

People, pay and productivity

The economics of aged care

My contribution today

Practical economic tools for providers operating under constraint.

Economic context

Growth has returned, but inflation, wages and labour scarcity still shape provider choices.

Aged care context

Demand, regulation, funding and work structure create a capacity problem, not only a vacancy problem.

Provider tools

Measure labour capacity, map productivity leaks, redesign work and test technology against real constraints.

The economy today

Practical economic tools for providers operating under constraint.

GDP growth:
2.6%

Inflation (Perth):
4.6%

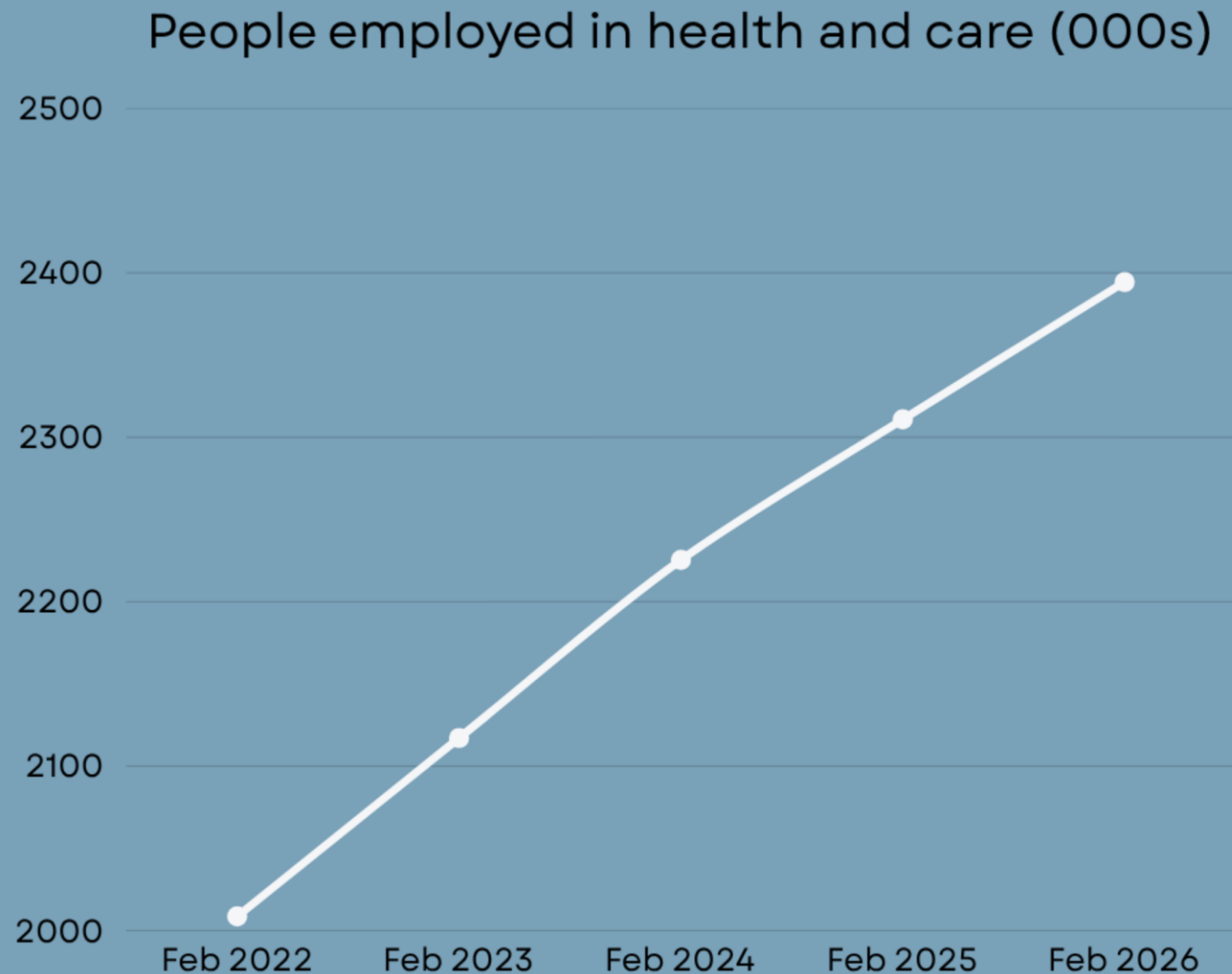
Wage growth (WA):
3.2%

**Unemployment rate
(WA): 4.1%**

**Unemployed people
(WA): 72,700**

Job vacancies (WA):
45,100

The economic message is simple:
Labour is too valuable to waste.



2.39m people
employed in health care and
social assistance
(nationally)

+19% growth
from Feb 2022 to Feb 2026

Aged care is competing for workers across adjacent care sectors that may offer different hours, status, supervision, autonomy and career paths.

Productivity is the bridge from context to action

When labour is scarce, the question becomes how to protect and use it better.

Productivity in aged care should mean less wasted time around care, not faster or thinner care.

Wrong frame

Ask care workers to absorb system failure through pace, goodwill or unpaid time.

