Raising Sydney's Care Factor

The critical role of care work to Sydney's productivity & prosperity

Committee for Sydney

Acknowledgement of Country

The Committee for Sydney acknowledges Aboriginal and Torres Strait Island peoples as the traditional custodians of the land. Sovereignty was never ceded: this was, and always will be, Aboriginal land.

Thankyou

Thankyou to the following organisations for their contributions

Major partners on this report include EY, Arup and BVN.

Between June and August 2025, we conducted a series of interviews with a diverse range of stakeholders. We also held a workshop on 30 July 2025 to explore solutions within the sector.

Over 50 organisations and members have been involved in this research, whether participating in interviews, workshop or both.

Anglicare
Architectus
Arup
Australian Catholic University
Australian Unity
Bates Smart
Blacktown City Council
Blix Architecture
Bridge Housing
BVN
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Carers Australia
Carers NSW
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Lifeline
Macquarie University
NSW Health
NSW Nurses and Midwives Association
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Penrith City Council
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Randwick Innovation Precinct
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Sydney Local Health District
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UNSW
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Western Sydney Local Health District
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Executive Summary

Imagine a Sydney where care is recognised as essential infrastructure, as vital as housing, transport or energy

Where every child, parent, worker, elder and person with a disability is supported, as well as the people who care for them. Where everyone, regardless of gender, contribute equally, and carers – paid and unpaid – are valued, fairly paid, and respected. Where families who choose to, can afford to have children without sacrificing their career or wellbeing. Where housing and transport make care accessible and easy.

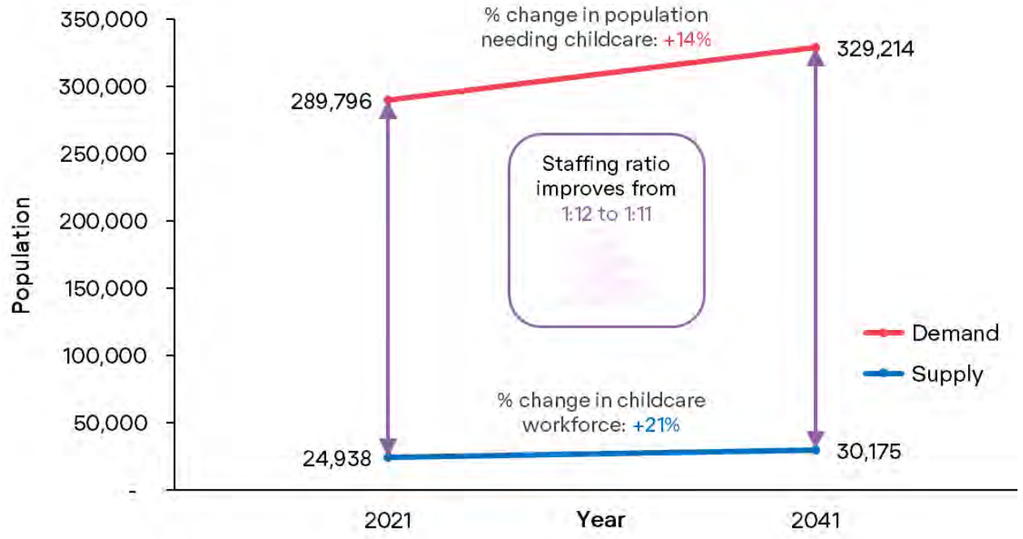
Now consider the alternative - a city where care is priced out, and carers leave at increasing rates

An ageing population, a declining birthrate, a housing crisis, climate change, a loneliness epidemic and the rising cost of living are colliding with long-standing and stubborn gender, economic, spatial and racial inequalities across our city.

If we do nothing, carers will burn out, workers will remain trapped in insecure, low-paid jobs, and people with disability and an estimated 60,000 older people will go without support. Families will be forced to step back from the workforce to fill the gaps left by formal care, with long-term costs for productivity and economic participation. Families will continue to delay or forgo having children because housing and childcare are unaffordable and unpaid care falls unevenly.[1] Put simply: demographic decline, deeper divides and growing strain on the next generation.

Influenced by declining birth rates, child care demand is expected to rise only modestly, with projected workforce supply sufficient to meet demand and potentially improve staffing ratios.

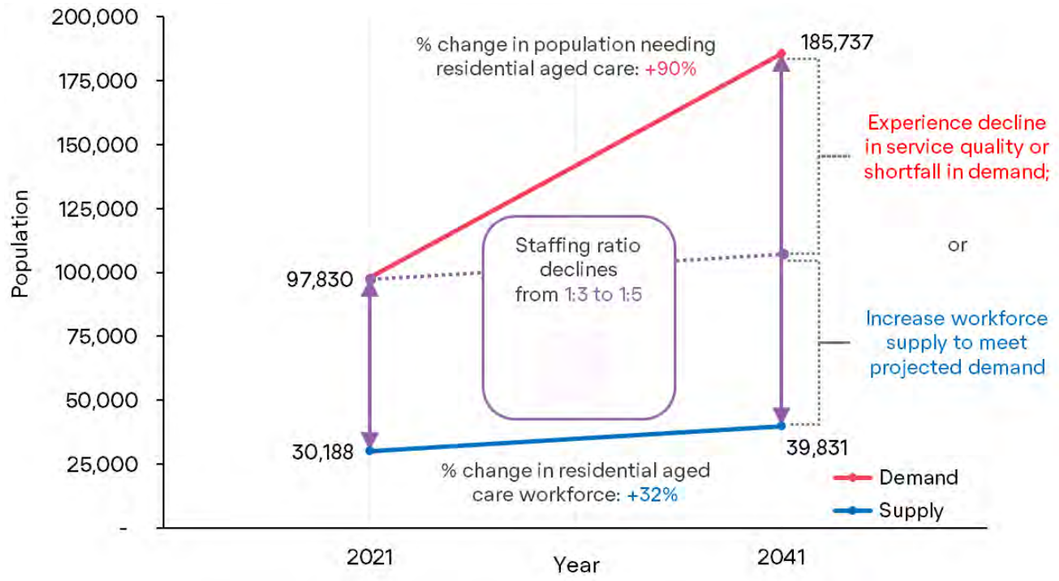
Projected child care worker supply versus population demand* from 2021 to 2041



Source: ABS 2021 Census, NSW Planning population projection to 2041, SGS Economics and Planning Workforce projection for 2041. Demand assumptions based on childcare usage data by Department of Education, with adjustments: 30% of children aged 0-14 uses childcare.

With the elderly population projected to rise sharply, the workforce must expand accordingly. Otherwise, the system faces a choice between declining care quality from lower staffing ratios, or a shortfall leaving about 57,000 elderly people who need residential aged care without access.

Projected residential aged care worker supply versus population demand* from 2021 to 2041



*Source: ABS 2021 Census, NSW Planning population projection to 2041, SGS Economics and Planning Workforce projection for 2041. *Demand assumptions based on residential aged care usage data by AIHW: 9% of females aged 65–84, 54% of females aged 85+, 5% of males aged 65–84, and 41% of males aged 85+.*

If Sydney fails to raise the care factor, the costs will be profound. But if we act, the rewards are significant: higher productivity, greater gender equity, stronger communities and long-term savings across health and social spending.

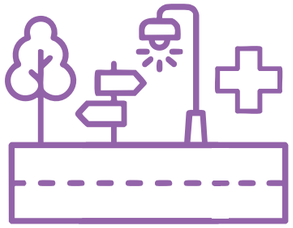
This report sets out a roadmap for change, identifying six priority areas where reforms can transform how Sydney supports care in our workplaces, homes, neighbourhoods and public policies.

It draws on census data, qualitative research and case studies, combined with insights from those on the front line of Sydney's care economy. We interviewed 30 experts and practitioners, including care providers, social service agencies, unions, councils, government departments and academics, and convened 50 stakeholders in a city-wide workshop. The draft was peer reviewed by 20 sector leaders to test and refine its findings:

1. **Shift the narrative: make care visible, valued and shared –** recognise unpaid carers, integrate formal and informal care, and challenge gendered stereotypes.

2. **Futureproof the care workforce –** provide paid training, create career pathways, ensure fair pay, and deliver flexible supports for unpaid carers.

3. **Simplify access to care –** establish local care navigators, streamline aged and home care pathways, and expand childcare access for all.



4. **Design cities and places that enable care and connection** – deliver affordable and adaptable housing, improve transport and street design for carers, and embed health services in communities.

5. **Optimise tax and regulation for a productive care economy –** adopt fairer measures of productivity, streamline rules, and reform tax to unlock housing mobility and fund sustainable care.

6. **Harness data, technology and innovation to strengthen the system –** invest in telehealth, expand assistive technology, coordinate data, and apply ethical AI.

Key facts at a glance:

Theme	Key facts
Care industry and workforce 	Care is Sydney's largest employer, with 14% of the workforce.
	One in five women (22%) in Greater Sydney are employed in care roles. Within the care sector, 77% of the workforce is female.
	48% of care workers are born overseas and 40% speaks a language other than English at home.
	46% of female care workers are part-time, limiting job security, benefits, and super, and reinforcing lifetime economic inequality.
	36,000 essential workers in Sydney live in overcrowded housing.
	In 2020–21, the aged care sector spent just $465,000 on R&D out of $2.9 billion in total expenditure. By comparison, ambulance services spent $1.3 million, the regulatory services industry spent $8.3 million, and the beekeeping industry spent $4 million.
Value of unpaid care	$650 billion is the estimated annual value of unpaid care in Australia (50% of GDP).
	There are over 1.4 million carers across Greater Sydney, Wollongong and Central Coast, and 64% of these carers are women.
	1.1 million persons or 27% of adult population care for own or other's children.
	478,000 persons or 11% of adult population provide unpaid assistance to persons with disability, long-term health condition or of old age
	The role is financially precarious: 40% of primary carers rely on a government allowance as their main source of income, compared with just 16% of non-carers.
	Caring is often intensive: 30% of primary carers provide more than 40 hours of care per week, the equivalent of a full-time job.
	On average, women do 13 additional hours of unpaid work each week or 676 hours a year. Comparing to men, this equates to nearly 18 extra full-time weeks in a year of unpaid work done by women.

Theme	Key facts
Emerging trends 	Central Coast currently has the largest concentration of older people as a proportion of the population. However, the regions with fastest rate of ageing will be Northern Sydney and Northwest Sydney, whereas Eastern Sydney and Central Sydney will maintain a relatively young population.
	Births across Greater Sydney, Central Coast and Wollongong hit the lowest historical fertility rate of 1.68, far below the replacement level of 2.1 – which is the rate required to maintain a steady population
People needing care 	In NSW, 390,000 older people are receiving aged care support, 450,000 children are enrolled in approved childcare in NSW. In Greater Syndey, Central Coast and Wollongong, one in four people living with a long-term health condition require daily assistance with core activities.
	Estimates suggest 6–10% of older Australians identify as LGBTQI+, around 270,000–360,000 people currently aged 60 and over, yet many choose not to disclose their identity to care providers for fear of mistreatment.
Spatial and economic inequality 	In the care sector, most female workers earn between $52,000 and $65,000 annually, whereas male workers most often earn nearly two times as much, at $104,000 to $156,000.
	A national survey of 2,359 nursing students reported that one-third incurred financial liabilities, 79% faced financial hardship, and 73% found placements stressful, with 62% noting an impact on health and wellbeing.
	Care workers mostly live in Western Sydney but jobs cluster in the east and north, causing large commuter flow out of the west (14%) and into the east and north (20%).

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Credit: Arcadia Landscape Architecture, photo Brett Boardman.

1. Introduction

Care is the invisible engine keeping our homes, communities and economy running. From raising children to supporting ageing loved ones or those with disability, both formal paid care and informal unpaid care fuel daily life.

But too often, this engine runs on empty. The care economy – a vast network of time, effort and resources – is under growing pressure yet remains largely invisible in policy, the built environment and national conversations about productivity.

This report changes that. By making care work visible, we can better understand its impact on households and society, and why investing in the care economy is essential for a productive, equitable and prosperous city.

It also asks a critical question: is our city geared to care? From housing and transport to streets and public space, we explore how urban planning, infrastructure and the built environment can support or constrain our ability to care for ourselves and each other, and what the personal, social and economic costs are if we don't get it right.

To answer this, we combined analysis of census data, research and case studies with insights from those on the front line of Sydney's care economy. We interviewed 30 experts and practitioners – including care providers, social service agencies, unions, councils, government departments and academics – and brought together 50 stakeholders in a city-wide half-day workshop. The draft was peer-reviewed by 20 leaders across the sector to sharpen its findings.

Our scope is broad: it covers unpaid care work – including parental care, unpaid assistance to people with disability, illness or ageing, and domestic work – as well as paid care work across health care, aged care, disability support and early childhood education and care. These are the people who keep Sydney going.

This report recognises the wide-ranging reforms already underway – from the new Aged Care Act and changes to parental leave, to universal childcare and the NSW Government's commitments around early learning. While these reforms are vital, they remain largely service-focused.

What has been missing is a place-based perspective: how neighbourhoods, infrastructure and the city itself shape our ability to give and receive care right across Sydney. By bringing this spatial lens together with system reform, the report shows how Sydney can unlock the next wave of productivity and quality-of-life gains.

1.1 The need to raise the care factor for care work in Sydney

Despite Sydney's reputation for professional services, the care sector is Greater Sydney's largest employer, making up 14% of the workforce compared to 11% in professional, scientific and technical services. Over 1 in 5 working women in Greater Sydney are working in the care economy (22%).[3]

Far from peripheral, the care economy underpins everything from quality of life and household stability to workforce participation, productivity and long-term national prosperity.

Investment in care delivers higher productivity, greater gender equity, reduced inequality, and long-term savings in social and health expenditure. A more caring city supports health and independence, keeping people well and connected, and reducing the need for costly hospital or residential care. In the face of an ageing population and growing social divides, a stronger care system is vital to building an inclusive, sustainable and more resilient economy.

The care sector is Greater Sydney's largest employer, making up 14% of the workforce. Over 1 in 5 working women in Greater Sydney are working in the care economy (22%).[2]

Credit: Randwick Hospital

Care work shapes who can participate in the workforce, education, and community life. Without a functioning care economy, our city cannot function.

Care work is the foundation of Sydney's productivity and prosperity

Care underpins the entire global, Australian and NSW economy. It is an engine for growth, prosperity and wellbeing, and the foundation for social life. Investing in the care economy both addresses longstanding inequalities, as well as fuelling economic growth. According to the World Economic Forum,[4] a well-designed care economy achieves:

- Higher levels of productivity and growth
- Higher levels of gender parity
- Higher levels of workforce participation
- Higher levels of educational attainment
- Higher business profitability and efficiency
- Lower levels of inequality
- Lower long-term social expenditure.

Care work is priceless, but unaccounted for in the economy

Price is the measure of value in economics, yet the things we value most – like caring for loved ones or being cared for – are deemed 'priceless'. Because this value is hard to quantify or monetise, it falls through the cracks of standard metrics such as GDP, leaving care work undervalued and overlooked.

Despite this, there have been attempts to put a price on the value of unpaid care work. The monetary value of unpaid care work in Australia has been estimated to be $650.1 billion, the equivalent to 50.6% of GDP.[5] According to McKinsey, women do an estimated 75% of unpaid work, valued at the equivalent of 13% of global GDP.[6] Regardless of this quantification, the truth is our common accounting and productivity metrics do not properly account for unpaid care. Decision-makers who rely on these metrics don't see the benefits of a well-functioning and equitable care economy.

The monetary value of unpaid care work in Australia has been estimated to be $650.1 billion, the equivalent to 50.6% of GDP.[7]

If productivity is output per hour worked, then care poses a challenge: is the output the number of patients seen, or the quality and dignity of the care? The former is easier to measure than the latter, but that doesn't make it more important.

This mismatch in how we account for growth and productivity in care is captured by Rebecca Thistleton in the opening of a McKell Institute report: *"Why is it that buying cow's milk to feed babies contributes to gross domestic product (GDP) and economic growth, but breastfeeding babies has no measurable economic value?"*[8]

Care work is off the books, but still comes with a hidden tax

While unpaid care work doesn't appear in national measures of GDP, the hidden costs of care too often place an unfair tax on individuals and families – whether it's needing to rely on Ubers or taxis because there are no accessible entrances at a train station, having to move houses to live near a school that accommodates a child with a disability, or giving up work to manage a chronically ill family member's medical appointments. Too often, carers are paying to care – an inequity this paper seeks to address.

The care work that does show up in GDP is growing, but drags on productivity measures

Over the past century, Australia's economy has shifted away from traditional industries like agriculture and manufacturing towards services, with healthcare emerging as one of the fastest-growing sectors. Once a negligible share of GDP, healthcare has steadily expanded since the 1960s and now makes up almost 10% of the national economy. This rise reflects profound demographic and social changes; an ageing population, longer life expectancy and growing demand for disability and aged care.

Credit: Unsplash

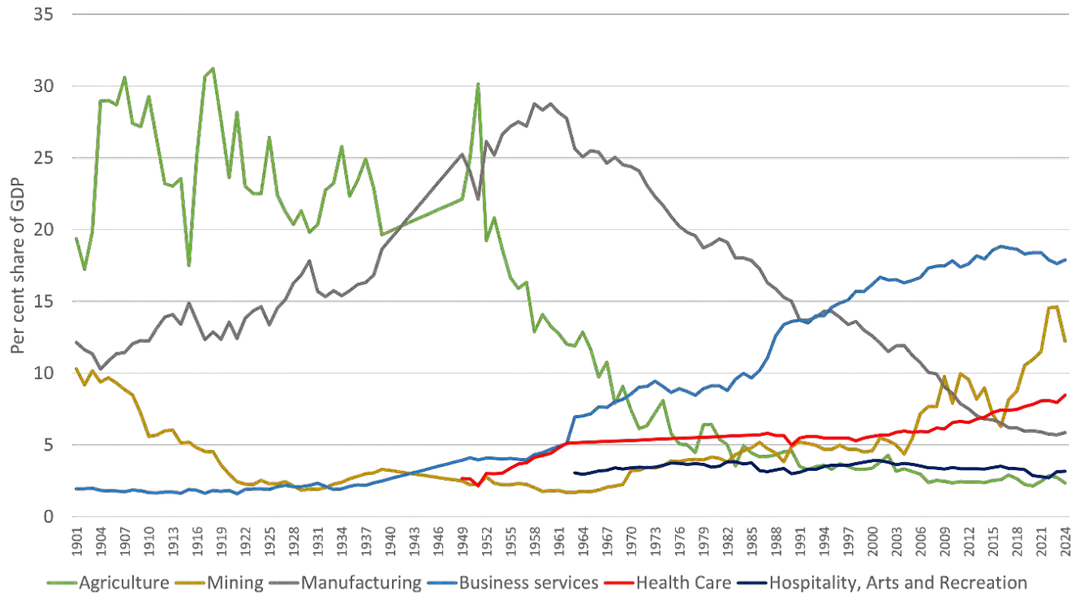
Unlike industries such as mining or agriculture, which have become less labour-intensive over time due to technological advancements, the care economy remains highly people-driven. Care work relies on human relationships, not machines, meaning traditional efficiency gains are limited without undermining quality. Regulations deliberately reinforce this, with staff-to-patient and staff-to-child ratios designed to protect safety and dignity.

Care work relies on human relationships, not machines, meaning traditional efficiency gains are limited without undermining quality.

Credit: Canberra Hospital, EVN

Mapping structural changes in the Australian economy.

Healthcare has been one of Sydney's fastest-growing industries over the past 20 years, reaching 10% of GDP in 2022.



Source: SGS Economics and Planning

This makes the formal care economy inherently less productive when assessed through narrow economic metrics. Productivity Commission Chair Danielle Wood has cautioned that as the care sector grows, it will "drive down productivity overall," requiring other industries to pick up the slack.[9] The e61 Institute estimates the care sector's expansion accounts for around 10% of Australia's recent productivity slowdown, largely because growth in care jobs often comes from reallocating workers out of other sectors like retail and hospitality, fueling competition for labour and wage pressures.[10] But this shouldn't be seen as inherently negative. Care underpins the wider economy: an engineer can remain on a construction site, or a teacher in the classroom, because their children are in early learning or their ageing parents receive home care support. By valuing care through the market, we are exposing the historically hidden subsidy of (predominantly) women's unpaid work. Productivity looks lower as more care is marketised, but in reality the overall economy is expanding because of it, with more women able to participate in other sectors. What appears as a decline is simply the cost of making invisible work visible.

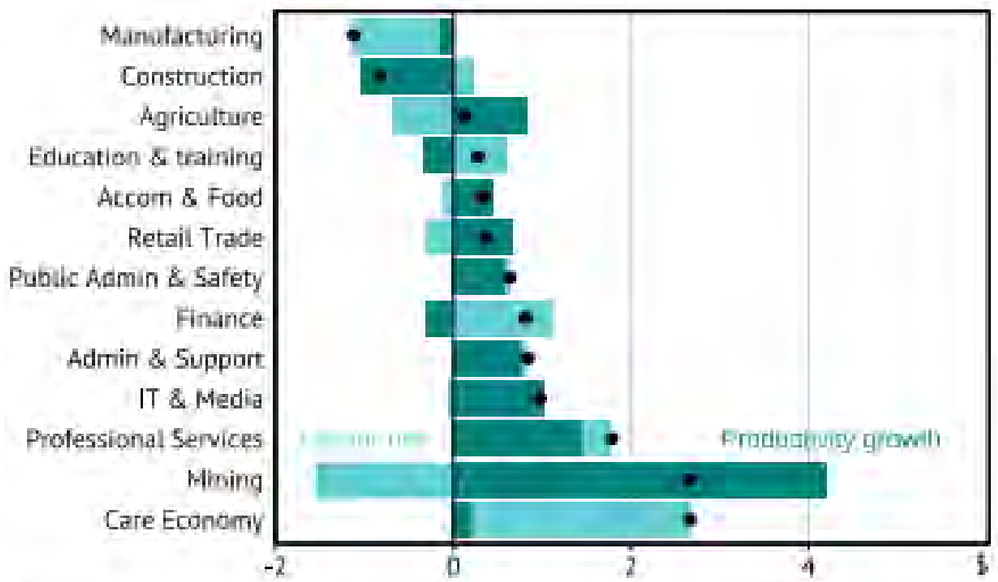
While there are frequent calls to increase efficiency in care, this cannot come at the expense of quality or human-centred practice. Real efficiency gains lie in reducing duplication, improving administration and supporting the workforce, not in rushing or stripping back the care itself.

The care economy sector is growing as more people join, not because of higher productivity

The invisible subsidy of unpaid work becoming marketised is skewing productivity statistics

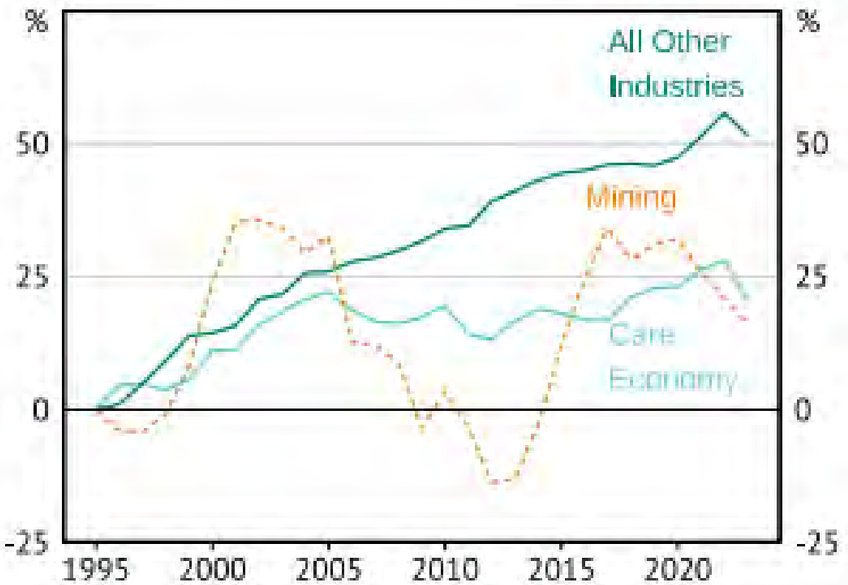
Figure 2: Output has grown rapidly in the care economy, reflecting labour inputs rather than productivity growth

Change in output per person ($000s)
Select Industries, 2013-2023



*Per Person is defined as Australians aged 15+
Sources: ABS; e61

% Change in Productivity Growth
Since 1995



Sources: ABS; e61

Source: ABS; e61

2. Defining the care economy

2.1 What is care work?

Care is all-encompassing

We all need care, and we both give and receive care every day. It's in the unpaid work of cooking, cleaning, doing laundry, managing bills, organising appointments, helping out with homework or checking in on loved ones.

It's also in the paid care work carried out in childcare centres, aged care homes, hospitals, local health facilities, and in people's own homes. This includes early childhood educators, nurses, aged care workers, disability support workers, social workers and personal carers.

While we often talk about care work as something that only older people, people with disability or chronic illness and children need, "no-one can exist without, at some point, being taken care of and treated as valuable by other people."[11]

- Care is also reciprocal. Carers need to be cared for, and those being cared for, also care for the people who care for them.
- *Care work is the paid and unpaid mental, manual and emotional labour that sustains our wellbeing and survival.* [12]
- *Care affects us all, it shapes our bodies, minds, homes, workplaces, cities, state and country.* [13]

What care looks like at different stages of life

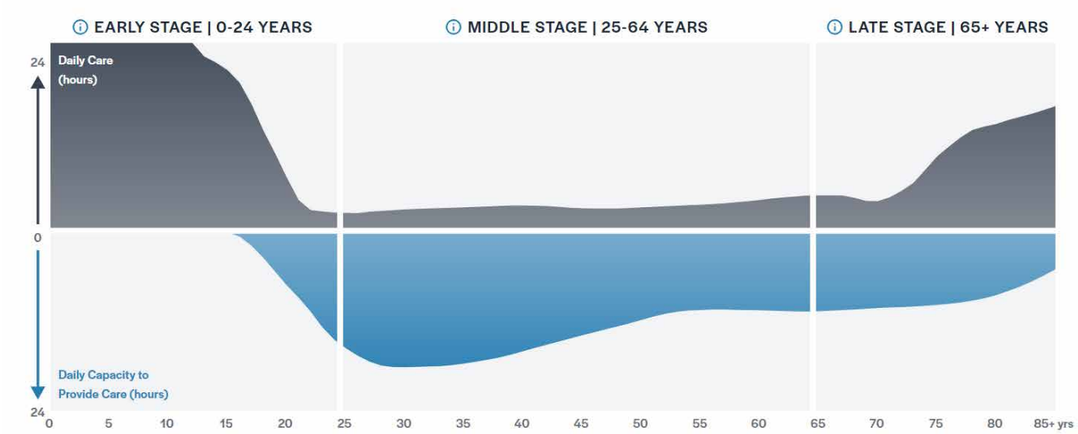
Care changes throughout our lives, shaping how much care we require and our capacity to provide it. The kind of care we need also shifts based on life stages and circumstances.

Care work is even more essential in the following key periods of our lives:

- The beginning of life, during infancy and childhood when we can't survive without care
- Later life, as we age and our mobility, health and ability to live independently declines
- Periods of illness, injury or other life-changing events, or
- As part of daily life for some people with disability, where care supports independence inclusion and participation.

People need care in early life, and later life, with more capacity to give care in middle stage.

Estimated daily care, and capacity to provide care based on age



Source: University of Kansas, 2025 [14]

Ways of categorising care

We all give and receive care throughout our lives, in many different forms. Care can mean supporting development, helping with daily living or health needs. It can be paid or unpaid, and it can happen in formal services or informal family and community settings. While some types of care are visible and widely recognised, many remain hidden – yet they are just as important for the wellbeing and cohesion of our society.

Visible, formalised care
- Medical care
- Childcare / aged care
- Disability support
- Mental health support

Semi-visible care, often unpaid and undervalued
- Cooking, cleaning, transport, shopping
- Personal care (bathing, grooming, dressing)
- Home maintenance (gardening, repair)
- Caring for young, elderly, persons in-need
- Medication management

Invisible care, critical for wellbeing
- Companionship from family, friends, volunteers, neighbours
- Play, leisure activities and shared meals
- Connection to culture and religion
- Respite for carers

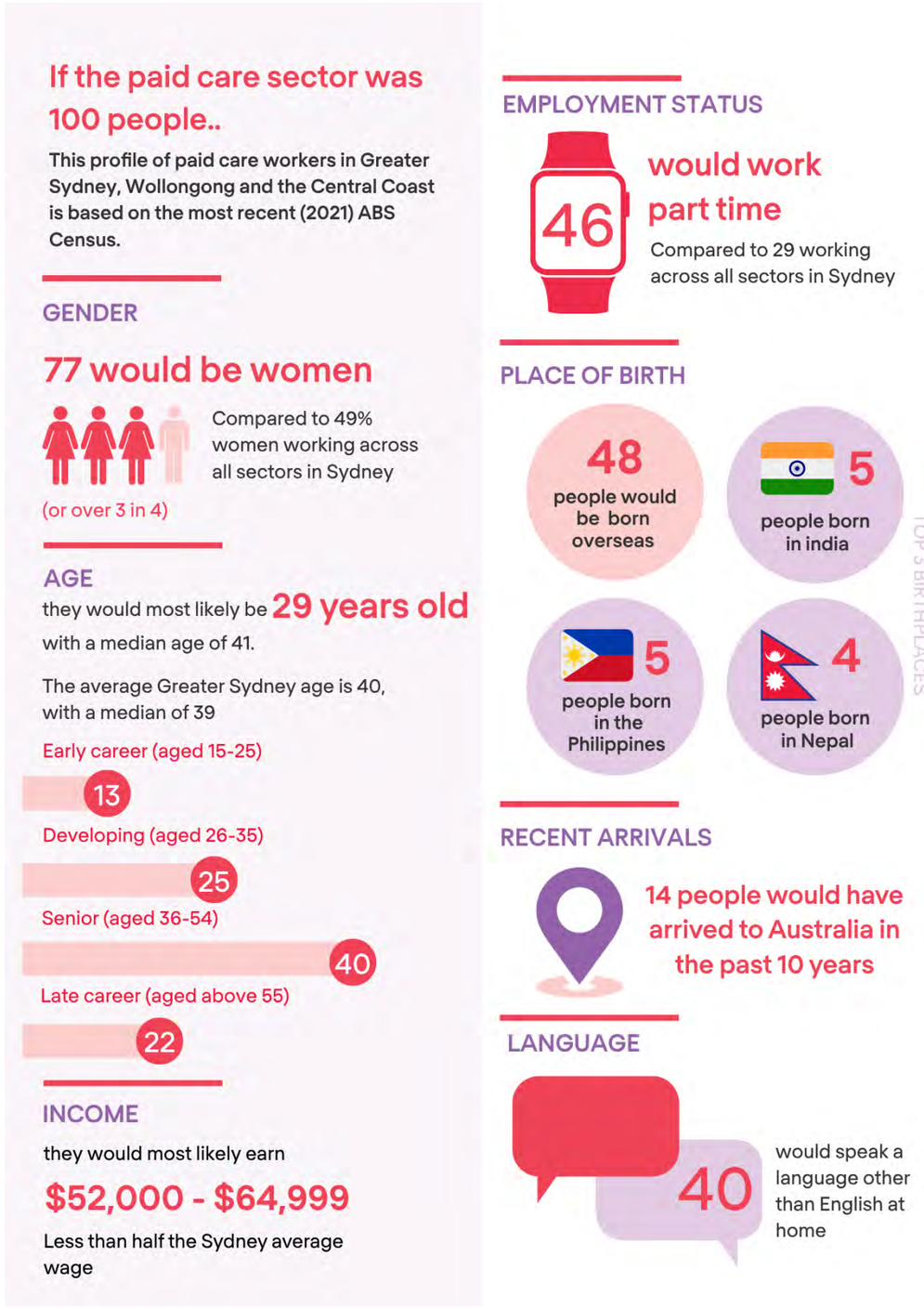
Credit: Canva stock photo

2.2 Who is providing care?

Care work exists across a spectrum. It can be paid, unpaid or a combination of both. While this section separates the two for clarity, in practice the lines are often blurred. The term 'unpaid care work' can also be problematic, as it risks obscuring the significant economic and social value of this essential contribution.

It is important to acknowledge that this report does not capture every type of care worker. The care economy is a vast, 24-hour ecosystem that includes a wide range of roles from cleaners, hairdressers and food delivery drivers, administrative staff and many more – all of whom provide care or enable others to care for themselves. These occupations are essential parts of the care economy, but they sit outside the scope of this paper's statistical analysis. The reality is the care economy is even broader than the numbers presented here, and its impacts are felt even more widely across our city.

The state of the paid care workforce in Sydney[15]



The care economy spans a wide range of services and occupations – from hospitals and aged care to childcare, disability support and community health. It includes the workers who provide direct care, such as nurses, paramedics and childcare educators, as well as those delivering essential support through allied health, counselling and social assistance.

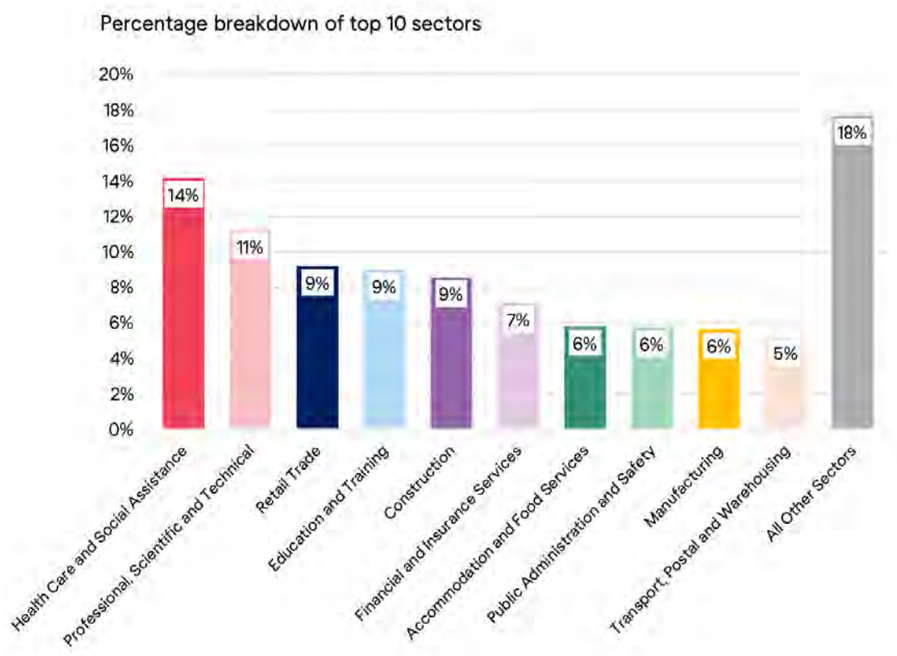
Care workers earn lower incomes, are more culturally diverse, and are predominantly women. These patterns reflect broader forms of intersectional inequality, highlighting the care sector as a critical site for addressing structural disadvantage.

- Around 15% of care workers earn between $52,000 and $65,000 a year – the most common income bracket in the sector. By contrast, the typical worker in Greater Sydney falls in the $104,000 to $156,000 range, more than double. This starkly highlights the economic disadvantage faced by care workers.[16]
- The care sector is also predominantly female, with women making up 75% of the workforce as compared to 49% across all employees in Greater Sydney. Over 1 in 5 women who work in Greater Sydney are employed in the care sector (22%).[17]
- Additionally, care workers are more culturally and linguistically diverse than other workers within the regions. A greater proportion speak a language other than English at home, with 40% compared to 36%, and slightly more identify as Aboriginal or Torres Strait Islander, at 1.5% versus 1.4%. [18]

Credit: Canva stock photo

Despite Sydney's reputation for professional services, the care sector employs the largest share of the workforce

Share of Sydney's top 10 employment sectors

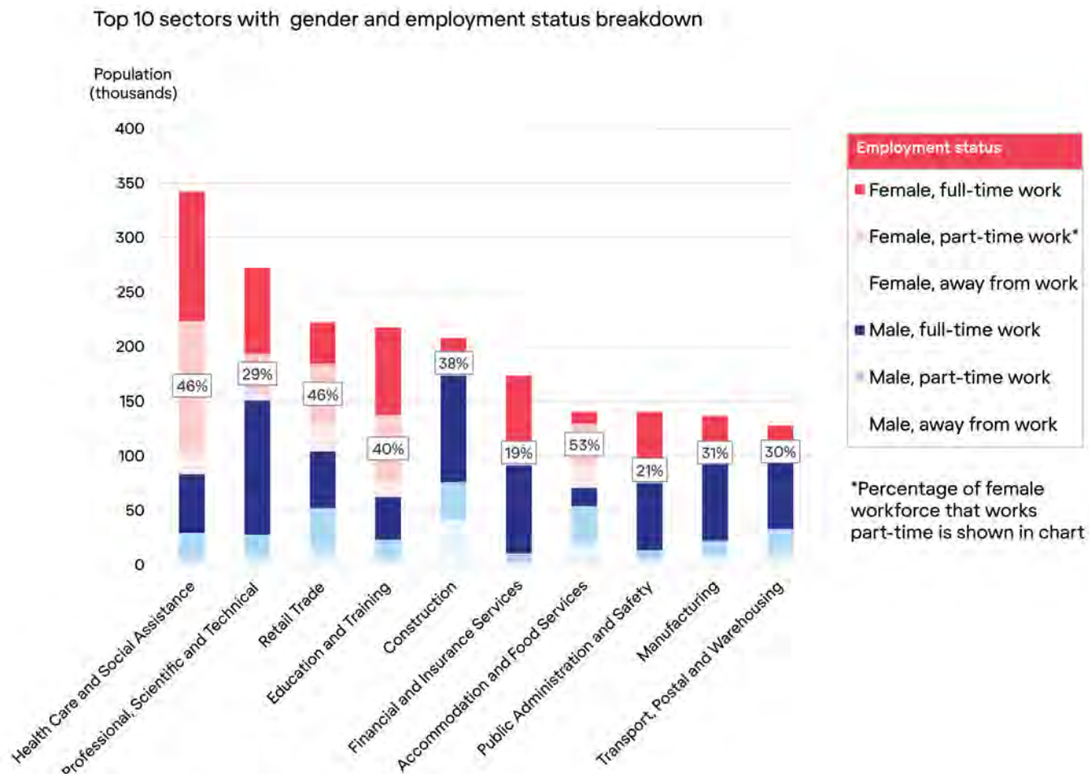


Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Despite Sydney's reputation for professional services, the care sector is Greater Sydney's largest employer, making up 14% of the workforce as compared to only 11% in professional, scientific and technical services.

