ACU PLUNKETT CENTRE FOR ETHICS

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AI and Medicine
The challenge of human dignity

Last month, in conjunction with the International Federation of Catholic Medical Associations, the Pontifical Academy for Life held a Congress on 'AI and Medicine', after which it published a statement on the challenges to respect for human dignity occasioned by the use of AI.

The statement builds on the *'Rome Call for AI Ethics'* which was signed by representatives of Microsoft, IBM, FAO, the Italian Ministry of Innovation together with the Pontifical Academy for Life, in 2020.

Three objectives informed that call: a development in ethics which serves and protects human good, an education that leaves no one behind, and a recognition of genuine human rights.

Now the Academy has published a new statement.

IN THIS ISSUE

We republish a Joint Statement from the Pontifical Academy for Life and the Federation of Catholic Medical Associations entitled 'AI and Medicine: The Challenge of Human Dignity.

Keith Hartman, AM, distinguishes the science and the art of medicine, and records his debt to the Sisters of Mercy at the Mater Hospital in Sydney for what that they taught him about the care of people in hospital.

Susan Pennings, a Research Fellow at the Plunkett Centre, explains the significance of the recent implementation of the Commonwealth's Aged Care Act of 2024.

We also include an invitation to participate in next year's Colloquium of the International Association of Catholic Bioethics to be held in Rochefort-du-Gard, France. The theme is 'Wise Decisions: the place of love in AI-informed health care'.

12th BiAnnual IACB Colloquium

Wise Decisions: The place of love in AI-informed health care

Rochefort-du-Gard, France • 19-23 June 2026

Organized by the International Association of Catholic Bioethics
Hosted by the Chateau St. André Center for Ethics and Integrity

Location & Travel

The seminar takes place at a stunningly beautiful ancient abbey, now a retreat & meeting center, located high above the village of Rochefort-du-Gard near Avignon in the south of France. Avignon is connected by highspeed direct trains with the Paris CDG airport and downtown Paris, as well as Brussels, Frankfurt, Geneva, Barcelona and Madrid. Participants will be picked up by car at the Avignon train station. More travel info will be provided online.

Program

The Colloquium will begin with an opening session (15h30) and welcome dinner on Friday June 19, 2026. The Colloquium will then run through the next 3 days with shared meals among participants throughout. We will conclude on Tuesday morning 23/6 after breakfast. Interspersed with the academic sessions will be various excursions to relevant cultural sites in the area and a visit to the onsite museum.

The success of the IACB Colloquia is primarily due to the active participation by all attendees and ongoing exchanges about the Colloquium theme. Participants are encouraged to submit a paper, prepare a commentary, or serve as session moderator. Space is limited.

Registration Fees

Euro 560: Colloquium registration fee (incl. virtually all meals, refreshments and two excursions)
Euro 235: Lodging at the retreat center for four nights (incl. breakfast)
Euro 350: Accompanying person registration fee (incl. two additional half-day excursions)
Euro 175: Extra lodging fee for accompanying person at the retreat center (double occupancy)

Please note that the bedrooms are located in the old abbey dormitory wings and still reflect the simplicity of monastic life. For those seeking more comfort, two nearby small hotels and a several rentable vacation homes are available. More lodging information can be found online.

Registration, incl. submission of an abstract, shall be done online. A non-reimbursable downpayment of €250 is due six weeks after registration to reserve a spot. The remainder of the fee will be due on April 1.

https:// iacb.ca • https://chateausaintandre.center/iacb2026 • info@chateausaintandre.center

Statement for the International Congress on AI and Medicine: The Challenge of Human Dignity
Rome, 11 November 2025

The tremendous development of artificial intelligence systems in recent years generates both wonder at their achievements and concern about the many problems that face them. Also a great question surges about the future we want to build through these technologies.

For an ethical reflection about AI, as with any technology, it is important not to be limited only to a consideration of the performances it enables, however spectacular; the impact it has on personal and social relationships must also be included in the assessment. As Pope Francis has said, technology: "...always represents a form of order in social relations and an arrangement of power, thus enabling certain people to perform specific actions while preventing others from performing different ones. In a more or less explicit way, this constitutive power-dimension of technology always includes the worldview of those who invented and developed it."[1]

This is why Pope Francis reminds us that: "...the inherent dignity of each human being and the fraternity that binds us together as members of the one human family must undergird the development of new technologies and serve as indisputable criteria for evaluating them before they are employed".[2] In new digital technologies what is at stake are not only principles and rights, but the specificity and originality of the human mind, that has to be protected in the context of devices equipped with a specific and unprecedented form of agency.