Right frame

Redesign work so scarce time, skill and judgment reach residents and clients.

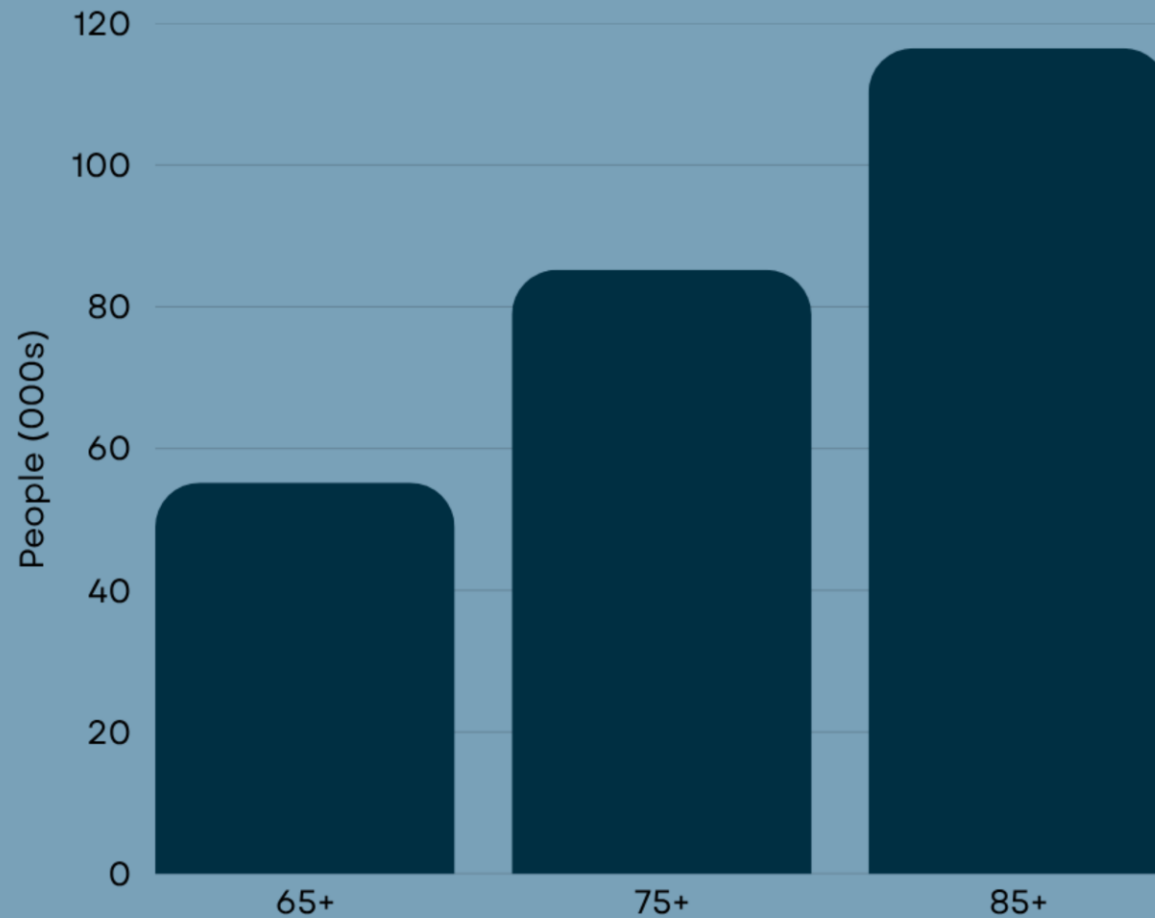
Practical frame

Measure where capacity leaks, then fix rosters, roles, handovers, systems and reporting.

The macroeconomy becomes an aged care operating problem:

demand rises, labour is scarce, regulation tightens,
and funding increasingly follows measurable delivery.

WA population growth 2022 to 2036



113,530 people
aged 85+ by 2036

+116.5% growth
in people aged 85+

The workforce is committed, but capacity is leaking

The 2024 survey shows motivation, part-time structure, unpaid effort and pay dissatisfaction.

64.7%

satisfied working in aged care

64.6%

want to keep working in the sector

26.4

average paid hours in prior week

6.5

average unpaid hours among those reporting unpaid hours

40.3%

dissatisfied with total pay

Capacity signal	Interpretation
58.7% permanent part-time; 20.8% casual	Headcount is not the same as usable hours.
27.5% wanted more hours	Some capacity may be trapped in job structure and rostering.
Unpaid work often due to too much work/no one else	Goodwill can hide under-capacity and weak work design.
64.6% want to stay	Retention is a productivity opportunity, not just a morale issue.

Regulation, funding and workforce are now linked

Controls are not only external obligations; they shape the operating model.

