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South Eastern Melbourne Primary Health Network

Palliative Care Needs Assessment

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Acknowledgements

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We acknowledge and celebrate diversity in all its forms and recognise the contribution people from diverse backgrounds and life experiences make to a strong, healthy and resilient community. We welcome everyone in the community as part of the SEMPHN organisation.

Disclaimer

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Executive Summary

South Eastern Melbourne Primary Health Network (SEMPHN) has completed a Palliative Care Needs Assessment (PCNA) to guide future activities under the Greater Choice for At Home Palliative Care (GCfAHPC) Program. This assessment identifies gaps, challenges and priorities for palliative care across the region. It aims to strengthen access to timely, coordinated and person-centred care at home and in the community.

Methodology

SEMPHN applied a mixed-methods approach to the needs assessment. Several information sources informed the PCNA, including:

- Research and policy documents to identify trends and best practice in palliative care.
- National and local datasets (i.e. ABS Census and AIHW Palliative care service in Australia releases) were analysed to examine population growth, disease patterns, service use and mortality across the region.
- Service mapping was conducted to understand the types, locations and integration of palliative care services.
- Targeted stakeholder consultations were held with providers, general practice, aged care and community representatives to gather insights on access, quality, workforce and emerging needs.

By combining evidence, data and stakeholder perspectives, SEMPHN developed a comprehensive picture of current and future palliative care needs in south eastern Melbourne.

Overview of palliative care in South Eastern Melbourne

The South Eastern Melbourne region covers ten local government areas (LGAs) and is experiencing rapid population growth and ageing. The number of people aged 65 and over has increased sharply (from 148,942 people in 2021 to 273,270 people in 2024). Across the catchment, Mornington Peninsula has the largest older population (65+).

Demand for palliative care is rising, especially among older adults and those with complex needs (i.e. multimorbidity). For example, in the SEMPHN catchment non-admitted care for those 75+ rose by approximately 50% over two years (2022-23 to 2023-24). Chronic and life-limiting conditions, including dementia, heart disease and cancer, are common and drive service demand. Cultural diversity is high in several LGAs including Casey and Greater Dandenong with overseas-born residents making up more than half of their older population.

Palliative care is delivered through a mix of specialist inpatient units, community-based teams, regional coordination services and home-based care. There are seven specialist inpatient services and four multidisciplinary community providers in the region. No standalone hospices exist with all hospice-style beds within hospitals. General practices, residential aged care home (RACHs), pharmacies and Aboriginal Community Controlled Health Organisations (ACCHOs) play key roles in referrals and continuity of care.

Summary of insights

Table 1 provides a summary of insights from the PCNA, consolidating evidence from demographic analysis, mortality and epidemiology data, service utilisation trends and stakeholder consultations. These themes highlight the key drivers of demand, gaps in care and emerging priorities for SEMPHN, forming the foundation for recommendations that follow.

Table 1: Summary of insights from SEMPHN's Palliative Care Needs Assessment 2025

The ageing population will drive increased demand for palliative care
Population growth has been strongest among older cohorts, with significant increases in residents aged 65 and over between 2021 and 2024, while younger age groups have grown in absolute terms but declined proportionally. Nearly half of residents live in Casey, Greater Dandenong, Frankston, and Mornington Peninsula, with the latter having the largest number of people aged over 75. Cultural and linguistic diversity is high in Casey, Greater Dandenong, and Frankston, while areas like Cardinia, Port Phillip, and Bayside have higher proportions of Australia-born residents. The demographic profile of South Eastern Melbourne highlights an ageing population, rising longevity, and diverse needs across subregions, driving increased demand for palliative care outside hospital settings.
The leading causes of death are coronary heart disease, dementia and cancers, indicating palliative care should focus on people with these chronic conditions
Deaths are concentrated among older adults. Fewer than 5% occur before age 55, about 20% between 55–74, and 70% in those aged 75 or older. Leading causes of death are chronic and degenerative conditions, with coronary heart disease ranking highest overall and for men, and dementia (including Alzheimer's disease) leading for women. Nine of the top twenty causes are cancers, with sex-specific patterns: lung and prostate cancers for men, breast and bowel cancers for women. Other major causes include stroke, COPD, diabetes, heart failure, kidney disease, accidental falls, and mental health. Mortality patterns indicate that palliative care should also focus on chronic cardiovascular, respiratory, neurological conditions, dementia, and age-related frailty.
The rise in complex, multi-morbid chronic disease means there will likely be a commensurate increase in the complexity of palliative care needs
Chronic disease prevalence in the region aligns with Victorian and national averages but varies locally. Greater Dandenong reports the highest rates of ischaemic heart disease, kidney, and lung disease. Frankston reports the highest mental ill-health prevalence, while Cardinia and Casey show elevated multi-morbidity. Bayside, Port Phillip, and Stonnington consistently report lower rates across most conditions. Dementia prevalence is slightly above the state average across SEMPHN LGA's. Palliative care utilisation reflects growing demand beyond cancer; non-cancer admissions

rose 19.5% from 2020–21 to 2023–24, narrowing the gap with cancer-related admissions. Combined palliative hospitalisations remain the lowest among metropolitan PHNs but have increased modestly. Pain relief prescribing trends show a 4% overall rise, with slight declines in anti-inflammatories, modest opioid increases, and notable growth in other analgesics, alongside upward trends in psychological and neurological medications, underscoring complex needs in ageing, chronically ill populations. Palliative care in the SEMPHN catchment must continue to meet the needs of an ageing population with complex, multi-morbidity profiles. Rising demand for community-based, integrated services highlights the importance of models that address chronic conditions, dementia and mental health alongside cancer care.

Demand for palliative care is outpacing resources

Demand for palliative care is rising sharply due to an ageing population and increasing complexity of needs. Funding and workforce capacity have not kept pace, forcing services to operate reactively and prioritise acute cancer cases. Earlier intervention remains limited, and without scalable models the gap between demand and resources will continue to widen.