In the field of health care is therefore crucial that AI be an aid that enhances clinical judgment, supports diagnostic accuracy, and improves patient outcomes, never a substitute for the physician's expertise, empathy, or accountability.

Key ethical principles for AI in medical practice include:

1. CLINICAL OVERSIGHT AND JUDGMENT

AI must remain subordinate to the physician's clinical reasoning. While it can assist with pattern recognition, risk stratification, and decision support, "decisions regarding patient treatment and the weight of responsibility they entail must always remain with the human person and should never be delegated to AI"[3]. In the process of using AI, the physician has to be careful not to be hypnotized by the fascination with technological results, leading him to

[1] Dicastery for the Doctrine of Faith and Dicastery for Culture and Education, *Antiqua et nova. Note on the Relationship Between Artificial Intelligence and Human Intelligence* (14 January 2025), 74
[2] Dicastery for the Doctrine of Faith and Dicastery for Culture and Education, *Antiqua et nova. Note on the Relationship Between Artificial Intelligence and Human Intelligence* (14 January 2025), 74
[3] Dicastery for the Doctrine of Faith and Dicastery for Culture and Education, *Antiqua et nova. Note on the Relationship Between Artificial Intelligence and Human Intelligence* (14 January 2025), 74

share and to delegate, without enough critical mind, too much power to a machine. Meaningful and adequate human supervision of AI means also to avoid uncritical use of techniques. AI recommendations have always to be questioned from outside!

2. TRANSPARENCY AND INTERPRETABILITY

Physicians should be able to understand and explain how AI-derived recommendations are generated. Black-box algorithms that lack interpretability risk undermining trust and clinical accountability, inducing deskilling and delegation of responsibility.

3. BIAS AWARENESS AND EQUITY

AI systems trained on incomplete or biased datasets can perpetuate disparities, in care as in other aspects of life. Clinicians must be vigilant in recognizing these risks and advocate for inclusive, representative data in AI development.

4. DATA PRIVACY AND PATIENT CONSENT

The use of patient data in AI applications must comply with legal and ethical standards. Patients should be aware that making available their data may be a form of participation in the common good and in improving medical knowledge and practice, but this should be an expression of free responsibility. The ethical profile of medical profession about confidentiality and management of information must be transposed also in the context of AI.

5. RESPONSIBILITY AND LIABILITY

Errors could be expression of a failure of programming, supervision, clinicians' action or of the algorithm. Therefore, it would be important to differentiate when the error can be traced back to the doctor for the improper use of these systems, or when it is only and exclusively attributable to the hospital that manages and sets the instrument, or of the AI company. The physician has also the responsibility to warn his/her patient of the dangers to use generative AI as psychological advisers and to help him/her to escape the trap of confinement in "numerical bubbles".

6. ACCESS AND FAIRNESS

AI should not widen the gap between resource-rich and resource-poor settings. Its deployment must be equitable, ensuring that all patients—regardless of geography or socioeconomic status— benefit from technological advances: "Optimizing resources means using them in an ethical and fraternal way, and not penalizing the most fragile".[4]

As stewards of patient care, physicians have a critical role in shaping how AI is adopted. By insisting on ethical rigor and patient-centred design, we can ensure that AI strengthens—not compromises—the integrity of medical practice. We are at the same time aware that we need to cooperate with other players working in the field: the power and interests at stake in the

[4] Pope Francis, *Address to the Participants at the Meeting Sponsored by the Charity and Health Commission of the Italian Bishops' Conference* (10 February 2017).

research and control of digital technologies make an alliance between all stakeholders essential. This is what "Ethics by design" is all about.[5]

Numerical techniques based on computations, as effective as they may be, have many epistemological and logical limits. Therefore, they cannot replace all the facets of human thought and all the dimensions of human relations. Some deep dimensions of patient care cannot be replaced by optimized numerical procedures and autonomous robots. They imply empathic gestures, looks full of tenderness, and taking time without any consideration for effectiveness and profitability.