As the largest employer in Sydney, the care sector is also highly feminised with a large proportion of part-time workers

Share of Sydney's top 10 employment sectors broken down by gender and employment status



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Within the care sector, 46% of female workers are employed part-time. This is second only to accommodation and food services (53%) and well above the all-industry average of 29%. Working part-time often means less job security, fewer paid benefits, and lower superannuation contributions from employers, reinforcing gendered economic inequality over the life course.

Not all paid care work is equal, with significant differences in demographic indicators across different types of care work.

Mapping income, gender, place of birth and language spoken across different parts of the paid care sector demonstrates that there are significant inequalities across the care sector. Aged care workers are some of the lowest income workers, mostly women and mostly migrants. Childcare workers are the lowest paid workers, with the least gender diversity – almost 100% women. Disability support workers are the closest to the Greater Sydney average in terms of gender balance, with only a slight skew to women, and have the least proportion of migrant and culturally and linguistically diverse workers.


Credit: Canberra Hospital, BVN

Mapping different types of care workers against key demographic indicators

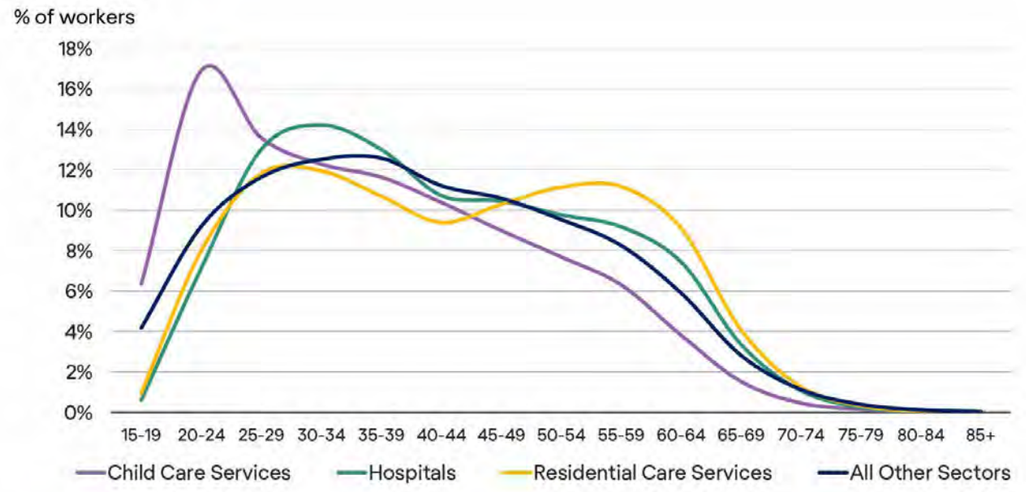
Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

When the age of workers across childcare, healthcare and aged care are plotted, there are also significant differences across the care sector.

- **Childcare** relies heavily on very young workers, raising concerns about retention and career pathways as many leave the sector early
- **Hospital workers** have a relatively young profile but are more evenly spread across middle age, giving them greater stability
- **Aged care** depends on a large share of workers close to retirement, creating looming shortages unless new entrants are attracted.

Childcare workers tend to be young, while a significant share of residential aged care workers are nearing 60 – caring for those not much older than themselves.

Snapshot of worker's age brackets in childcare, hospital, residential care and average across all other sectors



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Credit: Canva stock photo

The state of unpaid carers

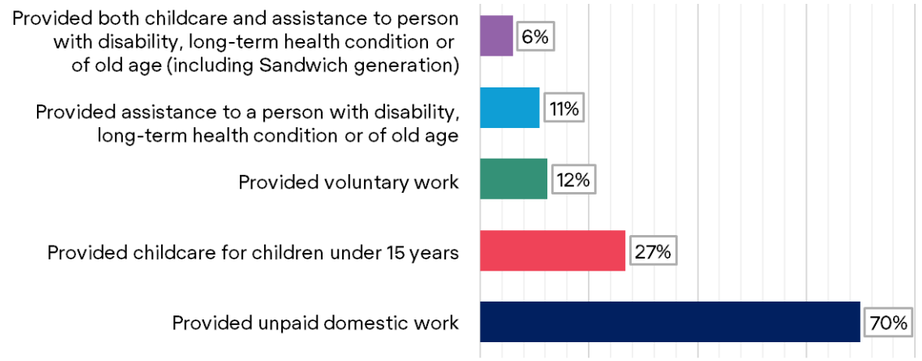
Unpaid carers, usually family or friends, provide unpaid support to loved ones with disability, illness, addiction or age-related needs. They play a vital role in Australia's health and care systems, contributing to Sydney's economic and social resilience by assisting with daily tasks like personal care, transport, medication, emotional support and managing appointments or emergencies.[19]

Unpaid care statistics for Greater Sydney, Wollongong and Central Coast

- There are over 1.4 million carers across Greater Sydney, Wollongong and Central Coast, and 64% of these carers are women.
- 1.1 million persons or 27% of adult population care for own or other's children.
- 478,000 persons or 11% of adult population provide unpaid assistance to persons with disability, long-term health condition or of old age
- Approximately 250,000 persons or 6% of adult population provide both childcare and unpaid assistance, this includes the sandwich generation who cares for children and elderly parents.
- 26,300 persons or 0.5% of adult population simultaneously provide and need assistance themselves, leaving them especially vulnerable physical strain, financial pressure and social isolation.

Around 6% of adult population provide both childcare and unpaid assistance, this includes the sandwich generation

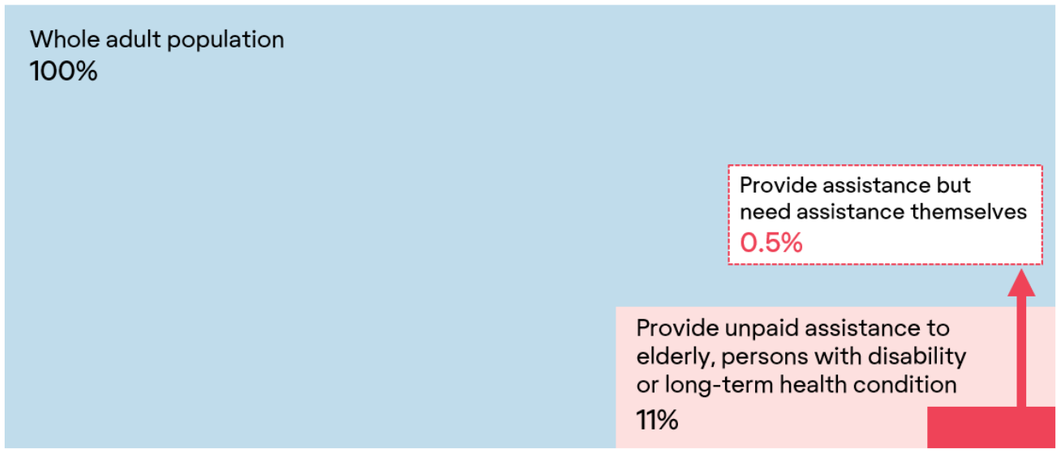
% of population aged 15 years+ providing different types of unpaid work



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

26,300 people across Sydney, Wollongong and the Central Coast simultaneously provide and need assistance themselves

% of population aged 15 years+ providing unpaid assistance and needing assistance with core activities



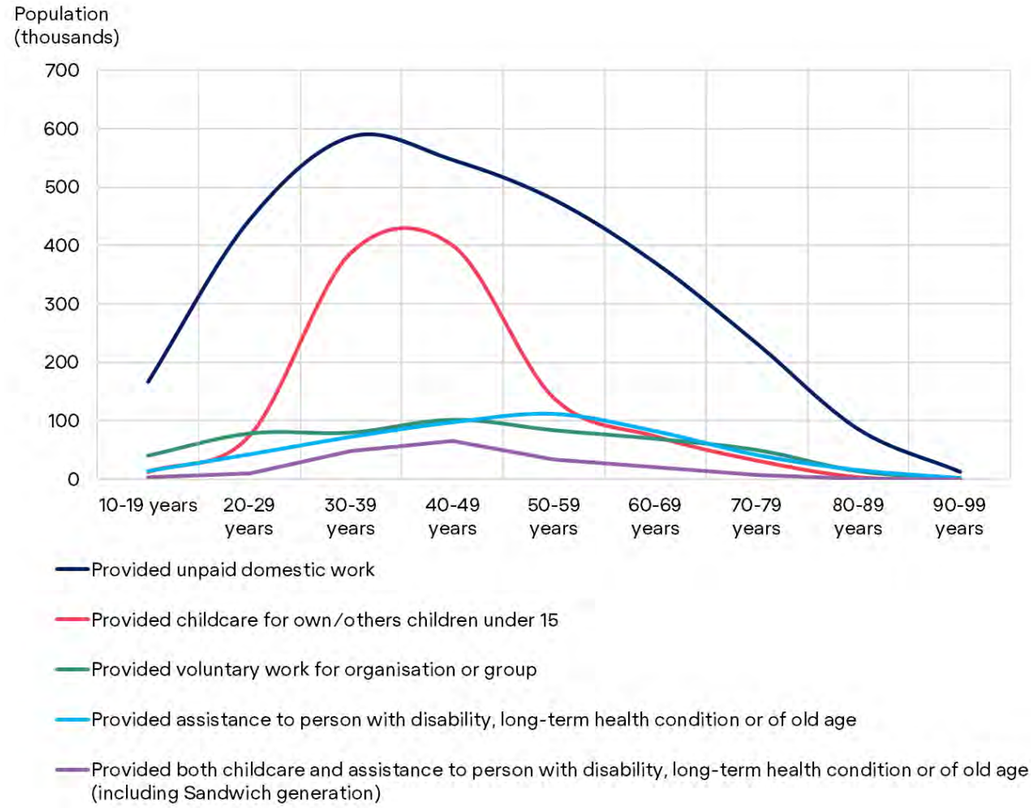
Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong. Those needing assistance in one or more of three core activity areas of self-care, mobility and communication because of long-term health condition, disability or old age.

When mapping the age distribution of unpaid carers in Sydney, caring responsibilities are most concentrated during the 30s and 40s – prime working years. This is when many people are raising young children while also increasingly supporting ageing parents, creating the so-called 'sandwich generation.' For many, this double load extends over decades, as children remain dependent longer due to housing pressures delaying adult children leaving home and parents living into older age. The graph also shows how unpaid domestic work extends across the life course, while childcare responsibilities taper off more sharply.

Credit: Stock photo from Canva

The care being provided by the sandwich generation is lasting longer with children remaining dependent and parents living longer, leaving little respite in-between

Age distribution of unpaid care providers and volunteers (excluding persons under 15 years)



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong.

Carers Australia also captures the extent of the time commitment, financial and emotional burden of carers:[20]

- **Caring is often intensive**: 30% of primary carers provide more than 40 hours of care per week, the equivalent of a full-time job
- **The role is financially precarious**: 40% of primary carers rely on a government allowance as their main source of income, compared with just 16% of non-carers
- **Carers also report significantly lower wellbeing**: 58.3% of carers report low wellbeing, compared with 30.4% of Australians overall (Carers Australia, 2023).

2.3 Who is receiving care?

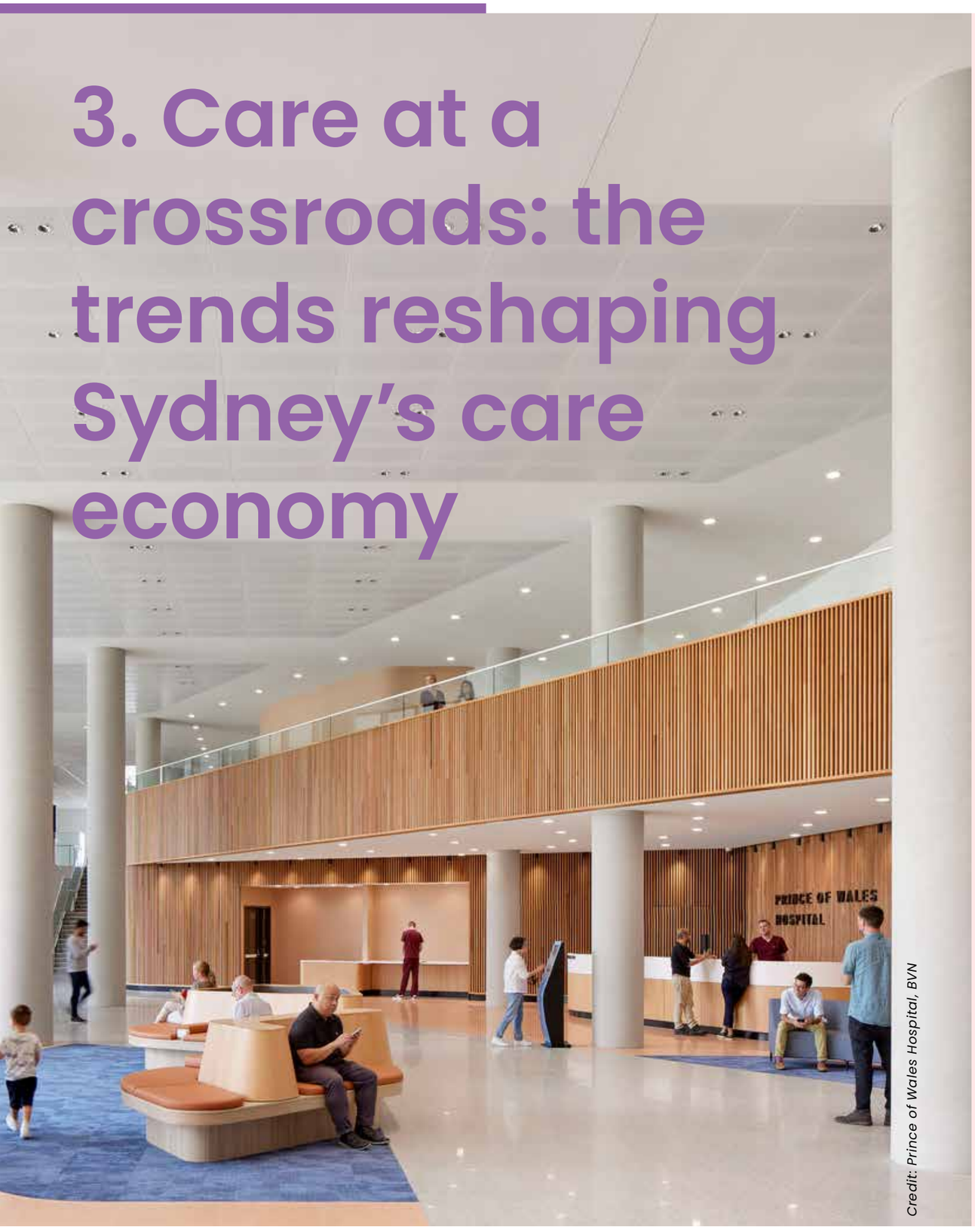
Receivers of care – children, elderly, persons with disabilities but also each of us

2021 Census data shows that care touches the lives of hundreds of thousands of people in Sydney and across New South Wales. Taken together, there are:

- Almost 390,000 older people are receiving aged care support in NSW.
- More than 450,000 children are enrolled in approved childcare in NSW.
- 1.5 million people are living with a long-term health condition. 1 in 4 require daily assistance with core activities in Greater Syndey, Central Coast and Wollongong. This includes:
    - 79% of people living with Dementia
    - 19% of people living with a mental health condition.

This means that well over 800,000 people in NSW (approx. 10% of the state) - spanning children, older people, and those living with disability or chronic illness - are formally receiving some form of care that is captured in government data. The true scale is even larger once unpaid and informal care is considered, reminding us that care is not the exception but the everyday reality for families and communities.

3. Care at a crossroads: the trends reshaping Sydney's care economy



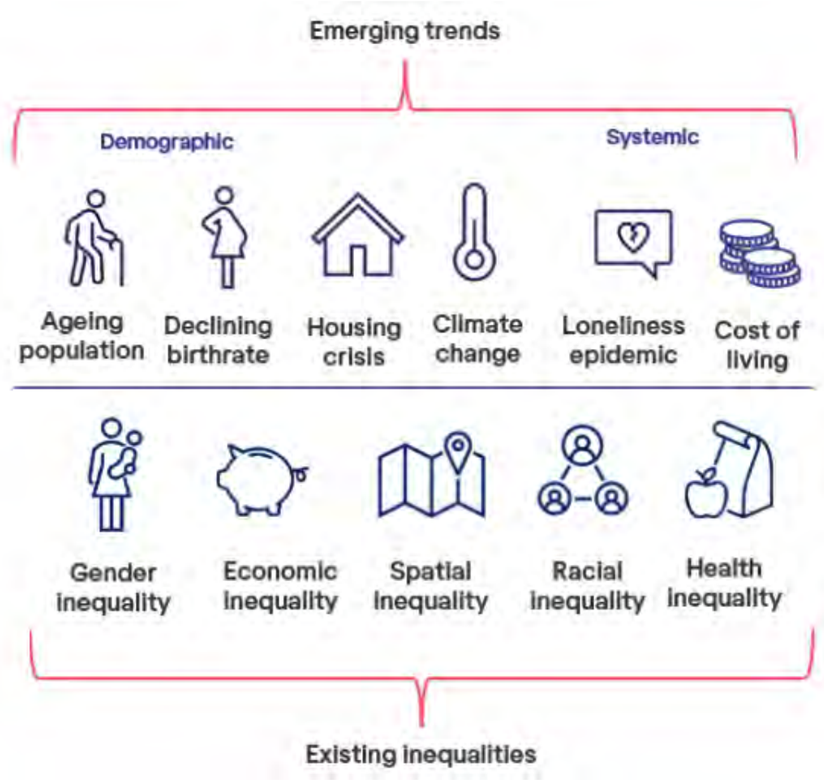
Credit: Prince of Wales Hospital, BVN

Sydney's care economy is at a crossroads. Our city is facing a silver tsunami with a rapidly ageing population, the increased disruptions of climate change, rising loneliness, fewer children being born, and the biting cost of living. At the same time, persistent inequalities of gender, income, race and place still shape who gives care, who receives it and whose work is valued.

These pressures aren't isolated; they collide, compound and reinforce one another. Ageing drives up demand for workers, but housing and transport costs push those workers further away. Declining birthrates reduce the future tax base, while an increasingly retired population puts more pressure on the public purse.

Gender inequality means women continue to carry the lion's share of unpaid care, impacting wellbeing, limiting workforce participation and lifetime earnings. As a result, they retire with far less superannuation despite living longer on average than men, leaving many with fewer resources but greater care needs.[21] Climate change exposes vulnerable populations to more hazards and shocks, while racial and health inequities magnify who misses out on support.

This section unpacks these trends and existing inequalities, making clear why Sydney's care economy now stands at a crossroads, with profound consequences for the city's prosperity and fairness depending on the path we take.



3 Emerging trends: demographic and systemic shifts

Sydney is already starting to feel the crunch of changing demographics – an ageing population and declining birthrate – as well as systemic pressures like housing unaffordability, increased climate hazards, rising loneliness and the biting cost of living. Together, these forces are transforming how the city provides and sustains care.

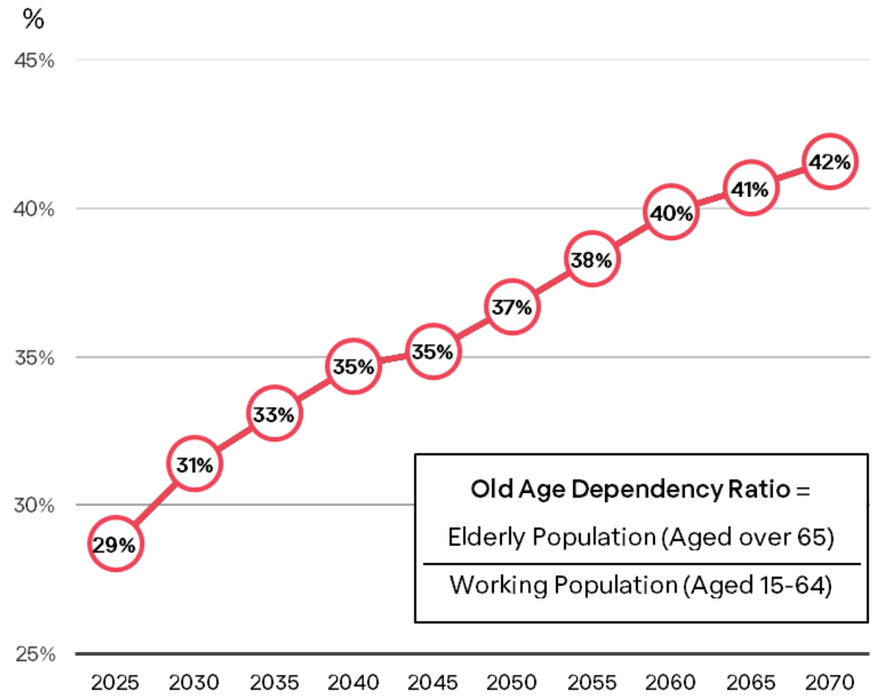
3.1 Demographic trends: Sydney is facing a silver tsunami and a declining birthrate

By 2070, there will be 42 people over 65 years for every 100 working age people in NSW

Today, for every 100 working age people, 29 are aged over 65 years old. This number is projected to increase to 42 people by 2070.
As the ratio increases, dual challenges emerge: growing financial and workforce pressure on the healthcare and aged care system, and a resultant reduced tax revenue. Combined, this diminishes the capacity for governments to fund services and social support.

The ratio of working aged people, to people over 65 is increasing rapidly over time

NSW Old Age Dependency Ratio, projections to year 2070



Source: NSW Government Medium Series Projection, 2025 – 2070

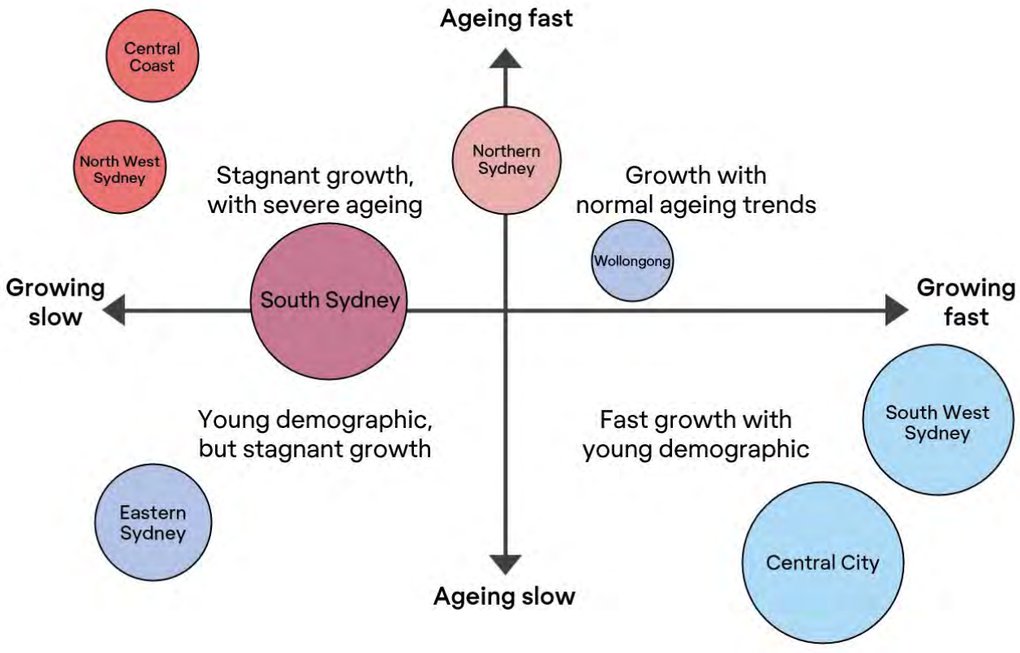
The impact of an ageing population will be felt differently across Greater Sydney, with the Central Coast, northwest Sydney and northern Sydney are projected to have the highest concentrations.

Population projections to 2040 show stark regional differences: the Central Coast, northwest Sydney and parts of south Sydney are expected to face stagnant growth combined with severe ageing, placing intense pressure on local services. By contrast, northern Sydney and Wollongong will see steadier growth alongside more historical ageing patterns. Eastern Sydney is projected to retain a relatively young demographic, but without strong population growth to balance demand for care.

Meanwhile, southwest Sydney and the central city are set to absorb much of Sydney's growth, fueled by migration and new greenfield developments that will bring in younger demographics and slow the pace of ageing. These uneven trajectories highlight the need for place-based planning for care services: the city's east and north will face the highest demand for services, while the south and west will continue to provide much of the paid care workforce. This imbalance risks widening disparities and placing significant strain on infrastructure and service delivery across the city.

Across the study area, the Central Coast has, and is projected to continue to have, the largest concentration of older people as a proportion of the population. However, all regions of Sydney are expected to observe a significant change over the coming decades, apart from Eastern Sydney and Central Sydney. The regions with the highest jump include Northern Sydney and Northwest Sydney.

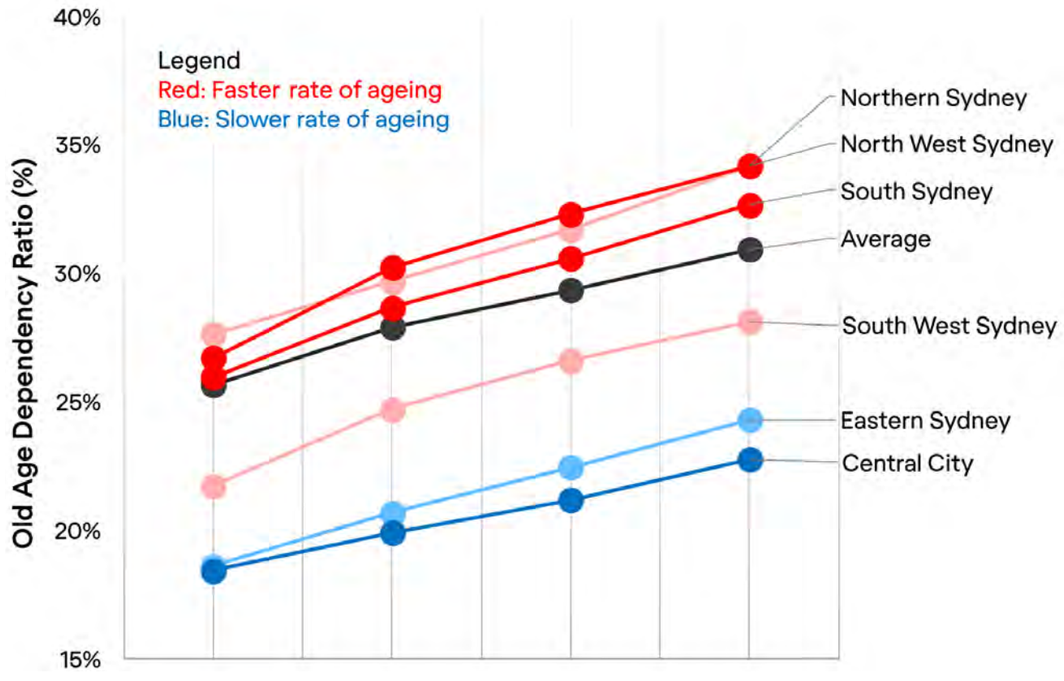
Where we are growing and greying: mapping growth and ageing trends



Source: Planning NSW, population projections to 2041 for locations across Greater Sydney, Central Coast and Wollongong (size according to population)

Parts of Sydney are ageing faster than others

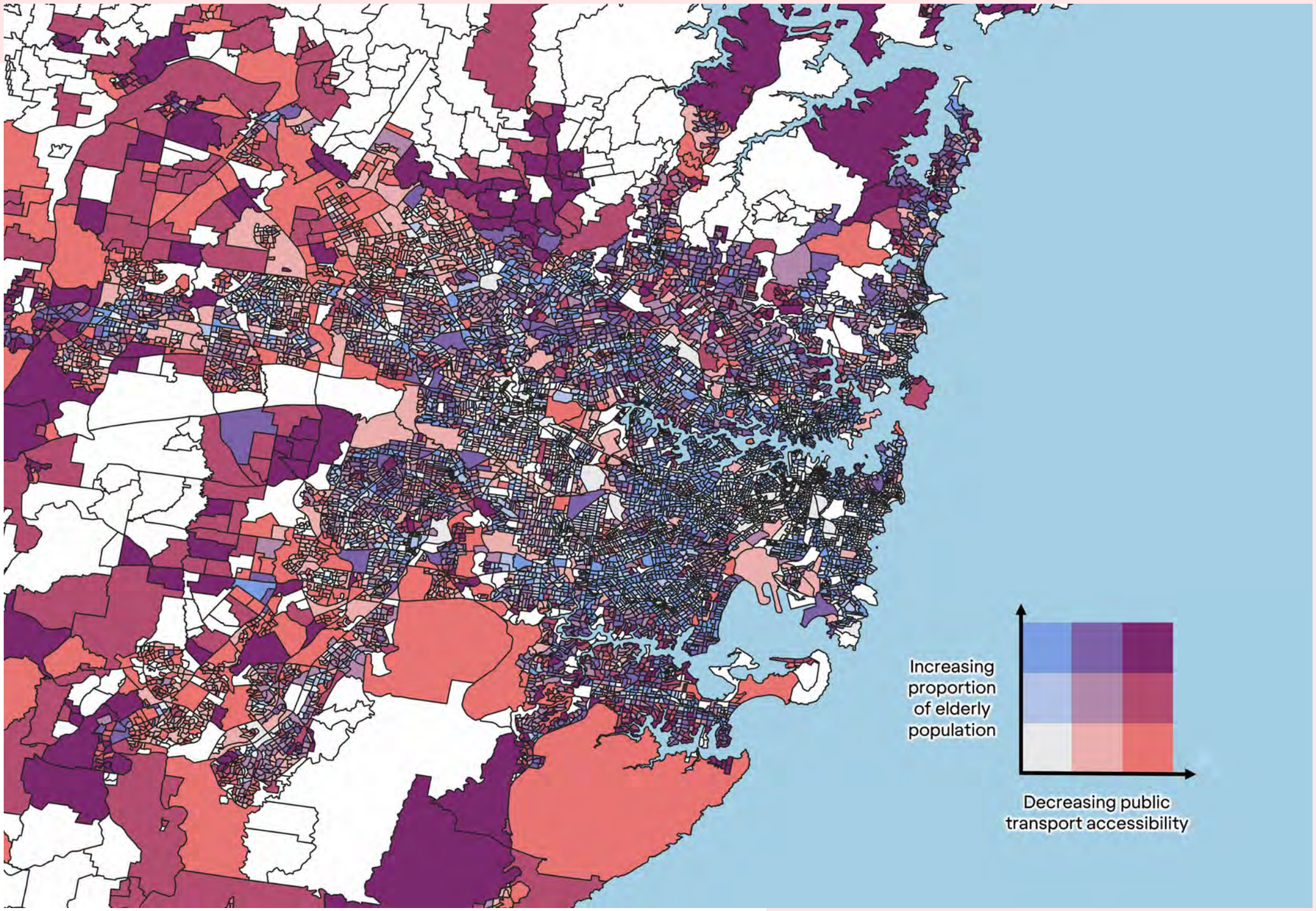
Old Age Dependency Ratio across locations, projected to 2040



Source: NSW DPHI, population projection to year 2040

The parts of Sydney ageing most rapidly are also those with some of the poorest levels of public transport access

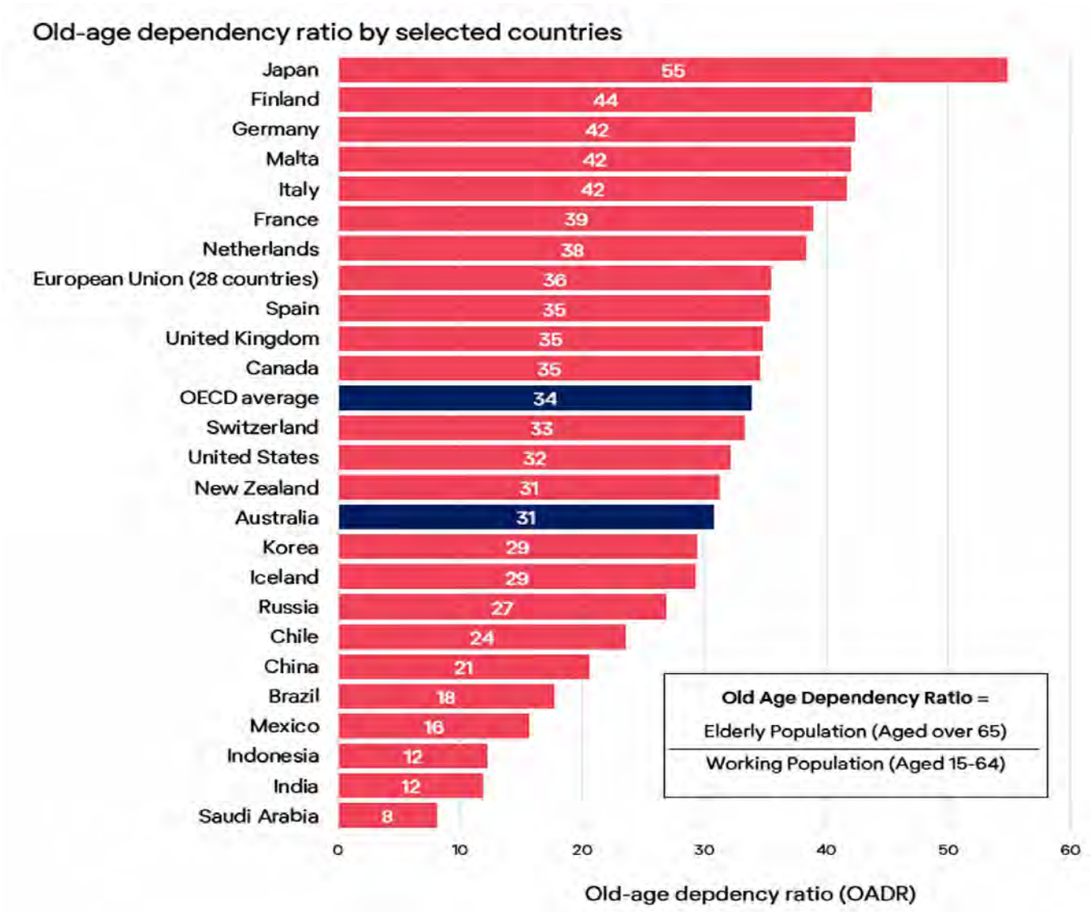
In the north and northwest, where demand for care is set to grow steeply, public transport is patchy and unreliable. Geography compounds the challenge: Sydney's peninsulas, rivers, mountains and harbour make the city difficult to traverse, especially for care workers who often live far from the areas of highest demand. As one stakeholder observed, geography itself is one of the biggest barriers to meeting Sydney's care needs.



Source: Transport for NSW, Data on PTAL (Public Transport Accessibility Level), ABS Census data 2021

Many developed countries are already experiencing high old age dependency which is impacting their productivity and economies

Old age dependency ratio across the OECD



Source: OECD Data Explorer, OADR for year 2025

Australia is relatively young compared to other OECD countries with an old age dependency ratio of 30.8, compared to Japan's 54.7, Germany's 42.2 and the United Kingdom's 34.8.