Fragmented systems and poor coordination undermine continuity of care

Care pathways are fragmented, with hospitals, GPs and community providers working in silos. Patients experience delays, duplication and missed referrals, while families struggle to navigate the system. Stakeholders highlighted the need for shared-care models, streamlined referrals and navigator roles to improve coordination.

Strengthening GP engagement is essential for improving care

GPs play a critical role in early identification and symptom management, yet engagement is low due to time pressures, limited incentives and confidence gaps. Few GPs provide home visits or after-hours support. Expanding practice nurse roles and offering targeted education were recommended to build capability and encourage proactive GP involvement.

Cultural and linguistic barries limit access to equitable palliative care services

Birthplace data reveals increasing diversity across LGAs, and consultations confirm that cultural beliefs, language barriers and taboos about death hinder access. CALD and First Nations communities face challenges accessing palliative care due to gaps in culturally tailored service models and limited interpreter availability. Stakeholders highlighted the need for funded interpreter services and culturally responsive approaches to improve equity and inclusion. Without targeted engagement and partnerships, equity gaps will persist. Diversity and access barriers point to the need for culturally tailored approaches. SEMPHN may need to work with CALD and First Nations communities to co-design models, expand interpreter availability, and address cultural taboos around death to ensure equitable access to palliative care.

Community awareness and death literacy remain low

Misconceptions about palliative care persist, with many associating it only with imminent death. Families often delay engagement and struggle to navigate services. Education gaps for patients, carers and clinicians contribute to missed opportunities for early intervention. Capacity pressures have reduced community education efforts.

Greater support is needed for carers to reduce strain and burnout

Carers sustain home-based care under significant physical, emotional and financial strain. Limited respite, poor discharge planning and confusing navigation contribute to burnout and avoidable hospitalisations. Structured support (i.e. predictable respite, tailored education and anticipatory grief resources) is essential to maintain home care. Carer strain highlights the importance of structured support. SEMPHN could explore options for predictable respite, tailored education, and anticipatory grief resources to sustain home-based care and reduce avoidable hospitalisations.

The focus of palliative care remains on cancers at the expense of dementia, frailty and other chronic diseases

Current palliative care models prioritise cancer, leaving people with dementia, frailty and chronic disease underserved. Referrals for non-malignant conditions often occur late, resulting in reactive care. Early intervention triggers and clearer access protocols were identified as priorities for equity.

Virtual and nurse-led models of palliative care could be leveraged to expand access and reach

Virtual models such as Hospital in the Home and telehealth are gaining traction as cost-effective and convenient options. They support home-based care but require investment in infrastructure and workforce capability. Nurse-led clinics and shared-care models were also highlighted as practical innovations.

Emerging models such as virtual care and nurse-led clinics suggest opportunities to expand system capacity. SEMPHN could pilot these approaches, embed ACP into nursing roles, and leverage digital tools to support proactive, integrated care.

Workforce shortages and system-wide capacity gaps
Workforce shortages affect all parts of the system. Rising demand and complexity strain small teams, while GP retirements and limited home visits reduce primary care support. Extended-scope roles and navigator positions were proposed, but sustainable funding and training are essential to embed these innovations.
Legislative reforms to VAD need to be incorporated into palliative care, including updating governance, workforce training and integration into ACP processes
The Voluntary Assisted Dying Amendment Bill introduced in 2025 proposes significant reforms including removing restrictions on clinicians discussing VAD, broadening eligibility criteria and expanding authorised practitioners to include nurses. These changes aim to improve access and flexibility but will increase demand on palliative care and ACP services adding complexity to workforce planning and governance. Clear protocols, culturally sensitive approaches and integration with ACP processes are essential along with investment in training and accountability measures to ensure safe and equitable care. Proposed VAD reforms may require updates to governance, workforce training, and integration with ACP processes. SEMPHN could review protocols to ensure safe, culturally sensitive implementation and plan for the additional complexity these changes introduce. VAD and palliative care are distinct but complementary approaches to end-of-life care. VAD activities within the program must be non-clinical and non-service delivery in nature.

Recommendations

The following recommendations (Table 2) provide a clear, actionable roadmap for SEMPHN to strengthen access to high-quality, home-based palliative care over the next three years, addressing workforce gaps, cultural equity, medicine access, and system coordination - aligned with Greater Choice for at Home Palliative Care priorities.

Table 2: Summary of recommendations

Recommendation	Summary of Action	GCfAHPC Impact Area Alignment
Strengthen primary-care-led ACP and early identification	Expand ACP facilitation via practice nurses, embed micro-learning for GPs, pilot virtual ACP clinics	Workforce education & awareness; Community awareness; Medicines (anticipatory prescribing & ACP)
Build culturally responsive and equitable models	Co-design with CALD & First Nations communities, fund interpreters, bilingual roles, culturally adapted resources	Priority populations; Community awareness; Workforce cultural capability
Develop integrated pathways for non-malignant conditions	Create dementia-inclusive ACP clinics, partner with memory clinics, train primary and aged care staff	Workforce education & awareness; Priority populations
Improve navigation and coordination	Establish centralised hub, liaison roles, shared-care protocols, standardised referrals	Community awareness; Workforce awareness
Enhance access to palliative medicines	Develop "palliative-ready" pharmacy network, anticipatory prescribing bundles, after-hours telehealth support	Workforce education & awareness; Community awareness
Strengthen carer support	Expand respite, structured education, psychosocial	Community awareness; Priority populations; Access to medicines

	support, link to financial/housing assistance	
Grow and upskill workforce	Pilot nurse-led models, advanced practice roles, capability frameworks, micro-learning	Workforce education & awareness
Expand digital and virtual care	Telehealth reviews, virtual case conferences, remote ACP support for outer-urban LGAs	Workforce education & awareness; Community awareness; Medicines access
Strengthen data, evaluation & prepare for VAD changes	Develop regional dashboard, data-sharing agreements, governance and training for VAD integration	Workforce education; Community awareness; Priority populations

Conclusion and next steps:

The needs assessment highlights significant opportunities for SEMPHN to strengthen palliative care access and equity across the region. The recommendations outlined are not prescriptive or time-bound but represent key areas for consideration in future planning and commissioning. The recommendations and actions seek to respond to clear signals from data and stakeholder insights - **an ageing population, rising multimorbidity, lower service utilisation compared to benchmarks, and persistent inequities for CALD and First Nations communities.**

Next steps include:

- **Integrate recommendations into strategic planning.** Use these areas as a reference point when shaping future workplans, commissioning priorities, and partnership initiatives.
- **Engage stakeholders early** and establish advisory mechanisms with clinicians, CALD and First Nations representatives to co-design culturally responsive models and navigation supports.
- **Consider piloting initiatives** such as nurse-led models, virtual care platforms, and anticipatory prescribing bundles in high-need LGAs.
- **Strengthen system enablers** and explore options for improved data sharing, evaluation frameworks, and governance to monitor progress and prepare for legislative changes.
- Ensure **all actions support Greater Choice for At Home objectives.**

By embedding these considerations into future workplans, SEMPHN will move toward a more coordinated, person-centred palliative care system that enables more people to receive care in their preferred setting.

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Abbreviations

Abbreviation	Description
ABS	Australian Bureau of Statistics
ACP	Advanced Care Planning
AIHW	Australian Institute of Health and Welfare
ASR	age-standardised rate
CALD	culturally and linguistically diverse
COPD	chronic obstructive pulmonary disease
ED	Emergency department
EMPHN	Eastern Melbourne Primary Health Network
EOLC	end of life care
FTE	Full time equivalent
FY	Financial Year
GCfAHPC	Greater Choice for At Home Palliative Care

Abbreviation	Description
GP	general practitioner
LGA	Local Government Area
MBS	Medicare Benefits Schedule
NP	Nurse Practitioner
NWMPHN	North Western Melbourne Primary Health Network
PCNA	Palliative Care Needs Assessment
PCOC	Palliative Care Outcomes Collaboration
PHN	Primary Health Network
POLAR	Population Level Analysis & Reporting
RACH	Residential Aged Care Home
SEMPHN	South Eastern Melbourne Primary Health Network
VAD	Voluntary Assisted Dying

1. Background and context

1.1 Context

South Eastern Melbourne Primary Health Network (SEMPHN) has undertaken this Palliative Care Needs Assessment (PCNA) as a key input to inform decision-making on the most appropriate activities to deliver as part of the Greater Choice for At Home Palliative Care (GCfAHPC) Program. It will enable SEMPHN to:

- Identify gaps and challenges in palliative care across the region
- Align Activity Work Plans (AWPs) with GCfAHPC program objectives
- Measure the impact of the program on local palliative care systems
- Support local providers, services, and community engagement
- Justify flexibility and resourcing for targeted activities.

The Department of Health, Disability and Ageing (DHDA) will use this assessment to monitor and evaluate program outcomes and ensure SEMPHN delivers flexible, locally tailored initiatives. Ultimately, this work supports the GCfAHPC Program's core aim: increasing access to quality, person-centred palliative care at home and in the community, informed by local evidence and consumer needs.

1.2 Purpose of this document

This Palliative Care Needs Assessment has been developed by SEMPHN to provide a comprehensive and evidence-informed understanding of current and emerging palliative care needs across the region. Its purpose is to guide SEMPHN in determining clear, actionable priorities that strengthen access to timely, coordinated and person-centred palliative and end-of-life care.

In line with the Commonwealth's requirements for Primary Health Networks, this assessment contributes to SEMPHN's broader mandate to commission services that improve efficiency, effectiveness and equity in primary health care. Palliative care is a national priority, with strong alignment to the National Palliative Care Strategy (2018), the Greater Choice for At Home Palliative Care (GCfAHPC) program, and Victorian statewide frameworks. This document supports SEMPHN to fulfil its role within these policy settings and respond to local needs with targeted, evidence-based investment.

The assessment draws on updated quantitative analysis, service mapping, literature review findings and targeted stakeholder engagement to provide a refreshed picture of population needs since SEMPHN's 2022 internal Health Needs Assessment. It examines demographic and epidemiological trends, system pressures, workforce capability, cultural and structural barriers. Together, these insights highlight where primary care, community services and palliative care pathways are working well, where inequities persist, and where strengthening is required.

The overarching purpose of this document is to define the priority actions SEMPHN should consider over the coming years to:

- improve access to compassionate, coordinated palliative care closer to home
- build capability within general practice and aged care
- address cultural, linguistic and attitudinal barriers to care
- streamline pathways across primary, community and acute settings
- strengthen support for carers
- and position the region to respond to rising demand and increasing complexity.

This needs assessment is intended to serve as the foundation for SEMPHN's future commissioning decisions, workforce strengthening activities, and collaborative initiatives with providers, consumers and partners across the south-eastern Melbourne region.

1.3 Limitations and considerations

This palliative care needs assessment provides a robust evidence base to inform SEMPHN's future planning, however, several factors should be noted when interpreting findings:

- **Data sources**: Analysis relied on publicly available data at PHN and LGA levels, with Victorian and national averages used as benchmarks. While these sources are reliable, they may not fully capture local nuances or recent service changes.
- **Workforce insights:** Findings highlight capability gaps, however, quantitative data on workforce capacity (e.g., FTE, service locations) was not available. This represents an area for further data collection to strengthen planning.
- **Stakeholder engagement:** Consultations were conducted over a two-week period from 17 to 26 November and provided valuable insights, however, engagement was limited to a small number of stakeholders, including only one general practice representative. Residential aged care providers, carers, and consumers were not consulted, and patient experience data was not captured due to time constraints. Broader engagement will be important to validate and deepen sector-specific insights.
- **Recommendations:** The recommendations are intended as areas for consideration in future workplans rather than a prioritised or sequenced roadmap. Policy changes and funding shifts may influence the feasibility or timing of these actions.

Despite these limitations, the assessment draws on credible data and stakeholder perspectives to identify key opportunities for improving palliative care access and equity. Future work should focus on addressing identified gaps to ensure planning remains comprehensive and responsive.