AI cannot lead to forgetting that medicine is not only a science or a technique but a human way to support the patient in his/her suffering, even when any technology is useless. The major risk of AI successes in medicine could well be the insidious way to suggest progressively that medicine is only a technique to cure and not a deep human relation of care.[6] The patient is not a *problem* to be solved (by AI or other technologies) he/she is a *mystery* revealing the Christ Himself.

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[5] *Rome Call for AI Ethics* (28 February 2020), https://www.vatican.va/roman_curia/pontifical_academies/acdlife/

[6] Cfr Léon XIV, Apostolic exhortation, *Dilexi te*, of the Holy Father Leo XIV to all Christians on love for the poor: "The Christian tradition of visiting the sick, washing their wounds, and comforting the afflicted is not simply a philanthropic endeavour, but an ecclesial action through which the members of the Church 'touch the suffering flesh of Christ.' " (n. 49).

The Science and the Art of Medicine
Dr Keith Hartman AM

I have been invited to reflect on my own journey of being a bedside doctor for fifty-five years, and on some of the changes I have experienced in medicine during that time. I would also like to share with you some of my thoughts and hopes for the future of our profession.[1]

Every story has a beginning. In my case, I decided that I wanted to be a doctor when I was about 9 years old. I greatly admired our fantastic family GP - a caring, kind, compassionate man and a wonderful listener. His counsel and reassurance were powerful therapeutic tools especially for my mother who had no close family in Australia. I can recall home visits at the end of his very long day, and even on occasions during the night, to see me or one of my siblings. I was in no position to assess the quality of the science he employed, but his compassion and kindness were exemplary.

When I left Riverview in 1963, there were only two medical schools in NSW - Sydney University and the newly established UNSW. Each university offered an undergraduate course of six years duration: the first three pre-clinical years covering physics, chemistry, anatomy, physiology and biochemistry. In the first year we chose an elective subject from any faculty, a token effort to broaden our outlook! For the second three years we were allocated to a Clinical School based at one of the teaching hospitals, returning one day a week to the University Campus for lectures.

Many will not know that until the mid-sixties, secondary school was only five years in duration, so when I (and many others) started at Uni I had not turned 17! One woman in our year actually graduated before her 21st birthday and could not be registered as a doctor until she had turned 21! Clearly, we were much younger than today's students and I for one was pretty immature. Some left home to come to college, or to live in flats with friends, but most were still living at home with their parents.

Interestingly, from my class at Riverview twelve boys came to Sydney Uni to do medicine and about half of them came to St John's College.

I loved every minute of my time on campus. Because we were full time "uni students" for three years, we interacted with students from many other faculties, and all the campus-based activities, sports and distractions could be enjoyed to the full.

In the sixties and seventies, Sydney Uni campus was a vibrant, social and exciting place. It was a time of significant social change. The Women's Movement was really getting traction, Uni students were at the forefront of anti-Vietnam war protests, the oral contraceptive pill became available and pretty well everything in established society was being questioned and challenged by the large numbers of long-haired baby boomers who were by now at Uni. It was a very exciting time in history.

[1] This is an abbreviated version of a talk given by Dr Hartman at the Annual Faculty of Medicine Dinner at St John's College, University of Sydney, in October 2025.

For many students there were no fees. In medicine, selection was purely on Leaving Certificate marks, so pretty-well all students who got into the faculty also qualified for a (non "means-tested") Commonwealth Scholarship. A very clear difference from today: no HECS debts !

In 4th year we went to our allocated Teaching Hospital for the second three years of the course. During this time, we "lived in" at the hospital for extended periods and as you can imagine, a great deal of partying occurred, great friendships were formed, and many romances flourished.[2]

During those three clinical years we were exposed to the various medical specialties (sadly, not to General Practice nor to Indigenous Health). I was particularly keen on Obstetrics: it was to become my life's work.

After graduation in Jan 1971, we were allocated to a public hospital for our pre-registration intern year and to start specialist training. In my case that was the Mater Hospital in North Sydney, then a general public hospital administered by the Sisters of Mercy. I worked there for four years, two as an Intern and Senior Resident and two as a Surgical Registrar.

The Mater had a profound effect on me as I found the care offered by the Sisters was extraordinary. The nuns did much of the hands-on nursing themselves. Their kindness and empathy to every patient, together with their commitment to excellence in care, were inspiring to all, nurses and doctors alike. For me, their standard of care became the standard by which I judged my own care and that of others. The Mater became my life-long partner in the care of my patients.