While Australia is younger than many of its OECD peers, Japan's experience provides both a warning and a roadmap: the risks of population growth stagnation on one hand, and the opportunities that come from investing in productivity and ageing well on the other.

More than one-in-10 people in Japan are aged over 80, and almost one-in-three is over 65. It currently has an old-age dependency ratio of 55%, and the impacts on the economy have contributed to long-term economic stagnation and even deflation.[22]

However, it isn't all doom and gloom for Japan. Despite having some of the lowest GDP growth rates in the G7, Japan is the fourth largest economy in the world. Advanced industries, technological development and high rates of productivity have meant maintained quality of life despite falling working age population. This contrasts to Australia, economic and productivity growth has largely been linked to population growth.

As Sydney ages, its older population will become far more culturally diverse. The care sector must adapt to an ageing population that is increasingly multicultural.

As Australia's population ages and becomes more culturally diverse, the care sector faces increasing pressure to adapt. Currently, the elderly population is predominantly of European and Anglo descent, including Australian and Italian backgrounds. Over the next 50 years, the demographic composition will shift to a growing proportion from South and East Asian communities. This continued cultural diversification in Australia calls for shift in the care sector with the need to incorporate cultural sensitivity in training and service delivery.

Projected overseas migration trends by geographic distribution from 2022-2041

Top 5 LGAs with highest cumulative overseas migrants (persons)	Top 5 LGAs with fastest compound annual growth rate of overseas migrants (%)
Sydney	Camden
Parramatta	Wollondilly
Canterbury-Bankstown	Ku-ring-gai
Cumberland	Bayside (NSW)
Bayside (NSW)	Parramatta

Source: Planning NSW, Population projections (2022-2041) by LGA[23]

The experience of aged care is a historic first for many Aboriginal Australians

For many Aboriginal and Torres Strait Islander peoples, ageing is a relatively new experience in a population historically marked by systemic disadvantage and lower life expectancy. As Stan Grant, Wiradjuri, Kamilaroi and Dharrawal man, powerfully noted:[24]

> **"I stand here today older than both of my grandfathers were when they died. It's an incredibly sobering thought that as First Nations people, we are experiencing the first generation of ageing."** [25]
>
> **– Stan Grant**

The experience of ageing for First Nations peoples is shaped by complex cultural, social and historical factors. Home ownership and education were key enablers that helped Grant "close the gap," underscoring how deeply intertwined housing security and intergenerational opportunity are with long-term health outcomes. Research confirms this link: older Australians who rent their homes tend to live shorter lives and enjoy fewer years of good health compared to homeowners – even when income and education are accounted for. Yet in 2021, only 42% of First Nations Australians were homeowners, compared with 67% of the broader population,[26] highlighting the entrenched inequalities still at play.

Cultural disconnection is a significant challenge for many Aboriginal and Torres Strait Islander peoples as they age. Being separated from Country can disrupt the transmission of cultural knowledge, leadership roles and intergenerational bonds undermining both individual wellbeing and community resilience. Western care models also clash with Indigenous approaches to care, which are rooted in shared responsibility and kinship rather than individualised care.

Mainstream aged care services often fail to recognise and accommodate these cultural nuances. Due to a lack of cultural safety and persistent experiences of racism, some First Nations Elders are further discouraged from seeking aged care support, even when care is urgently needed.

Improving aged care for First Nations Australians requires more than expanded services, it calls for a culturally informed shift. Policy must be shaped in partnership with First Nations communities, drawing on their knowledge, values and lived experience to build respectful and inclusive care systems.

Credit: Wyanga Aboriginal Aged Care

CASE STUDY:

Culturally safe aged care in Redfern

Overview

The City of Sydney is enabling a transformative partnership between Wyanga Aboriginal Aged Care and Uniting to deliver a not-for-profit residential aged care home for 50 residents in Redfern. The project will repurpose a $20 million council-owned site, with the existing 55-space public car park to be relocated underground to maintain access for local businesses and shoppers.

Key Features

- **Culturally safe design**: The facility will be designed and operated by First Nations community members, ensuring it reflects cultural values and practices.
- **Community connection**: The home will allow Aboriginal and Torres Strait Islander Elders to remain close to family and community, supporting intergenerational bonds.
- **Inclusive housing**: This initiative contributes to the City of Sydney's broader commitment to providing diverse housing options for people at all life stages.

Impact This project exemplifies how local government assets can be reimagined to meet social needs, particularly for communities historically underserved by mainstream aged care models. It prioritises dignity, cultural safety and local connection setting a precedent for inclusive, community-led development.

Source: City of Sydney

Up to 360,000 LGBTQI+ older Australians may need aged care, yet many hide their identity for fear of discrimination

As Sydney's population ages, many LGBTQI+ people face additional barriers to accessing safe and affirming care. This is not due to their identities, but to a legacy of stigma, discrimination and systemic exclusion that has shaped their health and social outcomes over decades. The result is poorer health, higher rates of mental distress, social isolation and reduced trust in services.[27]

Estimates suggest 6–10% of older Australians identify as LGBTQI+, around 270,000–360,000 people currently aged 60 and over, yet many choose not to disclose their identity to care providers for fear of mistreatment.[28]

LGBTQI+ elders have lived through periods of criminalisation, conversion practices and widespread social rejection. Entering residential care, especially in faith-based settings, can mean returning to environments that once excluded or harmed them. As one expert put it, "For older, straight and cisgendered people, you can pick almost any retirement village. For older queer people, choices are limited and sometimes unsafe."[29] This fear leads many to delay seeking support or to hide their identities, even at the expense of their wellbeing.[30]

There are promising signs of change. The national *Silver Rainbow* project, for example, is building the capacity of aged care providers to deliver inclusive services and connect LGBTQI+ elders to safe supports.[31] Internationally, models like Stockholm's *Regnbågen*, a purpose-built housing and community centre for LGBTQI+ seniors, demonstrate what it looks like when care is designed around dignity, visibility, and belonging.[32]

In aged care, reform must go beyond policy statements to practical change. This means embedding LGBTQI+ cultural safety in workforce training so staff can confidently provide inclusive, respectful care.[33] It requires recognising chosen families – friends and community networks, not just biological relatives – in visitation rights and decision-making, so older LGBTQI+ people are not left without advocates in residential settings.[34]

Capturing LGBTQI+ identities and experiences in aged care data collections is also critical, ensuring services can identify and respond to real needs rather than treating LGBTQI+ elders as invisible. Finally, scaling up peer-led initiatives such as the Silver Rainbow program can provide sector-wide education and create visible pathways for safe, affirming aged care.35 Without these changes, many LGBTQI+ elders will continue to hide their identities, delay accessing support or face unnecessary barriers to ageing with dignity.

Credit: Regnbågen.net

CASE STUDY:

Regnbågen (Rainbow) – inclusive housing for LGBTQI+ seniors, Stockholm

Overview

Founded in 2009, *Regnbågen* ("Rainbow") is Europe's first housing and community centre designed specifically for LGBTQI+ seniors. Located in Stockholm, it provides safe and secure apartments alongside shared community spaces, offering residents both privacy and connection. The project emerged from recognition that older LGBTQI+ people often face isolation and discrimination in mainstream aged care settings.

Key Features

- **Inclusive design:** Purpose-built to create a safe, welcoming environment where residents can openly express their identities without fear of prejudice
- **Community belonging:** Communal areas foster connection and visibility, ensuring residents are surrounded by kindred spirits and not marginalised in older age
- **Secure housing:** Provides stability for LGBTQI+ seniors who may otherwise face exclusion or hostility in traditional aged care or housing options.

Impact: Regnbågen has been an overwhelming success, with a long waiting list reflecting the demand for inclusive aged care. It demonstrates how intentional design and cultural safety can combat loneliness, affirm identity and improve wellbeing for marginalised older populations. The project has become a model internationally, showing how aged care can move beyond 'one-size-fits-all' to meet the diverse needs of ageing communities.

Source: https://www.regnbagen.net/english/

Sydney's fertility rate is declining despite the inflow of younger migrant families

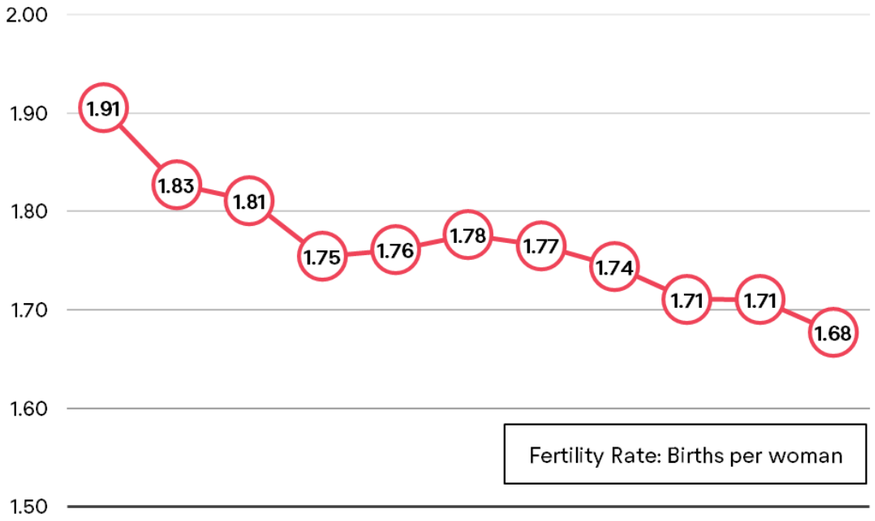
Births across Greater Sydney, Central Coast and Wollongong peaked at 71,174 in 2018 but have fallen below that level every year since. In 2023, only 58,170 babies were born, hitting the region's lowest historical fertility rate of 1.68, far below the replacement level of 2.1 – which is the rate required to maintain a steady population. Despite Western and South-western suburbs recording solid increases in births due to an inflow of younger migrant families, a drop in births of more than 20% has been recorded over the past decade in the Eastern suburbs, Northern suburbs and Inner West.

Alongside these numbers, attitudes towards family size are changing. Both men and women report wanting fewer children: for men, the reported figure dropped from 2.22 in 2005 to 1.99 in 2023, and for women from 2.35 to 2.09. This decrease is prominent in younger age groups.

The size and price of homes also influence fertility patterns in Sydney, as suggested by KPMG urban economist Terry Rawnsley[36]. Rawnsley's analysis shows that suburbs with bigger, more affordable houses tend to have higher birth rates, while inner-city areas like Darlinghurst or Potts Point with their smaller, pricier properties see far fewer children being born.

Sydney's fertility rate has steadily declined from 2013 to 2023

Yearly average of fertility rate for LGAs across Greater Sydney, Central Coast and Wollongong



Source: ABS Birth and fertility rate data for LGAs across Greater Sydney, Central Coast and Wollongong


Credit: BVN

3.2 Sydney's housing crisis is impacting where care workers can afford to live

The average care worker cannot find any affordable place to rent in Sydney

SGS Economics and Planning's annual Rental Affordability Index (RAI)[37] demonstrates rental affordability relative to household incomes. It highlights that there is nowhere in Sydney that is rated as 'acceptable,' 'affordable' or 'very affordable' for the average care worker income.

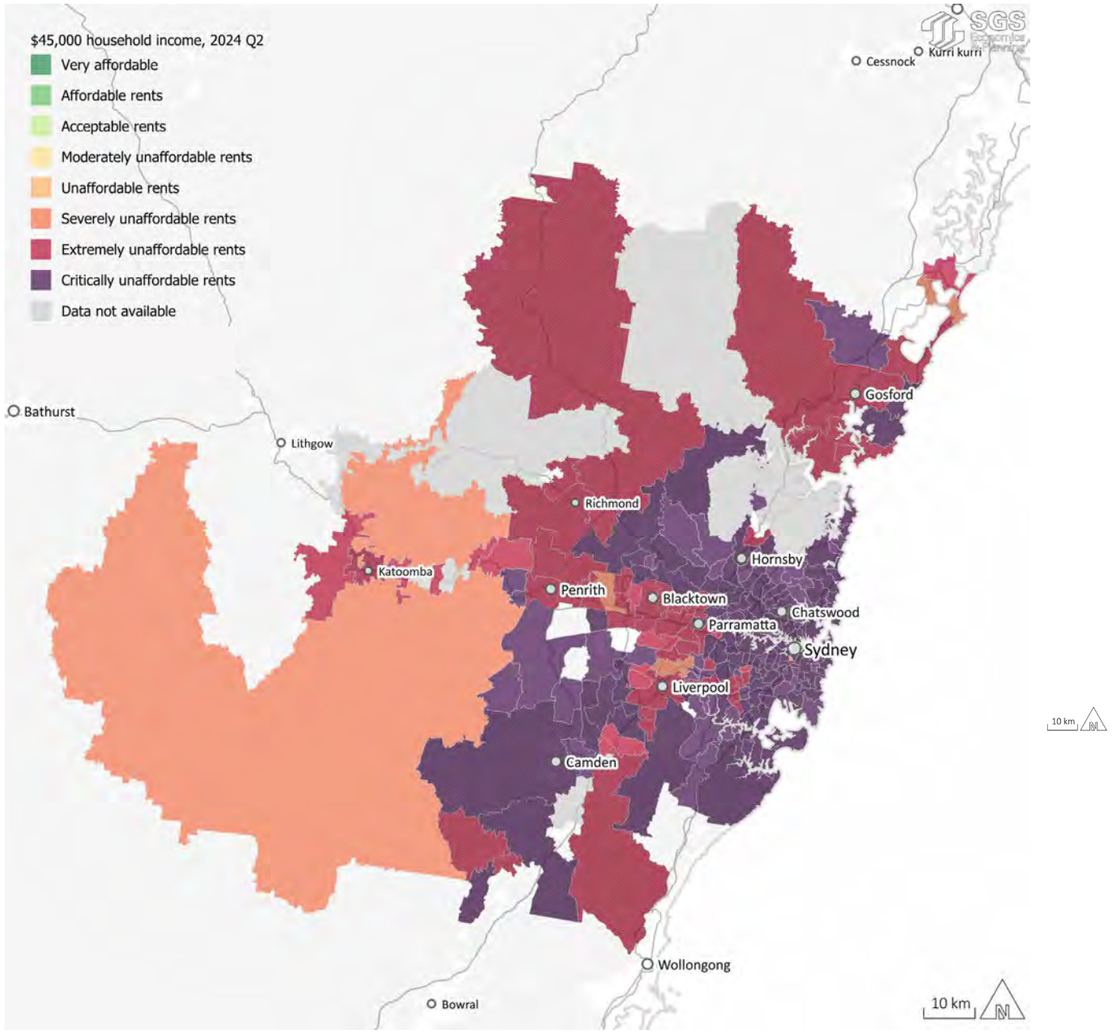
There is nowhere in Sydney that is rated as 'acceptable,' 'affordable' or 'very affordable' for the average care worker income.

Even at the higher end of the care sector, with incomes of around $60,000 (within the $52,000 – $64,000 median range), the story is the same: there is nowhere in Sydney rated as 'acceptable,' 'affordable' or 'very affordable.'

By contrast, an individual earning $130,000 a year (well beyond the broader Greater Sydney median income range of $52,000-$64,000) has far more options. While rents in the inner city remain unaffordable or severely unaffordable even at this income level, much of Greater Sydney becomes relatively liveable. This comparison starkly illustrates the inequity of Sydney's housing market: where average households can begin to access housing choice, care workers remain locked out entirely, with no affordable options anywhere across the metropolitan area. Without change this will only worsen over time.

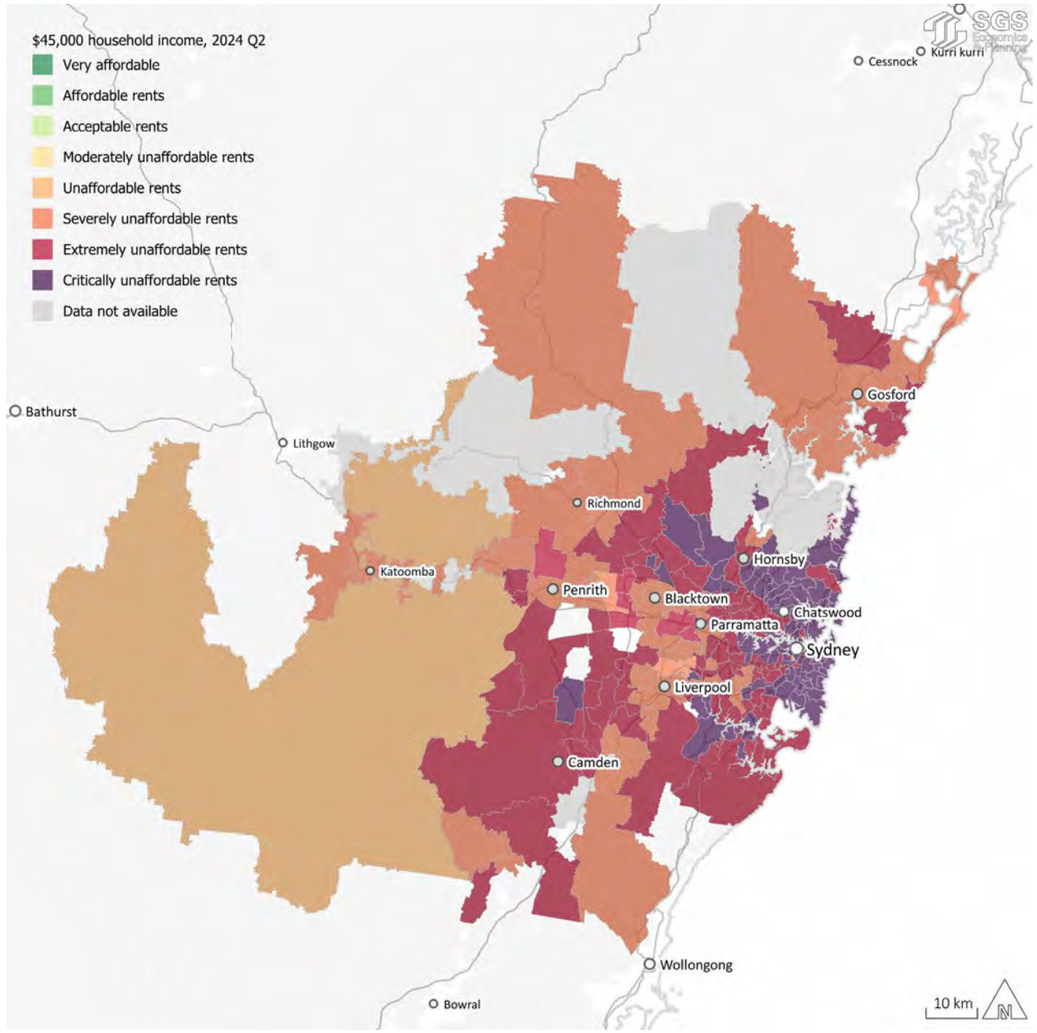
For individuals earning $45,000 dollars annually

Baseline rental affordability



For individuals earning $45,000 dollars annually, there is nowhere that is affordable to live in Sydney.

Rental affordability after a 20% discount for market rent

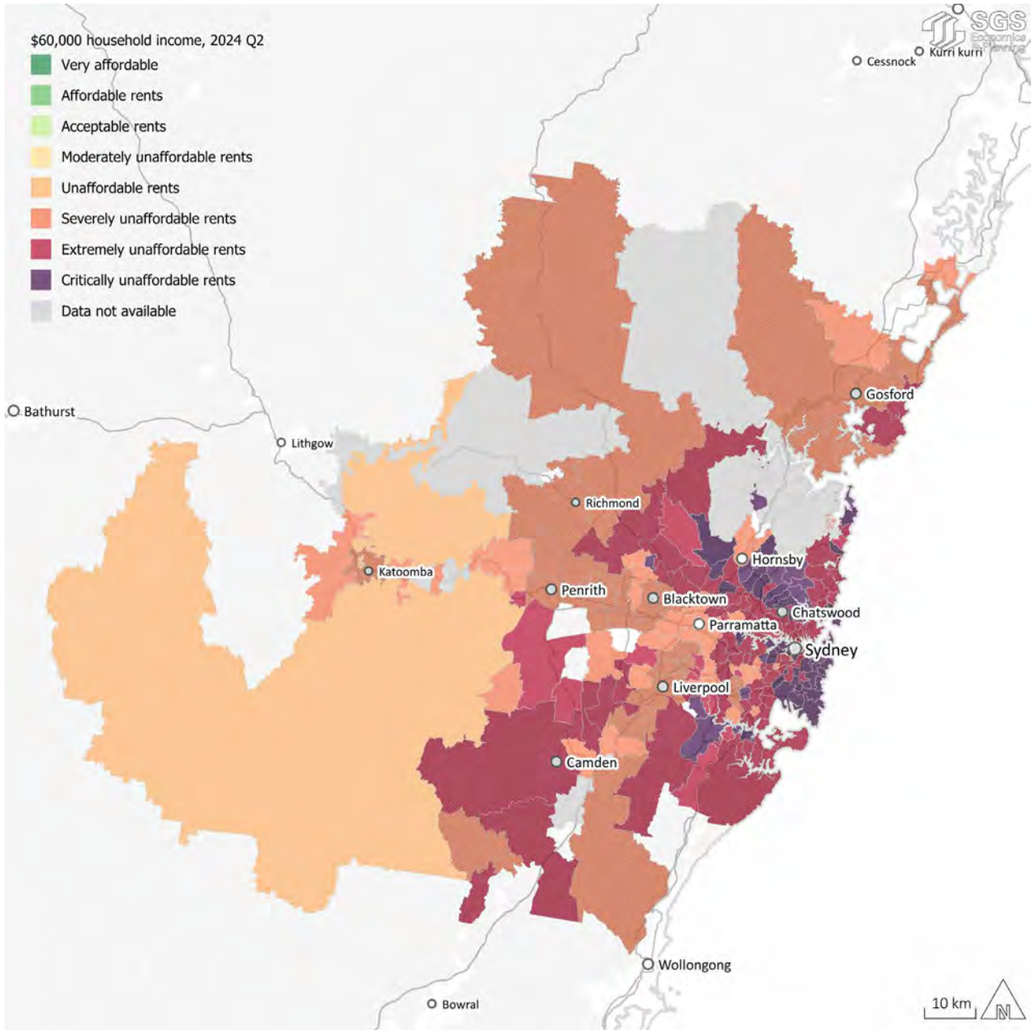


With a 20% discount to market rent, all of Sydney's Eastern Suburbs, Inner City, Inner West and North Sydney, North West and Northern Beaches is still critically unaffordable.

Source: SGS Economics and Planning.

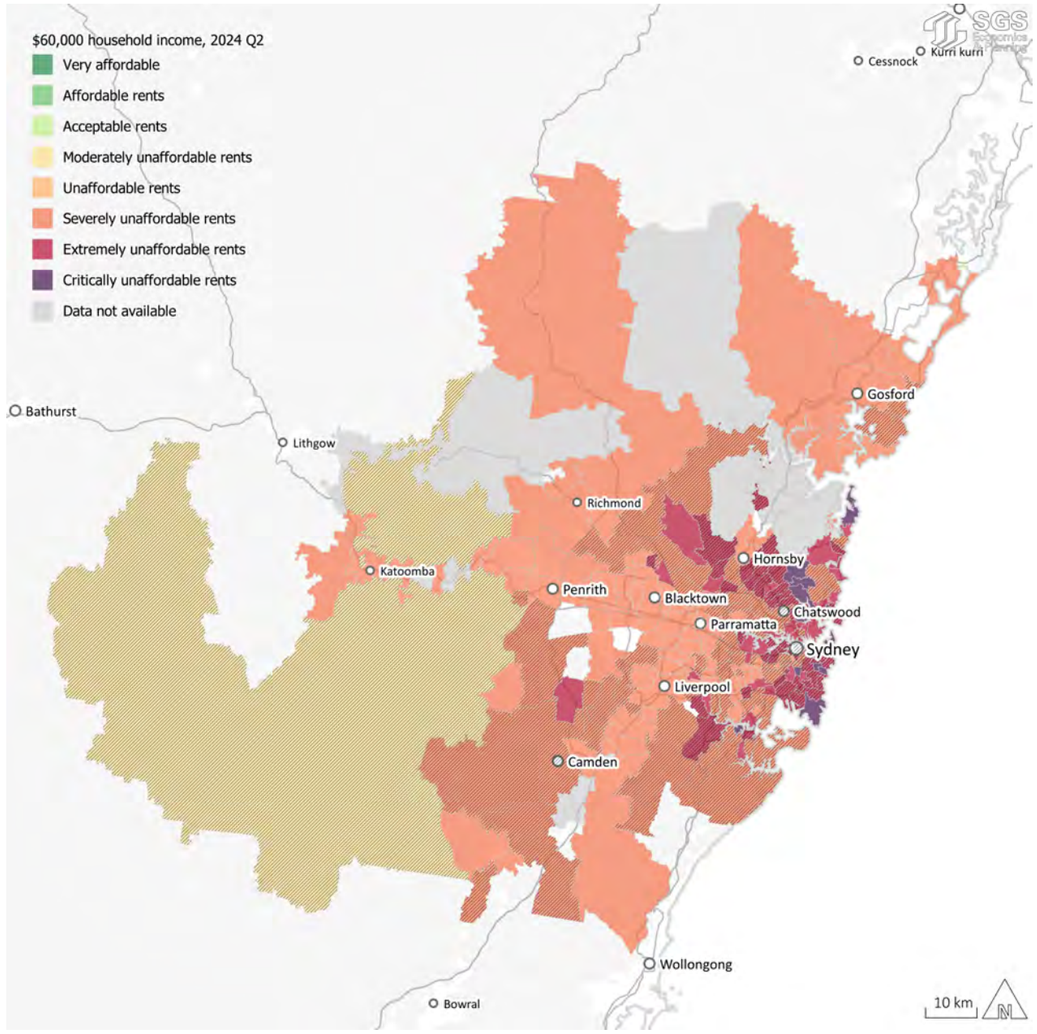
For individuals earning $60,000 dollars annually

Baseline rental affordability



For individuals earning $60,000 dollars annually, at the higher end of the $52,00-$64,000 median care sector income, there is still nowhere that is affordable to live in Sydney.

Rental affordability after a 20% discount for market rent

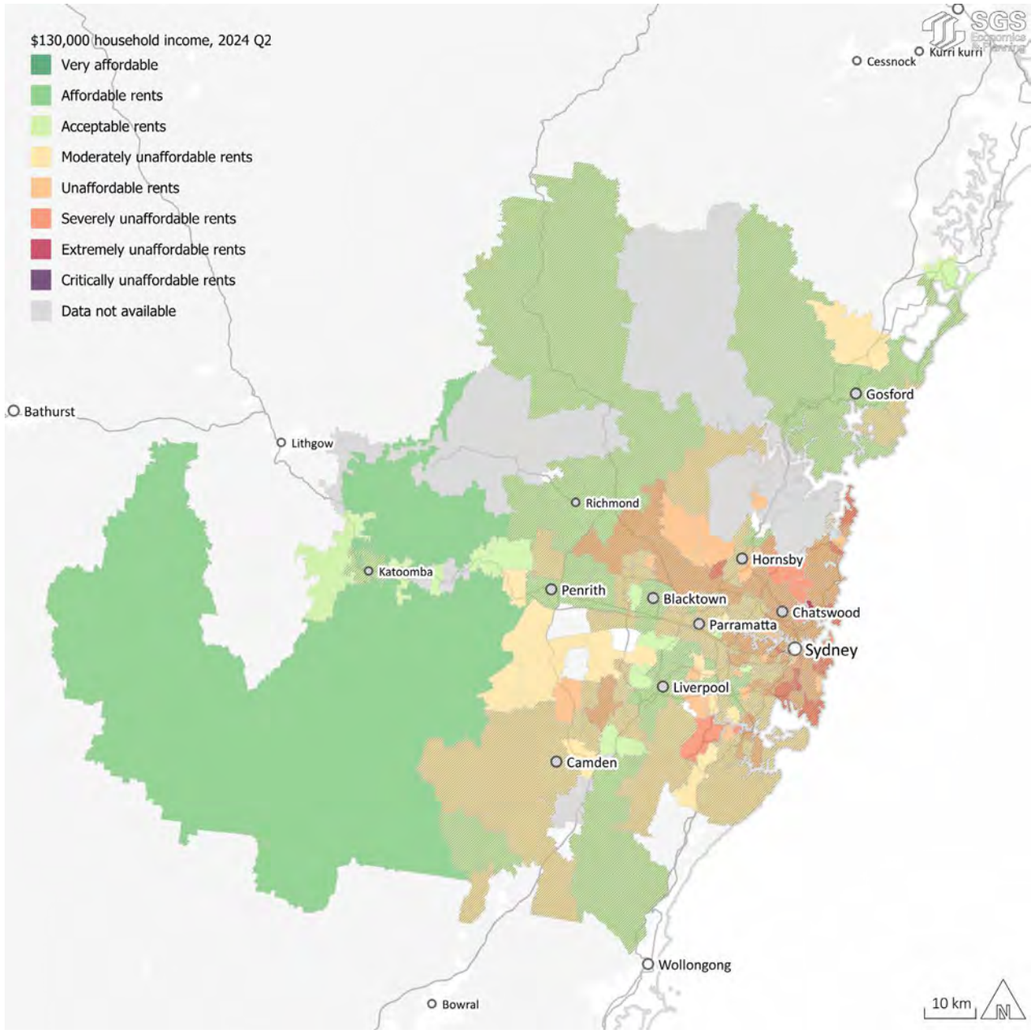


With a 20% discount to market rent, much of the city remains unaffordable, with the Northern Beaches and North still critically unaffordable, and Inner Sydney and the Inner West extremely unaffordable.

Source: SGS Economics and Planning.

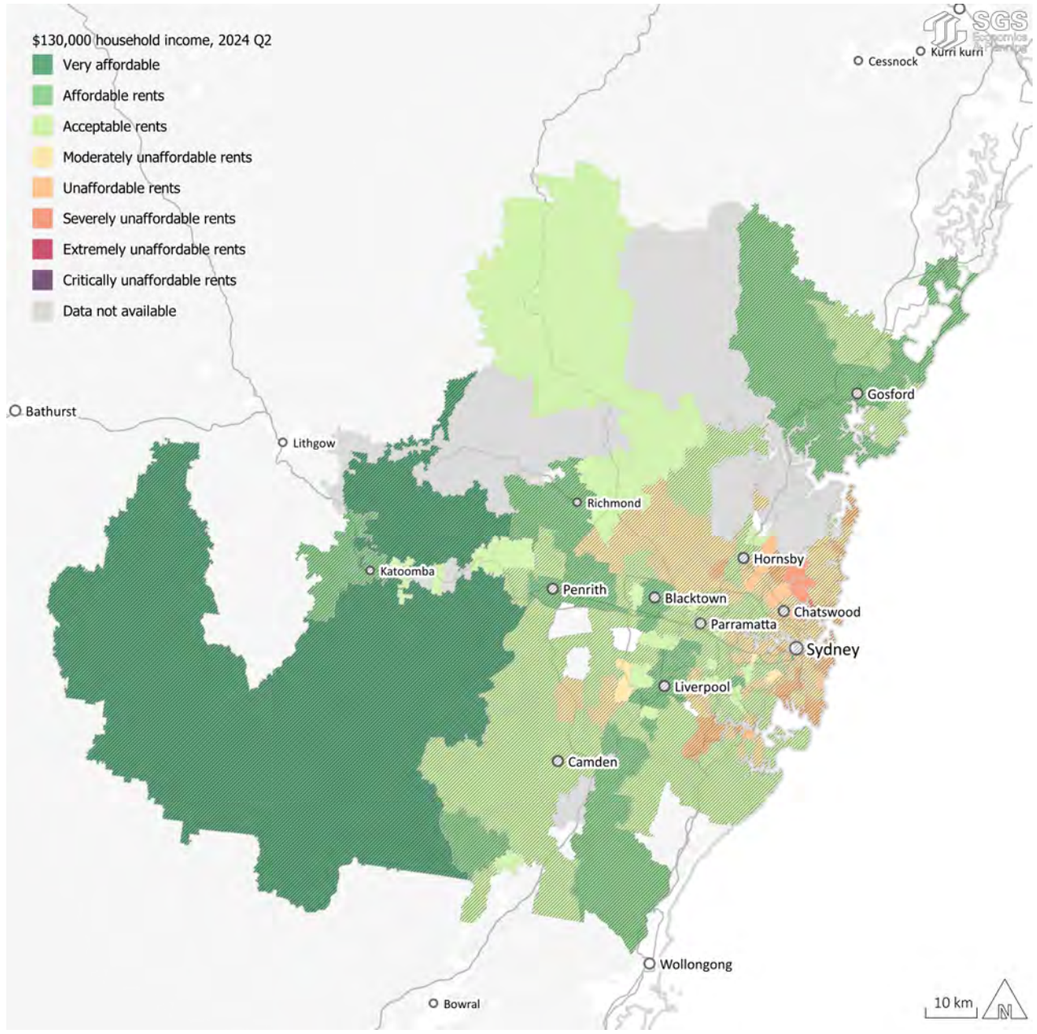
For individual earning $130,000 dollars annually

Baseline rental affordability



For individuals earning $130,000 dollars annually, some areas in the west becomes affordable but most areas are still considered unaffordable.

Rental affordability after a 20% discount to market rent



These individuals benefit significantly from a 20% discount, with many areas becoming affordable or only moderately unaffordable. This suggests higher income care workers are likely to benefit most from affordable housing.

Source: SGS Economics and Planning.

Analysis of the impact of a 20% discount on median market rents by SGS Economics and Planning reveals a clear divide across Sydney. In many middle and outer-ring suburbs, the discount makes a noticeable difference, bringing rents closer to affordable levels for the average childcare or aged care worker. However, the effect is not uniform across Western Sydney. Some suburbs across the Southwest like Camden, and Northwest like Schofields remain extremely unaffordable. It also shows that most inner-ring suburbs remain critically unaffordable and out of reach even after a 20% discount. This aligns with University of Sydney research showing that some of Sydney's most critical health precincts, including Canada Bay, Randwick, the City of Sydney and Willoughby, continue to record rents far above what essential workers can afford.[38]

By contrast, inner-ring LGAs remain largely out of reach even after a 20% discount. Some of Sydney's most critical health precincts - Canada Bay, Randwick, the City of Sydney and Willoughby - continue to record rents far above what essential workers can afford.[39]

This result shows policy failure when it comes to the current flexibility in affordable housing planning bonuses. The NSW Ministerial guidelines for Affordable Housing are ambiguous and offer two options to pricing affordable rental housing – renting at 30% of an eligible households' income, or a 20 – 25% discount to market rent. In high-cost inner-city markets, pegging affordability to market rents fails to deliver homes that care workers can actually afford. While market conditions may ease if rents stabilise, the policy settings themselves were designed before the surge in rental prices, and no longer reflect the reality of Sydney's housing market.

Credit: Prince of Wales Hospital, BVN

The average care worker cannot find any affordable place to buy in Sydney

Owning a home remains a powerful aspiration for many Sydneysiders, but it is now out of reach for most care workers. University of Sydney research shows that on salaries ranging from $960 to $1,550 per week (child carers to registered nurses), there are no affordable LGAs for houses or units in Greater Sydney, and only two regional LGAs where a Registered Nurse's salary could stretch to a unit. Just five years ago, areas like Campbelltown, Fairfield, the Central Coast and Newcastle were still within reach – highlighting how quickly housing affordability for essential workers has disappeared.[40]

House and unit prices vary within LGAs, and borrowing capacity reflects household structure. While dual-income households may be able to pay more, those with dependent children face reduced borrowing capacity. Particularly in the inner and middle ring, the gap between care worker salaries and real median prices is vast. For example, the median price for a strata home exceeds what an early career Registered Nurse could afford by more than $600,000 in Randwick, $500,000 in Willoughby, $450,000 in the City of Sydney, and $200,000 in Parramatta. The gap is even larger for workers on lower wages, such as Enrolled Nurses.[42]

There are no LGAs that have houses affordable for any of the professions in this table

Proportion of LGAs with affordable median unit price for a sample of care workers.

Weekly wage	Indicative occupation and career stage	Greater Sydney	LGAs in metro adjacent cities and regions
$960	Child carer	0	0
$1,150	Aged and Disability carer	0	0
$1,250	Enrolled Nurse	0	0
$1,550	Registered Nurse/Midwife (5 years)	0	2

Source: Gilbert et. Al 2024[41]

Credit: Prince of Wales Hospital, BVN

Levels of overcrowding experienced by care workers across Greater Sydney

Weekly wage	Sydney – City and Inner South	Sydney – Eastern Suburbs	Sydney – Inner South West	Sydney Inner West	Sydney – Parramatta
Nursing Support and Personal Care Workers	16%	13%	31%	38%	32%
Registered Nurses and Midwives	7%	6%	18%	12%	15%
Enrolled and Mothercraft Nurses	6%	9%	23%	13%	13%

Source: Gilbert et. Al 2024[44]

The impact of housing unaffordability means that care workers are likely living at home for longer, with partners or housemates, with evidence of overcrowding in the least unaffordable parts of Sydney

Sydney's unaffordable housing market is forcing care workers into increasingly precarious living arrangements. Many are living at home for longer, sharing with partners or housemates, or relying on family and friends who own housing. Others are pushed into affordable or social housing, while some face overcrowding in the very parts of the city where care services are most needed.