2. Methodology

The Palliative Care Needs Assessment (PCNA) draws on multiple data sources and methods to develop a picture of current and future needs. Specifically, the approach combines a review of recent evidence, quantitative analysis of population and service use data, service mapping across care settings, and targeted stakeholder engagement to capture qualitative insights on access, quality and capability.

2.1 Literature Review

A rapid literature scan was undertaken to refresh the evidence base with research and policy developments from 2022 - 2025. The scan focused on emerging trends, leading practice models and system strategies relevant to:

- Palliative and end-of-life care (EOLC) for people living with dementia
- Palliative care for culturally and linguistically diverse (CALD) communities
- Advance Care Planning (ACP) models and implementation approaches
- Carer needs, burden and support models.

Peer-reviewed articles, national and jurisdictional policy documents, and other relevant grey literature were included in the review. Findings were synthesised to identify themes and implications for SEMPHN, with a focus on approaches that strengthen patient-centred care, improve access and equity, and build primary care and community capability.

2.2 Data analysis, sources and gaps

Quantitative analysis draws on publicly available datasets (for example AIHW, ABS) alongside data made available to SEMPHN by stakeholders or through internally held datasets. The analysis examines:

- **Demographics:** age and gender distribution of the South Eastern Melbourne catchment population and key subgroups relevant to palliative care need.
- **Epidemiology:** prevalence, incidence and distribution of chronic and life-limiting conditions in the region, and how palliative care needs differ across population groups.
- **Mortality:** leading causes of death in the South Eastern Melbourne catchment and the proportion of deaths occurring in hospital, at home or in residential aged care homes (RACHs).
- **Projections:** the likely impact of demographic changes and other trends on future demand for palliative care, workforce requirements and service capacity.

Where possible, national and State comparators (i.e. Eastern Melbourne PHN and North West Melbourne PHN) are also provided.

Table 3outlines the key data sources used to inform this needs assessment, including their origin and period of coverage.

Table 3: Data sources used for SEMPHN PCNA

Data source	Organisation	Period
2023–2025 SEMPHN Health Needs Assessment	SEMPHN	2023
AIHW Palliative care service in Australia (PCSiA) 2025 PHN Palliative Care Services releases	Australian Institute of Health and Welfare	2020 – 2023
AIHW Mortality Over Regions and Time (MORT) books, Primary Health Networks	Australian Institute of Health and Welfare	2019 - 2023
Census	Australian Bureau of Statistics	2021

2.3 Service mapping

A high-level regional service mapping exercise identified the availability, distribution and integration of services involved in palliative care and EOLC across the South Eastern Melbourne region based on available data. This includes:

- Specialist palliative care services
- General practice and primary care
- Community health and home-based services

The mapping outlines service types, coverage and integration points where easily identified.

2.4 Stakeholder consultation

Stakeholder engagement formed a central component of the needs assessment methodology, providing essential qualitative insights into current state, access barriers, workforce capability, and opportunities for strengthening palliative care and EOLC across the South Eastern Melbourne region. Engagement focused on groups with direct experience delivering, referring to, or accessing palliative care, including specialist and community providers, ACP services, hospitals, primary care and RACHs.

Consultations explored service strengths, challenges, referral and handover processes, workforce pressures, cultural considerations, emerging population needs, and opportunities for improving coordination, continuity and patient-centred care. Workshops were conducted virtually and where stakeholders were not available to participate in consultations, written submissions were accepted.

In total, 22 stakeholders were consulted through five 60-minute consultation sessions conducted between 10 November and 21 November 2025.

The combination of literature, quantitative datasets, service mapping and stakeholder engagement presents a coherent and comprehensive picture of current and emerging palliative care needs in the South Eastern Melbourne region.

3. Literature review

Palliative care in Australia is evolving in response to an ageing population, increasing cultural diversity and the growing prevalence of dementia and other life-limiting conditions. Recent research and policy developments emphasise the importance of ACP and models that address the needs of culturally and linguistically diverse (CALD) communities, people living with dementia and their carers. This literature review update is a distillation of insights from 2022 - 2025, reviewing evidence to identify trends, leading practice and strategies that strengthen patient-centred care and improve access and quality across palliative care systems.

Advance Care Planning

The need for ACP is increasing due to an ageing population, rising chronic and life-limiting conditions, and patient preferences to avoid hospitalisation and burdensome treatments at the end of life (RACGP, 2019). Many patients also favour palliative care at home or in RACHs (RACGP, 2019). Despite this, ACP awareness and uptake remain low. Only 35% of Australians surveyed for the *Advanced Care Planning Prevalence in Australia* report were aware of ACP, and just 33% had undertaken any form of ACP. Furthermore, only one in five Australians (19%) had discussed their future planning with someone else (Advance Care Planning Australia, 2025). While awareness and uptake is low, Australians recognise the benefits of ACP, with 73% open to having conversations about it (Advance Care Planning Australia, 2025). Although some patients found ACP conversations shortly after diagnosis emotionally challenging, they ultimately considered them helpful (Tros et al., 2022).

Multiple studies note that general practitioners (GPs) are well positioned to initiate and promote ACP due to the trusted, ongoing relationships GPs have with patients (RACGP, 2019, 2023; Tros et al., 2022). However, GPs report several challenges including emotional complexity of ACP conversations, fear of diminishing patient's hope, and their own lack of knowledge about ACP and palliative care guidelines, particularly among overseas-trained practitioners (Herrmann et al., 2019; Tros et al., 2022). Uncertainty around roles and responsibilities within multidisciplinary teams spanning across services, and time constraints further complicate ACP completion. These challenges are compounded by the lack of a dedicated ACP item number under the MBS, with billing rules for both ACP preparation and ongoing facilitation often complex and requiring additional practice management support to navigate.

Further barriers to ACP include rushed or brief conversations held by health professionals, cultural misunderstandings, and limited patient awareness of ACP overall (Herrmann et al., 2019; Kubi et al., 2020; Risk et al., 2019;).