The history of the Mater is a subject of another talk, but suffice it to say, it was closed as a public hospital some thirty years ago and the Sisters of Mercy re-developed it as a not-for-profit private hospital. Its reputation has grown enormously as a general surgical and maternity hospital. It is now part of St Vincents Health Australia and is an internationally recognized Centre of Excellence for Orthopedics and Melanoma research and treatment.[3] Incidentally, it has given me enormous satisfaction to have contributed to the extraordinary development of the hospital. My training as a specialist was at St Margaret's Darlinghurst (another excellent public Catholic hospital later closed by the government), and the John Radcliffe Hospital Oxford. In each of these hospitals I had some outstanding mentors.[4]

Those three years in Oxford were transformational for many reasons.[5] I was fortunate to work in the Obstetric Unit which was, at that time, probably the best in the world in terms of outcomes for patients and in the quality and quantity of its research. It was an incredibly stimulating educational environment, and I loved teaching students and being involved in the

[2] Kerry-Anne, a very talented law student, and I married in my Final Year.

[3] Much of its growth has been enabled by funds raised by the Friends of the Mater Foundation which I have been honoured to chair since its inception 25 years ago. In that time, we have raised over $85 million - thanks to our amazing benefactors.

[4] In Sydney, Dr Frank Thong (a distinguished alumnus of St John's) was an inspirational teacher, an outstanding surgeon and a very caring doctor, along with Drs Bob McInerney, David Mc Grath and Brian Spurrett.

[5] Firstly, it was a beautiful and fascinating place to live. Our two children at the time, Simone and Luke, went to school in Oxford and together our little family explored England and Wales on our weekend adventures. Being so close to Europe enabled easy travel especially to France.

research. But I also was profoundly influenced by a couple of individual clinicians for whom I was a Registrar.

One, Professor Sir Alec Turnbull, was an international legend for his ground-breaking research. But his lasting influence on me was through his kindness, his humility and his sincere empathy. On Grand Rounds, always with an entourage of twenty or more doctors and students in white coats (often including senior visiting colleagues), he would regularly stop, sit down beside a patient's bed and, having asking the expected medical questions, would enquire whether she was missing her family, or how she was sleeping or whether the food was up to scratch. To me, Sir Alec was an exemplary doctor and an authentic Renaissance man.

I started in practice in Sydney in 1979 at St Margaret's, the Mater and a little later at Royal North Shore Hospital. I had been exposed in my training years to the system of specialists working and teaching for nothing in public hospitals - as 'Honoraries' - in exchange for admission rights for their private or paying patients. The idea of teaching and of caring for those who couldn't afford it seriously appealed to me; but of course, one needed to feed the family, and so private practice was an essential part of the mix.

I opened offices in four locations and worked incredibly hard. As was usual at the time I worked in solo practice and so was on call 24/7.[6] Over the next thirty-seven years I maintained my public hospital commitment at Royal North Shore whilst managing my private practice, which was based mainly at the Mater, both of which gave me enormous satisfaction. I loved the fact that in Obstetrics one's relationship with patients and their families often extends for the whole of the woman's reproductive life. In the later years of my practice it often became multi-generational in that I delivered the babies of the babies. During those thirty-seven years in specialist practice, I delivered approximately 10,000 babies.

To this day I reflect on and treasure the extraordinary level of trust our patients place in us doctors. I regard being so entrusted as a sacred privilege.

I retired from private practice in 2017. I had long felt that I had missed out on experiencing medicine outside an educated, compliant and affluent demographic. For the next eighteen months, until the pandemic prevented it, I did locums in rural and remote locations, mainly with the Flying Specialist Service, an initiative of the Queensland Government and the Royal Flying Doctor Service. This proved to be an enriching experience and a career highlight. I was shocked to see and experience the extent to which distance, obesity, poor dental care, smoking, poverty, unemployment and lack of access to advanced medical facilities have a deleterious effect on health outcomes. However, I was hugely inspired by the resilience of the people, especially since, when I was there, the enormous area we covered on our daily flights had already been in drought for years. It was a stark contrast to my experience as a doctor in an affluent area in Metropolitan Sydney.