Research by University of Sydney found that overcrowding is most severe in the Inner West, Inner South West and Parramatta, home to many of Sydney's major hospitals and health services. Nursing support and personal care workers are the hardest hit, with 38% in the Inner West, 32% in Parramatta and 31% in the Inner South West living in overcrowded homes. Enrolled and mothercraft nurses also face high rates, including 23% in the Inner South West. Even Registered Nurses and Midwives, despite higher salaries, are significantly affected, with 18% in the Inner South West, 15% in Parramatta and 12% in the Inner West. Across NSW and Victoria combined, more than 7,000 Registered Nurses are living in overcrowded homes - stark evidence of the scale of housing stress across the essential workforce.[43]

Unlike knowledge-based jobs, care work cannot be done remotely, and its high-intensity, low-flexibility nature makes long commutes unsustainable. Without affordable housing options close to key health precincts, Sydney risks pricing out the very workers who provide its essential services, undermining both the availability and quality of care, and putting the city at risk of dysfunction.

Lived experience:
Skills pushed out by housing costs

Early in her career, midwife Emma lived near the hospital, ready for any shift or emergency. But as her family grew, nearby housing was unaffordable. She moved further out just as she gained rare specialist skills the hospital relied on.

Now, when night-time emergencies strike, Emma can't always get there in time. Junior staff step in, doing their best, but without her expertise. Housing unaffordability isn't just a personal hardship – it's leaving critical skills out of reach when patients need them most.

Lived experience:
When care work can't pay for a home

After his divorce, David, a dedicated care worker, found himself without secure housing. He moved into a shed at his parent's home, paying child support for his three children but unable to afford a place of his own. Like many in his position, he faced impossible choices – fuel or food, sleeping in his car, or relying on temporary arrangements. The work he does is essential, yet the pay and housing costs keep him stuck, far from the stability his family and community need.

3.3 Climate change is reshaping how people need, provide and access care

Climate change is known to exacerbate disadvantage, and its impact on the care economy is twofold: it impedes the ability to deliver care and increases the need for care – sometimes in dire or urgent circumstances.

We know that climate change is intensifying the severity and commonality of disasters in Sydney. Since 2020, twelve 'significant' events, including bushfires, storms and floods, have been declared in Greater Sydney alone.[45] The Hawkesbury-Nepean floodplain experienced 4 major floods between 2020-2022 which damaged over 100 thousand homes and businesses, and caused the evacuation of thousands of people, and resulted in $2.5 billion in road damage. Western Sydney experiences record breaking extreme heat days, most notably in 2020 when the suburb of Penrith was identified as the hottest place on earth at 48.9°C at that moment in time.[46]The recently released National Climate Risk Assessment Report 2025 predicting heat related deaths will increase by 444% if Australia experiences 3 degrees of warming.[47]

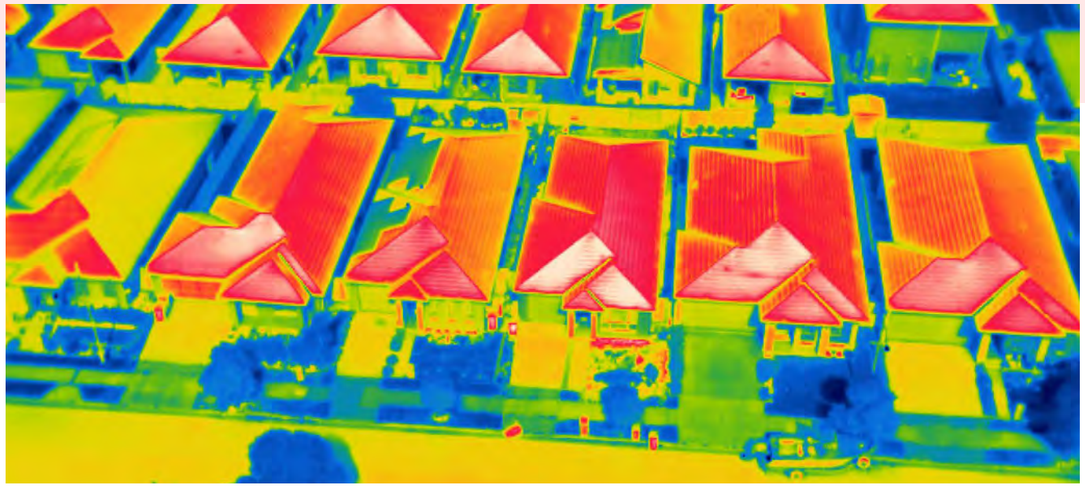
Many care workers rely on public transport and road networks to reach multiple clients each day. However, floods, bushfires and storms, now more frequent, intense and particularly impactful in outer suburbs, often disrupt travel and delay access to clients. This leads to missed appointments, backlogs in scheduling and more unpaid travel time.

Compounding this, much of Australia's existing housing stock is ill-equipped to cope with extreme weather. In Western Sydney, the urban heat island effect intensifies exposure, especially for vulnerable populations, such as children (0–14) and the elderly (70+). The Committee for Sydney's 2024 Burning Money report projects a dramatic increase in instances of heat-related stress in this region – from 3 million in 2020 to 23 million by 2079[48].

Stakeholders interviewed in our research expressed concerns about how, during extreme weather, elderly populations become more vulnerable as they are less likely to be able to independently move to public spaces for respite or safety if needed, for example, while facing extreme heat or flooding. Under these conditions, care workers must often shift their focus from routine tasks to urgent welfare checks – especially for elderly clients who are socially isolated or living in hard-to-reach, poorly serviced areas.

For people needing care, extreme weather events also make services harder to access. Elderly patients are skipping medical appointments during extreme weather as they feel unsafe to step outside their homes, especially if they require assistive mobility devices.

These risks are not only felt by those needing care. The parts of Sydney most exposed to extreme and prolonged heatwaves are also where many lower-income and migrant households live – the very communities that make up much of the paid care workforce. This means climate impacts compound across the system: vulnerable populations face greater health risks while the workers who support them are themselves living in the areas hardest hit by heat and extreme weather.



Credit: S. Pfautsch

3.4 The rising cost of living is squeezing Sydney's care economy

The rising cost of living is compounding the pressures already facing Sydney's care economy. Stakeholders described how carers, workers, students and volunteers are being squeezed by higher housing, transport, food and energy costs. These financial strains reduce the sustainability of care work, erode the pipeline of future workers, and threaten the viability of the volunteer networks that many services depend on.

Families are paying a hidden 'care tax'

Unpaid carers described being forced to pay for taxis when transport is inaccessible, moving homes to be closer to services, or leaving the workforce to provide care. Carers are often in precarious financial positions[49]: 40% of primary carers rely on government allowances as their main income, compared with 16% of non-carers. Rising rents, food and energy costs only deepen this strain.[50]

Rising transport costs make frontline care harder to sustain

Many care workers rely on cars to reach clients spread across Sydney or to travel during off-peak hours for shift work. With petrol prices, tolls and parking costs climbing, the financial burden of simply getting to work is pushing people out of the sector. For in-home care in particular, travel time often goes unpaid, leaving workers out of pocket.

Unpaid placements are creating 'placement poverty'

Unpaid placements are contributing to what stakeholders described as "placement poverty." Nursing, allied health, medicine, aged care and early childhood education and care students are required to complete long blocks of unpaid training, often far from home, which means covering the costs of transport, fuel, food and parking while losing income from paid work. To manage, many take on extra shifts in retail or hospitality, adding to stress and fatigue. These pressures are felt most by low-income and migrant students, and by women who already juggle caring responsibilities. As one stakeholder put it, "students are going broke just trying to qualify, and we wonder why we can't fill the pipeline."

Volunteering is a crucial element of the care economy yet the system is collapsing under shifting trends

Volunteers are a crucial part of the care sector, supporting services such as Meals on Wheels, aged care visits and social calls. Yet, volunteering is increasingly becoming a transient activity rather than a long-term commitment, leaving many community organisations struggling to maintain the reliable support they once depended on. Societal trends such as an ageing population or rising costs of living like means that each demographic group faces a unique set of challenges. The research within the National Strategy for Volunteering 2023–2033[51] presents the following insights:

Volunteering is uneven across sectors. Sport and recreation organisations attract the largest share of volunteers at 25 %, followed by community services, welfare, and homelessness at 22.2 %, and religious or faith-based groups at 20.5 %. By contrast, volunteering roles related to direct care roles attract a much smaller volunteer pool, with aged care at 8.8 %, disability at 4.7 %, and mental health at only 4.4 % of total proportion of volunteers[52].

The traditional volunteer base consisting of older Australians in the baby boomer generation are ageing and may be physically less capable to volunteer. Younger generations, particularly those living in capital cities would report rising cost of living pressures as the main barrier, opting for paid work over volunteering opportunities. Volunteering may also be seen as a transactional action to enrich their experience and reputation, potentially a mentality developed through schooling years. Women are disproportionately affected by work and family commitments, with 46.3% of women citing this as a barrier to volunteering as compared with 35.6 % for men. Lastly, people born in non-English speaking countries often experience a lack of suitable opportunities as a barrier to volunteering, potentially due to cultural or language barriers. Interestingly, other changes in the volunteering landscape, such as increases in administrative requirements lead some indicating that onerous paperwork or administrative requirements was a deterrent to volunteering.

These barriers disproportionately affect the availability of volunteers in high-demand care sectors, compounding the decline in support at a time when consistent, skilled volunteer engagement is essential to the care economy.

3.5 The rising costs of loneliness and the role of care

Rising loneliness is one of the most significant but under-recognised issues in Sydney's care economy. It affects both those who provide care and those who rely on it, with consequences for health, wellbeing and demand on services.

Isolation in Sydney's fastest-ageing suburbs is already driving depression and earlier entry into aged care

For older people, the risk of isolation is growing as entire suburbs age rapidly without matching investment in transport or community infrastructure. Stakeholders noted that in Sydney's north and northwest, where populations are ageing fastest, patchy bus and rail access makes it difficult for older residents to stay connected, particularly when they reach an age where driving is no longer possible. Social isolation in these areas is already linked to higher rates of depression, earlier entry into aged care, and avoidable hospitalisations.

Carers of all ages are isolated and can face high levels of loneliness from adults tied to the house to young people carrying hidden responsibilities

Unpaid carers also spoke of being "tied to the house," with little opportunity for respite or social contact. Many manage complex caring roles alongside jobs and household duties, leaving them isolated from friends, community and even their own healthcare. Carers NSW emphasised the vulnerability of young carers, often children or teenagers who quietly balance schooling with caring for parents or siblings. These young carers frequently manage emergencies alone, fall behind at school, or drop out of education altogether. As one stakeholder noted, "there's at least one young carer in every classroom – but most teachers wouldn't know."

Loneliness can be a contributor to carers lower reported rates of wellbeing

Stakeholders often described the effects of loneliness as "death by a thousand cuts" – a gradual erosion of wellbeing for both carers and those they support. The toll is evident in the data: 58.3% of primary carers report low wellbeing, compared with 30.4% of Australians overall. Loneliness also drives system costs, leading to increased demand for GP visits, mental health services and emergency care.

4. Existing inequalities within the care economy

Sydney's care economy is under growing pressure from deepening inequality

For Sydney to achieve shock-proof growth, the strength of its care economy is critical. Yet enduring gender, economic, spatial and racial inequalities in Sydney are placing increased strain on both the care system and the broader economy. This is because these inequalities are deeply linked with who provides care, who receives it, and how it is valued.[53]

This section breaks down what these existing inequalities mean for the current state of the care economy, acknowledging that all inequalities intersect.

Gender inequality

Economic inequality

Spatial inequality

Racial inequality

Health inequality

Spatial inequality

Where you live determines whether you can sustain a career in care, and where care is delivered.

Care work is spatial. The demand for, and supply of care work is not evenly distributed across Greater Sydney

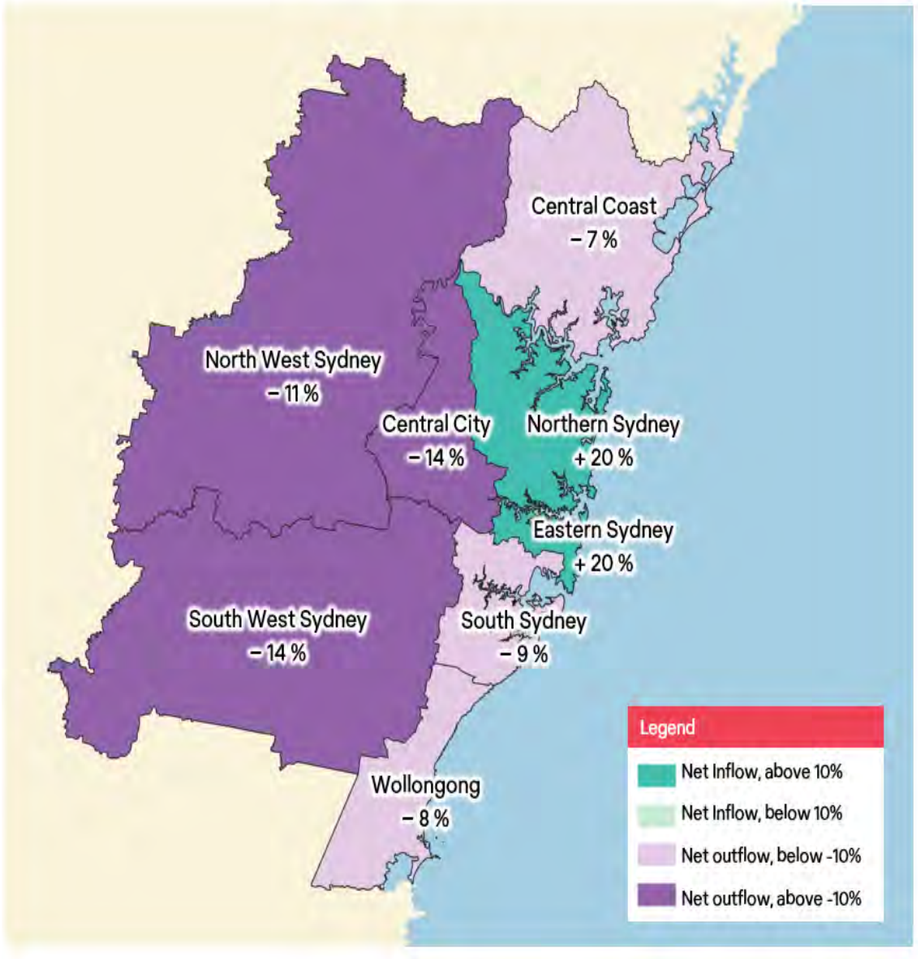
There are several spatial factors that create structural challenges for care workers. One key issue is the mismatch between where care workers live and where care is needed. Even when public transport is available, it may not be frequent enough or safe, particularly for those working non-standard hours like shift workers.

2021 ABS Census data shows a clear east–west divide in Sydney's care economy. Where care workers live is concentrated in the west and southwest, yet jobs are clustered in the east and north. The result is a significant daily net outflow of workers from Western Sydney, with central City and southwest Sydney both recording a 14% outflow, and the northwest at 11%. By contrast, northern Sydney and eastern Sydney each record a 20% inflow, indicating heavy reliance on workers commuting in. Smaller outflows are also seen from Wollongong (8%), south Sydney (9%) and the Central Coast (7%). This spatial imbalance forces many workers into long daily commutes and means that the areas with the highest demand for care in Sydney's north and east often cannot attract or retain enough workers, because those workers cannot afford to live nearby.

The matrix of care worker place of residence vs place of work also highlights that there is a high degree of self-containment in regional areas like the Central Coast (90%) and Wollongong (87%). This indicates that if care workers do leave Sydney, they are unlikely to continue working in Sydney's care sector unlike other professions. Stakeholders operating in Eastern and northern Sydney described how they face a revolving door – they invest in training and upskilling staff, only to lose them once jobs open up closer to home in Western Sydney, forcing the cycle to repeat.

There is a net flow of care workers from West to East of Sydney, reflecting spatial mismatches between where workers live and where jobs are located.

Net flow of care workers as % of care workers residing in area



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Matrix demonstrating care worker commute flow

Place of residence versus place of work

Place of Residence \ Place of Work	Central City	Central Coast	Eastern Sydney	North West Sydney	Northern Sydney	South Sydney	South West Sydney	Wollongong	Total
Central City	36,684 56%	106 0%	7,761 12%	3,824 6%	12,189 18%	2,446 4%	3,022 5%	18 0%	66,050 100%
Central Coast	312 1%	21,599 90%	446 2%	7 0%	1,609 7%	49 0%	36 0%	- 0%	24,058 100%
Eastern Sydney	3,516 7%	104 0%	33,844 67%	401 1%	6,542 13%	4,573 9%	1,502 3%	70 0%	50,552 100%
North West Sydney	5,283 24%	12 0%	899 4%	13,828 64%	869 4%	180 1%	664 3%	- 0%	21,735 100%
Northern Sydney	4,569 8%	501 1%	7,791 14%	346 1%	40,947 74%	866 2%	437 1%	25 0%	55,482 100%
South Sydney	2,410 5%	20 0%	13,828 27%	152 0%	3,044 6%	28,515 56%	2,611 5%	337 1%	50,917 100%
South West Sydney	4,010 10%	8 0%	3,163 8%	843 2%	1,303 3%	4,489 11%	25,499 64%	243 1%	39,538 100%
Wollongong	130 1%	4 0%	312 2%	17 0%	118 1%	957 7%	368 3%	12,392 87%	14,298 100%

Legend – Gradient represents concentration of worker movement	
Low	High

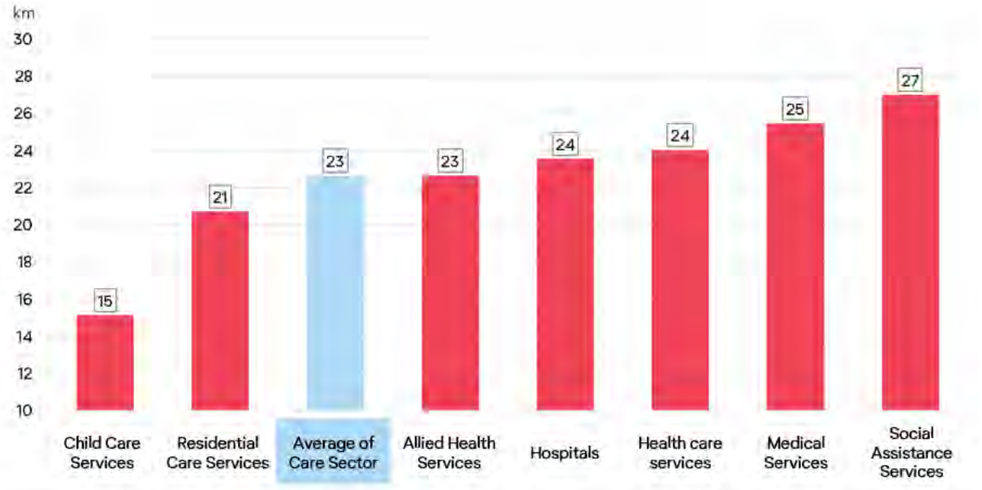
Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Care workers typically have to commute long distances, beyond their area of residence

Care workers typically have to commute long distances, beyond their area of residence. A major challenge is the mismatch between where care workers live and where jobs are located. Many live in western and southwestern Sydney, while employment is concentrated in the east and north. Long distances, poor transport connections, and limited late-night services mean workers are heavily reliant on cars. For shift workers, buses and trains are either unsafe or unavailable, particularly at night. Home care providers said this challenge is most acute in northern Sydney, where demand is strong but too few carers live nearby to cover shifts.

Long commutes drive high car reliance in the care sector

Average work commute distance (in km) and mode of transport by care sector occupations



2021 (COVID)								
Vehicle	80%	77%	83%	83%	83%	85%	86%	90%
Public Transport	12%	19%	10%	12%	11%	11%	9%	8%
Active Transport	8%	4%	7%	6%	7%	4%	6%	2%
2016 (Pre-COVID)								
Vehicle	76%	77%	77%	73%	76%	77%	80%	78%
Public Transport	16%	19%	18%	20%	17%	19%	15%	18%
Active Transport	8%	4%	6%	7%	7%	5%	5%	4%

Source: ABS Census Data 2021 and 2016 for pre-COVID comparison, for locations across Greater Sydney, Central Coast and Wollongong

Within the care sector, commuting patterns reveal a clear divide. As our analysis shows, social assistance and medical service workers show the highest reliance on cars (90%, 86%), reflecting both the longer distances they travel and the inefficiencies of public transport for long commutes, where driving is often significantly faster than taking a train or bus. By contrast, childcare and residential care workers are more able to use public or active transport, as their typically shorter travel distances make these modes more practical and accessible.

However, care sector workers still exhibit a higher reliance on cars compared to the averages across all industries, at 83% vs 82% in 2021, and 77% vs 68% in 2016 – a more accurate representation of normal commute patterns without COVID disruptions. This highlights how both commute length and transport system performance shape mode choices across the sector.

This reliance has real costs. Tolls, fuel and parking can take up a disproportionate share of modest wages, while long commutes reduce time with family and contribute to workforce fatigue. As one provider noted: *"You couldn't pay me to travel that far. It's not just about wages, it's an infrastructure and logistics challenge."*

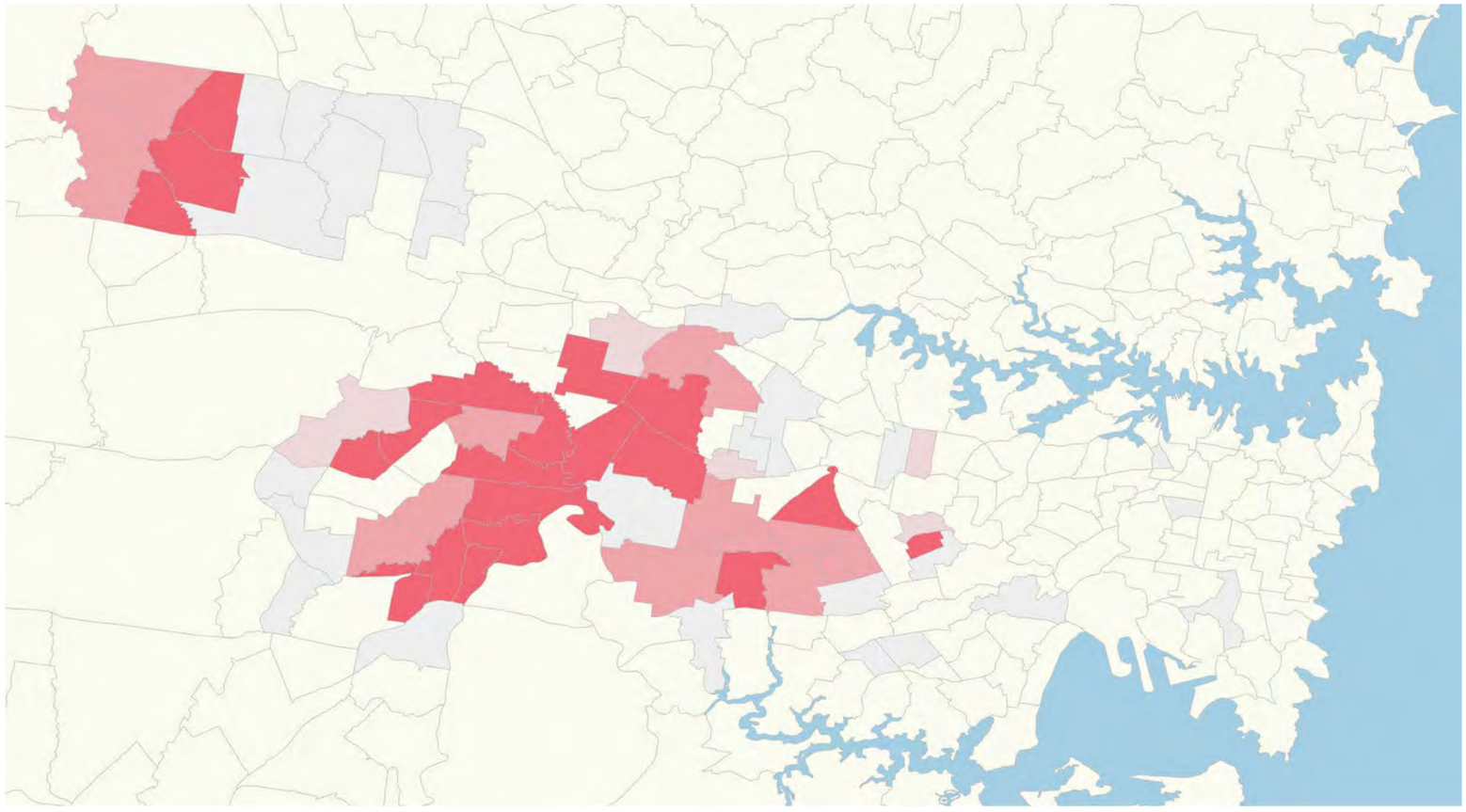
Childcare desert in the west further compounds the burden of care workers living in the area

The research conducted by Social Ventures Australia (SVA), in partnership with Deloitte Access Economics and the Mitchell Institute,[54] highlights the urgent need to address early childhood disadvantage across Australia. The study identifies 737 communities with high levels of early childhood disadvantage, including 131 childcare deserts (areas with limited or no access to ECEC).

This is particularly relevant for care workers, as many tend to live in the west of Sydney but commute to work in the east and north. Typically, parents prefer to drop their child off near their place of residence, rather than near their place of work, to avoid the need to commute with their child. For care workers living in the west where childcare desert exists, they are often forced to seek childcare far from their homes – adding financial strain and time cost.

The consequences of these barriers are significant. Children in childcare desert areas who are unable to access early education services miss out on high-quality early learning, which increases their risk of social exclusion and developmental delays. The burden of childcare often falls to family members, and if they are unable to provide care, children face a lack of supervision. All these factors compromise worker's ability to fully engage in both their professional and family responsibilities.

Areas identified as childcare deserts and undersupply of early education services. Parameters include population aged under six, facing significant disadvantage or are ATSI, preschool enrolment, remoteness classification, population growth.



Credit: S. Pfautsch

Source: Social Ventures Australia (SVA), 2025[55]

Women with care responsibilities experience a spatial leash

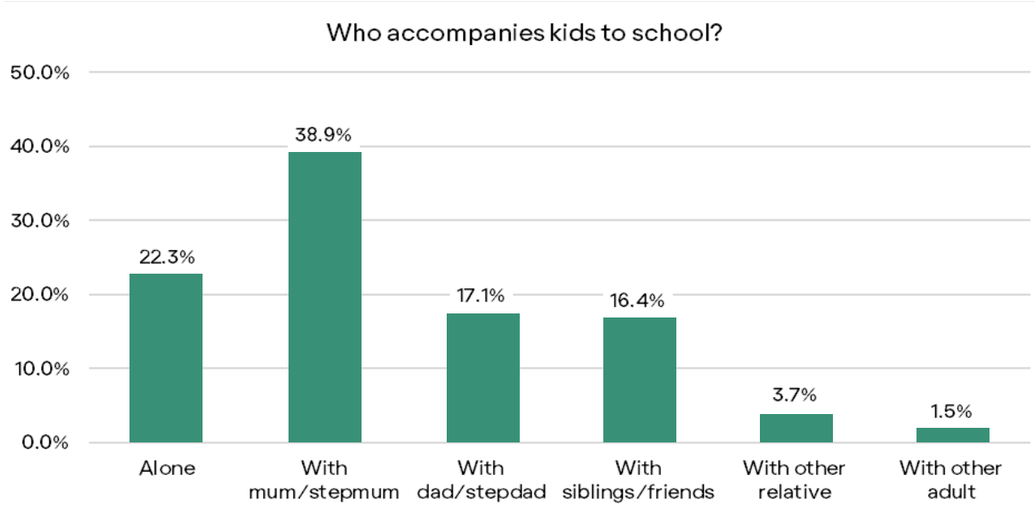
Women's mobility is constrained by the unpaid care they provide. The daily reality of trip-chaining including dropping children at school, escorting them to extracurricular activities, picking up groceries, visiting older relatives - ties women's movements to a tight geographic leash. This reduces their access to jobs, limits time for rest or leisure, and reinforces economic inequality.

The limited publicly accessible gender disaggregated travel data for Sydney available highlights this imbalance. As the graph shows, nearly 40% of children are accompanied to school by their mother or stepmother, compared with just 17% by fathers or stepfathers. A further 16% travel with siblings or friends, while only small proportions are accompanied by other relatives (3.7%) or other adults (1.5%). Over one in five children (22%) travel alone. This snapshot reveals the disproportionate role women play in children's mobility, but it still underrepresents the full extent of women's care-related travel across the city.

Transport for NSW does not currently collect statistically significant data on how care workers travel, meaning that care-related mobility patterns are not currently informing transport planning. Without gender-disaggregated data on trip chaining, time-of-day patterns, and the interaction between paid and unpaid care travel, the invisible labour of care will remain excluded from investment decisions.

Who accompanies children to school?

Most children are accompanied by their mothers to school, followed by 22% who commute to school alone



Source: Kent, J.L. (2025) The Australian School Travel Survey, University of Sydney.

4.2 Gender inequality

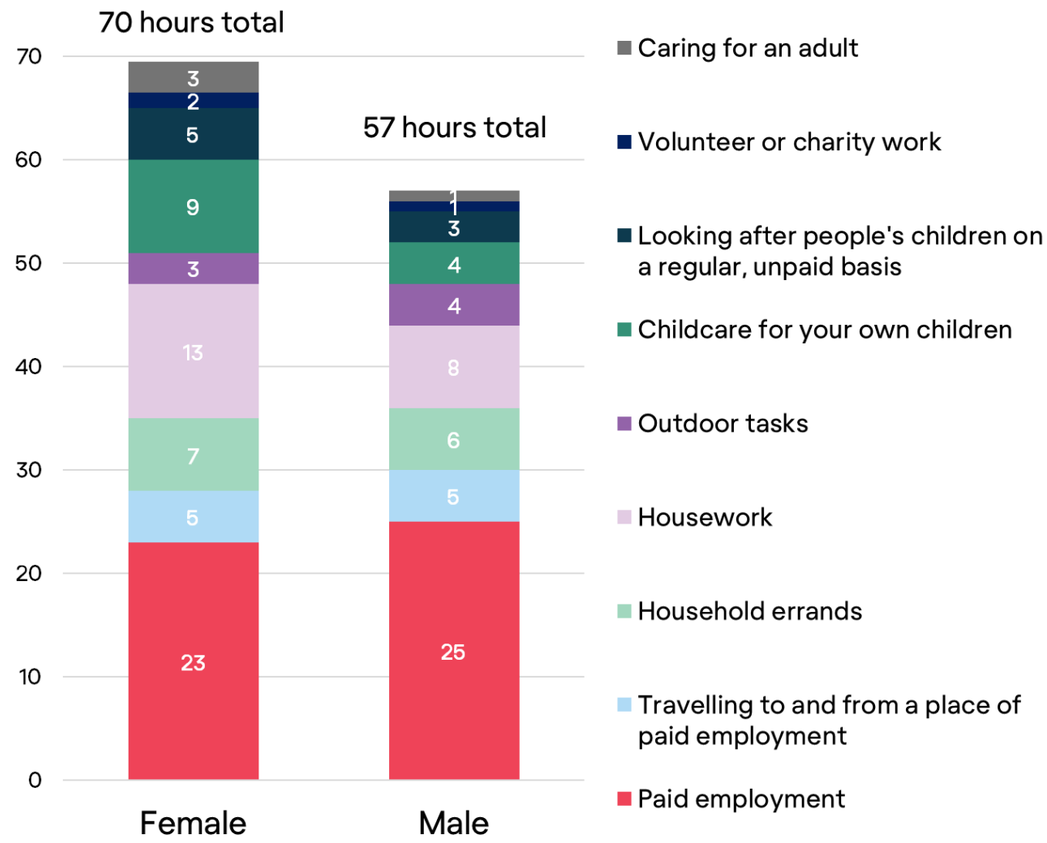
Care work is deeply gendered. Women do the majority of both paid and unpaid care, shaping their time, income and long-term economic security. Women face a series of time, economic and structural penalties when it comes to care.

There is a distinct gender time gap when it comes to care work. Women in Sydney work the equivalent of 18 extra weeks of unpaid care each year.

The Committee for Sydney's annual *Life in Sydney* survey, with Ipsos, shows that even when women work similar paid hours to men, they take on much higher levels of unpaid care. On average, women do 13 additional hours of unpaid work each week – 676 hours a year – the equivalent of nearly 18 extra full-time weeks[56]. This gap is largely driven by caring for children (nine hours per week vs four for men) and housework and errands (six additional hours for women, compared with one additional hour of outdoor tasks for men)

Women work similar paid hours to men but take on the equivalent of 18 extra work weeks of full-time unpaid work each year.

Hours of unpaid care activities per week by gender



Source: Committee for Sydney x Ipsos Life in Sydney survey

Credit: Canva stock photo

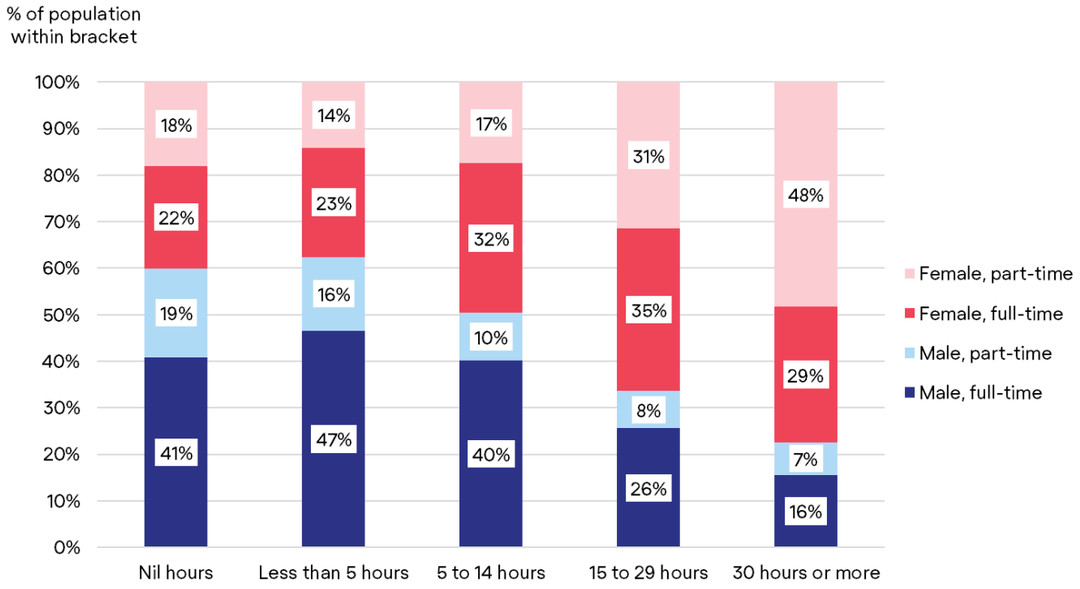
Care work is an economic penalty on women's earnings

As in many other countries, women's labour force participation rates in Australia have increased significantly over the past several decades, and the gender pay gap has gradually narrowed over time. The current gender pay gap in weekly ordinary time earnings for fulltime employees is 13.3% and reflects the persistent effects of industrial and occupational segregation (a trend highly prevalent in the care sector), women's time out of the workforce and higher rates of parttime work, and discrimination and bias.[57]

This gap is substantially higher when overtime and other earnings, and parttime employees are included. Australia has relatively high rates of female workforce participation compared to other OECD countries, but Australian women are much more likely to work parttime, and the female participation rate remains around 9 percentage points below men's (ABS 2022a)[58]. Survey evidence suggests that care responsibilities are the primary reason for women not participating in the workforce or working parttime, as women continue to take on the bulk of unpaid work in Australian households (ABS 2020a).[59]

Women are more likely to spend over 30 hours a week on unpaid domestic work, which often forces them into part-time employment out of necessity rather than choice; this inequitable distribution of care limits their ability to work full-time and reinforces broader gender inequality.

Relationship between unpaid domestic work and full-time employment, including gender distribution



Hours of Unpaid domestic work condcuted per week (including house maintenance, chores, meal preparation, etc)

Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Leanne

A 'sandwich generation' mother

"I am Leanne, aged 40 years old, living in western Sydney. I am currently working as an enrolled nurse. I am a mother to two daughters aged 3 and 7, and the primary carer for my 64-year-old mother-in-law who is in poor health and showing early signs of dementia. My husband works full-time, frequently works after hours and has little flexibility in his work arrangements.

While my eldest has started primary school, I have only been able to get my youngest into daycare three days a week. We have been on the waitlist for full-time care for months, but there is no sign of movement.