Recent programs and campaigns focused on ACP indicate that key enablers for adoption and uptake by consumers and GPs include:

- Greater support for practices to optimise the use of MBS item numbers that apply to ACP, clarifying roles and responsibilities across teams and providers, fostering multidisciplinary

collaboration and coordination, and introducing education resources for GPs and patients, tailored to the local area (Herrmann et al., 2019; Nagarajan et al., 2022; Risk et al., 2019).
- The trust and familiarity patients have with practitioners also encourages ACP, but GPs should also recognise that patients do not need to be ready for all aspects of ACP to start discussions, simply raising awareness can enhance patient preparedness (Kubi et al., 2020; Zwakman et al., 2021).
- Short, targeted training sessions. Evidence from The Advance Project shows that brief sessions (30–45 minutes) are highly effective for time-poor GP staff (Nagarajan et al., 2022).
- Team-based approaches. Implementing ACP collaboratively across GPs, nurses, and aged care professionals improves confidence and engagement (HammondCare, 2025).
- Active involvement of PHNs and practice champions. These roles are critical in influencing peers and driving change within practices (Nagarajan et al., 2022).
- Trusted community partnerships. Campaigns like Speak(easy) Howard demonstrate that working with community organisations and embedding ACP conversations in familiar settings can normalise end-of-life planning and improve uptake (Zhang et al., 2025).
- Equity-focused engagement strategies. Ensuring culturally appropriate approaches and addressing demographic disparities is essential for inclusive ACP adoption (Zhang et al., 2025).

Practical tools, training and community engagement are effective enablers for ACP engagement and uptake. Two such tools include the Advance Project, which offers short evidence-based training and resources for GPs, nurses and aged care staff (Nagarajan et al., 2022), and Speak(easy) Howard, a community campaign that uses public education and partnerships to normalise end-of-life planning (Zhang et al., 2025). Both have demonstrated measurable improvements in ACP adoption.

ACP is crucial for patient-centred palliative care, however, improving uptake requires clearer roles, improved training and awareness, and accessible resources for both practitioners and patients.

CALD Communities

Cultural perceptions around death and dying can significantly influence engagement with palliative care and ACP, creating barriers that require sensitive and tailored approaches. Prevalent cultural perceptions, norms and beliefs include:

- Death and dying are taboo topics and not openly discussed, as simply raising these subjects can be seen as disrespectful (Australian Department of Health, 2020; Dadich et al., 2024).
- Nuanced and culturally significant ways of undertaking conversations about death and dying. Aboriginal communities observe ‘Sorry Business’ after a death, and mentioning the deceased’s name is considered inappropriate as it may disturb their spirit (Korff, 2023; Leonard et al., 2023).
- In African cultures, talking about dying is believed to cause death (Dadich et al., 2024; Australian Department of Health, 2020; Leonard et al., 2023).
- In Chinese cultures, writing a will or planning for EOLC is sometimes viewed as a curse (Leonard et al., 2023).

- Preference to verbally communicate their end of life wishes to a family member or eldest child rather than formalising them in writing (Dadich et al., 2023).
- The religious or spiritual beliefs that death and dying is ‘God’s will’, placing it outside the scope of clinical intervention (Australian Department of Health, 2020).
- In faith traditions such as Buddhism and Islam, pain may be seen as something to be accepted, leading to preferences for minimal pain medication and, in some cases, spiritual objections to practices like palliative sedation (Australian Department of Health, 2020).
- It is considered inappropriate for health professionals to inform a patient directly that they are approaching death or share their prognosis; instead, this information should be communicated to the family to preserve hope and avoid diminishing the patient’s spirit (Dadich et al., 2024).
- A cultural norm of prioritising curative treatment over palliative approaches, driven by beliefs that transitioning to palliative care equates to “giving up””. Others prioritise comfort and dignity over aggressive interventions (Australian Department of Health, 2020).
- Different decision-making styles, with some communities expecting an authoritative approach from clinicians, while others prefer family-led decisions (Australian Department of Health, 2020).

Regardless of the cultural background, a reluctance to discuss death can make planning hard, particularly for the health care system to plan treatment pathways or understand EOLC preferences (Leonard et al., 2023).

Besides cultural norms and perceptions, additional barriers to engaging with palliative care and ACP in CALD communities include:

- Limited familiarity with palliative care – For many CALD communities, palliative care is an unfamiliar concept, and their country of origin often lacks an equivalent system (Dadich et al., 2024).
- Misconceptions - Where some knowledge exists, misconceptions are common, such as the belief that palliative care hastens death, leading to delayed access and individuals avoiding a service they mistakenly believe will accelerate dying (Dadich et al., 2024; Leonard et al., 2023).
- Health literacy – Low health literacy compounds challenges. Even when people have heard of palliative care, understanding its purpose and navigating options remains difficult (Australian Department of Health, 2020; Leonard et al., 2023).
- Language barriers - Interpreters are often unavailable in time-critical settings, and reliance on family members for interpretation can introduce bias and hinder transparency (Australian Department of Health, 2020; Dadich et al., 2024; Lambert et al., 2023).
- Language and resource barriers – Interpreters are often unavailable in time-critical settings, and reliance on family members for interpretation can introduce bias and hinder transparency. Translated and culturally appropriate resources are limited, and written materials alone may have little impact (Australian Department of Health, 2020; Dadich et al., 2024; Lambert et al., 2023).
- System complexity – Understanding and navigating the Australian health system is challenging, particularly for recently arrived communities (Hayes et al., 2020).

- Cultural expectations – End-of-life care is often viewed as a family responsibility. In Australia, this can be difficult when family support is limited, and shame about accepting government services may further complicate care (Dadich et al., 2023; Leonard et al., 2023).

Culturally responsive, community-led communication strategies have been shown to be effective in addressing these barriers. The Courageous Conversations with CALD Communities pilot project, launched by the Multicultural Communities Council of South Australia in collaboration with Palliative Care South Australia, CareSearch and the Hospital Research Foundation Group, is an example of this. This initiative engaged Cantonese, Mandarin, Greek, Croatian, Ukrainian and Spanish-speaking communities using trusted communication channels and multimedia formats. Six podcasts in seven languages were developed, covering topics such as “What is Palliative Care?”, “Plan Early”, “Services Available”, “Pain and Symptom Management”, “What Matters Most” and “Financial Support”. These podcasts, combined with FAQs and useful links on the project website, increased knowledge about palliative care by 60% within targeted communities (Multicultural Communities Council of South Australia, 2021; Palliative Care in Your Language, n.d.). This demonstrates the value of delivering information in multiple languages and accessible formats to improve health literacy and engagement among CALD communities.