I have been delighted to continue to engage in weekly tutorials with 3rd year medical students. For the past six years I have also been on the Board of Western Sydney Local Health District: we are responsible for Westmead, Blacktown and Mt Druitt Hospitals. I have been fascinated to gain some insight into the strategic and operational challenges of delivering quality health

[6] By then we had 4 of our 6 children so none of this would have been possible without Kerry-Anne's selfless and consistent support.

care to a rapidly expanding and sprawling population, of great ethnic diversity and of mostly low socio-economic status.

So, what changes have I seen in the 55 years since my graduation as a doctor? I will mention six.

1. Medicare. Since 1984, Medicare has provided access for all citizens to high quality health care. I believe we Australians can be very proud of a system which regards all people as having the right to health care. However, Medicare certainly has its faults and deficiencies, and these are exacerbated by rapidly increasing costs and probably unrealistic community expectations.

2. Medicine becoming a *post-graduate degree*. Initially I was unenthusiastic about this change but having taught students from both undergraduate and postgraduate courses, I now have no doubt that the extra commitment needed, and the maturity and insight which come from lived experience, provide a good basis for a very demanding and at times confronting course.

3. The *numbe*r of students and medical schools has increased enormously. The implications of ‘safe working hours’, an increasing desire for work/life balance and a growing but ageing population have all led to a shortage of doctors (particularly GPs) as well as a mismatch in the distribution of doctors and the population, with severe deficits growing in rural and remote areas.

4. The establishment of *gender balance*. In my student days about 20% of medical students were women. Now the proportion of women in most medical schools is at least 55-60%. In O&G, 85% of new specialists are women: fifty years ago, the figure was less than 10%.

5. Technology. It is easy to forget that home and office computers became available only in 1977 and were not commonplace in hospitals or practices for at least another 10 years, so what is now an everyday tool is quite a recent innovation. Mobile phones appeared in the early eighties, but they were very bulky and expensive. Modern cellular phones absolutely transformed life for those of us who were always on call.

6. Medical innovations – diagnostic tools like CT scans, MRI, PET scans and even ultrasound have all become available in that time. Laparoscopy - keyhole surgery - and more recently robotic surgery have led to amazing innovations in surgical techniques and instruments. New drug therapies have led to enormous improvements in patient outcomes. There is no better example than the bespoke immunotherapy for advanced Melanoma which was developed at the Melanoma Institute of Australia based in the Poche Centre on the Mater Campus.[7]

And what of the future? The next fifty years will certainly be a very exciting time to be a doctor.

I think that there will be increasing government driven training of nurses and other members of the healthcare team to undertake some of the tasks of doctors, especially of GPs, both to address doctor shortages but also to save money. Increasingly doctors will be part of multi-disciplinary teams - even in private practice. This is already happening in some specialties. I believe that solo practice will disappear.

I don’t think we can even imagine the possible advances in technology. Without doubt, AI will enable many innovations in equipment, diagnosis and in bespoke drug treatment planning, in

[7] The Poche Centre was funded by Mr. Greg Poche AO, through the Friends of the Mater Foundation.

particular. AI will also relieve doctors of many tedious and repetitive tasks. Some of the AI based technology has already found its way to the bedside, and these tools will make the practice of medicine much more precise and time efficient.

These advances will almost certainly create even more complex ethical dilemmas than already exist in all specialties, but especially in reproductive medicine and end of life care. The fact that something is possible doesn't justify its application without thorough examination of the ethical and moral aspects of the consequences.

Whilst the Science of Medicine, and accompanying use of technology will continue to develop at an accelerating pace, I believe that the Art of Medicine will become even more important. Technology can never adequately replace the special relationship which exists between a patient and their doctor. Central to that relationship are the uniquely human qualities of trust, care, kindness, compassion, empathy and shared ethical decision making - the core qualities one expects of a good doctor. Just ask anyone who has ever been a patient!

Policy reforms to aged care
Susan Pennings

On 1 November 2025, a large number of reforms to residential aged care and in-home care came into effect. These changes implement the *Aged Care Act 2024,* which was a response to the recommendations of the Aged Care Royal Commission.

In this article I provide a brief background to the current process of aged care reforms, and I suggest some challenges and opportunities for the provision of aged care into the future.

AGED CARE ROYAL COMMISSION

The Royal Commission into Aged Care Quality and Safety was established in 2018, following media reports and public inquiries into instances of neglect and abuse in aged care.