I applied for subsidised in-home aged care for my mother-in law but was told that the waitlist could be up to nine months. As a result, I have been working part-time to care for my mother-in-law and daughters, which has really made things even harder financially. On top of that, I also support my own ageing parents when I can.

As my husband drives the family car to work, I usually catch the bus and train to work in Sydney's eastern suburbs, which takes around 2 hours. The long commute puts a real strain on my time and energy.

The costs keep adding up, from out-of-pocket childcare fees to rent, transport, and other essential living expenses. My own health is starting to suffer, especially my mental health. I feel trapped, with little or no contact with friends, and honestly, I am exhausted."

1 HILDA | Statistical Report (2022)
2 Australian Seniors Whitepaper | Sandwich Generation Report 2025
3 Social Ventures | Mapping childcare deserts
4 SMC | Older women's economic security in retirement
5 Pay Calculator
6 Superannuation Balance Calculator

Caring isn't optional for Leanne – but who is caring for carers like her?

If formal care for children and older Australians were more accessible and affordable, Leanne would have a genuine choice: to either provide care herself or rely on the formal system, weighing the out-of-pocket costs. But that choice is not available to her. Sydney's housing unaffordability crisis means Western Sydney is one of the few parts of the city that Leanne and her family can afford to live, where access to childcare is limited and aged care services come with long waitlists. With limited paid care options, she is forced to reduce her paid work to care for her children and ageing parents. The cost of this unpaid care is steep: lost income, stalled career progression, and diminished superannuation, all of which will affect her for years to come.

Societal expectations on gender roles

When care is needed, it is assumed Leanne will provide it.

Leanne is just one of many women in families where the wife takes on most of the caregiving responsibilities, while the husband takes the 'breadwinner' role.

2 in 3 unpaid carers are female[1]

Although these choices may seem voluntary, they are often shaped by deeply engrained social norms that position women as the default caregiver.

Mental health, wellbeing and burnout

Although surrounded by people, Leanne often feels isolated.

In addition to her work, Leanne spends most of her remaining time caring for her family, leaving her feeling 'tied' down to the house and disconnected from friends and the community.

3 in 5 sandwiched carers indicated that caregiving has adversely impacted their social life[2]

With few opportunities to respite, Leanne struggles to support her own wellbeing.

Juggling between work, care and family, Leanne is prone to burnout.

Leanne's feeling of being "trapped' and "exhausted" is a common experience amongst carers – a sign of caregiving burnout.

9 in 10 sandwiched carers have experienced symptoms of burnout[2]

Female sandwich carers are also more likely to **experience stress**, with **62%** reporting elevated levels compared to **42%** of men[2].

The daily juggle of drop-offs, pickups, and travel drains Leanne's time, energy, and capacity to work.

Living in Western Sydney means Leanne faces long commutes to get to work - a trade-off driven by housing affordability.

Western Sydney also faces major challenges around childcare deserts, where access to quality early childhood education is limited[3]. With no nearby options, Leanne has had to secure a childcare place further from home, adding even more time to her daily travel on Sydney's public transport.

The hours lost to commuting take a toll on her energy, her time, and her wellbeing.

Financial impacts

As the primary carer for her family, Leanne is imposed a 'motherhood' penalty.

Compared to if she was working full-time, Leanne earns around

$270*
less per week as an enrolled nurse[5].

AGE 40

Impacts on income
To care for her family, Leanne only has the option to work part-time. This comes at the cost of less income, reflecting a direct financial penalty for mothers where caregiving responsibilities limit their workforce participation and earning potential.

Diminished superannuation savings
Often overlooked, Leanne's decreased participation in paid work also means lower superannuation balances. This has major implications on Leanne's future financial security and retirement income.

On average, women tend to have lower super balances compared to men, with the gap as wide as around $53,000 for the 40-44 age group[4].

AGE 67

Compared to if she was working full-time, at retirement, Leanne would have around

$81,000*
less superannuation[6].

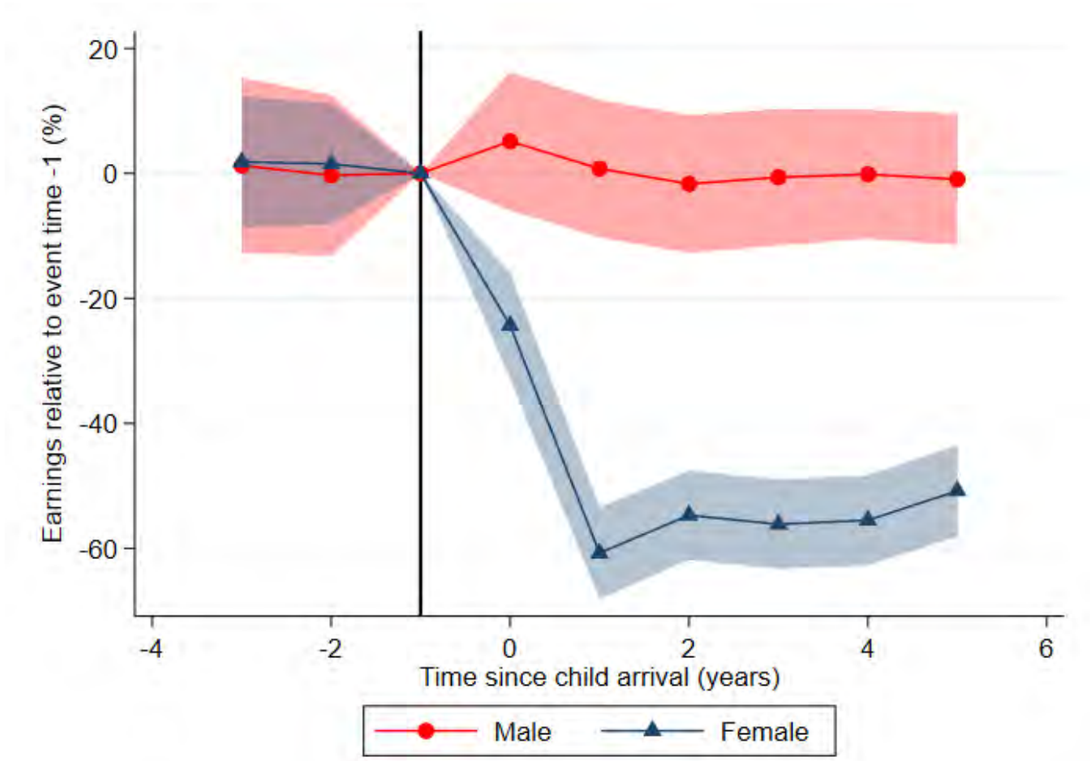
** The figures are determined using publicly available online calculators and are indicative only.*

Motherhood cuts women's earnings for a decade, while men's incomes keep rising

Treasury research shows women's earnings fall by 55% in the first five years after childbirth, and remain 35% lower even after 10 years. Men's earnings, by contrast, continue on the same trajectory or increase.[60]

International comparisons confirm how structural this penalty is. Australia's long-run motherhood penalty is 43%, more than double Denmark (21%) and Sweden (26%), higher than the US (31%), and only slightly better than Austria (51%) and Germany (61%) (Kleven et al. 2019)[61].

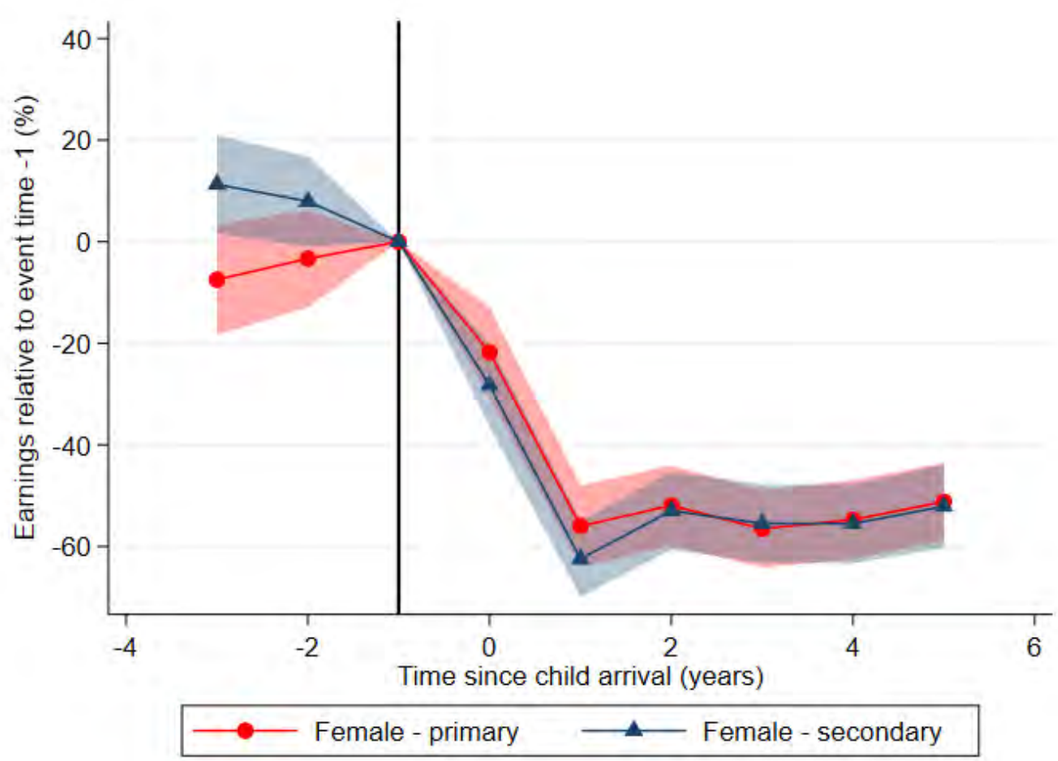
Impact of children on earnings, by sex. It shows a sharp decrease in earnings for women after the birth of the child, with a slight increase, or no difference in earnings for men.[62]



Source: Australian Treasury 2023

A common assumption is families make financially rational decisions, with the lower earner stepping back from work because they face the lowest opportunity cost. But Treasury's HILDA analysis challenges this[63]. It finds mothers experience the same earnings drop after having children regardless of whether they were the primary or secondary earner beforehand. In other words, even female breadwinners take a pay cut after becoming parents. This shows that primary care decisions are not driven by income alone, they are shaped by entrenched social norms.

Motherhood penalty, by breadwinner status[64]



Source: Australian Treasury 2023

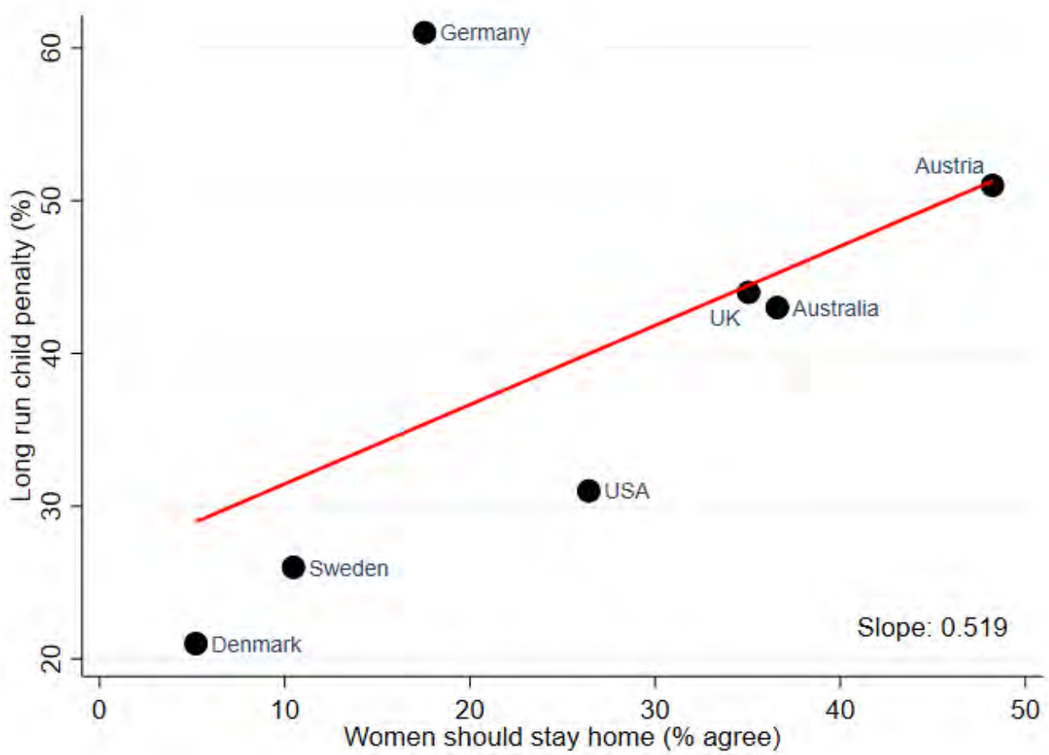
Care is not innately women's work. The economic penalty come from social norms, not biology

Studies of same-sex and adoptive parents show that whichever partner becomes the primary carer experiences the same drop in earnings, regardless of gender (Anderson & Nix 2022; Kleven et al. 2021)[65]. This reinforces that the penalty comes from social expectations, not biology. Even when women earn more than their partners, they are still expected to take on unpaid care.

Expectations remain powerful. Treasury analysis of the HILDA survey shows that between 2005 and 2019, agreement with statements such as, "mothers who don't need the money really shouldn't work" declined, but over a quarter (26%)[66] still hold this view. This highlights how slowly social norms shift, even as women's workforce participation rises.

International research shows that countries with more conservative gender norms – where a greater share of people believe mothers should stay home with young children – tend to have significantly higher motherhood penalties. Australia ranks among these, with both relatively traditional views about gender roles and a comparatively large earnings penalty for mothers. The evidence makes clear: the motherhood penalty is not a natural outcome – it is the product of outdated norms and institutions that continue to undervalue care and expect women to provide it.

Gender norms and income gaps across countries.[67]



Source: Australian Treasury 2023

Without affordable childcare and fair leave, women continue to carry the care load

Australia was the second-last OECD country to implement a national paid parental leave scheme, and childcare remains costly by international standards. Childcare in Australia operates primarily in a market-based system, with the federal government providing a means-tested subsidy to reduce out-of-pocket costs. Over the past several decades, there has been a substantial increase in both the use of formal childcare and the average hours of use (ABS 2018)[68]. However, out-of-pocket costs remain high compared with other OECD countries, continuing to limit workforce participation and disproportionately that of women.[69]

Attitudes and norms that care is 'women's work' hurt everyone

Framing care only as an economic burden or penalty risks missing its true value. Care work and time with loved ones are also a gift, it's valuable, necessary, and deeply rewarding. What is missing is balance. When children arrive, men's paid work hours change little, while women's workloads increase dramatically. Women carry disproportionate penalties in income, wellbeing and retirement security, but men also lose out. The status quo pushes men into the breadwinner role, often at the cost of time with children, caring relationships, and their own wellbeing. While attitudes are gradually changing, particularly over the last 10 years, men who want to share care can face stigma in workplaces, and those who cannot step back risk stress, burnout and rigid career pathways. This imbalance limits opportunities for both genders and perpetuates outdated expectations and social norms across generations. Sharing care more equally would not only improve women's economic security, but also give men greater freedom, connection and balance in their lives.

4.3 Economic inequality

Care work is among the lowest-paid work in Sydney

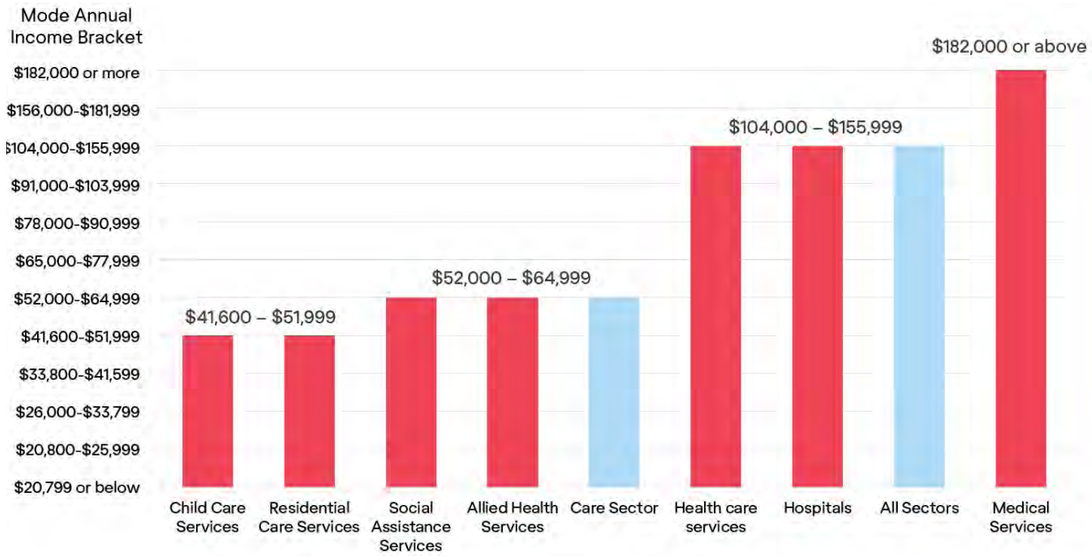
Workers in the care sector typically earn between $52,000 and $64,999 per year – roughly half the earnings of the average worker across all industries ($104,000–$155,999). Within the sector, those in child care and residential care are among the lowest paid, earning only $41,600–$51,999 annually.

These differences reflect qualification requirements, part-time vs full-time arrangements, industrial settings, and the way funding is structured. The result is a sector where some workers earn well above the average, while many others are left earning less than half.

Care workers' incomes vary widely, with those in child care and residential care earning only half as much as the typical worker across all sectors

Most common (mode) annual income bracket of care sector workers and workers across Greater Sydney, Central Coast and Wollongong

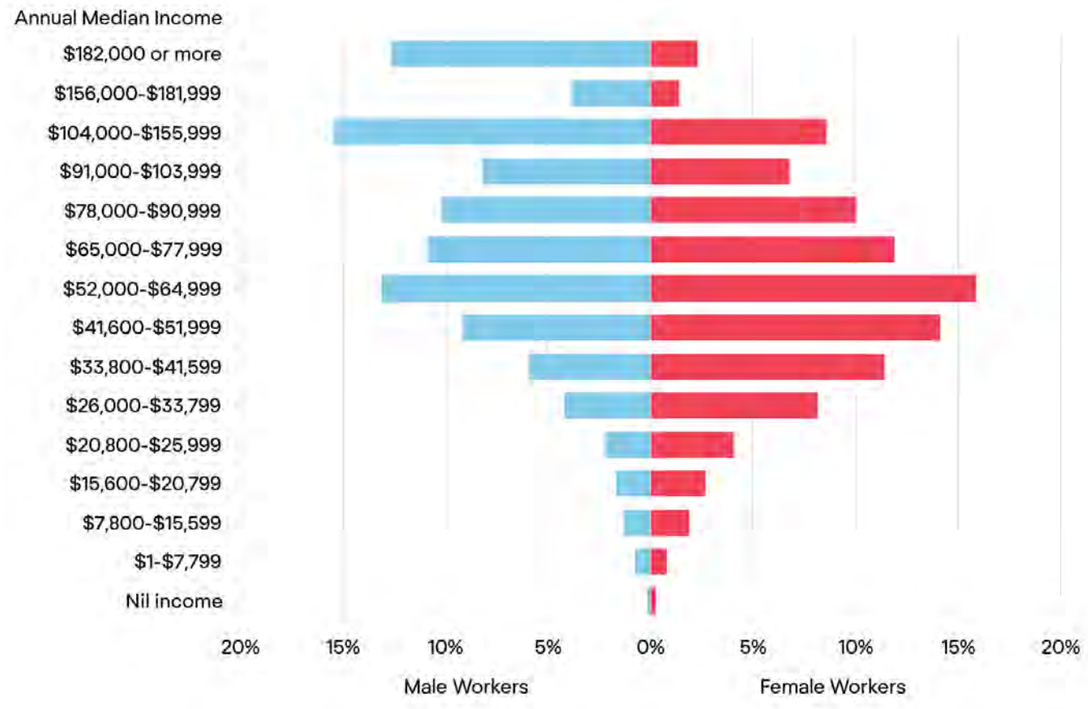
Annual median income of care worker by occupation



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Even though most care workers are women, men still make up a bigger share of the highest earners.

Annual median income of care worker by gender



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong

Women dominate the lowest-paid roles, while men hold senior and technical positions

Women make up the overwhelming majority of the care workforce at 77%, yet the highest share of women in the sector earn between $52,000 and $65,000 per year, compared with men who are more likely to earn above $104,000 annually.[70]

Women dominate income ranges between $400 and $1,500 per week (equivalent to $20,800–$77,999 annually), This reflects the reality that many women in the care sector are employed in frontline, part-time or casual roles, with limited opportunities for career progression or higher pay. In contrast, male care workers are overrepresented in higher income brackets, especially above $2,000 per week ($104,000+ per year). This suggests men in the sector are more likely to hold management, specialist or full-time roles, reinforcing a gendered divide in not only job type but job status.

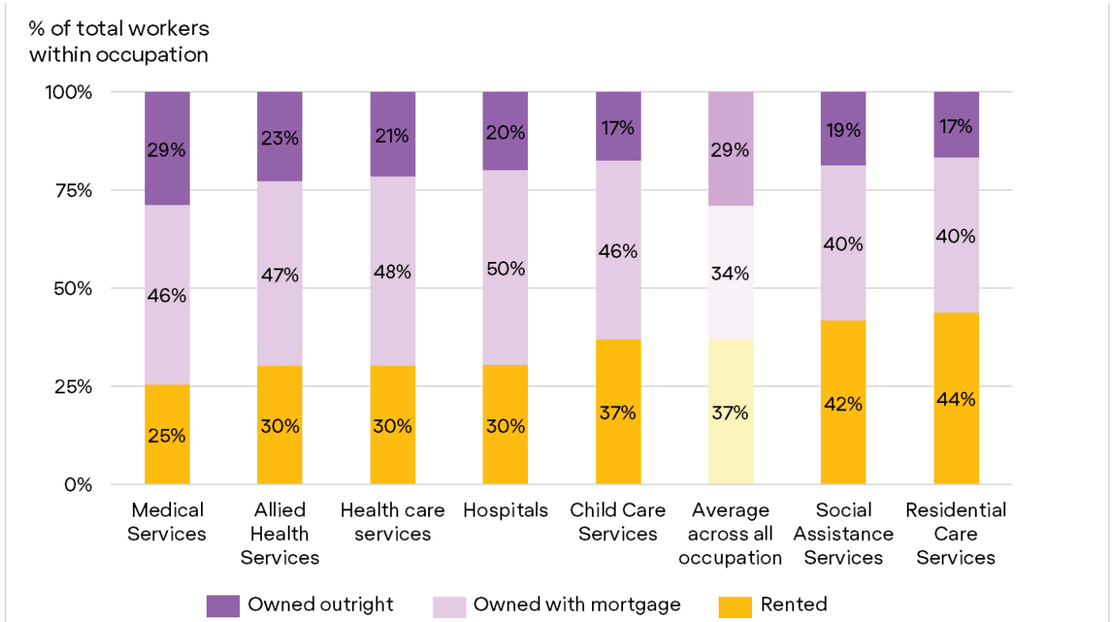
Care workers in the "missing middle" are being squeezed out of Sydney

Midwives, nurses and other health professionals in mid-income brackets are also under pressure. They earn too much to qualify for affordable housing, but too little to purchase property in Sydney. This is reflected in the generally lower home ownership rates for lower income care workers (residential care, social assistance, childcare) as compared to higher paid occupations within the care sector such as medical services and allied health services.

While over 70% of workers in health sub-sectors such as Medical Services an Allied Health own their homes (either outright or with a mortgage), in the lower-income sub-sectors such as Residential Care and Social Assistance that number drops to less than 60%. These statistics support the need for a more dedicated strategy to deliver sufficient essential worker housing.

Home ownership is highest among medical professionals including GPs and lowest among residential care workers, reflecting their respective income levels

Home tenure type of care sector workers, by occupation, and average of population in area

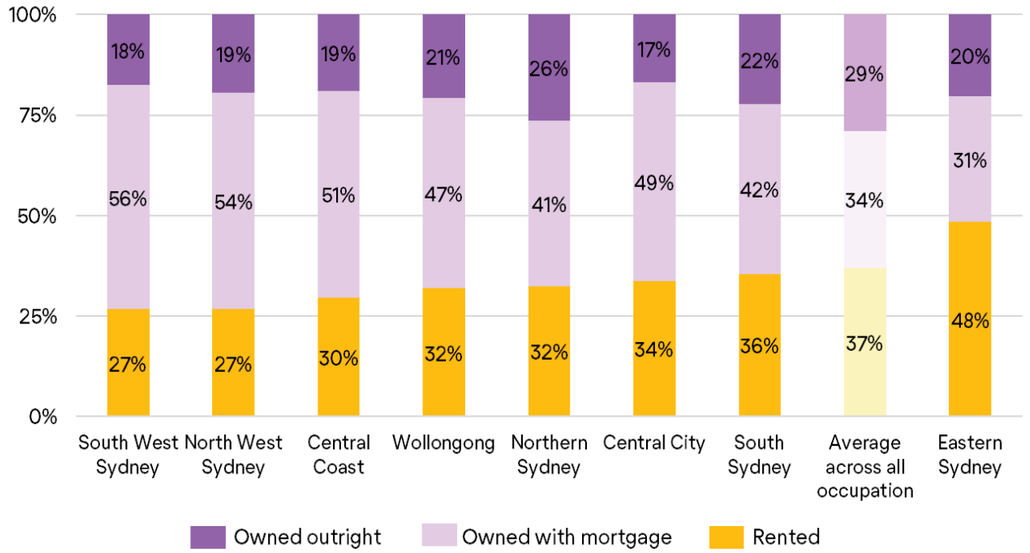


Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong, provided by SGS Economics & Planning

Past governments' wage suppression through the NSW public sector wage cap has further eroded their income relative to other states. As one stakeholder noted: "At the start of your career, you can live near the hospital. But once you have a family, housing costs push you further out – just when your skills are needed most." This mismatch between wages, housing and location is driving some workers to leave the sector or move interstate, creating a 'brain drain' that leaves Sydney's care system stretched thin.

Care workers in Eastern and South Sydney have the lowest home-ownership rates due to high housing costs, with many commuting to work from other areas

Home tenure type of care sector workers, by place of work



Source: ABS Census Data 2021, for locations across Greater Sydney, Central Coast and Wollongong, provided by SGS Economics & Planning

"Care workers are constantly exposed to this high-stress environment, and yet we expect them to bring softness to the care they give."
– STAKEHOLDER INTERVIEW

4.4 Racial inequality

A significant proportion of the care workforce is comprised of migrants and individuals from culturally and linguistically diverse (CALD) backgrounds. This trend has been shaped and sustained by immigration and visa policies that actively facilitate the recruitment of overseas workers into the sector, in addition to Australia's mish-mash approach to overseas acquired skills and qualifications recognition.[71]

The latest example of this is the Australian Government's introduction of a dedicated Industry Labour Agreement in 2023[72] specifically aimed for aged care, streamlining the process for providers to sponsor migrant workers. Notably, this agreement offers a pathway to permanent residency, making Australia an attractive destination for migrant care workers.

However, while these policies help address critical labour shortages, they also exacerbate the systemic reliance on migrant labour to perform care work. There is also the controversial issue of housing – there is a shortage of essential worker housing stock that is affordable and near health facilities or precincts that is felt more acutely by recent arrivals often without family connections to rely on for support.

Migrant care workers often face racism, which is easier to address in residential care settings through enforceable policies and supervision but far harder in in-home care, where individual client preferences can result in discriminatory requests. Many migrant workers are also less likely to challenge poor working conditions or report issues due to fears of losing their job or visa, creating a significant power imbalance. This vulnerability increases the risk of exploitation and unfair treatment.

4.5 Health inequities determine who can access self-care or not

Self-care - the ability to maintain one's own physical and mental health – is the foundation of a functioning economy. Both carers and those they support need the time and resources to look after themselves.

Stressful, isolating, and sometimes unsafe work environments make it harder for care workers to practise self-care and maintain their own wellbeing.

During interviews, providers expressed concerns around care workers' ability to sustain their wellbeing in a system that exposes them to constant stress, grief and trauma, such as workers in emergency departments, or carers working with dementia patients.

Interviewees also pointed out the isolating nature of much care work as a weakness within the system, particularly with in-home aged care where staff often work alone. Without peer support, professionals experience dissatisfaction and burnout.

"Health professionals prefer collaborative team settings, but the current system leads to isolated and disconnected work experiences. This makes the sector unappealing to emerging professionals, despite the rewarding nature of patient care."
– STAKEHOLDER INTERVIEW

On top of this, physical safety remains a concern for many frontline care workers. For hospital workers working night shifts, they could encounter aggression linked to alcohol and drug-related admissions. After their shift ends, they may need to navigate potentially dangerous areas to reach their public transport and home. These pressures add another layer of strain to an already stretched workforce.

Lack of healthy food options within facilities or during the night

A recent study based on the experiences of hospital-based staff across the UK, USA and Australia found unhealthy food offerings are the norm, such as snacks from vending machines which are high in salt and sugar. [73] Long shifts and a lack of breaks make unhealthy choices the default. Night shift staff often reported relying on caffeine and high-carb foods to stay awake, only to feel "revolting" afterwards. Over time, these habits undermine health and compound the stresses of care work.

"When you haven't taken a bathroom break in six hours, it's hard to sit down to a salad instead of grabbing a Snickers."

Food affordability is another significant challenge for care workers. The 2023 Australian Bureau of Statistics Food Security Survey[74] showing that 15.3% of families in the second income quintile and 28% of people living in group households experience marginal to severe food insecurity. Many care workers share traits that heighten this risk. They often earn low wages while supporting children, live in shared or insecure housing such as group households or short-term rentals, or work in Australia on temporary visas that exclude them from some supports. University students and young adults in the sector juggle study with unstable jobs and high housing costs, while culturally and linguistically diverse workers can struggle to find affordable, culturally appropriate food[75]. Together, these pressures make food one of the most frequently compromised part of care workers' household budgets.

Unequal access to time for exercise and respite

Exercise, a key pillar of wellbeing, is not equally accessible between genders. A study by Professor Lyndall Strazdins highlights the "gender exercise gap," referring to the consistent disparity in physical activity levels between men and women.[76] Women, particularly mothers, face a double burden of paid work and unpaid care, which limits their ability to prioritise exercise. Because care responsibilities are often unpredictable and fragmented, women typically only have short windows of five-to-10 minutes, making sustained physical activity difficult. Strazdins observed that when men's work hours increase, they tend to reduce their family responsibilities, while women continue to carry the same care load. As a result, men are more able to protect time for their health, while women's time is continually compromised – widening the gender gap in exercise over time.[77]

Access to respite is also uneven across regions. In metropolitan Sydney, carers are generally closer to parks, community centres and health services, while those in areas like the Central Coast or Wollongong may face limited public transport, fewer local facilities and longer travel times. This disparity makes it harder for carers outside the city to access consistent breaks.

The situation is further complicated when carers themselves live with disabilities or chronic health conditions. If their health deteriorates suddenly, there is often no immediate system in place to step in, leaving care recipients at risk and families scrambling to find urgent support.

5. Industry trends shaping Sydney's care economy

5.1 Financial pressures undermining the care sector

Financial pressures are significantly impacting the care sector, but the nature of these pressures varies across subsectors. In privatised areas such as aged care and childcare, providers operate in highly regulated environments and face substantial costs for compliance, reporting and staff training. The physically demanding nature of care work also drives high insurance costs due to injury risks and compensation claims. Low profit margins in these industries limit investment in innovation, and many providers minimise costs in unfavourable ways, such as hiring less qualified staff, increasing staff-to-client ratios, or relying on temporary contracts to reduce liability. While these practices may ease financial strain in the short term, they compromise the quality of care and contribute to workforce turnover.

In the not-for-profit social and community services sector, financial pressures often stem from government funding arrangements that fail to cover the full costs of service provision, including overheads and infrastructure. This leaves organisations constantly operating on thin margins, limiting their ability to plan for the long term or invest in service quality.

Across all subsectors, the result is the same: financial strain reduces the sector's capacity to deliver high-quality, sustainable care, undermines innovation and contributes to ongoing workforce instability. Since these issues are complex and play out differently across the system, coordinated strategies are needed to strengthen funding models and ensure providers can meet community needs without compromising quality.

5.2 Training gaps and an unstable workforce pipeline

The care sector faces not only a shortage of workers, but also serious challenges in preparing a high-quality, consistent workforce. ECEC is a prime example of the challenges in equipping the prospective care workforce. The sector currently faces a significant workforce shortage, driven by high demand, while the quality of the prospective workforce is compromised by inconsistent training. Although the minimum qualification of Certificate III is required, the shift from TAFE or university to various private providers has created a patchwork of training programs. This inconsistency undermines the ability to build a stable workforce pipeline capable of delivering high-quality, consistent care.

Childcare: "We've got systems that work against themselves when it comes to quality, it's often the youngest children that have the least qualified staff, which is why we see seeing some of the problems that are coming out right now."

– STAKEHOLDER INTERVIEW

Moreover, some describe the current training approach as a "merry-go-round," where prospective carers are forced to repeatedly retrain without meaningful career progression. This affects migrants, especially women with care responsibilities disproportionately. Even if training is technically free or low-cost, hidden costs cannot be overlooked:

- Time away from potential work
- Travel expenses
- Opportunity costs such as missed career opportunities, lost income or forgone personal commitments
- Disruption to personal care responsibilities like looking after children
- Psychological burden of constant re-certification.

5.3 Bureaucracy and exclusion in the welfare system

Australia's welfare and support systems are complex and highly bureaucratic, causing many people to fall through the cracks. Disability support (NDIS), aged care packages (HCP and CHSP), and childcare subsidies (CCS) each operate with separate rules and requirements. In a report highlighting ECEC barriers in Fairfield, Uniting drew attention to how navigating the system is difficult for many families, especially when 23% of people self-report that they do not speak English well or at all, and 52% struggle to enter the labour force.[78]

LIVED EXPERIENCE:

Locked out by red tape

When Sarah's son turned 14, she suddenly lost access to his Medicare record. Under the rules, children can grant parents' permission to view their records, or parents can use power of attorney after the child turns 18. But her son has an intellectual disability and could not give that consent. For the next four years, Sarah was locked out and unable to see vital health information or manage care decisions – trapped in a loophole that left her family navigating the NDIS system in the dark.

5.4 Chronic underinvestment in research and innovation

Despite the scale of the care economy, government investment in research and development (R&D) remains minimal. In 2020–21, the aged care sector spent just $465,000 on R&D out of $2.9 billion in total expenditure. By comparison, ambulance services spent $1.3 million, the regulatory services industry spent $8.3 million, and the beekeeping industry spent $4 million.[79] The fact that beekeeping attracts more R&D than aged care underscores how little priority is given to innovation in the sector.

This underinvestment makes it difficult to modernise care systems or develop new models that could improve outcomes. As a result, the sector struggles to move beyond short-term fixes, even as demand grows.

Projected government spending[80] shows large headline investment in the care economy – $103 billion in 2024–25 rising to $124 billion by 2027–28 – but most of this funding is directed to service delivery, not innovation. In 2024–25, this includes $38 billion for aged care, $49 billion for disability support, $15 billion for early childhood education and care, and $999 million for veterans' care. Without a stronger emphasis on research and system improvement, these investments risk entrenching existing inefficiencies rather than driving the innovations needed to lift quality, workforce sustainability, and long-term productivity.

Solutions

The care economy is deeply complex, spanning paid and unpaid work, health, disability, childcare, aged care, housing and transport. There is no single fix and change will not happen overnight. What we set out here is a suite of possible solutions – ranging across workforce development and fair pay, housing and transport access, and new ways of funding, measuring and delivering care. Together, these ideas show the breadth of reform needed to build a stronger, fairer care economy for Sydney.

1. Shift the narrative: make care visible, valued and shared

Care is the invisible backbone of our society and economy, yet too often it is undervalued, underpaid, or assumed to be the responsibility of women in families. Shifting the narrative means recognising unpaid carers as contributors to the economy, redefining who we see as 'essential,' and challenging harmful gender and cultural stereotypes. By telling more diverse stories and embedding care into how we talk about productivity, we can build a city that truly values and shares the work of care.

Acknowledge and support unpaid care

Unpaid carers provide millions of hours of support each year, but often at great personal cost to their social, financial and physical wellbeing. Recognising their contribution through financial support, superannuation, respite and peer networks would make this essential work more sustainable.

1.1 Introduce a NSW Carer card

Why it's needed

Carers often face financial strain, social isolation and a lack of recognition for their contribution. While there are concession schemes for seniors, there is no universal recognition for carers, despite the millions of hours of unpaid work they provide. A NSW Carer Card would provide dignity, visibility and practical benefits that reduce stress and connect carers to support networks.