Dementia

Dementia is a rapidly growing issue in Australia. In 2024, an estimated 425,000 Australians were living with dementia, a number projected to rise to 800,000 by 2058 (Dementia Australia & Palliative Care Australia, 2023). Within the South Eastern Melbourne region in 2023, approximately 15% of the population were living with dementia (Australian Institute of Health and Welfare, 2025). The progressive, terminal nature of dementia, coupled with complex and evolving symptoms, means many people do not receive timely or appropriate palliative care (Dementia Australia & Palliative Care Australia, 2023). Aged and community-based services are often not equipped with appropriate resources and training to address the unique palliative care needs of someone living with dementia (Dementia Australia & Palliative Care Australia, 2023).

Early diagnosis of dementia is critical but often delayed due to short consultation times, symptom denial, overlapping mental health issues, and family distress, creating a significant lag between onset and diagnosis (Australian Government Department of Health Disability and Ageing, 2024). GPs play a key role but face barriers such as emotional strain, inconsistent diagnosis guidance, coordination challenges across multidisciplinary teams, and limited access to local referral pathways (Herrmann et al., 2019). These delays impact timely access to palliative care, as late diagnosis reduces opportunities for early planning and support. The *National Dementia Action Plan 2024-2034* (Australian Government Department of Health and Aged Care, 2024) aims to address this through dementia-specific pathways and tools to support GPs to initiate conversations, refer to memory clinics, and provide post-diagnostic navigation.

ACP is particularly important for people with dementia where cognitive decline limits future decision-making capacity (Australian Government Department of Health Disability and Ageing, 2024). Supported decision-making approaches recognise the importance of making decisions with, rather than for, a patient allowing individuals to make decisions and share end-of-life preferences soon after diagnosis (Dementia Australia & Palliative Care Australia, 2023). However, many professionals lack the confidence to have ACP discussions with people diagnosed with dementia (Bamford et al., 2018). Research emphasises that framing ACP conversations to highlight how ACP helps to reduce stress for families, align future care with the patient's wishes, and prevent unnecessary hospitalisations can improve engagement and uptake of ACP (Bamford et al., 2018).

People living with dementia and their carers frequently report fragmented support, limited post-diagnostic guidance, and difficulty navigating available services (Australian Government Department of Health Disability and Ageing, 2024). Tailored care for those living with dementia is not widely available and services often lack coordination across different care settings, leaving people feeling isolated and confused.

The UK *Gold Standards Framework* supports earlier identification of dementia patients nearing end of life through regular team meetings and monitoring of functional decline, triggering timely symptom management, medication review and end-of-life discussions (Bamford et al., 2018). Establishing strong, consistent links between RACHs and a single GP practice were shown to enhance continuity of care and improve overall quality of care for dementia patients in this case, but the study also mentioned this model could be applicable to all residents to ensure a proactive approach in addressing signs that a person may be approaching end-of-life (Bamford et al., 2018).

Ongoing developments in dementia research and treatment, such as Dementia Australia's BrainTrack app, are supporting earlier referral to palliative care, better symptom management and improved quality of life.

Carer Needs and Supports

Carers provide essential support for patients, enabling many to remain at home and, in some cases, die at home (Challis et al., 2025). While caregiving can be rewarding, it often brings significant burden, including financial strain and reduced quality of life (Challis et al., 2025). Carers need tailored information and support to manage the physical, mental, and social demands of their role, which is crucial for sustaining their ability to provide care (Australian Government Department of Health Disability and Ageing, 2024; Challis et al., 2025).

Studies show that increased time devoted to care correlates with poorer physical, psychosocial, and economic outcomes (Franchini et al., 2022; Ulutaşdemİr et al., 2022; Xu et al., 2021), with female carers particularly affected more than men (Franchini et al., 2020). Carers are often away from family, work, and social environments, and this isolation, coupled with the overarching anxiety of losing a loved one can impose a significant psychological strain (Ulutaşdemİr et al., 2022). Financial concerns are common, including treatment costs and employment insecurity, especially for self-employed carers or those with inflexible employers (Challis et al., 2025; Xu et al., 2021). Navigating financial aid systems adds stress due to complex and inflexible processes (Miller & Porter, 2021). Furthermore, emotional exhaustion is compounded by anticipatory grief and difficult decisions, such as whether to use life-prolonging interventions that may increase suffering of the patient and burden for the carer (Olesen et al., 2023). Due to their location, rural carers face additional challenges, including service gaps, delays, and poor referral pathways and distances to travel to access care (Mason & Hodgkin, 2019; Miller & Porter, 2021).

Carers frequently struggle to navigate fragmented palliative care systems, leading to uncertainty and lack of continuity (Challis et al., 2025; Kim et al., 2023). Nurse navigators have proven valuable in addressing these challenges, offering personalised care, emotional support, and guidance during transitions, which are often stressful for carers (Hudson et al., 2019). To reduce navigation challenges, educational resources tailored to local areas can empower carers and assist health professionals in providing navigation support (Challis et al., 2025; Kim et al., 2024).

Leading practice in supporting carers emphasises structured, proactive and multi-layered support rather than relying on crisis-driven or ad hoc approaches. Evidence shows that many carers struggle to take breaks due to fear of leaving their loved one (Miller & Porter, 2021; Palliative Care NSW, 2023; Ulutaşdemİr et al., 2022), which highlights the need for respite models that are predictable, trusted and easy to access. Embedding routine, scheduled respite options, enabling carers to maintain basic routines are necessary to reduce burnout (Miller & Porter, 2021). Similarly, evidence indicates that bereavement support integrated early—beginning before death and extending through the acute grief period—improves preparedness and long-term wellbeing (Aoun et al., 2017; Coelho et al., 2025; Franchini et al., 2020). Peer-led approaches also represent leading practice: peer support groups offer safe spaces for carers to share experiences, reduce isolation and exchange practical coping strategies (Olesen et al., 2023). Together, these models demonstrate opportunities for SEMPHN to work with other stakeholders in the region to strengthen the carer experience through initiatives such as embedded anticipatory grief support, facilitated peer groups, and exploring availability of flexible respite care that reduce crisis presentations and sustain home-based care.