The final report of the Royal Commission was published in March 2021.[1] It found numerous problems in the aged care system, including that:

- The aged care system was difficult to access and navigate, and there was a lack of helpful information that would enable older people to make informed decisions about their care.
- Many older people experienced significant waiting times to access care, and had limited access to allied health professionals.
- The abuse of older people in residential aged care facilities was 'far from uncommon' and there was an overuse of physical and chemical restraint in residential aged care.
- Many aged care providers did not have the skills and capacity required to care adequately for people living with dementia.
- Many older people experienced substandard routine care, including a lack of assistance to eat and drink (resulting in malnutrition), inadequate prevention and treatment of pressure injuries, inappropriate management of medication, lack of social connection, and lack of oral health care.[2]

The Commissioners identified systemic problems which lay behind these deficiencies. One key problem was that successive federal governments had prioritised limiting the growth in aged

[1] Royal Commission into Aged Care Quality and Safety, Final Report: Care, Respect and Dignity, https://www.royalcommission.gov.au/aged-care/final-report (All references accessed 24 November 2025)
[2] Royal Commission into Aged Care Quality and Safety, Final Report: Summary (https://www.royalcommission.gov.au/system/files/2021-03/final-report-executive-summary.pdf) pp. 68-73,

care expenditure over concern for providing high quality care. In their final report, the Commissioners noted that:

> Funding for aged care is insufficient, insecure, and subject to the fiscal priorities of the Australian Government of the day. For several decades, one of the priorities for governments dealing with the aged care system has been to restrain the growth in aged care expenditure in light of demographic changes. This priority has been pursued irrespective of the level of need for care, and without sufficient regard to whether the funding is adequate to deliver high quality and safe care.[3]

The Commissioners also found that 'inadequate staffing levels, skill mix and training are principal causes of substandard care' noting that the sector had difficulty attracting and retaining highly-skilled people due to low wages, poor employment conditions, lack of investment in staff, and limited opportunities to progress in their career or be promoted. Despite the best intentions of staff, aged care workers often lacked the time, knowledge, skill and support to deliver high quality care.

The Commissioners further found that 'one of the key causes of substandard care in aged care, particularly residential aged care, is that people do not consistently receive the health care they need'. In part, this is due to a lack of funding and availability for health care professionals to visit people at their place of residence. Aged care providers and health care providers often did not communicate or work together effectively to ensure that older people received health care.[4]

The Commissioners made 148 recommendations, which were intended to achieve a broad systemic reform of the aged care system. They recommended that the government pass a new Aged Care Act which would 'enshrine the rights of older people who are seeking or receiving aged care'.[5] They also recommended reforms to improve monitoring and enforcement of aged care quality standards, establish a new system of pricing for services, provide greater respite services for carers, improve the quality of meals and nutrition in residential care, and simplify the process of gaining access to aged care.

A notable aspect of the Aged Care Royal Commission is that while the two Commissioners[6] agreed that systemic reforms were needed, they disagreed about a number of policy recommendations. For example, Commissioner Pagone recommended establishing a new independent agency to regulate the aged care sector, whereas Commissioner

Briggs recommended that a reformed Department of Health and Aged Care[7] should take a broader role in aged care regulation.[8] The Commissioners also disagreed about whether aged care should continue to be funded through general federal government revenue or through other funding mechanisms (such as a dedicated levy), and how the prices for aged care services should be regulated by the federal government.

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[3] ibid, p. 74.
[4] ibid, pp. 76-77
[5] ibid, p. 79
[6] While Joseph McGrath and Richard Tracey had been Commissioners earlier in the Royal Commission, Tony Pagone and Lynelle Briggs were the two Commissioners at the time of publishing the final report.
[7] This has been renamed the Department of Health, Disability and Ageing since May 2025.
[8] ibid, p. 83

AGED CARE REFORMS

The federal government delivered a response to the final report of the Aged Care Royal Commission in May 2021[9] and began a series of reforms, including:

- Implementing the Australian National Aged Care Classification (AN-ACC) funding model for aged care. This model provides a schedule of different kinds of services in residential aged care homes and the federal government subsidies applicable for each service. The government updates this schedule annually with pricing advice from the Independent Health and Aged Care Pricing Authority.[10]

- Measuring the quality of aged care facilities through the Star Rating system. Each aged care facility receives an overall rating and a rating based on indicator data in each of four sub-categories (residents' experience, compliance, staffing, and quality measures). This is intended to help older people to be able to compare the quality of aged care facilities.[11]

