResourceID=372>

<sup>36</sup> Kelly, A. (2024). Transforming Aged Care for Aboriginal and Torres Strait Islander people. Commonwealth of Australia. <https://www.health.gov.au/resources/publications/transforming-aged-care-for-aboriginal-and-torres-strait-islander-people?language=en>.

Utilisation Assessment (BRUA) is disrespectful to people with lived experience of dementia, does not align with international language guidelines or best practices, and may negatively influence practice by condoning inappropriate language.<sup>37</sup> Similarly, concerns were raised about the language used in the Royal Commission into Aged Care Quality and Safety.<sup>38</sup> Similarly, we have found it difficult to demonstrate to Aboriginal and Torres Strait Islander members of the AAG how their voices are being heard in the reform process when basic terminology, such as their preference for using “Aboriginal and Torres Strait Islander” in place of First Nations, is not consistently addressed. Language used in policy, including within assessment instruments, must align with the strengths-based, human-rights-focused, culturally safe, and inclusive approach to care that the reforms aim to achieve.

Engagement with AAG members has also highlighted a broad range of ways in which the processes within the system can fail to provide safety and respectful environments for diverse older people. For example, existing care record systems are often not set up to capture essential information for inclusive care, such as preferred names or pronouns. Even if this information can be entered, it does not always transfer between different care settings (such as from residential care to a hospital). This is not only an issue of respect and dignity in the care environment, but one of safety for individuals who may have a history of trauma, discrimination, and persecution because of their sexuality or gender identity. AAG members have also expressed concern regarding whether respect for cultural protocols and data sovereignty principles will be enacted into the new aged care data collection and management system.<sup>39</sup>

In another practical example provided by our members, this time relating to end-of-life care, a trans woman was unable to access basic personal care (shaving), demonstrating a lack of dignified support even at end of life. Our members have emphasised that fundamental principles of dignity, respect, and inclusion should apply across all care pathways. Frameworks need to move beyond identifying what excludes people to understanding the practices and conditions that enable the experience of inclusion.

## The importance of intersectionality

Inclusive care requires a nuanced understanding of diversity and its role in shaping people’s needs and preferences, which goes beyond simple categorisation and instead embraces the complexity of individual identities. Rather than using diversity as a blunt instrument where individuals are reduced to a set of labels or categories, inclusive care seeks to appreciate the intersectionality of factors to foster a more personalised, respectful, and effective care experience. In our consultation with AAG members, they emphasised that intersectionality is a crucial lens for understanding the “whole person,” considering multiple dimensions of disadvantage, but also of resilience and strengths.

For example, the experiences and perspectives of an older trans woman in residential care who has migrated to Australia earlier in her life and is living with dementia cannot be adequately understood if viewed only through the lens of her gender or sexuality, or through the lens of her

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<sup>37</sup> Wesson, J., et al. (2023). Australian National Aged Care Classification behaviour assessment and people living with dementia in residential aged care: Inclusive language for reform? *Australasian Journal on Ageing*. 42: 234-240. doi: 10.1111/ajag.13142

<sup>38</sup> Chelberg, K. (2023). ‘Vulnerable monsters’: Constructions of dementia in the Australian Royal Commission into Aged Care. *Int J Semiot Law*, 36, 1557–1580. <https://doi.org/10.1007/s11196-023-09979-w>

<sup>39</sup> Australian Association of Gerontology (2025)

dementia diagnosis. The individual experience of care must be understood not just through the experience and effects of dementia, but also how these interact with the experience of being an older woman, being an older trans woman, as well as diminished social and family networks following the move to residential care (for an in-depth discussion of this example, see Smith et al.<sup>40</sup>). When diversity is approached through categorisation alone, it risks reinforcing stereotypes and undermining inclusion, as it fails to consider the unique intersections of identity that influence people's lived experiences.

There can be pressure, often unintentional, particularly within residential aged care settings, for individuals to “conform” or to suppress aspects of their individuality. This comes at the expense of personal identity and preferences. For example, as one of our members highlighted, a key issue is recognising the “unique collection of affinities” that shape someone as a person and providing a physical and social environment that supports and facilitates their free, and safe, engagement with people and things that are meaningful as well as their sense of belonging.