Summary of Key Insights:

The literature indicates individuals frequently enter palliative care late and often receive care that is not fully aligned with their values, cultural needs or preferred trajectory. ACP uptake remains low due to limited GP capacity, unclear roles and insufficient system prompts; CALD communities experience substantial barriers related to culture, language and misconceptions about palliative care; and individuals with dementia face delayed diagnosis and fragmented support. Evidence indicates that earlier and more routine ACP in primary care, culturally tailored engagement with CALD communities and strengthened dementia-capable primary care and navigation would support more timely, equitable and coordinated palliative care across the region.

4. Needs assessment data analysis

The following analysis examines demographic, epidemiological, service utilisation, and mortality patterns within the South Eastern Melbourne catchment to identify key drivers of palliative care needs and inform future planning and activities.

4.1 Demography

Population growth and ageing trends in the South Eastern Melbourne catchment

The SEMPHN catchment spans roughly 2,935 square kilometres and covers ten local government areas (LGAs): Bayside, Glen Eira, Port Phillip, Stonnington, Casey, Cardinia, Greater Dandenong, Frankston, Mornington Peninsula and parts of Kingston. The catchment shares geographic borders with Eastern Melbourne PHN, Gippsland PHN and North Western Melbourne PHN, and care is predominantly delivered by three major health service networks—Alfred Health, Monash Health and Peninsula Health—each of which plays a distinct role in delivering inpatient, consultancy, outpatient and community-based palliative care.

The SEMPHN catchment is undergoing significant population growth coupled with an ageing population (Table 4). While there has been a growth in population across all ages, the largest growth has been to the 65+ cohort (2.9% increase from 2021 to 2024). In contrast, the proportion of younger age groups has declined slightly despite absolute growth. These shifts indicate that South Eastern Melbourne region is not only growing but also ageing, which will drive higher demand for palliative care services over time.

Table 4: SEMPHN Catchment Population by Age Group, 2021 and 2024 (Number and Percentage of Total Population).

SEMPHN Catchment population age, 2021 - 2024							
	0-30		30-65		**65+**		Total
	Number	% of pop	Number	% of pop	**Number**	**% of pop**	Number
2021	445,282	40.0%	518,693	46.6%	**148,942**	**13.4%**	1,112,917
2024	631,140	↓ 37.6%	775,154	↓ 46.2%	**273,270**	**↑ 16.3%**	1,679,564

Note: The population aged 65+ in the SEMPHN catchment grew by 83% between 2021 and 2024, while younger age groups declined proportionally, indicating a rapidly ageing population and rising demand for palliative care services.

Source: Australian Bureau of Statistics. (2022, August 30). Regional population by age and sex, 2021 [Data set]. https://www.abs.gov.au/statistics/people/population/regional-population-age-and-sex/2021

Birthplace distribution and cultural diversity across South Eastern Melbourne LGAs

Analysis of older persons[1] (65+) across South Eastern Melbourne LGAs highlights variation in population size and birthplace composition (Table 55). Mornington Peninsula has the largest population of people aged 65+ (47.1 per 1,000 population), followed by Casey (42.7 per 1,000 population), Kingston (31.1 per 1,000 population), and Glen Eira (27.9 per 1,000 population). Smaller LGAs such as Cardinia (15.2 per 1,000 population) and Port Phillip (14.8 per 1,000 population) have comparatively fewer older residents. Larger LGAs tend to have higher numbers of older people, while smaller LGAs have fewer. Furthermore, cultural composition differs by LGA. Coastal LGAs like Mornington Peninsula and Bayside have predominantly Australian-born older residents, whereas rapidly growing and inner LGAs such as Casey, Greater Dandenong, and Glen Eira show higher proportions of overseas-born residents. These trends highlight both geographic and cultural diversity within the older population across the SEMPHN catchment.

Table 5: Older persons aged 65+ (thousands) by country of birth and LGA, 2021.

LGA / Region	Australia	Overseas	Born elsewhere[2]	Not stated	Total
Bayside	13.4	7.1	1.2	0.9	22.6
Cardinia	8.8	5.0	0.8	0.6	15.2
Casey	15.7	21.9	3.1	2.0	42.7
Frankston	12.0	8.7	1.3	1.0	23.0
Glen Eira	10.4	12.7	3.7	1.1	27.9
Greater Dandenong	5.7	17.9	2.1	1.3	27.0
Kingston	14.4	13.6	1.8	1.3	31.1
Mornington Peninsula	29.6	13.1	3.3	1.1	47.1
Port Phillip	7.4	5.4	1.2	0.8	14.8
Stonnington	10.0	6.7	1.0	0.7	18.4

Note: Mornington Peninsula has the largest older population (47.1 per 1,000 population), while Casey and Greater Dandenong show the highest cultural diversity, with overseas-born residents making up more than half of their older population. Coastal LGAs such as Mornington Peninsula and Bayside remain predominantly Australian-born.

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[1] Throughout this PCNA, 'older persons' refers to people aged 65 and over (definition consistent with Australian Institute of Health and Welfare: https://www.aihw.gov.au/reports/older-people/older-australians/contents/demographic-profile).

[2] Born elsewhere refers to countries not identified individually, 'Inadequately described', and 'At sea'. Excludes 'not stated' (definition consistent with ABS)

Source: ABS Census 2021, Australian Bureau of Statistics (June 2022 release) Country of birth of person by age by sex, Victoria.