What it will take

- Establish a NSW Carer Card that provides access to concessions across health, transport, recreation and cultural services, eligibility can align with the Carer Recognition Act
- Partner with NGOs, councils and cultural institutions to expand the range of benefits available
- Build partnerships with councils and the private sector to offer discounts and incentives for people with carer cards, providing affordable access to pools, gyms, sports facilities and other activities that promote health, connection and wellbeing.

Making care visible and valued

Summary

Barcelona launched the Targeta Cuidadora (Caregiver Card) in 2021 to acknowledge and support the city's unpaid and paid carers. The card provides access to respite and leisure activities, training, 24/7 emotional support, and legal advice. By embedding recognition in everyday life, Barcelona reframes care as essential social infrastructure rather than a private burden.

The Caregiver Card provides carers with access to a wide range of resources, including:

- Respite and peer support through cultural, leisure and awareness-raising activities
- Training opportunities to strengthen skills and improve wellbeing
- 24/7 emotional support via a dedicated phone line and WhatsApp chat
- Legal and practical advice, including support in drawing up domestic care contracts
- Visibility and recognition, with carers subscribed to a dedicated monthly bulletin (Infocures) and included in city-wide narratives about who is 'essential.'

The card is available to anyone over 18 living in Barcelona who provides unpaid or professional care, broadening recognition beyond family carers to include migrant and domestic care workers who are often invisible in policy debates.

Why it matters

Barcelona's initiative reframes care as essential social infrastructure rather than a private burden. By offering tangible supports and positioning carers as contributors to the city's wellbeing and productivity, the program reduces isolation, prevents burnout and builds social recognition for undervalued roles.

Source: Barcelona Care Strategy

1.2 Expand access to respite care and peer support networks across Greater Sydney

Why it's needed

Carers often juggle work, family responsibilities and their own health alongside the demands of providing care. Without adequate respite, many experience isolation, exhaustion and burnout, which undermines both their wellbeing and the sustainability of the care they provide. Access to respite and peer support is uneven across Sydney, with services concentrated in some areas but limited or non-existent in others. Expanding availability would reduce stress, strengthen health and social connection, and make unpaid care more sustainable.

What it will take

- Expand funding for respite services across metropolitan Sydney located near transport and other public service hubs. To be successful, location really matters to make respite less not more work.
- Partner with NGOs and community organisations to deliver local, culturally appropriate support
- Strengthen peer networks that provide emotional connection, shared advice, and social support.

Rethink and reframe how we talk about care

Care should be seen as essential infrastructure, not a private family responsibility or a 'cost' on government budgets. Public campaigns and policy frameworks must broaden the definition of essential workers and recognise the value of both frontline and back-office roles.

1.3 Run public campaigns positioning care as essential economic, health and social infrastructure

Why it's needed

Care is too often dismissed as a private family responsibility or a budget cost, rather than a driver of prosperity and social wellbeing. This framing holds back investment and leaves the sector under-resourced compared to physical infrastructure like roads, rail or energy. Yet care enables all other forms of productivity – workers can only participate in the economy when children, older people and people with disability are supported. Cities such as Barcelona now position care explicitly as essential infrastructure, enshrining it as a universal right and investing in it alongside housing, transport and energy. Public campaigns that frame care as essential to economic and community life are critical to building the cultural and political momentum for change.

What it will take

- Fund sustained, state-led campaigns that reframe care as vital economic and social infrastructure. Focus on what care infrastructure makes possible. Shift the narrative to think about what is the cost of not investing in care infrastructure.
- Partner with unions, business and community groups to amplify diverse voices – including unpaid carers, frontline staff and back-office workers
- Align campaigns with wellbeing and productivity frameworks so care is visible in the same way as physical infrastructure
- Showcase international best practice, for example, Barcelona embedding the right to care in its city strategy, to demonstrate the transformative potential of investment in care.

Challenge gendered stereotypes in both paid and unpaid care

Both paid and unpaid care remains heavily feminised, contributing to gender pay gaps and limiting male participation. Changing perceptions through education, media and workplace policies is critical to addressing skill shortages and building a balanced workforce.

1.4 Actively challenge stereotypes of care as 'women's work' through education, media and workplace initiatives

Why it's needed

Care remains heavily feminised, contributing to gender pay gaps and locking men out of care roles. Stereotypes discourage men from entering care careers and undervalue women who dominate the sector. This reinforces shortages in aged care and childcare, where demand is growing fastest. Actively encouraging men to take up care roles helps break down stereotypes, expands the workforce and models care as a shared social responsibility.

In unpaid care, the benefits of men sharing the everyday care load are clear. Policies such as equitable parental leave and flexible working arrangements make it possible for men to participate more fully in care work. This not only enhances men's wellbeing and strengthens family bonds, but also enables women's greater participation in paid work, reducing gender inequality across the economy.

Actively encouraging men to take up both paid and unpaid care roles helps expand the workforce, challenge cultural norms and show that care is a responsibility shared by all. While care is becoming more diverse, workers from multicultural and LGBTQI+ backgrounds are still underrepresented in public narratives, which limits visibility and inclusion. Embedding change in schools, workplaces and media coverage can help shift perceptions, broaden participation and build a more sustainable workforce.

What it will take

- Fund education campaigns and curriculum changes that present care as a gender-neutral profession.
- Introduce incentives for men to take substantial periods of parental leave, helping normalise shared care.
- Pilot 'Fathers as Carers' programs (see Barcelona case study).
- Showcase positive male role models working in aged care, childcare, health and disability support.
- Partner with unions, training providers and employers to recruit and retain more men in care roles.
- Address pay equity across feminised professions to attract a more diverse workforce.
- Promote inclusive workplace initiatives that challenge stereotypes and support all workers.

CASE STUDY:

Fathers as carers, Barcelona's co-responsibility programs

Barcelona is tackling gender stereotypes in care by directly promoting men's involvement in raising children and sharing family responsibilities. Through its new five-year *Right to Care* plan, the city is funding programs in nurseries, family centres and community hubs that encourage fathers and men to take a more active role in care.

Key Features

- Training for families and professionals in nurseries, parents' groups and men's groups on co-responsibility in childcare (0–3 years)
- Educational and pedagogical resources integrated into municipal facilities to encourage young men and adolescents to see care as a shared social role, not just 'women's work'
- Community-based programs that provide spaces for men to discuss fatherhood, care responsibilities and gender equality.

Why it matters

- Challenges stereotypes that assign care to women, helping rebalance the workforce and family responsibilities
- Normalises men's participation in care from the earliest years of a child's life
- Lays the foundation for long-term cultural change by embedding co-responsibility in schools, nurseries and community settings.

Source: Barcelona care strategy

2. Futureproof the care workforce

Credit: Australian Institute of Workplace Training

Futureproofing Sydney's care workforce means building a system that is skilled, sustainable and ready to meet rising demand. Today's workforce is already stretched, with acute shortages across aged care, disability support and health. Without urgent reform, Sydney risks a widening gap between care needs and available workers, leading to poorer services, lower quality of care and mounting pressure on families and the health system.

Build a strong workforce pipeline

Sydney cannot meet growing care needs without attracting and retaining the next generation of workers. Building a strong pipeline means recognising the skills of migrants already here, opening clear pathways for students to enter care careers, and creating flexible models that share scarce expertise across facilities. These reforms expand the workforce quickly, unlock hidden capacity and make care careers more viable and rewarding.

2.1 Streamline the skills recognition of migrant and refugee workers trained in care-related fields overseas so they can work at their appropriate skill level

Why it's needed

Many migrant workers in health and care are employed in roles well below their qualifications. This wastes talent, lowers morale and limits productivity. Unlocking these skills could deliver significant economic and social benefits, while also easing workforce shortages.[81]

What it will take

- Clearer, faster pathways to assess and recognise overseas qualifications
- Tailored bridging programs that integrate international training into local standards
- Safeguards to prevent exploitation and ensure fair treatment
- Partnerships with migrant organisations and unions to provide ongoing support.

2.2 Establish a single digital 'passport' that records a worker's qualifications, training and experience and is portable across providers, employers, and jurisdictions

Why it's needed

Care workers are repeatedly required to complete the same onboarding and training when they change employers or move across care settings. Each provider runs its own systems, leading to duplication, wasted time and hidden costs for workers who often hold multiple part-time roles. The lack of a standardised process creates inefficiency for providers and frustration for workers, making the sector less attractive and harder to navigate as a career. A portable passport would also improve safety and accountability across the sector by allowing relevant authorities to track compliance and ensure that serious breaches or poor behaviour are visible across jurisdictions.

What it will take

- National agreement on the scope and governance of the passport
- Integration with existing training and accreditation systems
- Federal Government to invest in required digital infrastructure and a trusted body to maintain it
- Evaluation of the Queensland pilot (see case study) and adaptation for other states.

CASE STUDY:

Connected orientation and onboarding training and processes Queensland pilot

Summary

- In 2023, the Queensland Government funded the National Care Workforce Alliance (NaCWA) under its *Jobs Queensland Health and Community Services Sectors Workforce Development Project 2022–2025.*
- The pilot, led by Australian Catholic University with Queensland partners, is testing two solutions:
  - Standardising orientation and onboarding across employers so training is recognised sector-wide
  - Creating a digital Skills Passport so workers can carry proof of training between jobs.
- These initiatives aim to cut duplication, speed up hiring, support worker mobility and open clearer career pathways, laying the foundation for a national rollout.

Why is this important?

- Reduces duplication by requiring training only once, not at every new employer
- Standardises onboarding processes across the sector, making the workforce more mobile
- Enables easy transfer of credentials, giving workers flexibility and choice
- Creates clearer, more flexible career structures to attract and retain staff
- Supports workforce sharing across providers, helping to meet demand where it is greatest.

Source: Pilot Phase 1 – Queensland, National Care Workforce Alliance, Jobs Queensland Health and Community Services Sectors Workforce Development Project 2022–2025.

2.3 Enable specialised care workers – such as physiotherapists, allied health professionals and senior clinical staff – to be shared across multiple facilities, strengthening collaboration and broadening career opportunities

Why it's needed

Smaller organisations and facilities often cannot justify employing full-time specialised staff leading to inconsistent standards of care and limited access for patients and families. At the same time, skilled professionals may find career progression blocked in single organisations, reducing retention. The lack of shared roles fragments the system and prevents collaboration between providers.

How it helps to futureproof the care workforce

- Expands access to specialised skills across the sector, ensuring all facilities can meet care needs
- Creates new career pathways and leadership opportunities, improving retention
- Allows skilled staff to work at their full scope of practice, maximising productivity
- Strengthens collaboration between providers, building a more integrated care system
- Delivers more consistent, high-quality care for patients and families.

What it will take

- Policy and funding frameworks that allow shared roles across facilities and providers
- Agreements between providers on employment models, rostering and cost-sharing
- Investment in workforce planning tools to coordinate deployment
- Clear standards to ensure continuity of care for patients when staff rotate between sites.

International models of shared care workforces

Summary

- The Netherlands – Buurtzorg model: Self-managed community nursing teams work across neighbourhoods, not just single facilities. Staff share caseloads flexibly, building trust with clients and creating more autonomous, rewarding roles. This model is credited with improving retention, reducing overheads and delivering high patient satisfaction.
- Sweden – Regional specialist pools: Municipalities employ physiotherapists and occupational therapists in shared pools who rotate across smaller aged care homes. This ensures equitable access to specialists and reduces recruitment pressure on individual facilities.
- Denmark – Cross-facility dementia care: Dementia specialists are employed centrally by municipalities but embedded part-time in multiple facilities. This allows small centres to maintain consistent standards of dementia care without hiring full-time staff.

Why is this important?

These international precedents show that sharing skilled staff across facilities can reduce duplication, strengthen retention and deliver more consistent care. Adapting these models locally would support smaller providers, broaden career opportunities, and build a more resilient system.

*Sources: Buurtzorg International, **Neighbourhood Care Model** (Netherlands); OECD (2020), **Who Cares? Attracting and Retaining Care Workers for the Elderly**; Swedish Association of Local Authorities and Regions (SALAR); Danish National Board of Social Services.*

2.4 Ensure students are paid a living wage while on student placement

Why it's needed

Students in care-related training such as nursing, midwifery, allied health and disability support routinely undertake long unpaid placements. These placements impose a significant financial burden:

- A national survey of 2,359 nursing students reported that one-third incurred financial liabilities, 79% faced financial hardship, and 73% found placements stressful, with 62% noting an impact on health and wellbeing.[82]
- Across nursing, allied health, dentistry and medical students, the financial impact of unpaid placements is well-documented and considered a serious risk to the sustainability of the future health workforce.[83]
- Attrition is high in nursing, with between 10 and 40% of students leaving their programs, many citing cost pressures and the inability to afford unpaid placements.[84]

From July 2025, the Commonwealth Government's *Prac Payment* has been in place for nursing, midwifery, teaching and social work students, providing $331.65 per week during clinical placements. While this is an important step in addressing placement poverty, it does not cover the full spectrum of care roles such as aged care, disability support or allied health. Nor does it address the need for relevant paid work to be recognised as part of mandatory placement hours.

What it will take

- Reform placement rules to allow relevant paid work to count toward mandatory hours
- Extend placement financial support beyond current *Prac Payment* recipients to include aged care, disability support and allied health students.

Support workforce wellbeing

A care workforce under constant strain will not be able to keep pace with demand. Supporting wellbeing means improving pay and conditions, ensuring fair treatment for migrant workers, reducing discrimination, and providing the housing and transport supports that keep people in care careers. These measures protect workers from burnout, make care jobs more attractive and strengthen retention so the system can deliver high-quality care for the long term.

2.5 Strengthen protections for migrant care workers against discrimination and bias from both employers and clients, and create pathways for them to thrive in fair, safe and respectful workplaces

Why it's needed

Migrant workers make up a large share of Sydney's care workforce but face systemic barriers, including systemic racism, that limits their opportunities and wellbeing. Stakeholder interviews revealed that:

- Workers on temporary visas are vulnerable to mistreatment, with many afraid to report bullying or unsafe practices for fear of deportation
- Cultural and gendered expectations see male migrants excluded from frontline care roles, despite willingness and need
- Workers with English as a second language are often passed over for leadership positions
- Racism and bias in hiring and promotion contribute to underemployment and poor morale
- Migrants in regional areas often lack community networks, leaving them isolated and more vulnerable to exploitation.

What it will take

- Confronting systemic racism by making equity and inclusion part of organisational practice
- Stronger monitoring and enforcement of anti-discrimination laws in the care sector
- Programs that support migrant workers to report issues safely, with whistleblower protections
- Leadership and professional development programs designed for workers with English as a second language
- Public awareness and employer education campaigns to challenge bias and stereotypes about who can do care work
- Partnerships with unions, community groups and providers to co-design inclusive workplace practices.

CASE STUDY:

Tackling discrimination in long-term care in Ontario, Canada

Summary

- Ontario has piloted diversity and inclusion initiatives across its long-term care (LTC) sector to address discrimination faced by migrant and internationally educated care workers.
- The *Embracing Diversity in Long-Term Care* toolkit was developed by the Ontario Centres for Learning, Research and Innovation (CLRI) to help care homes identify bias and embed inclusive practices.
- The toolkit provides practical resources for managers, including anti-racism training, guidance on hiring and promotion, and strategies to improve cultural competency among staff.
- The program was designed in recognition that many internationally educated nurses and personal support workers in Canada face racism, underemployment, and barriers to advancement.
- Provides a practical precedent for Sydney, where migrant workers are essential to the care system but face discrimination and bias that undermine retention.

Why it's important

- Confronts systemic racism by making equity and inclusion part of organisational practice.
- Improves retention by creating safer, fairer workplaces for migrant and minority workers.
- Ensures a more diverse and culturally competent care workforce, better reflecting the communities served.
- Provides a practical precedent for Sydney, where migrant workers are essential to the care system but face discrimination and bias that undermine retention.

Source: Ontario Centres for Learning, Research and Innovation (CLRI), Embracing Diversity: A Toolkit for Long-Term Care Homes (2020).

2.6 Design and dedicate places and systems that allow staff to rest, recharge and practice self-care

Why it's needed

Stakeholders highlighted that many care workers lack even the most basic facilities to support their wellbeing during shifts. Facilities like hospitals or aged care facilities often have no staff nursing/expressing rooms for mothers returning to work and limited access to quiet or wellness spaces. Many care workers experience long shifts without proper break rooms, adding to the isolation and stress of emotionally demanding work. These gaps increase burnout and turnover, and make care roles less attractive.

For home care workers, the challenge is different. Without a purpose-built workplace, they spend their days moving between clients' homes, often with long commutes in between. In these cases, providers need to focus on "soft" solutions, such as encouraging workers to take breaks in local parks or build in time for rest between appointments, to support wellbeing in the absence of physical workplace design.

How it helps to futureproof the care workforce

- Improves retention by protecting worker wellbeing through proper spaces for rest
- Supports women to stay in the workforce by providing family-friendly facilities like nursing rooms
- Makes care work less isolating by embedding break and common areas that foster peer connection
- Signals that staff wellbeing is valued, improving morale and recruitment.

What it will take

- Standards requiring all care facilities to provide designated rest areas, quiet rooms and wellness spaces for staff
- Staff nursing rooms and family-friendly facilities in hospitals and large aged care centre
- Embedding facility design standards for worker wellbeing into accreditation and regulatory frameworks.
- Provider-led initiatives for home care workers, including rostering systems that build in recovery time, wellbeing guidance and access to community facilities for breaks

Enable flexibility in the workplace to support unpaid carers

Unpaid carers are found in every part of the workforce, from frontline roles to professional and white-collar jobs. In 2022, there were 3 million unpaid carers in Australia, up from 2.6 million in 2018, representing nearly 12% of the population; this includes 1.2 million primary carers who provide the majority of care, and 391,300 young carers under 25.[85]

These care roles often sit alongside full-time professional jobs, but without flexible work arrangements, many carers are forced to reduce their hours, forgo promotions or leave the workforce altogether. Strengthening workplace flexibility, through enhanced carer-friendly accreditation and stronger

Credit: Canberra Hospital, BVN

access to flexible working, will help carers stay employed at the level they are qualified for, safeguard their economic participation, and preserve valuable talent across fields.

2.7 Embed flexible work into workplace culture to support unpaid carers without stigma or career costs

Why it's needed

Although unpaid carers have a legal right to request flexible work under the Fair Work Act, many face stigma or subtle penalties when they use it. Stakeholders reported that carers often feel unsafe disclosing responsibilities in professional workplaces, particularly in white-collar industries where presenteeism and long hours are valued. Without cultural change, carers either leave the workforce or limit their career progression. Embedding flexible work will help keep skilled carers in the workforce at their qualified level, supporting gender equity by normalising flexibility for all carers, especially those who experience a 'spatial leash.'

What it will take

- Update the Fair Work Act's right to request flexibility with stronger protections against unreasonable refusal and an appeals mechanism.
- Mandate reporting of flexible work uptake in large organisations (similar to gender pay gap reporting), so progress is visible and measurable.
- Expand accreditation programs like the Carer-Inclusive Workplace Initiative (CIWI) and link them to government procurement to incentivise adoption.
- Require flexible work policies to be explicit in enterprise agreements and awards**,** with examples of how roles can be done flexibly.
- Promote senior leaders as carer "champions"**,** modelling use of flexible work to reduce stigma from the top down.
- Fund public campaigns (similar to WGEA's Equal Pay Day work) that normalise flexible work for carers as a mainstream workplace entitlement, not a concession.

Credit: Arcadia Landscape Architecture, Photographer: Brett Boardman

2.8 Scale up accreditation programs so employers are recognised and rewarded for being carer-inclusive, creating positive competition and raising standards across industries

Too often, carers face stigma or disadvantage at work when trying to balance paid employment with caring responsibilities. Accreditation programs provide a clear signal of which employers are carer-inclusive, raising visibility, building trust and setting a benchmark for best practice. By recognising and rewarding employers, accreditation not only lifts standards across industries but also creates positive competition, encouraging more organisations to adopt flexible, supportive practices. This helps retain skilled workers, improves workplace wellbeing and makes caring compatible with long-term careers.

What it will take

- Expand the Carer-Inclusive Workplace Initiative (CIWI) nationally
- Promote accreditation as a benchmark of good employer practice
- Provide procurement or funding incentives for accredited employers.

Recognise and support unpaid carers and volunteers

Grandparents and other forms of kinship carers and volunteers provide a critical but often invisible layer of support in Australia's care system. The 2022 ABS survey found that one-in-five children under 12 are cared for by grandparents on a regular basis, with higher reliance among migrant families[86]. For some migrant women, cultural or religious expectations mean they cannot participate in the paid workforce, while others are brought to Australia specifically to care for grandchildren. These carers are rarely recognised in formal systems, yet their contribution is vital to family wellbeing and women's economic participation. Providing training, respite care and financial support, and ensuring inclusion in policy and funding programs, would help sustain this informal workforce and protect the wellbeing of carers themselves.

2.9 Design support that reflects the realities of migrant and multicultural families where grandparents often provide primary childcare

Why it's needed

Stakeholders highlighted that older migrant women are often brought to Australia to care for grandchildren or are unable to work in the paid workforce due to cultural or religious expectations.[87] These carers are essential for family wellbeing and women's workforce participation, but their needs are often invisible to policy. At the same time, research shows that children benefit from having some engagement with the formal childcare system outside the family, making it important that grandparent care complements, rather than replaces, access to early learning.

What it will take

- Partner with migrant and multicultural organisations to co-design supports
- Provide translated information and culturally tailored respite services
- Ensure migration and settlement policies explicitly recognise and support care roles, including grandparent and kinship care
- Strengthen pathways that balance informal and formal care, so children in grandparent or kinship care also have opportunities for early childhood education and development

2.10 Support informal carers to strengthen care quality and value their contribution

Why it's needed

Grandparents and kinship carers provide essential care but receive little support or training. Stakeholders highlighted the need for practical skills such as first aid, child development knowledge and disability awareness to improve safety and quality of care for children and vulnerable people.[88] Without training, carers may feel underprepared and undervalued.

What it will take

- Develop short training modules tailored to grandparents and kinship carers
- Provide free or subsidised access through TAFE or community colleges
- Create a simple accreditation or certificate system to formally recognise skills.

2.11 Make volunteering attractive, social and non-exploitative

Why it's needed

A positive and enjoyable volunteer experience is essential to attract and retain people in the care economy. Younger generations are more likely to volunteer if it feels social, fun and purposeful rather than simply unpaid work or résumé-building. Creating opportunities for connection and enjoyment can help overcome cost-of-living and time pressures. At the same time, volunteering must remain safe and ethical; when it is used as 'free labour' to replace paid staff or deliver core public services without support, it undermines both quality and retention.

What it will take

- Incorporate social elements within volunteering opportunities, e.g. group activities, shared meals, or post-activity gatherings, to maximise the time value of volunteers
- Use contemporary outreach channels and platforms (social media, Humanitix, Eventbrite, Meetup) rather than relying solely on organisational websites to increase visibility and reach of a volunteering opportunity
- Ensure volunteering remains safe and ethical by putting in place adequate supervision, insurance and clear guidelines that prevent volunteers from being used as substitutes for paid staff.
- Design meaningful, well-defined roles that align with volunteers' skills and aspirations, and clearly communicate how their contributions deliver tangible outcomes for the organisation and community to reinforce their sense of impact.

2.12 Pilot innovative volunteering solutions such as 'time banks', to strengthen reciprocity and reduce shortages

Why it's needed

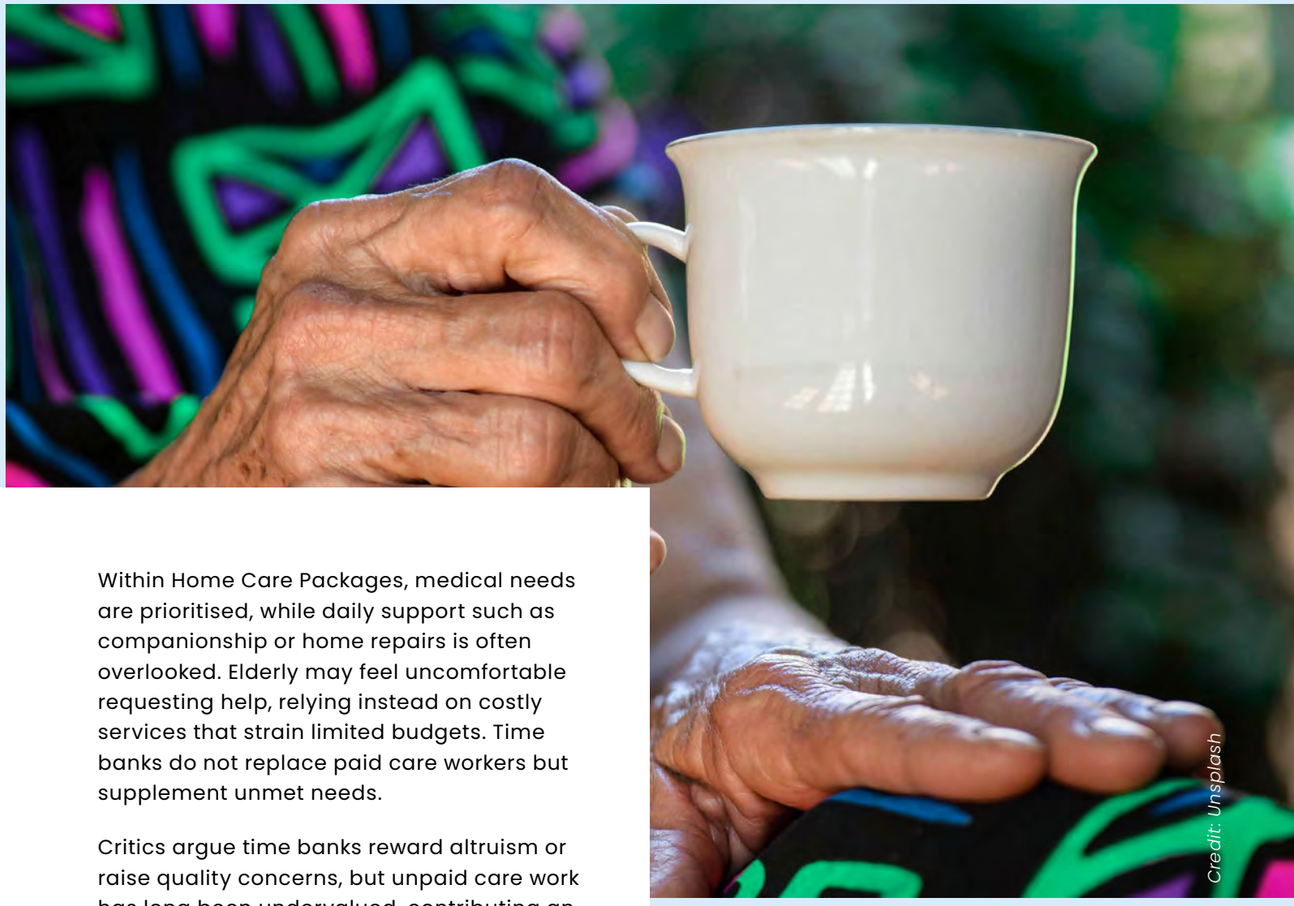
A time bank is a system where volunteers earn credits for providing practical support, which they can later redeem for services themselves or gift to family. While applicable across sectors, it is particularly useful in aged care.

Within Home Care Packages, medical needs are prioritised, while daily support such as companionship or home repairs is often overlooked. Elderly may feel uncomfortable requesting help, relying instead on costly services that strain limited budgets. Time banks do not replace paid care workers but supplement unmet needs.

Critics argue time banks reward altruism or raise quality concerns, but unpaid care work has long been undervalued, contributing an estimated $650.1 billion to the Australian economy. Evidence also shows that volunteers do not compromise care quality. When well-designed, time banks build social capital, foster reciprocity, and give younger volunteers a stake in their future care.

What it will take

- Pilot time-credit models for community and aged-care volunteering in Australia
- Partner with local governments, aged-care providers and multicultural organisations to co-design programs
- Evaluate outcomes to ensure that credits improve volunteer retention without undermining altruism or quality of care



Credit: Unsplash

CASE STUDY:

Time Bank schemes enrich elderly care choices in China

Summary

- The time bank scheme was first piloted in Nanjing in 2019 and later expanded to multiple cities, including Beijing.
- A mobile app facilitates interaction: elderly people or their families can request services, while volunteers can showcase the skills and services they offer. This provides a diverse range of options to suit different needs.
- Scheme awards volunteers one "coin" per hour of elderly care, coins can be redeemed after age 60 or gifted to ageing relatives, with 10,000 coins securing a place in a state-run care facility.
- Limitations include overcoming traditional expectations that elderly care should be provided by family, establishing a unified information exchange platform, and securing supportive policies and funding.

Why it's important

- Volunteers provide everyday support that is often overlooked but essential for seniors' daily lives, helping to reduce financial and emotional strain.
- The program also strengthens community connections and fosters intergenerational social ties.

Source: China Global Television Network (CGTN), 202389

Make it simple for everyone to get the care they need

Trying to access care too often feels like being stuck on a roundabout, going in circles, passed from one service to another, and never quite reaching the right destination. Families, older people and people with disability face multiple portals, long wait times and inconsistent information that make it stressful and confusing to access the care they need. Without reform, vulnerable groups in particular, will continue to fall through the cracks, with children missing early learning opportunities, older people missing preventative healthcare and carers missing the respite and support the need. Making it simple for everyone means building clear entry points, embedding trusted navigators within neighbourhoods, and ensuring services are truly accessible, culturally appropriate and easy to use.

Fund and embed local system navigators

Sydney's care system is complex, fragmented and difficult to navigate. For many people, the biggest challenge is not cost, but knowing where to go, whose advice to trust and how to access services. Creating a 'no-wrong-door' approach, backed by local navigators who are trained in disability support and intersectionality, within trusted community spaces, will help people find the right support, with less stress.

3.1 Place trained navigators in every community to guide people through aged care, disability, childcare, and health systems

Why it's needed

Many families, older people and people with disability struggle to navigate care services. Multiple portals and providers mean people are passed between services without getting the help they need. Migrant families often rely on informal networks, while others who may speak English as a second language, or have low levels of digital literacy struggle to access government channels.[90] Providing an in-person service in familiar, low-stigma settings helps to both build trust, as well as increase accessibility, especially for people with low digital literacy.

What it will take

- Secure long-term funding for local navigator roles, not short-term pilots.
- Embed navigators in trusted community spaces like libraries, councils, health precincts and First Nations organisations.
- Train navigators in cultural competency, disability and intersectionality to support diverse needs.
- Link navigators to government portals and data systems to reduce duplication and ensure people aren't bounced between services.

CASE STUDY:

Local navigators to support communities, Waterloo

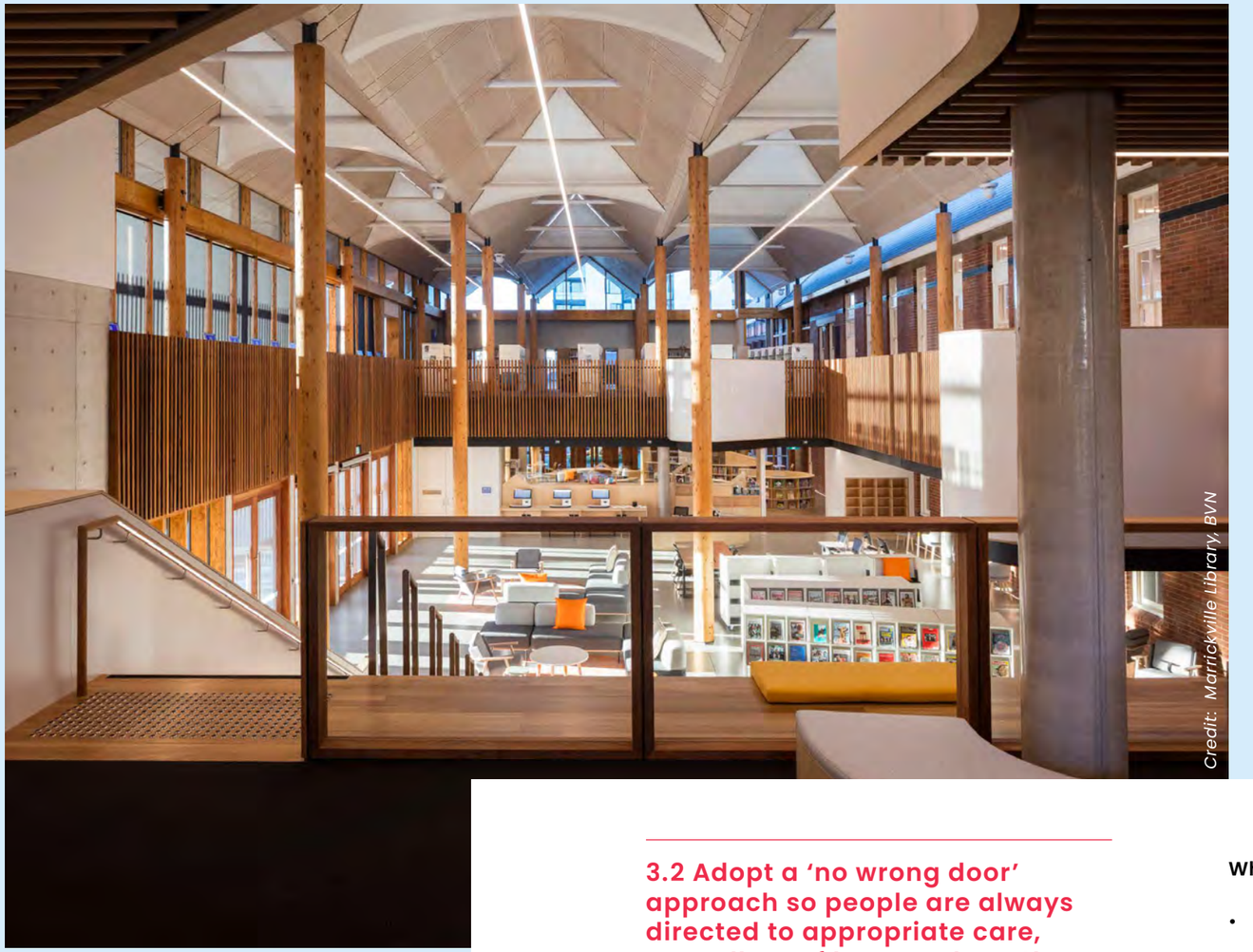
Summary

In Waterloo, a peer education model has been used to help local residents navigate housing, health and social services. Trained community members act as trusted guides, helping neighbours who may face language barriers, low digital literacy or a lack of confidence in dealing with government systems. By being embedded in familiar spaces and grounded in local relationships, the peer educators reduce stress, cut through confusion and ensure people can actually access the services they are entitled to.

Why it's important

The Waterloo example shows how local navigators can make a tangible difference. Parents are supported to enrol their children in early learning, older residents are linked with preventative health checks before conditions escalate, and carers are connected with respite services they might otherwise miss. By turning fragmented systems into a clear entry point, peer educators demonstrate how trusted, local guidance can prevent people from slipping through the cracks.

Source: https://waterloo2017.com/peer-educators/



Credit: Marrickville Library, BVN

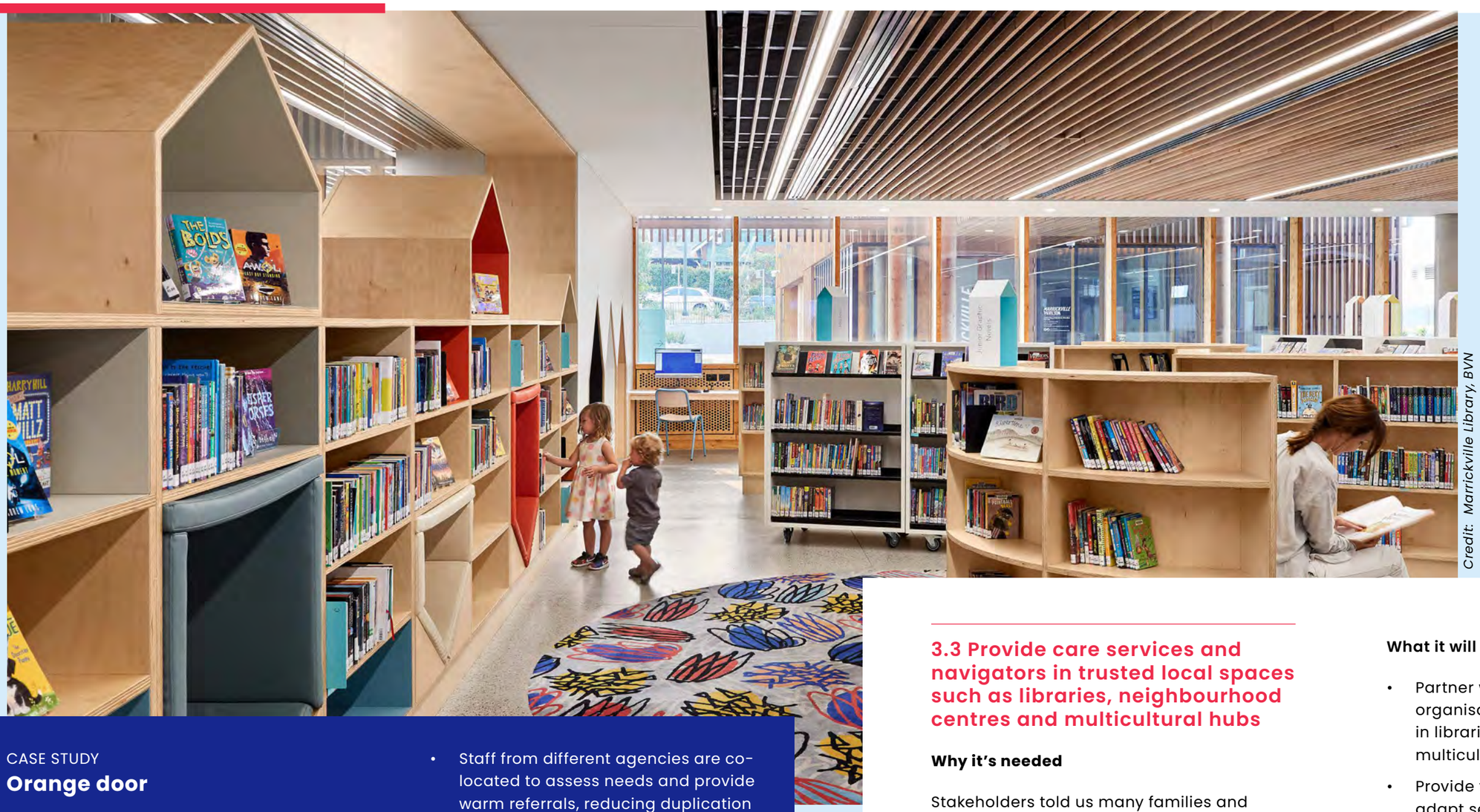
3.2 Adopt a 'no wrong door' approach so people are always directed to appropriate care, regardless of how or where they seek help without being passed around or retraumatised.