Therefore, resources such as diversity frameworks and their accompanying practical guidelines play a vital role in establishing an environment of informed and respectful care. However, they need to be understood in the context of intersectionality and the complexity of real, individual, lived experience if they are to support genuine inclusion. This is why detailed guidance tools as well as other forms of professional education are vital supplements to such frameworks.

## The promise of co-design

Ensuring genuine inclusion requires a commitment to meaningful engagement and the dismantling of barriers that hinder full participation. To this end, the aged care reform process was premised on a co-design approach, which is intended to promote inclusion. Indeed, we contend that a system designed for inclusion is not possible without co-design. However, reform processes have demonstrated several challenges to realising genuine co-design in this complex aged care system.

A concern among a number of our stakeholders is the tokenistic nature of many co-design processes. Meaningful engagement requires adequate funding, trained facilitators, and sufficient time to ensure that all participants can contribute effectively. Without these resources, co-design efforts may be reduced to mere formalities rather than transformative processes. As a result, the real needs of diverse older people are not adequately recognised in system design.

As others have noted, while a significant number of consultations have been conducted, these often occur late in the decision-making process, limiting the influence of participants.<sup>41</sup> Stakeholders have been asked to provide feedback on draft legislation that often references blank clauses or requires responses within very small windows of time. Professionals and policymakers can dominate discussions, unintentionally sidelining the experiences and insights of older participants. This imbalance can undermine the effectiveness of the co-design process, as genuine collaboration is essential for meaningful reform.

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<sup>40</sup> Smith, L., et al. (2024). Ageing, disability, dementia and gender and sexuality diversity: What do the intersections tell us about models of care? In *The Routledge International Handbook of Disability and Global Health* (1st ed., pp. 659–671). Routledge. <https://doi.org/10.4324/9781003228059-52>

<sup>41</sup> Orthia L., et al. (2021). Co-designing aged care: Views of 4,562 older Australians. Australia: National Seniors Australia and EveryAGE Counts. National Seniors Australia

Indeed, AAG members, like other stakeholders in the reform process, have expressed concern about the underrepresentation of diverse voices in the processes. They highlight that older individuals from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander communities, and those who are LGBTIQ+ often find their unique needs and perspectives overlooked. People living with dementia are often not directly heard, with processes prioritising the voices of care partners, family, and experts. Older individuals with cognitive impairments, mobility challenges, or those residing in regional areas may find it difficult to engage in traditional consultation formats, and the increasing reliance on digital platforms for consultations further exacerbates this issue. This exclusion can result in services that do not adequately cater to the diverse population of older Australians.

Another significant issue is the lack of a feedback loop following consultations. Participants often do not receive information on how their input influenced decisions, leading to feelings of disillusionment and a diminished sense of agency. Justifiably, AAG members were disappointed to see that the work done on the definition of cultural safety by NATSIAACC and supported by many across the sector was not referenced in the (legally enforceable) new Aged Care Act, but only in the Explanatory Memorandum.<sup>42</sup> This has led to questions regarding the extent this allows the definition to inform enforceable requirements, other than as a matter of tone-setting. This is just one example where consultation and participation in the process felt as though it failed to net an outcome.

## Conclusion

A system design process that fails to be genuinely inclusive cannot result in a system that is inclusive. A fundamental shift is needed to appropriately and adequately address the diverse needs and experiences of older Australians. This requires tackling systemic issues of rationing and access, integrating fragmented services, actively combating ageism and ableism, and embracing the complexity of individual identities through personalised and flexible care.

Effective co-design processes must also include the voices of all stakeholders. Broader consultations, conducted in accessible ways and within suitable timelines, would improve transparency and provide diverse insights on priorities, timelines, and areas where reforms may fall short. Ongoing review cycles are essential to assess reform impacts and gather iterative feedback for necessary adjustments. Additionally, alternative approaches to engage those with lived experience, in a variety of forms, should be explored to ensure a wide range of perspectives and experiences to inform the continuous development of aged care services.

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<sup>42</sup> Australian Association of Gerontology (2025). <https://aag.asn.au/libraryviewer?ResourceID=372>

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