51

providers with significant
workforce gaps under increased
supervision

32% to 60%

homes meeting both total and RN
targets from Q2 2023-24 to Q1
2025-26

65.17%

homes meeting both targets in Oct-
Dec 2025

\$33.41

maximum care minutes
supplement per resident per day
for eligible MM1 homes

**The risk is not regulation itself. The risk is control that
consumes scarce capacity without improving care.**

Productivity 101 for aged care

Define productivity so it protects care rather than threatens it.

$$\text{Productivity} = \frac{\text{Care value delivered}}{\text{Scarce resources used}}$$

safe care + relational care + continuity +
outcomes + worker sustainability

labour hours + RN time + skill +
management attention + technology +
compliance effort

Effective care capacity = paid labour hours – capacity leakage

The productivity question is not “how do we make workers move faster?”
It is “how much of the labour, skill and judgment we already pay for actually reaches care?”

Tool 1: The aged care capacity equation

Separate the workforce problem into levers providers can actually diagnose.

$$\text{Effective care capacity} = \text{Headcount} \times \text{Usable hours} \times \text{Skill fit} \times \text{Continuity} \times \text{Workflow efficiency}$$

people on the books after leave, vacancies and admin right worker for the task stable relationships and local knowledge share of time that reaches care

A shortage may be a headcount problem. Or it may be an hours, skill mix, continuity or workflow problem.

If you diagnose the wrong constraint, you choose the wrong intervention.

Tool 2: Map productivity leaks

Look for the work around care before asking people to do more care.

Rostering friction

last-minute shifts, avoidable overtime, agency churn

Documentation burden

duplicated entry, poor templates, rework

Travel and coordination

inefficient routes, missed information, weak handovers

Role confusion

unclear delegation, repeated escalation, underused skills

Turnover and induction

lost knowledge, recruitment cost, supervision drain

Compliance layering

controls added on top of work instead of built into workflow

If you do not measure where time is lost, you cannot know whether technology or work redesign is helping.

Tool 3: A monthly capacity dashboard

Use a small set of measures to see whether work is becoming more sustainable.

Dimension	Example measures
Demand	Occupancy, clients, case mix, waitlist, complexity signals
Labour supply	FTE, paid hours, vacancies, agency hours, overtime, sick leave
Work design	Roster stability, preferred hours met, supervision time, training completion
Productivity leaks	Documentation time, duplicate entry, travel time, handover failures, rework
Quality guardrails	Complaints, SIRS, missed care, continuity of worker, resident/client feedback
Financial link	Labour cost per care hour, revenue per care hour, supplement at risk, margin by service line

Do not add a metric unless someone will use it to change a decision.

Tool 4: The work design diagnostic

Retention is partly a design problem. Diagnose the job before blaming the worker pipeline.

Question	What to look for
Can workers get enough predictable hours?	Underemployment, split shifts, short shifts, casual reliance, last-minute changes
Can workers exercise judgment?	Autonomy, ability to adapt care, unnecessary escalation or micro-control
Can workers get support?	Supervisor availability, clinical escalation, peer support, manager workload
Can workers improve?	Training time, progression, delegated tasks, leadership pathway
Can workers do the job safely?	Workload, manual handling, aggression, travel, emotional strain
Does technology help or burden them?	Double entry, system usability, mobile access, time to document

Tool 5: Technology and AI, the economist's test

The question is whether a tool removes a real constraint.

Test	What to look for
Scarcity	What scarce input does this save: care worker time, RN judgment, manager attention, travel time or training time?
Workflow	Does it remove work, or create another system for people to feed?
Quality	Does it improve safety, continuity, communication or resident/client experience?
Adoption	Will frontline workers use it under real roster pressure?
Risk	What privacy, accuracy, bias, consent or accountability risk does it create?
Benefit capture	Where does saved time go: back to care, supervision, training or more reporting?

Practical starting points for technology

Start where risk is manageable and the workflow problem is visible.

Area	Possible use	Caution
Documentation	Draft non-clinical summaries, policies, family communication, meeting notes	Must be checked; do not invent clinical facts
Rostering	Identify patterns in overtime, missed shifts, travel time and agency use	Do not optimise cost at the expense of continuity
Training	Scenario-based induction, quizzes, refreshers, manager prompts	Must reflect provider policy and actual settings
Quality systems	Detect recurring complaint, incident or documentation themes	Bad data produces confident bad analysis
Management	Board papers, dashboard narratives, grant drafts, decision summaries	Governance responsibility remains human

The first technology project should be a workflow project with a tool attached, not a tool looking for a workflow.

A 90-day provider action plan

A practical way to get ahead without waiting for perfect policy settings.

Weeks	Action	Output
1-2	Pick one service line or site and map the capacity equation	A clear view of headcount, usable hours, skill fit, continuity and workflow loss
3-4	Measure three productivity leaks	Baseline for documentation, travel, handover, agency, overtime or rework
5-8	Redesign one work structure issue	A roster, supervision, role clarity, training or handover improvement
9-10	Run one low-risk technology test	A small pilot with before/after time, quality and worker feedback measures
11-12	Review dashboard and scale what worked	Decision on whether to stop, adjust or expand the change

Three takeaways

- 1** Aged care workforce pressure is an economic capacity problem, not only a vacancy problem.
- 2** Pay matters, but retention is built through work design, leadership, rosters, autonomy and training.
- 3** Productivity means reducing wasted time around care so scarce labour and judgment reach people receiving care.

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