Why it's needed

Being passed repeatedly between services was described as exhausting and sometimes traumatic. A single portal will not work for everyone, particularly people with complex needs or cultural barriers. A 'no wrong door' approach means multiple entry points, but with consistent referrals so people only have to tell their story once. This reduces stress and prevents vulnerable people from falling through the cracks.

What it will take

- Replace fragmented portals with an integrated "no wrong door" framework that connects aged care, disability, childcare and health services
- Establish protocols so frontline staff and navigators can make warm referrals to the right service
- Invest in training for call centres, frontline workers and digital platforms to provide consistent information
- Learn from Victoria's *Orange Door* family violence model to design a coordinated system for care navigation.



Credit: Marrickville Library, BVN

CASE STUDY

Orange door

Summary

- Orange Door improves efficiency by connecting siloed services into a coordinated pathway and prevents people from being passed around and retraumatised
- A statewide 'no wrong door' model that provides multiple entry points – phone, online and local hubs – into family violence and child wellbeing services
- Staff from different agencies are co-located to assess needs and provide warm referrals, reducing duplication and stress.

Why it's important

- Shows how multiple entry points can still lead to a consistent, coordinated pathway
- Demonstrates a scalable precedent for Sydney to adapt in aged care, disability and childcare navigation.

Source: https://www.vic.gov.au/research-evaluation-orange-door

3.3 Provide care services and navigators in trusted local spaces such as libraries, neighbourhood centres and multicultural hubs

Why it's needed

Stakeholders told us many families and carers avoid formal government offices because they feel intimidating or unwelcoming. Migrant and multicultural communities, in particular, rely on familiar community spaces where they already feel trust. At the same time, many people with low digital literacy or limited English struggle with online portals like MyGov and the NDIS, leaving them without access to vital support. Locating services in everyday spaces, and ensuring in-person assistance is available in multiple languages, reduces stigma, and makes it easier for people to get help close to home.

What it will take

- Partner with councils and community organisations to co-locate care services in libraries, neighbourhood centres and multicultural hubs
- Provide flexible funding so local hubs can adapt services to community needs
- Train staff in cultural competency and provide support in community languages
- Scale proven models such as *Lifeline Connect*, which delivers free, low-stigma mental health consultations from local libraries in community languages.

Credit: Lifeline Connect, North Sydney Council

CASE STUDY

Lifeline connect in local libraries

Summary

- Lifeline Connect operates from local libraries, offering free, low-stigma mental health consultations in community languages
- The familiar, trusted environment has proven effective in breaking down stigma and encouraging people to seek help.

Why it's important

- Shows how care services embedded in everyday spaces can improve access and uptake, and demonstrates the value of libraries and community hubs as low-barrier points of access for diverse communities.

Source: Lifeline

Improve childcare accessibility by breaking down barriers to use

One in ten children in Australia miss out on early learning opportunities due to barriers beyond cost - including distance, hours of operation, transport and cultural appropriateness. Expanding access across these dimensions is critical to ensure all children benefit, particularly those from low-income, migrant and disadvantaged families.

Improved access requires both the provision of additional facilities and action to remove the barriers that prevent families from using them - from spatial and transport challenges to cultural stigma or inflexible service models. It is also important to emphasise that early childhood education and care is not simply a place for children to go while parents work. It is critical for children's learning, development and wellbeing, especially in the first 1,000 days of life.

3.4 Ensure Early Childhood Education and Care is provided in major health and innovation precincts

Why it's needed

Major hospital and innovation precincts are among the largest employment hubs in Sydney. The health sector is highly feminised, with many workers balancing shift work and caring responsibilities, while innovation and tech sectors often struggle with the opposite problem – a lack of gender equity in the workforce. A 2022 report found that women account for 43% of jobs in Med Tech, 34% in Advanced Manufacturing and 25% in Digital Technology.[91] Yet both face the same barrier: limited access to early childhood education and care in and around these precincts. Without convenient, high-quality childcare, health workers are forced to cut back hours or leave the workforce, and innovation districts miss an opportunity to attract and retain more women. Embedding ECEC into precincts would relieve pressure on essential workers while also supporting gender diversity in Sydney's globally competitive innovation economy.

What it will take

- Integrate ECEC facilities in the planning and development of major hospital and innovation precincts
- Provide incentives to co-locate childcare within or adjacent to health facilities
- Partner with health districts, universities, and childcare providers to deliver precinct-based models of care
- Explore funding models that ensure affordability for essential workers, including subsidies or prioritised access for precinct employees

3.5 Pilot 24/7 childcare in hospital and health precincts to meet the needs of health care shift workers

Why it's needed

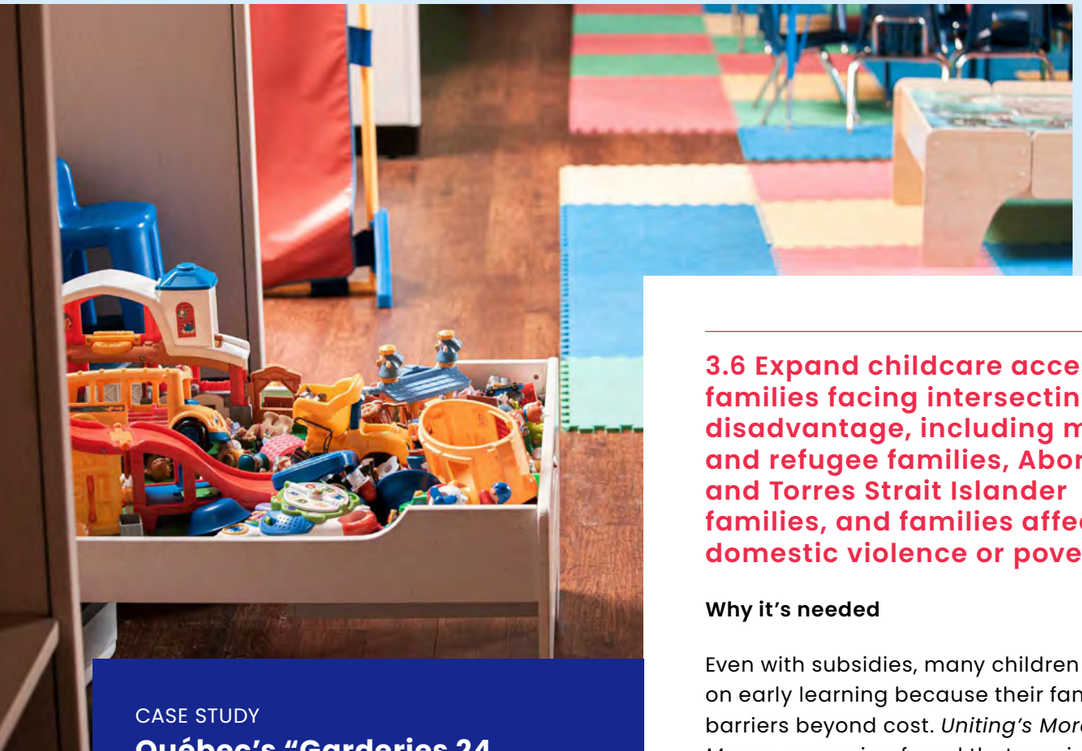
Care and health workers often work nights, weekends and unpredictable rosters, yet childcare services are typically only available during standard hours. This mismatch forces many workers, particularly women, to cut back hours or leave the workforce. Evidence from Canada and Scandinavia shows that 24/7 childcare services located in or near hospitals improve staff retention and support women's participation in essential services.[92]

At the same time, any move towards extended-hours ECEC must carefully consider the workforce that delivers it. Educators are themselves a predominantly female workforce, many with their own caring responsibilities. Their wages, conditions and wellbeing must be protected, and children's developmental and educational needs safeguarded.

What it will take

- Pilot 24/7 ECEC centres in major hospital and health precincts, co-designed with educators and families
- Partner with state health, hospital operators, childcare providers and unions such as UWU to ensure fair wages, conditions and rostering for educators
- Design models that align with health shift patterns while supporting children's developmental needs
- Evaluate pilot outcomes with equal weight on workforce, child development and family participation impacts, to inform wider rollout across Sydney precincts

Credit: 24-Hour Teabreak, artist-led community engagement project as part of the Randwick Health & Innovation Precinct implementation of the Safer Cities Program funded by Transport for NSW



CASE STUDY

Québec's "Garderies 24 heures" (24-hour childcare)

Summary

- Québec funds a limited number of 24-hour childcare centres to support parents working non-standard hours, including health and emergency services staff
- These centres operate evenings, nights and weekends, with staffing models tailored to shift work.

Why it's important

- Shows flexible, 24/7 childcare can be delivered in practice
- Provides a tested international precedent Sydney could adapt in hospital precincts.

Source: Government of Québec (2023), Childcare Services: Garderies 24 heures.

3.6 Expand childcare access for families facing intersecting disadvantage, including migrant and refugee families, Aboriginal and Torres Strait Islander families, and families affected by domestic violence or poverty

Why it's needed

Even with subsidies, many children miss out on early learning because their families face barriers beyond cost. *Uniting's More than Money* campaign found that one in ten children will miss out due to systemic challenges such as transport difficulties, lack of flexible hours, cultural inappropriateness of services, and family stressors like domestic violence.[93] Stakeholders also highlighted that migrant and First Nations families in particular need services delivered in familiar, culturally safe environments. In some migrant communities, stigma or distrust of formal childcare prevents families from enrolling children, underscoring the need for proactive education on the developmental and social benefits of early learning.

What it will take

- Partner with Aboriginal, multicultural and family violence organisations to co-design services
- Foster collaboration between services, as demonstrated by the *Fairfield Child and Family Interagency*.
- Fund flexible, culturally appropriate childcare models, including mobile services and extended hours
- Recruit and support educators who reflect the cultural and linguistic backgrounds of local communities

Support intersectional needs in care

Sydney's care system must work for everyone. Groups such as LGBTQI+ elders, young carers, migrant families and Aboriginal and Torres Strait Islander peoples face unique barriers, making inclusive design essential to ensure dignity and equity in care.

3.7 Ensure LGBTQI+ elders can age with dignity through inclusive aged care

Why it's needed

- Many LGBTQI+ elders go back "into the closet" in residential aged care because they fear discrimination from staff or other residents. This erasure leads to isolation, poorer mental health, and delays in seeking help.
- Current visitation and decision-making rules often prioritise biological relatives, leaving chosen families - friends, partners, or community members - without recognition. This risks older LGBTQI+ people being left without advocates in moments of need.
- Data collections in aged care rarely capture LGBTQI+ identities or experiences. Without visibility in official statistics, policymakers and providers are unable to identify or respond to real needs, leaving LGBTQI+ elders effectively invisible in the system.
- Workforce training rarely includes cultural safety for LGBTQI+ elders, leaving staff without the skills or confidence to provide inclusive, respectful care. This results in inconsistent practice across the sector.

What it will take

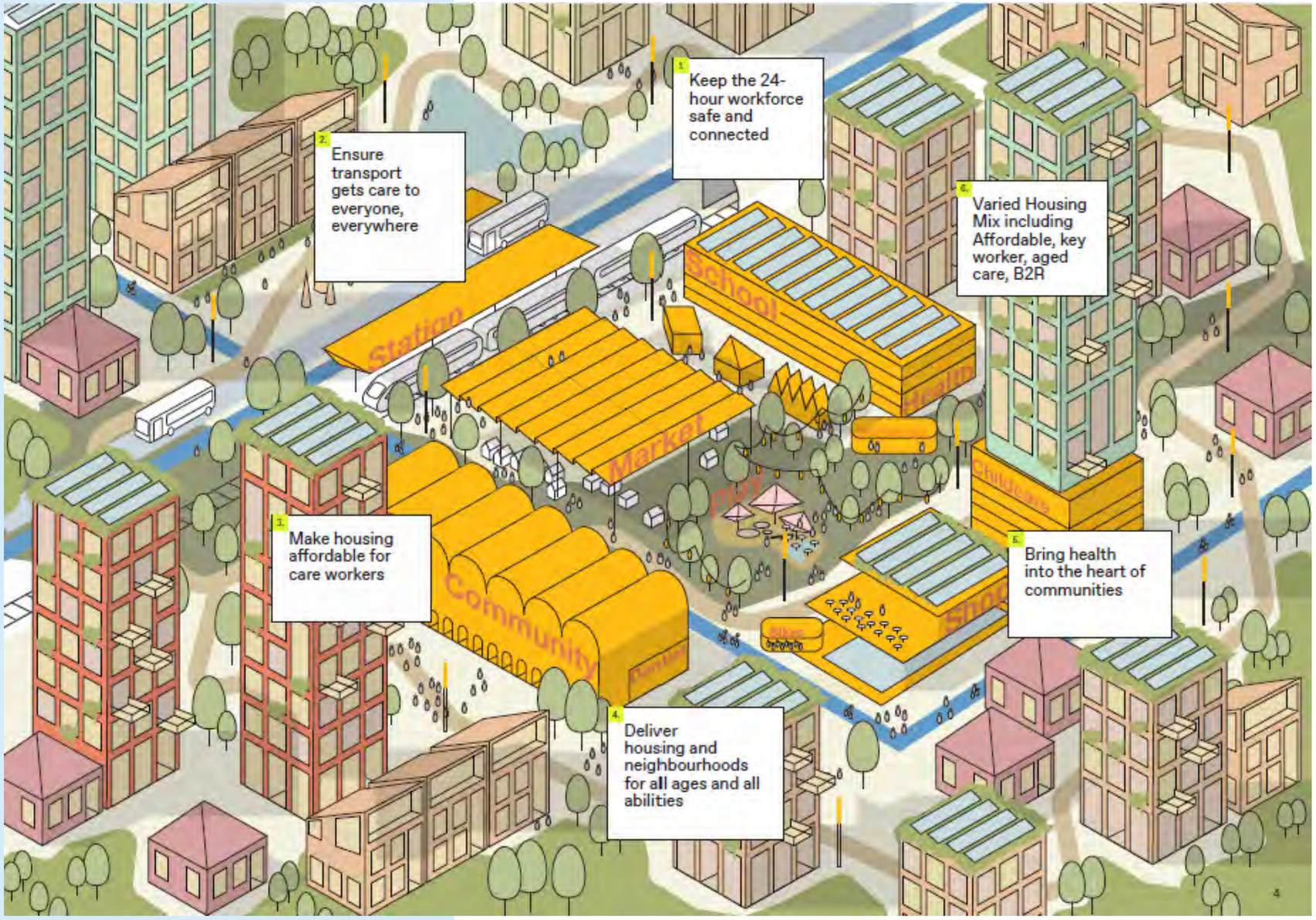
- Embed LGBTQI+ cultural safety as a mandatory component of aged care workforce training, ensuring staff at all levels can deliver inclusive, respectful care.
- Reform visitation and decision-making frameworks to recognise chosen families alongside biological relatives, ensuring no LGBTQI+ elder is left without an advocate.
- Introduce consistent national standards for collecting and reporting on LGBTQI+ identities and experiences in aged care data, to make needs visible and guide evidence-based reform.
- Support the scaling of peer-led education and inclusion initiatives across the aged care sector, creating consistent pathways to safe, affirming care.

4. Make cities places that enable care and connection

The design of our cities – from transport to housing to neighbourhood services – directly shapes whether care is accessible, inclusive and sustainable. Long commutes, unaffordable housing and poorly designed neighbourhoods make it harder for care workers to stay in the sector and for families to get the care they need. Creating cities that enable care means transport systems that serve shift workers, safe public spaces at all hours, affordable housing close to jobs, and embedding health and social infrastructure into everyday communities.

Ensure transport gets care to everyone, everywhere

Transport is a key barrier to attracting and retaining the care workforce. Staff often face long commutes, expensive or limited parking, and unsafe conditions when travelling at night. Public transport is built around white-collar commuting hours, leaving shift workers stranded. To keep the workforce moving, we need targeted subsidies, flexible services and safer, family-friendly transport options.



Source: BVN for Committee for Sydney

Credit: Cycling Without Age

4.1 Guarantee safe and reliable transport for care workers beyond the 9-to-5 extended hours, on-demand services, and workplace or community shuttles

Why it's needed

Care work doesn't run on office hours, yet most transport networks still do. Nurses, aged care staff, disability support workers and cleaners often travel late at night, early in the morning or on weekends when public transport is infrequent or feels unsafe. In outer-suburban and regional areas, limited fixed-route services leave workers and care recipients isolated, while congested precincts push providers to rely on costly company cars. Without better options, many workers face long commutes, unsafe conditions, or simply leave the sector. More research and consultation needs to happen with care workers themselves to better understand how transport can better service them across all shifts.

What it will take

- Extend evening, overnight, and weekend services to major hospitals, aged care clusters and disability hubs – start by focusing on a major health precinct like Liverpool or Randwick to engage workers what their transport challenges are and co-design, trial and pilot solutions that meet their needs. If successful, this approach can be rolled out to other precincts.
- Pilot workplace-based shuttle services in major health precincts, supported through partnerships between providers, councils, and government
- Invest in safe, well-lit interchanges and secure waiting areas near hospitals and care facilities
- Provide incentives for pooled and sustainable transport options, reducing reliance on individual cars, particularly for visitors to health precincts so that more parking can be freed up for staffs.

4.2 Adapt buses, trains, stations, car share networks and active transport routes so carers and care workers can travel safely, easily and with their dependants

Why it's needed

For paid care workers: many shifts fall outside standard commuting hours, yet public transport options at night or early morning are infrequent, poorly connected or feel unsafe. Care workers often move between multiple clients in a day, carrying equipment and needing to travel efficiently. Inadequate services and unsafe active transport routes force many into costly car travel, adding financial strain to already low-paid roles.

For unpaid carers: family and friend carers often travel with dependents that can include prams, mobility aids or children, and struggle with steep bus steps, narrow station entries, limited lifts or missing footpaths. These barriers make everyday trips to school, medical appointments or community services stressful or even impossible.

Both groups need a transport system that is safe, affordable, and accessible, but their challenges are distinct: care workers need reliable, safe transport across variable hours and locations, while unpaid carers need family-friendly design that accommodates dependents and mobility needs. Without reform, both groups are left with long, unsafe or unaffordable journeys.

What it will take

- Ensure all new service planning includes family-friendly design and the input of parents, carers, workers and people with disability, so services reflect real trip patterns and everyday needs.
- Integrate shared mobility (Carshare, Micromobility) into Public Transport to enable "trip chaining" and accessibility beyond the station giving care workers affordable, first and last mile alternatives to car trips.
- Trial shared cargo bike and e-bike services near schools, shops, childcare centres and health precincts to give families affordable alternatives to car trips for first and last mile trips.
- Ensure safety features – such as lighting, sheltered waiting areas and staff presence -make travelling with children or dependents feel secure and autonomous.
- Make it safe and simple for children to walk to and from school autonomously.

Credit: Unsplash

CASE STUDY:

Umea, Sweden cargo bike share

Summary

In Umeå, Sweden, the city has introduced a cargo bike sharing scheme that allows residents and workers to borrow heavy-duty e-bikes capable of carrying children, shopping, or equipment. Bikes are stationed across the city for easy pick-up and drop-off, offering a practical and affordable alternative to car trips.

Why it's important

For carers, the scheme helps solve the "last mile" problem, making it easier to travel between clients without relying on taxis or private vehicles. Families can also avoid the cost of owning a second car, easing financial pressure. More broadly, the program shows how shared mobility can support the care economy while advancing climate and liveability goals.

4.3 Give carers and older people dignity in street crossings by providing barrier-free access and extending pedestrian signal times to reflect real walking speeds of older people, people with disability and parents with prams

Why it's needed

Current signal times are calibrated for a tall, able-bodied adult, disadvantaging older people, carers with prams, and anyone moving with reduced mobility. This forces many to rush or risk being stranded mid-crossing, undermining safety and dignity. Research in Vienna highlighted how standard signals allowed just eight seconds to cross, yet real users needed three-to-four times longer. A mother with a pram averaged 26 seconds and an older woman 32 seconds. Recognising this inequity was a turning point for Vienna and many other age-friendly cities like Tokyo and Barcelona, which have all reset crossing times as part of a broader movement to make streets barrier-free and inclusive.

But crossing times are only part of the problem. Many streets in Sydney are simply not designed for prams, wheelchairs or mobility devices – with narrow footpaths, steep kerbs, or missing curb cuts making crossings unsafe or impossible. Without sustained council investment in basic road and footpath maintenance, families, carers and people with disability are effectively excluded from safe street use.

What it will take

- Audit crossing times across health precincts, public transport hubs, high streets and school zones to reflect real user needs
- Adopt international best practice pedestrian speeds (0.8 m/s, not 1.2 m/s) as the design standard
- Prioritise changes where high numbers of older people, carers and people with disability walk
- Encourage and resource councils to upgrade crossings and footpaths, ensuring safe curb cuts for prams and wheelchairs
- Embed equity principles into transport design guidelines to ensure future signal settings are inclusive by default.

4.4 Design family- and child-friendly transport routes and infrastructure in high-density neighbourhoods

Why it's needed

Families with young children and carers often face unique barriers when travelling around the city. Care work typically involves "trip-chaining" combining multiple journeys such as school drop-offs, medical appointments, grocery shopping and paid work. Women, who shoulder the majority of caring responsibilities, are disproportionately affected when transport and public spaces are not designed with care in mind. Neighbourhoods that prioritise child-friendly routes connecting schools, childcare centres, libraries and playgrounds, and provide essential care infrastructure like accessible footpaths, rest stops, public toilets, and change and feeding amenities, make these daily journeys safer, more efficient and less stressful.[94]

What it will take

- Prioritise the design of child- and carer-friendly travel routes that safely connect schools, childcare centres, playgrounds, health services and community facilities
- Incorporate care infrastructure into transport and street upgrades, including accessible footpaths, curb cuts, rest stops, public toilets, change/feeding amenities and water fountains
- Embed care-sensitive planning principles into precinct and transport strategies to reflect the realities of trip-chaining, particularly for women and carers balancing multiple daily journeys
- Partner with local councils, health districts and community organisations to co-design solutions that reflect lived experience of carers and families

4.5 Make care work and women's travel visible in the transport data we collect

Why it's needed

Care responsibilities strongly shape how people move around Sydney, yet these patterns remain largely invisible in transport data. Women in particular experience a "spatial leash," with daily trip-chaining to schools, shops, health services and relatives limiting their mobility and access to jobs. Despite multiple requests, Transport for NSW has been unable to provide data on how care workers travel, indicating that these journeys are not informing transport decisions. Without robust, gender-disaggregated data, the invisible labour of care will continue to be overlooked in planning and investment.

What it will take

- Integrate care-related travel questions into the Household Travel Survey and ensure findings feed into the Future Transport Strategy.
- Require Transport for NSW to collect data intentionally across all modes to build a fuller picture of mobility beyond the 9–5 commuter.
- Enable *Opal Next Gen* to allow passengers to voluntarily share gender and limited demographic details, strengthening the dataset while protecting privacy.
- Require e-micro mobility providers to collect and share anonymised gender data through licensing and micro-reform, to better understand who uses these services and for what trips.
- Ensure care and gender-disaggregated transport data is made publicly available and freely accessible for researchers, councils and communities.
- Publish and use this information transparently to guide investment, so care-related journeys are valued and the "spatial leash" that limits women's participation is reduced.

Keep the 24-hour workforce safe and connected

Care is delivered around the clock, yet the city is not designed with a 24-hour workforce in mind. Gig economy and migrant workers, who often overlap with care shifts, are left without safe facilities or public infrastructure. Interviewees warned: *"We talk about a 24-hour economy, but forget the people who make it work."*

Credit: Transit Systems NSW

CASE STUDY:

Create dedicated spaces for night-time and gig workers

Summary

- A safe space for night workers with toilets, rest areas and visa support
- Provided social connection for migrant workers.

Why it's important

- Melbourne's Essential Worker Hub showed the value of small, low-cost hubs, although their closure due to funding highlighted fragility of support.

Source: gigworkers.org.au

Stakeholder interviews revealed how staff self-organise "walking buses" to the nearest free parking so they can feel safe walking 15–20 minutes to their cars. Others described deliberately paying higher parking fees or arranging informal lifts with colleagues. These coping strategies add time, cost and stress to workers already under pressure and expose a systemic failure to provide safe, basic infrastructure around some of Sydney's busiest health precincts.

What it will take

- Fund precinct-level upgrades: Prioritise Randwick, Westmead, RPA and other major health precincts in state budget allocations for lighting, footpaths and surveillance improvements
- Co-design safety audits with staff: Involve night-shift workers and carers in identifying unsafe routes and hotspots
- Apply a gender and equity lens: Health precinct planning must recognise the workforce is predominantly female and commuting late at night
- Integrate with transport and mobility services: Strengthen links between precincts and bus stops, cycleways, rideshare drop-off zones and secure bike storage, reducing reliance on private cars and unsafe walking routes

4.6 Deliver '24 hour break rooms' dedicated spaces where night-shift and gig care workers can rest, connect and access facilities

Why it's needed

Many night-shift and gig economy workers - including care staff — lack access to basic facilities such as toilets, seating or safe places to rest between jobs. This can make already demanding work more unsafe, isolating and exhausting. Small, low-cost hubs can provide dignity and practical support, while also creating spaces for connection and recognition of workers who keep the city running at night.

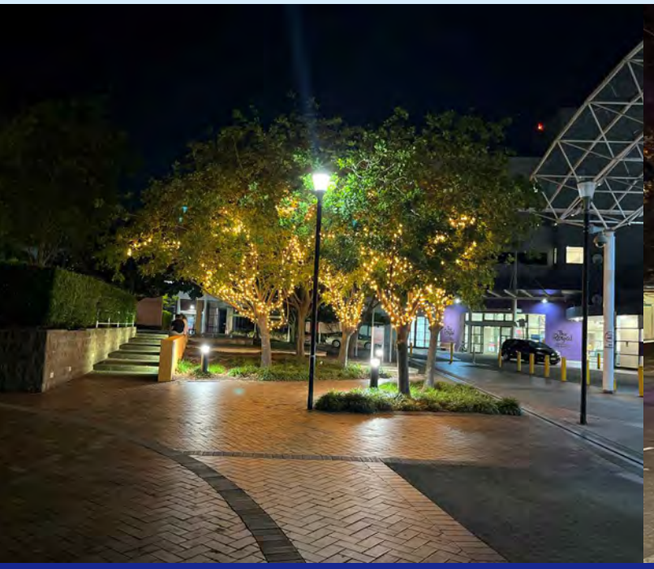
What it will take

- Partner with councils and local businesses to establish 'essential worker hubs' in areas with high concentrations of gig and care staff
- Repurpose empty shopfronts or other underused spaces as meanwhile uses, providing toilets, seating, charging stations, fresh fruit, and safe places to rest
- Integrate access to information and support services, including visa and legal advice for migrant workers
- Trial models in health and entertainment precincts with large night-time and gig economies, evaluating effectiveness for wider rollout

4.7 Improve night-time safety around major health precincts with better lighting, footpaths and wayfinding

Why it's needed

Care workers across Sydney's health precincts consistently described feeling unsafe walking home at night, often during or after long shift work. Missing footpaths, poor lighting and isolated streets were common concerns, particularly for women commuting after late shifts. These safety gaps deter staff from using public or active transport, and place an unfair burden on workers who already face high housing and transport costs.




CASE STUDY:

Designing a Safer, More Accessible Randwick Health Precinct

As 24/7 hubs for doctors, nurses, patients, and visitors, health precincts operate as an essential part of the physical landscape of a city's care economy. However, safety concerns can limit their use, particularly after dark. The NSW Safer Cities Survey Report found that 59% of women feel unsafe in public places at night, and 76% of people would use walk more if they felt safer in public spaces. With women making up the majority of Australia's healthcare workforce, designing spaces where they feel safe and welcome is essential for creating truly functional environments.

This isn't just about the absence of crime; it's about a person's feeling of safety, which influences how they move through a space, their productivity, and their overall sense of mobility. At the Randwick Health & Innovation Precinct (RHIP), we observed these challenges firsthand through co-design with the health workforce and surrounding community: footpaths were too narrow, the area was car-dominated, and there was a lack of clear wayfinding cues. The absence of public art or aesthetic lighting further contributed to the uninvitingness of the space, and security managers reported that when incidents occurred, people often struggled to describe their location.

To address this, Arup developed a comprehensive Nighttime Masterplan for RHIP. Funded by Transport for NSW's Safer Cities program, the plan was rooted in community insights, co-design workshops, and Crime Prevention Through Environmental Design (CPTED) principles. RHIP also used sensor data to analyse pedestrian movement, helping us understand how people actually navigate the precinct.

Key Interventions

We focused on three core strategies to make the precinct safer and more inviting:

- **Activating Spaces Through Art:** We collaborated with local artists like Rochelle Haley to create integrated lighting installations, transforming underused areas and green spaces into calming, nature-connected environments.
- **Improving Wayfinding:** We used lighting and art to create a distinct identity for different areas, making it easier for people to orient themselves. This included illuminating built structures, using reflective paint, and adding illuminated signage.
- **Upgrading Infrastructure:** In addition to new art installations, we upgraded existing lighting. A pilot on Francis Martin Drive not only improved visibility but also reduced energy use by 79%.

Measurable Outcomes

Through the Safer Cities program, RHIP implemented pilot projects to test the core strategies and evaluate their impact on perceptions of safety. The results of these community-led interventions were tangible:

- **48%** of co-design participants reported feeling unsafe at night **before** the project.
- **83%** of staff reported that the lighting interventions had improved their sense of nighttime safety and enjoyment.
- **100%** of participants felt safer using key entrances and walkways after the new installations were in place.
- **58%** of visitors changed their perception of the precinct after experiencing the new lighting and art.

Ultimately, these improvements led to a more positive and welcoming environment for patients, visitors, and the precinct's diverse workforce. By getting the fundamentals right and understanding site context and user needs from the outset, the RHIP Nighttime Masterplan has created a blueprint for designing healthcare precincts that are not only functional but also supportive and safe for everyone, day and night. This approach creates a better overall experience, which in turn helps support higher staff productivity, better retention, and positive long-term outcomes for the precinct.

Source: Arup

Pictured: Rochelle Haley, *Lunar Sway*, 2024

Sequence of six lighting sculptures with shifting composition of colour, light and shadow.

Commissioned by Randwick Health & Innovation Precinct as part of Transport for NSW Safer Cities Program.
Photo: Zan Wimberley. Courtesy the Artist

Make housing affordable for care workers

Housing costs are one of the biggest reasons care workers leave Sydney. As one stakeholder told us: *"We have nurses spending half their income on rent. It's not sustainable."* Providing affordable, stable and diverse housing close to jobs is critical to workforce retention.

The NSW Government's focus on housing supply is welcome. The State Government's densification reforms - the TOD Program, Low- and Mid-Rise Housing changes, and the Housing Delivery Authority's residential projects - represent a once-in-a-generation opportunity to establish a certain and sustainable pipeline of affordable housing. Sydney urgently needs hundreds of thousands of new homes to address a global-scale affordability crisis, and concentrating this supply in well-located areas will create communities better suited to care. Dense, modern housing near health and education hubs supports carers and those receiving care by improving access to public and active transport and co-locating essential services within walking distance.

Because Sydney's housing is overwhelmingly delivered by the private sector, alignment between profit and public value is essential. Increased density is one of the most effective ways to enable the inclusion of social, affordable and accessible housing within new developments.

The timing is urgent. The care crisis is projected to crescendo by 2041, just as the first wave of 15-year affordable rental housing is due to expire and return to the private market – a shift that risks worsening rather than easing shortages. Affordable housing in perpetuity is needed as long-term community infrastructure, ensuring carers are securely housed not only today, but over the next 40 years as demand for care grows.

4.8 Deliver affordable housing for care workers through a consistent, city-wide contributions framework

Why it's needed

Essential care workers need affordable homes in every part of Sydney, particularly in the east and north where demand for care is high and housing is least affordable. At present, affordable housing contributions are negotiated differently in each council area. This patchwork approach creates inconsistency, delays and uncertainty for developers and communities, and undermines the ability to scale delivery.

Rezonings and major housing supply opportunities also too often deliver little or no affordable housing, missing the chance to capture land value uplift for long-term community benefit. A clear, consistent, city-wide framework will provide certainty, reduce disputes, and ensure affordable homes are delivered close to jobs and services, where they are most needed.

What it will take

- Greater Sydney-wide inclusionary zoning standards: Establish a clear base rate of affordable housing contributions, with a pathway to increase over time (e.g. 1% rising to 5–10% depending on market conditions and land value uplift).
- Standardise Affordable Housing Contribution Schemes (AHCS): Require and support councils to adopt standard AHCSs so they can collect monetary contributions or in-kind dwellings – this avoids the loss of 'fractional' contributions and ensures smaller developments still contribute
- Monetary contributions and Distribution Plans: Direct monetary contributions through a standardised Distribution Plan, allocating funds to registered Tier 1 and 2 Community Housing Providers (CHPs), which can leverage them with government finance to grow supply
- Community Housing Provider ownership: Transfer ownership of affordable homes to CHPs rather than councils to reduce strata risks, unlock borrowing capacity and ensure long-term viability – evidence shows CHP ownership can deliver 21–27% more affordable dwellings over time compared to council ownership[95]
- Prioritising and favouring the delivery of affordable housing dedicated in perpetuity: note that it may be a better outcome to provide less affordable housing, but in perpetuity, than 15% affordable housing for 15 years.
- Monitoring and reporting: Introduce clear reporting requirements to track affordable housing stock unlocked by planning provisions aligned with the NSW Registrar of Community Housing. Routing data collections by DPHI and ABS would enable the mapping of affordable rental housing supply, demand analysis and an understanding of regional containment rates.
- Have a stronger commitment to delivering social and affordable housing on government land

4.9 Deliver diverse and affordable housing for care workers within or close to health and hospital precincts

Why it's needed

Care and hospital workers are among the most housing-stressed groups in Sydney. Many are priced out of areas close to their workplaces, forcing them into long commutes or unstable living arrangements. Hospital staff, in particular, need affordable, housing near health precincts, especially for shift workers and early-career staff. More broadly, care workers across aged care, disability and childcare sectors need diverse, affordable options that provide stability without requiring ownership. Without action, essential workers will continue to leave the sector or relocate further from the communities they serve.

What it will take

- Embed affordable and worker housing requirements in all new health and care precinct masterplans, including expanding models like Landcom's Joinery project.
- Deliver modular housing pilots on surplus hospital land or nearby government-owned sites to provide immediate housing for hospital workers.
- Review NSW Health and other care providers' land holdings for underutilised properties that could be converted to affordable worker housing, building on examples such as vacant properties near North Sydney hospital precincts.
- Incentivise diverse housing models – including mixed-tenure and build-to-rent – through tax and planning levers.

CASE STUDY

International precedents

- **UK National Health Service (NHS):** Many NHS Trusts provide subsidised on-site or nearby housing for nurses, junior doctors and other essential staff, recognising the importance of retaining workers in high-cost cities like London
- **Singapore's Public Housing Strategy:** By integrating affordable rental flats for healthcare and essential workers within public housing estates, Singapore ensures staff can live near hospitals and community care facilities
- **California's Essential Worker Housing Initiatives (USA):** State and city governments have partnered with developers to fast-track affordable, mixed-tenure housing projects near major hospitals, with rental discounts targeted to care and hospital staff.