- Requiring aged care services to adhere to a Code of Conduct. If a provider acts in a way that is inconsistent with the Code of Conduct, the Aged Care Quality and Safety Commission can prevent them from delivering aged care services in the future.[12]

- Funding a network of care finders to help older people navigate the aged care system.[13]

- Requiring a registered nurse to be onsite and on duty at all times in approved residential aged care facilities.[14]

- Mandating that residential aged care facilities provide a certain number of minutes of direct care per resident per day.[15]

[9] Department of Health, Disability and Ageing, Australian Government response to the final report of the Royal Commission into Aged Care Quality and Safety, https://www.health.gov.au/resources/publications/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety?language=en,
[10] Department of Health, Disability and Ageing, Australian National Aged Care Classification funding model, https://www.health.gov.au/our-work/AN-ACC?language=en,
[11] Department of Health, Disability and Ageing, About Star Ratings, https://www.health.gov.au/our-work/star-ratings-for-residential-aged-care/about-star-ratings?language=en,
[12] Aged Care Quality and Safety Commission, Aged Care Code of Conduct, https://www.agedcarequality.gov.au/for-providers/code-conduct
[13] Department of Health, Disability and Ageing, Care finder program, https://www.health.gov.au/our-work/care-finder-program?language=en
[14] Department of Health, Disability and Ageing, 24/7 registered nurse requirement, https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/24-7-rns?language=en
[15] Department of Health, Disability and Ageing, Care minutes in residential aged care, https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes?language=en

- Developing a new policy framework to improve diagnosis and care for people with dementia.[16]

- Funding a pay rise for some aged care workers, through an increase in Aged Care Award minimum wages.[17]

The federal government also commissioned an Aged Care Taskforce to provide recommendations as to how aged care should be funded in the future. In its final report, the Taskforce noted that both residential aged care and home care providers faced significant financial challenges and stated that 'improved financial viability is necessary to deliver improvements in service, quality and to address service gaps'.[18] The Taskforce recommended that older people with financial means should pay a greater proportion towards the cost of aged care, arguing that 'given the increasing wealth of many older people and the declining working age (that is tax paying) population, there is a strong case to increase participant co-contributions for those with the means to contribute, noting that there will always be a group of participants who need more government support.'[19]

THE NEW AGED CARE ACT

The *Aged Care Act 2024* replaced previous federal aged care legislation and established a new framework for the delivery of aged care services.[20] While the Act was passed by federal Parliament in November 2024, many details about how the Act would be put into practice were not finalised until September 2025[21] and came into effect on 1 November 2025.

In introducing the legislation to the House of Representatives, the then Minister for Aged Care, Anika Wells, stated that 'the new rights-based Aged Care Bill we are introducing puts older people, and the services they need, front and centre.'[22] The *Aged Care Act 2024* describes these rights in detail, including the right to exercise choice and make decisions, to equitable access to services, to be treated with dignity and respect, to be free from all forms of violence, neglect and abuse, and to be supported by an advocate. These rights are also legally enforceable, and

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[16] Department of Health, Disability and Ageing, National Dementia Action Plan 2024–2034, https://www.health.gov.au/our-work/national-dementia-action-plan
[17] Malbon, E, Aged care, Budget Review Article 2024-25, Australian Parliamentary Library, https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Budget_Review/2024-25/AgedCare#heading_7f8a91ca3f0c437e8737a1af9b81d397
[18] Department of Health, Disability and Ageing, Final report of the Aged Care Taskforce, https://www.health.gov.au/resources/publications/final-report-of-the-aged-care-taskforce?language=en p. 8
[19] ibid, p. 20
[20] Australian Parliament House, Aged Care Bill 2024, https://www.aph.gov.au/Parliamentary_Business/Bills_LEGislation/Bills_Search_Results/Result?bId=r7238
[21] Federal Register of Legislation, Aged Care Rules 2025, https://www.legislation.gov.au/F2025L01173/asmade/text
[22] Commonwealth, Parliamentary Debates, House of Representatives, 12 September 2024, https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=CHAMBER;id=chamber%2Fhansardr%2F28033%2F0174;query=Id%3A%22chamber%2Fhansardr%2F28033%2F0173%22

aged care providers must 'take all reasonable and proportionate steps' to act in a way that is compatible with these rights.[23]

One significant change which came into effect on 1 November 2025 was to the structure of payments for aged care services. For example, older people who are entering residential aged care may be required to pay means-tested fees towards the cost of non-clinical care. New residents with significant means may also be required to pay more towards their daily living costs through a top-up Hotelling Supplement fee.[24] Older people receiving services in their home may also be required to pay more for the cost of their care. In the new Support at Home program (which replaced the Home Care Packages Program)[25] people who are not eligible for the Age Pension may be required to pay 50% of Independence services (such as personal care), and 80% of Everyday Living services (such as cleaning and gardening).[26] The federal government will pay the whole cost of Clinical Care services (such as nursing and physiotherapy). Older people who were already receiving aged care services before September 2024 have been promised that they will not be worse off due to the changes.[27]

REFLECTIONS ON THE PROCESS OF REFORM

The Royal Commission has emphasised that substandard and inadequate aged care services are the result of systemic problems with aged care funding and regulation, rather than being caused by the failings of individual workers or facilities. In response to the Royal Commission, the federal government has made significant changes to data collection, funding, legislation, and enforcement of standards in the aged care sector.

However, with the ageing of the Australian population and shortages of aged care workers, there are likely to be continuing challenges in providing aged care services to everyone who needs them. Many people still experience lengthy waiting times. In a report published in October 2025, the Office of the Inspector General of Aged Care found that older people assessed as needing more intensive home care often wait 9-12 months to get the care they need, and that this delay placed the older person at significant risk of deterioration and decline in the intervening period.[28] While the federal government has announced an intention to maintain an average 3-month waiting time for care and support, the Inspector-General is concerned this average wait-time will not be achieved.[29] It is likely that continuing increases in funding will be required to address these shortages of aged care services, either through

[23] Federal Register of Legislation, Aged Care Act 2024, https://www.legislation.gov.au/C2024A00104/asmade/2024-12-02/text/original/epub/OEBPS/document_1/document_1.html#_Toc184211456

[24] Department of Health, Disability and Ageing, Understanding fees for aged care homes – 1 November 2025 fee arrangements, https://www.health.gov.au/sites/default/files/2025-06/understanding-fees-for-aged-care-homes-1-november-2025-fee-arrangements_1.pdf

[25] Department of Health, Disability and Ageing, About the Support at Home program, https://www.health.gov.au/our-work/support-at-home/about?language=en

[26] Department of Health, Disability and Ageing, Support at Home participant contributions, https://www.health.gov.au/sites/default/files/2025-10/support-at-home-program-participant-contributions.pdf

[27] ibid, p. 2

[28] Office of the Inspector-General of Aged Care, 2025 Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety https://www.igac.gov.au/sites/default/files/2025-10/support-at-home-2025-progress-report.pdf, p.1

[29] Ibid, p. 1

additional government funding, larger individual contributions towards the cost of care, or both.

It is notable that in the years of reform to the aged care system, there has been comparatively little discussion of how governments can help families, friends, and community members to provide informal support to older people. The findings of the Household, Income and Labour Dynamics in Australia (HILDA) Survey indicate that an increasing proportion of older people are living alone.[30] Across the Australian population as a whole, people are socialising with friends and relatives much less frequently than two decades ago and report having fewer friends.[31] The proportion of Australians who undertake volunteer work has also declined over time.[32] It appears that Australia is becoming less socially connected, and this makes it more difficult to provide informal care, meaning that many older people are increasingly reliant on services purchased from aged care providers. While some types of aged care may be most appropriately provided by professionals, there are other kinds of social and household assistance that could be provided informally, at least in part.

In addition to the process of reforms to aged care, the Australian government could commission research to understand the structural factors behind decreased social connectedness, and the barriers to people volunteering and providing informal care. Addressing these issues could not only benefit older people, but improve the social cohesion and well-being of the Australian population as a whole.

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[30] Laß, I., Botha, F., Peyton, K. and Wilkins, R., The Household, Income and Labour Dynamics in Australia
Survey: Selected Findings from Waves 1 to 23, https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0010/5387806/2025-HILDA-Statistical-Report.pdf, p. 117

[31] ibid, pp. 176-178

[32] Australian Institute of Health and Welfare, Volunteers, https://www.aihw.gov.au/reports/australias-welfare/volunteers