CASE STUDY

The Joinery, Annandale by Landcom

Landcom's *Joinery* project is one of Sydney's first build-to-rent developments with a dedicated essential worker component.

- 280 apartments total
- 45% reserved for key workers such as nurses, teachers and paramedics, at rents below market
- Mix of studios to three-bedroom homes, with shared courtyards and community spaces

By reserving almost half the dwellings for essential workers, The Joinery shows how publicly backed BTR can keep frontline staff close to inner-city jobs, reducing commutes and transport costs. It provides a model for scaling affordable BTR as part of Sydney's housing and care strategy.

4.10 Enable care-related industry superannuation funds to invest in affordable housing for the benefit of their members, particularly build-to-rent models that provide both secure homes and long-term returns

Why it's needed

There are a number of industry super funds whose members comprise those working in the care sector, from health workers to teachers. Superannuation legislation requires that funds invest in the best financial interests of their members but often the best interests of members in the care sector is the investment of significant superannuation funds into dedicated housing to enable them to live affordably, securely and close to the work that contributes to the superfund itself.

Yet current investment guidance treats affordable housing as too risky or low-return, limiting the sector's ability to expand stock at scale. This is not about minor tweaks, but a fundamental rethink of superannuation legislation, investment rules and incentives. A rethink that recognises affordable housing as essential economic and social infrastructure.

At present, much of the investment in affordable and build-to-rent housing in Sydney comes from overseas pension funds, while Australian super funds face regulatory barriers to doing the same for their own members. Unlocking domestic superannuation capital would align member interests with investment outcomes, creating affordable homes for essential workers while delivering stable, long-term returns.

What it will take

- Overhaul federal superannuation investment guidance to recognise affordable housing as a core asset class, alongside traditional infrastructure
- Provide tax incentives, credit guarantees or risk-sharing mechanisms to make worker housing projects bankable
- Prioritise build-to-rent and mixed-tenure developments tailored to essential workers, ensuring affordability and long-term sustainability
- Foster partnerships between care-related industry super funds, community housing providers and government to deliver projects at scale.

4.11 Expand shared equity scheme pilots for essential workers

Why it's needed

Many essential care workers fall into the "missing middle", earning too much to qualify for social housing but not enough to buy a home in Sydney's market. Shared equity schemes can bridge this gap, reducing deposit hurdles and mortgage stress, and helping retain workers in critical roles.

What it will take

- Scale up state shared equity pilots with a dedicated stream for essential workers.
- Partner with community housing providers and super funds to co-invest and expand access.
- Prioritise housing near major health, education and care precincts to reduce commute times and support workforce retention.

Deliver housing and neighbourhoods for all ages and all abilities

Designing inclusive housing enables people to age in place, live with dignity and access care at home.

4.12 Embed accessibility and adaptability in housing and neighbourhood design to support families with children, ageing in place and lifelong independence

Why it's needed

As people age, their housing needs change, yet most homes in Australia are not designed to adapt. Retrofitting bathrooms, entrances or layouts is costly and often happens too late, forcing people into aged care earlier than necessary. Designing accessible and adaptable homes from the outset allows older Australians and people with disability to remain in their communities, sustain independence, and access care at home.

Neighbourhood design matters just as much as individual dwellings. Walkable streets, nearby shops, health services, transport and green space all reduce isolation and keep people active.

Globally, initiatives like Bogotá's *Care Blocks* show how co-locating childcare, elder care, health services, training and leisure within a 15-minute walk reduces the burden on carers, helps people stay in their homes for longer, and strengthens whole communities.[96] Designing neighbourhoods that support ageing in place benefits everyone from families with prams to people recovering from injury, by making cities more inclusive and liveable across the life course.

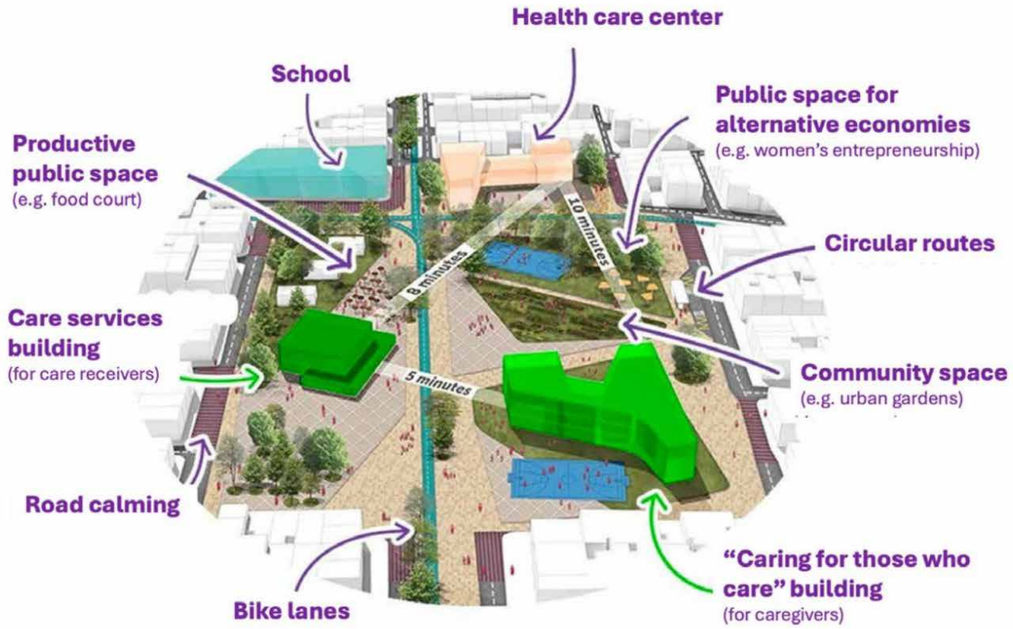
What it will take

Housing and building scale

- Enforce the Liveable Housing Design Standard consistently across all jurisdictions
- Require a share of new social housing projects to include adaptable layouts with space for live-in carers or visiting family support
- Incentivise developers to exceed minimum accessibility standards through fast-tracked approvals, density bonuses or funding programs
- Promote innovative models such as multigenerational housing, dual-key apartments and modular layouts that flex as needs change
- Provide communal and social spaces: Integrate shared play areas, flexible community rooms and social lobbies that encourage intergenerational connection and reduce isolation.
- Explore and pilot community lands trust models to provide options for care workers in retirement who don't own a home, but have some super assets which makes them ineligible for social housing.

Neighbourhood and precinct scale

- Embed universal and accessible design into masterplans, ensuring proximity to shops, healthcare, social infrastructure and public transport
- Deliver walkable, safe streetscapes with green space that support mobility, activity and social connection
- Prioritise co-location of housing with health, education and community services to reduce reliance on residential aged care
- Provide diverse play and rest opportunities: local and neighbourhood parks, nature play and caregiver-friendly infrastructure designed for all ages and abilities
- Ensure child- and age-friendly travel routes: safe, shaded, and accessible streets, with continuous footpaths, seating and wayfinding to support mobility for people of all ages.



(Manzanas del Cuidado), recognised internationally as a benchmark in designing cities around care. Each Care Block clusters services such as childcare, elder care, health, training, leisure and legal support in one neighbourhood hub, ensuring carers and those they support can access help within a 15–20 minute walk.

Key features

- Integrated services: While carers access training, wellbeing or employment programs, professional staff provide care for children, older adults or people with disability
- Universal design: Care Blocks feature safe streets, shaded walking routes, rest areas and accessible facilities that make daily life easier for all ages
- Impact: The model reduces caregiver stress, delays premature entry into residential aged care and fosters inclusive neighbourhoods where people remain active and connected throughout their lives.

Why it matters

Bogotá's approach shows how designing housing and neighbourhoods as care infrastructure can reduce pressure on families, promote equity and enable ageing in place. It demonstrates the value of embedding care into urban planning – lessons that can be adapted for Sydney's growth areas and established suburbs alike.

Source: https://www.weforum.org/stories/2024/04/future-of-care-economy-examples/

4.13 Increase supply of disability-specific and adaptable housing by expanding Independent Living Arrangements and alternatives to group homes

Why it's needed

Stakeholders consistently raised concerns that traditional group homes can be unsafe, disempowering and isolating for people with disability. Residents often have little control over daily routines, who they live with or the support they receive. By contrast, Independent Living Arrangements (ILAs) provide greater dignity, autonomy and choice. They enable people with disability to live in settings that feel like a home rather than an institution, while still receiving tailored support. ILAs and other housing alternatives also reduce social isolation by embedding people in the broader community. Meeting changing health and mobility needs through adaptable and disability-specific housing is critical to ensuring independence and rights across the life course.

What it will take

- Enable and align NDIS funding streams to support the scaling of ILAs and homeshare models, ensuring they are a viable alternative to traditional group homes
- Fund pilots and evaluate outcomes to identify the most effective models, with priority for those that improve safety, autonomy and inclusion
- Embed rights-based safeguards to ensure housing options protect dignity, prevent neglect or abuse, and promote genuine choice and control
- Expand supply of adaptable housing by requiring new developments to include a share of units designed to accommodate changing health and mobility needs

CASE STUDY:

Independent Living Arrangements (ILAs) – Alternative to group homes which offers more independence

Summary

Megan is an individual with intellectual disability, and her parents want her to have the chance to build independence by moving out of the family home. Until recently, the only path seemed to be a group home. That changed in 2020, when the National Disability Insurance Agency (NDIA) launched Individualised Living Options (ILOs), also known as Independent Living Arrangements (ILAs), giving people with disability the chance to design their own living situations. With support from this new funding stream, Megan found a shared rental in Melbourne's inner north and moved in with Isabel, a matched housemate.

Key features

- Co-designed support: Disability support organisation worked with Megan and her family to explore rental listings, secure ILO funding and plan her supports.
- Matched housemate model: Megan shares her home with Isabel, a carefully chosen housemate who provides companionship and informal support rather than being a paid worker; Milparinka covers Isabel's housing costs.
- Flexible, tailored assistance: Megan receives about 26 hours of support per week for prompting and daily tasks, while Isabel regularly checks in with Megan's ILO facilitator to keep arrangements on track.

Why it matters

This ILA shows how tailored support and shared living can help people with exercise choice and build a deeper connection with the community. It demonstrates a cost-effective and person-centered alternative to group homes.

Source: Living my best life, Story of Meghan - Summer Foundation

Bring health into the heart of communities

Care is not only delivered in hospitals – it happens every day in neighbourhoods right across Sydney. Stakeholders told us the absence of preventative and wraparound health supports forces families into emergency departments for issues that could be managed locally. Building integrated, community-based health hubs is essential for both patients and workers. Reintroducing wraparound services is not just about convenience it is a workforce strategy. In an industry facing high turnover, these supports would help level the playing field, foster stronger communities within precincts, and improve retention of staff across roles.

4.14 Provide neighbourhood-based health hubs to reduce hospital demand and boost preventative care

Why it's needed

Hospitals are costly and overstretched, yet families often have no alternative for non-emergency issues. Without accessible, affordable, community-based services, families are left to rely on overstretched hospitals as a 'catch-all' for care.

The absence of affordable and accessible community-based services forces patients into emergency departments, driving up costs and straining capacity. Stakeholders shared how this gap plays out in practice: one described an elderly parent being abruptly discharged from hospital, leaving the family scrambling to arrange transport and accommodation at short notice. Others highlighted that most GPs are closed or unaffordable on weekends, again pushing people into emergency care for conditions that could be managed locally. As one interviewee put it:

> **"We're so geared to a hospital being the perfect place to get care… but it's not an optimal use of results when you go to the hospital for everything."**

What it will take

- Fund and scale pilots: Establish health hubs co-located with community services, including allied health, mental health and social prescribing
- Ensure equity of access: Prioritise hubs in underserved communities and regional areas, where hospital access is limited
- Integrate funding models: Encourage Primary Health Networks, state health and local councils to jointly fund hubs
- Prevention focus: Embed programs like chronic disease management, women's health, mental health and early intervention services to reduce demand on hospitals
- Digital integration: Connect hubs to telehealth platforms and health records, so patients don't have to repeat their story at every service.

CASE STUDY

HealthOne Green Square

Summary

- HealthOne centres bring together GPs, community health, and allied health services in one place.
- At Green Square, HealthOne co-locates services like physiotherapy, child and family health, chronic disease management and mental health support.
- The hub model reduces the need for people to navigate multiple clinics or repeat their story to different providers.

Why it's important

- Families can access child and family health checks in the same place they see their GP.
- People with chronic conditions receive coordinated care, improving outcomes and reducing hospital admissions.
- Older residents and carers can connect with preventative and allied health services close to home.
- Co-locating services makes care simpler, more accessible, and easier to navigate, especially for those with complex needs.

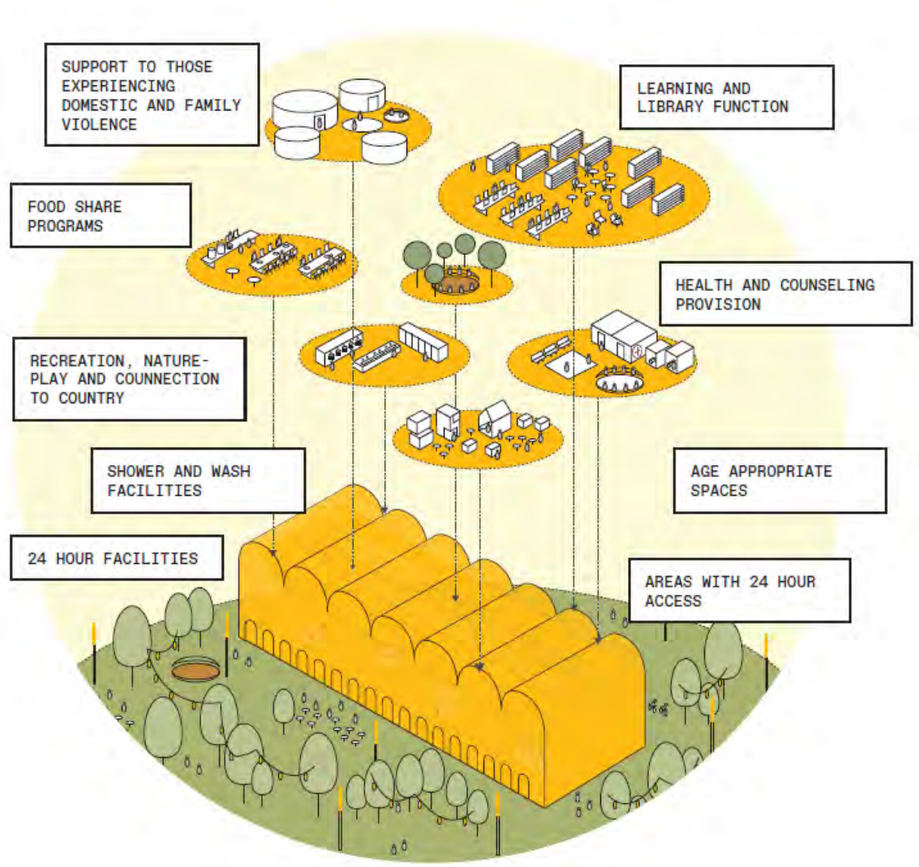
Source: RPA HealthOne Green Square

Imagine if we designed community facilities as care infrastructure?

Community facilities could evolve into vibrant neighbourhood hubs that bring together different forms of care and support in one place. Instead of being single-purpose, they can act as the social heart of the community — welcoming, inclusive and responsive to local needs.

A care-focused model might include safe spaces for people experiencing domestic or family violence, food share programs, and respite for the homeless. It could also offer shower and wash facilities, health and counselling services, childcare, recreation, and nature play.

By centralising these functions, community hubs can provide 24-hour access for key workers, spaces for connection, and opportunities for work and learning. Designed through a care lens, they become places of support and opportunity for all ages and life stages.



Source: BVN

5. Optimise tax settings and regulations for a productive, caring economy

Remove regulatory bottlenecks in aged care, childcare and disability services

The care sector is weighed down by overlapping rules, compliance burdens and excessive reporting that pull time and resources away from frontline care. Stakeholders consistently emphasised the need for simpler, clearer and faster processes to free workers and providers to focus on people, not paperwork.

5.1 Redesign aged care regulation to reward outcomes, not inputs

Why it's needed

Aged care providers face heavy compliance burdens, with duplicative reporting across safety, quality standards, staffing and workforce metrics. Current rigid rules such as mandated care minutes and restrictive pricing structures divert time and resources away from personalised care. Providers are forced to focus on ticking boxes rather than meeting the needs of older people. Stakeholders stressed that this undermines both quality of life and workforce morale and discourages innovation in the sector.

What it will take

- Consolidate duplicative reporting requirements across safety, workforce and quality standards while maintaining essential safeguards
- Review compliance rules, such as mandated care minutes, that restrict personalised and non-clinical care activities- give people choice regarding the dedicated care they receive i.e. do they need 40mins of clinical care everyday, or would they like support to do gardening, shopping or another activity.
- Redesign funding and reporting structures so providers are rewarded for outcomes that enhance dignity, autonomy and wellbeing alongside clinical care
- Build clearer, simpler regulatory roadmaps, so providers can understand and meet standards without unnecessary complexity.

5.2 Cut complexity in the Seniors SEPP to expand housing options for downsizers

Why it's needed

The Seniors Housing SEPP was designed to expand options for older people, but in practice its complexity makes it extremely difficult to find and deliver suitable sites. Providers report that "It's currently easier to get a brothel approved than seniors housing."

This barrier is holding back supply, leaving older people with limited alternatives to residential aged care or inappropriate housing.

Additionally, new planning bonuses and incentives like a 30% Floor Space Ratio and height bonus for market housing when providing 15% affordable housing is a positive step, but far outstrips the seniors housing bonus of 15–25%. The playing field must be levelled by increasing the seniors housing bonus to at least 30% bonus Floor Space Ratio and height where developments deliver 100% seniors housing in perpetuity.

At the same time, much of the seniors housing built in the 1960s and 1970s is no longer fit for purpose. Apartment blocks without lifts and other accessibility barriers fail to meet the needs of today's older population, yet cannot easily be converted to mainstream residential housing without triggering current Building Code of Australia requirements. This leaves large portions of older stock effectively stranded, neither suitable for seniors nor easily adaptable for broader use.

What it will take

- Increase the seniors housing bonus to at least a 30% Floor Space Ratio and height bonus for developments that deliver 100% seniors housing in perpetuity, to ensure a level playing field with other housing incentives.
- Reduce duplicative layers of assessment that discourage providers from bringing forward proposals
- Review existing seniors housing stock to assess suitability, and create pathways for renewal or adaptation without creating new regulatory dead ends
- Explore mechanisms to exchange or repurpose outdated seniors housing – for example, transferring older stock into the market or affordable housing sector when replaced with new seniors housing in more accessible, appropriate locations
- Ensure new models of seniors housing are integrated into health precincts and neighbourhood plans

5.3 Align regulatory settings across the care system to create a more cohesive regulatory environment across childcare, aged care and disability care

Why it's needed

Providers working across aged care, childcare and disability services face inconsistent definitions and compliance obligations, creating inefficiency and confusion. Terms such as 'qualified carer' or 'safe environment' vary by sector, making it harder for multi-service organisations to operate and discouraging innovation. This fragmentation raises costs without improving safety or quality.

What it will take

- Harmonise key definitions across aged care, childcare and disability regulation
- Develop a shared compliance framework for workforce qualifications and safety standards
- Establish a cross-sector taskforce to streamline regulatory design and remove duplication.

Reform tax settings to unlock housing mobility, boost fairness and fund care sustainably

Reforming Australia's tax settings is critical to securing both housing mobility and sustainable funding for care. Current arrangements too often lock older people into unsuitable housing, leave little incentive for investment in accessible homes, and fail to ensure that the growing wealth tied up in property contributes fairly to the cost of care. A more balanced approach can improve fairness across generations, unlock better housing options and provide a stable revenue base for care as demand rises with an ageing population.

5.4 Reform tax settings to unlock housing mobility and fund care fairly

Why it's needed

Older Australians often face financial disincentives to move into smaller, more suitable homes, while housing investment does not prioritise accessibility. At the same time, wealthier households contribute proportionally less to care funding, leaving lower-income families to carry the burden. Without reform, older people will remain stuck in unsuitable housing, essential worker housing will remain scarce, and care funding shortfalls will deepen as the population ages.

What it will take

- Introduce targeted stamp duty concessions and rollover relief for capital gains tax to encourage downsizing into accessible homes
- Offer specific investment allowances or concessional tax rates for housing designed to support ageing and care needs
- Limit the principal residence CGT exemption above a high-value threshold and adjust land tax rates on luxury holdings, with deferral options to protect cash flow
- Reform pension and care-related tax settings so they more accurately reflect real estate wealth and capacity to contribute
- Ringfence revenue from wealth or higher income taxes into a dedicated Care Fund to ensure resources keep pace with rising demand.

5.5 Establish a Care Investment Class to attract more long-term capital into care

Why it's needed

Australia's care infrastructure depends too heavily on short-term budget cycles, leaving services vulnerable to political shifts and unable to keep pace with rising demand. At the same time, superannuation funds and institutional investors are seeking stable, long-term assets that deliver social as well as financial returns. Without mechanisms to attract this capital, opportunities to expand housing and infrastructure for ageing, disability and childcare needs will continue to be missed. Public value created through rezoning or infrastructure uplift is also not systematically reinvested in care, despite the clear community need.

What it will take

- Establish a concessional tax regime for superannuation funds, insurers and not-for-profits investing in care-related housing and infrastructure
- Unlock institutional capital for worker housing in health precincts, aged care facilities and community-based services through a dedicated Care Investment Class
- Introduce social dividend models to capture value from rezoning, infrastructure uplift or natural resource rents and reinvest it directly into care services and workforce pipelines
- Ensure concessional investments and social dividends are transparently directed to expanding and improving care infrastructure.
- Explore alternative models of operation and service delivery

5.6 Expand co-operative and community-led models of care

Why it's needed

The dominant private provider model is under increasing strain, with many services struggling to remain financially viable. Smaller operators, particularly in regional areas, face mounting compliance costs that make it difficult to stay open. Co-operative and community-led models offer an alternative that can share resources, reduce costs and keep services local. These models also build stronger community ownership, improving accountability and resilience. Without targeted support, promising experiments will remain niche, and smaller services will continue to close.

What it will take

- Pilot co-operative and community-led care models in regions where market failure is most acute
- Provide start-up funding and legal support to establish co-operative governance structures
- Evaluate financial sustainability and community outcomes, and scale successful models nationally
- Enable co-operatives to access concessional capital through the Care Investment Class.


Source: caretogether.coop

CASE STUDY

Coleambally, NSW – Care Together Co-operative

Summary

A regional aged care provider in Coleambally established the Care Together Co-operative to pool governance and back-office functions across several facilities. By sharing resources, the model reduces costs that would otherwise force small providers to close, ensuring services remain available in rural areas.

Key features

- **Shared governance**: Collective oversight and pooled back-office functions reduce compliance and administration costs
- **Regional resilience**: The co-operative allows small, local facilities to remain viable where private operators might otherwise withdraw
- **Impact**: Facilities have stayed open, local jobs have been retained, and residents continue receiving care close to home.

Why it matters

The co-operative model shows how community-led governance can address market failure in regional care. It demonstrates that alternative ownership structures can stabilise services, preserve local employment and keep care embedded in communities.

CASE STUDY

HammondCare dementia cottages, Sydney

Summary

HammondCare has pioneered small-scale dementia care cottages in Sydney, designed to replicate home-like environments rather than institutional settings. The model prioritises autonomy, dignity and social connection for residents.

Key features

- Small-scale design: cottages house small groups of residents, creating a familiar, family-like environment
- Everyday activity: residents participate in gardening, cooking and socialising, restoring routine and purpose
- Impact: this approach improves wellbeing, reduces behavioural symptoms and provides more dignified living conditions compared to institutional models.

Why it matters

HammondCare demonstrates how design innovation can humanise aged care, shifting the focus from efficiency to quality of life. The model shows the benefits of embedding autonomy and social connection into care environments.

5.7 Support person-centred innovations in service delivery

Why it's needed

Rigid funding and regulatory structures discourage flexibility and innovation in how care is delivered. Too often, standards emphasise efficiency and clinical metrics over dignity, autonomy and social connection. International and local examples show that person-centred innovations, such as small-scale housing models, dementia-friendly design and culturally responsive environments, deliver better outcomes for both workers and clients. Without support for these approaches, the system risks continuing with institutional, one-size-fits-all models that undermine quality of life.

What it will take

- Embed flexibility in service standards so providers can balance safety with autonomy and dignity
- Fund and evaluate pilots that integrate cultural identity, community connection and non-clinical wellbeing
- Support providers to scale proven person-centred models through planning, funding and accreditation frameworks
- Share best practice nationally to encourage innovation and uptake across providers.

6. Use data, technology and innovation to strengthen the system

A modern care system cannot run on paper-based processes and delayed reporting. Technology, data and innovation are essential to strengthen quality and sustainability. By embedding digital tools, sharing real-time data and supporting innovation across the sector, care can be delivered more efficiently, consistently and sustainably.

Expand technological solutions in care

Technology can never replace the human side of care, but it can make the system work better for both workers and families. Smarter digital tools, from AI-enabled rostering to remote monitoring and tailored training platforms, can reduce paperwork, free up staff time and help families make informed decisions. By investing in technology that supports people rather than overwhelms them, Sydney can build a care system that is more efficient, more consistent and more focused on what matters: delivering care.

6.1 Expand the use of digital training and AI-enabled tools to operationalise care frameworks and translate legislation and standards into everyday practice

Why it's needed

As the new *Aged Care Act* is introduced, there is a need to ensure overarching directives are translated into practical, accessible tools for frontline staff. For example, the *National Palliative Care Standards (2024)* were introduced to guide best practice, but lacked a practical guide for aged care workers. Anglicare Sydney had to invest in its own Palliative Care Framework, which combines digital training and nurse support, to operationalise the standards. It is inefficient for each care provider to develop their own interpretation of what are intended to be standardised regulations. Without government-supported training, providers face high costs and staff are left without clear tools to deliver consistent care.[97] Using digital training will translate legislation and standards intro everyday practice across all care organisations, ultimately helping to improve the quality and consistency of care delivery.

What it will take

- Fund digital learning courses supported by AI decision-making tools
- Embed digital training into accreditation and compliance processes
- Scale cost-effective training models across providers.

6.2 Streamline operations and rostering

Support care services to adopt affordable AI rostering and workforce distribution systems that cut admin, reduce travel time and give staff more time to care.

Why it's needed

Stakeholders highlighted that staff spend too much time on rostering and admin. Larger providers use sophisticated CRM systems, but these are often too expensive for smaller organisations. Affordable AI solutions can streamline operations and improve workforce distribution. As one care worker put it: "Better care means spending more time actually caring for people, not on admin."[98] Using AI can help to improve efficiency by better matching workforce to demand. However, we should remain cautious: will this enhanced efficiency be used to maximise profits by packing more working hours into each worker's schedule, or to enable them to provide better care for recipients?.

Some providers noted that while small grants have been made available to support digital upgrades, these are insufficient against the scale of system-wide reform. Transitioning to new aged care standards will cost providers millions, with little dedicated funding to support this shift. A one-off grant, scaled by service volume and geographic reach, would provide the upfront capacity needed to implement affordable, efficient rostering systems across the sector.

What it will take

- Pilot AI rostering and workforce distribution systems
- Support shared workforce models to reduce duplication and travel times
- Develop predictive data models that match workforce supply to local demand.

6.3 Encourage investment in proven remote monitoring tools such as fall sensors, wearables and smart devices to improve safety, independence and care quality

Why it's needed

Older people remain at risk of preventable harms such as falls, poor nutrition and unmanaged chronic conditions. Remote monitoring can provide early alerts and reduce hospitalisations. Technologies under trial include fall detection pads, fridge sensors to track food access, and wearable devices such as Apple Watches. High-tech incontinence pads, although still maturing, may reduce unnecessary changes, cut waste and ease staffing pressures.

However, research shows that older adults often dislike wearing visible monitoring devices. Unobtrusive environmental sensors, such as floor-based systems that operate in the background, are generally more acceptable. Beyond the technology itself, a sociotechnical perspective is crucial: it is not enough to install a sensor or alarm. Clear service arrangements are needed for who responds when an alarm is triggered, how false alarms are managed, and how alerts are integrated into care workflows. Without this, technology risks creating more confusion than support.

While robots are unlikely to replace the need for human care, technology can play a powerful role in improving safety, prolonging independence, and enabling ageing in place. It can also cut waste and support environmental sustainability in high-waste settings like aged care.

What it will take

- Fund pilots of proven remote monitoring technologies
- Expand telehealth and wearable technology use across aged care
- Provide training and digital literacy for staff, clients and families.
- Remote monitoring tools should be co-designed with people with disability to avoid surveillance/disempowerment concerns.

Integrate and share data

Data is the backbone of a responsive care system, yet today's information is slow, fragmented and opaque. Providers often wait months for critical workforce and service data, making planning reactive rather than proactive. Families and carers are left in the dark about wait times or service availability.

Real-time dashboards and predictive tools could give providers visibility to recruit staff ahead of need, help government anticipate demand and give families clear information about what support is available and when. But from a sociotechnical perspective, complete integration of care data across sectors is extremely difficult and often unrealistic given the complexity of different systems and temporalities. The more practical focus is to strengthen the infrastructures that enable coordination, alignment and patchwork connections across services. Building these bridges can still unlock major improvements in planning, transparency and trust, without requiring a single, all-encompassing data system.

6.4 Create a real-time national dashboard to and predictive analytics tools to give providers visibility of home-care packages, improve planning and support families

Why it's needed

The rollout of new home care packages has been delayed, causing longer waitlists and leaving families and informal carers to fill critical gaps. Providers currently do not receive timely or geographically specific data on demand; instead, quarterly reports arrive three months late. This lack of visibility makes workforce planning reactive rather than proactive.[99] A national dashboard would enable providers to anticipate demand and recruit staff ahead of time, helping with the flow-on-effects of inadequate in-home care on the health system, and on family carers.

What it will take

- Federal Government to develop a national real-time dashboard tracking aged care assessments, approvals and allocations
- Publish a 12-month schedule of package releases to align with recruitment cycles
- Use predictive analytics to forecast workforce needs across regions.
- Include requirements to provide data disaggregation to enable equity focused responses and planning.

CASE STUDY:

National real-time dashboard for home-care packages

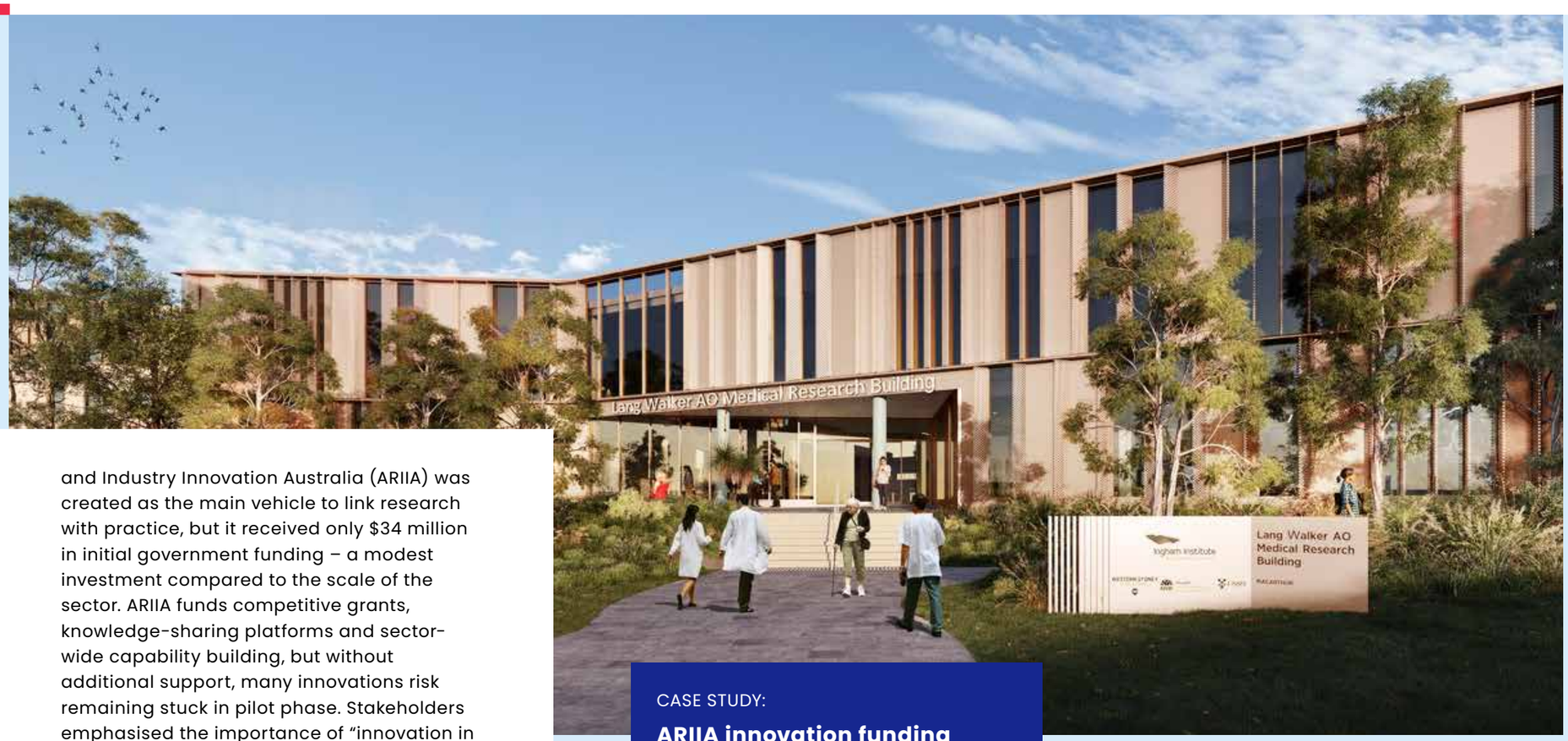
Summary

- Anglicare advocates for a live dashboard tracking demand and package allocation
- Would include provisional data on approvals, assessments and allocations.

Why it's important

- Allows providers to recruit ahead of need, not after the fact
- Shifts planning from reactive to proactive.

Source: *Anglicare*



Credit: Lang Walker AO Medical Research Building, BVN

Fund innovation and cross-sector collaboration

Innovation in care too often stalls at the pilot stage, with new ideas failing to spread beyond a handful of providers. Tight budgets mean small organisations cannot afford to experiment, while disconnected research risks producing solutions that never reach the frontline. By funding cross-sector partnerships and creating hubs that link providers, researchers and communities, Sydney can ensure innovation is practical, implementable and shared sector-wide. Innovation in service means instant implementation – tested, refined and embedded into everyday care.

6.5 Incentivise partnerships and innovation collaborations that connect providers, researchers and communities to test, scale and embed new solutions

Why it's needed

The Royal Commission into Aged Care Quality and Safety identified the need for stronger research and development in the sector, establishing two funds worth a combined $364 million. Aged Care Research and Industry Innovation Australia (ARIIA) was created as the main vehicle to link research with practice, but it received only $34 million in initial government funding – a modest investment compared to the scale of the sector. ARIIA funds competitive grants, knowledge-sharing platforms and sector-wide capability building, but without additional support, many innovations risk remaining stuck in pilot phase. Stakeholders emphasised the importance of "innovation in service" embedding research directly into care delivery with real-time feedback loops, rather than disconnected theoretical projects.[100]

What it will take

- Expand ARIIA and establish state-level innovation funds
- Create more innovation hubs linking providers, universities and communities
- Require results of publicly funded pilots to be made open access.
- Review the Research & Development Tax Incentive (RDTI) to explicitly reference care sector organisations and more directly incentivise enterprises to invest in R&D by rewarding industry collaboration with domestic research institutions

CASE STUDY:

ARIIA innovation funding

Summary

- In 2023, Anglicare, Wesley Mission and Western Sydney University piloted peer-led wellbeing networks across four independent living sites
- Networks reduced stigma, increased participation and built peer support capacity.

Why it's important

- Demonstrates how research tied to service delivery embeds into core practice
- Shows the value of partnerships in scaling new approaches.

Source: *Aged Care Research and Industry Innovation Australia (ARIIA),* ***Innovation Funding Program Overview*** *(2023).*

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- Residential aged care services
- Childcare services (ABS does not explicitly refer to ECEC as a separate category, however this does capture ECEC)
- Social assistance services (such as disability support and counselling)
- Hospitals
- Allied health services (dental, optometry, physiotherapy, chiropractic, etc.)
- Health care services (pathology, diagnostic imaging, etc.)
- Medical services (general practice, specialists, ambulance, etc.)
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Credit: Canberra Hospital, BVN

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