Among older persons (aged 65+), Mornington Peninsula has the highest proportion of people aged 65+ born in Australia (29.9 per 1,000 population). In contrast, Casey has the largest overseas-born group (21.9 per 1,000 population), alongside Greater Dandenong (17.9 per 1,000 population) and Glen Eira (12.7 per 1,000 population), highlighting areas of greater cultural diversity. LGAs like Cardinia and Port Phillip have both smaller total populations and fewer overseas-born residents (5.0 per 1,000 population and 5.4 per 1,000 population respectively).

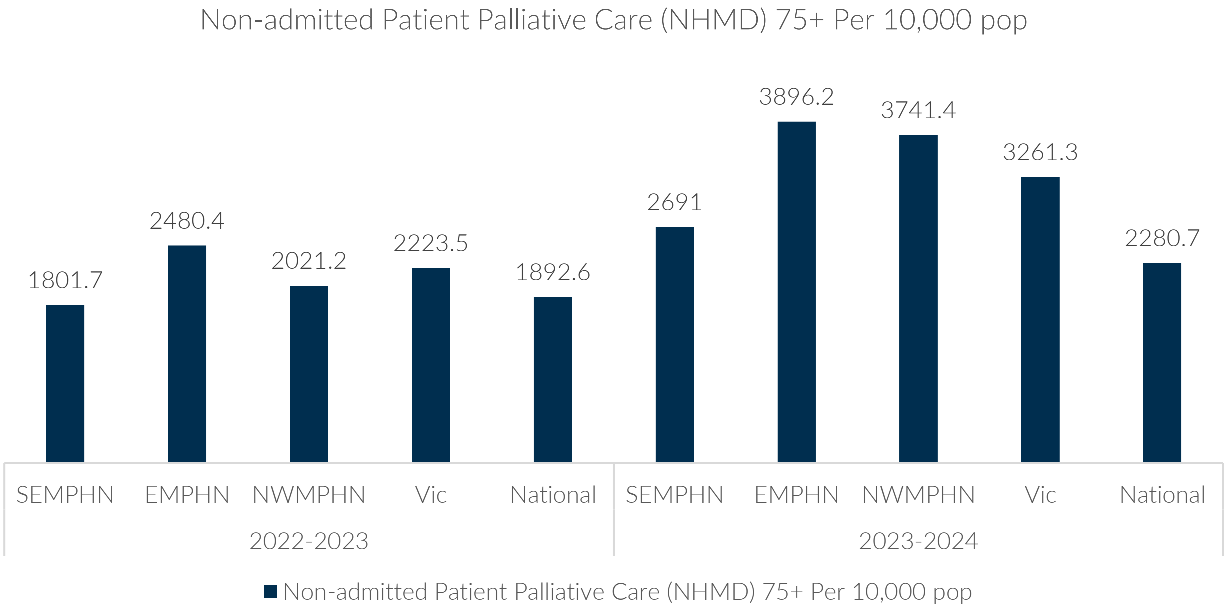
Insight:

These patterns suggest that planning for palliative care must consider both scale and diversity. Larger LGAs like Mornington Peninsula and Casey require increases in the volume of services, while more culturally diverse LGAs such as Casey, Greater Dandenong, and Glen Eira will need targeted, culturally sensitive engagement strategies.

Growing demand for palliative care in South Eastern Melbourne

Demand for palliative care services in South Eastern Melbourne is growing, particularly in non-admitted settings and among older age groups (Appendix item A). The increase is sustained and reflects a shift toward community-based care. While South Eastern Melbourne shows growth in demand, it remains lower than for neighbouring PHNs, and Victoria and national averages. For example, as seen in Figure 1 non-admitted care for people aged 75+ in South Eastern Melbourne rose by around 50% over two years (2022-23 – 2023-24), yet this remains well below the Victorian rate (which is 20% higher than for South Eastern Melbourne). Growth is most pronounced in the 75+ age group, consistent with statewide and national trends, though there is also a notable rise in the middle-aged cohort, as seen in Appendix item A.

Figure 1 Non-admitted Patient Palliative Care (NHMD) 75+ per 10,000 population.



Insight:

The pattern suggests changing service use, with non-admitted care expanding faster than admitted care, reinforcing the need for flexible models and community capacity. These trends are significant rather than marginal, pointing to a continuing upward trajectory in demand that will require proactive planning.

Socioeconomic patterns in palliative care utilisation across South Eastern Melbourne

Between 2022–23 and 2023–24, admitted palliative care rates in South Eastern Melbourne remained largely stable, with minor fluctuations across socioeconomic groups (see Appendix item B). In contrast, non-admitted palliative care services expanded, rising by 35–60% across all socioeconomic quintiles[3] and averaging a 43% increase. The sharp growth in non-admitted service provision far exceeds Victorian and national trends, signalling a regional shift toward community-based care. The trend is broad-based, affecting both low and high socioeconomic areas, and suggests drivers such as population ageing, improved case identification, and patient preference for home or outpatient services.

Insight:

These changes indicate that current inpatient capacity has remained stable but the expansion of community-based care has seen increased utilisation. This indicates that there is clear demand for palliative care to be delivered at home and in the community. These findings underscore a substantive change in how and where palliative care will need to be delivered in South Eastern Melbourne over the next planning cycle.

4.2 Mortality

Age-related mortality trends

In Table 66 below, mortality is highly concentrated in older age groups, as would be expected. Individuals aged 75 and above account for nearly 70% of all deaths. The proportion of deaths rises sharply with age, from just over 1% in each of the 0–24 and 25–34 groups, to 14.77% in 65–74 group. The mortality distribution across the different age groups highlights the strong association between advanced age and mortality, with deaths in younger age groups constituting a very small proportion.

Table 6: Age distribution of deceased persons, Victoria, 2024.

Age group (years)	Deceased persons Victoria 2024	Deceased persons Victoria 2024 (%)
0-24	608	1.32%

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[3] Socioeconomic quintiles are based on the ABS SEIFA Index of Relative Disadvantage (IRD), which ranks areas by collective socioeconomic status. Quintile 1 represents the most advantaged areas, and Quintile 5 the most disadvantaged, determined by where people reside and factors such as income, education, employment, and housing.

25-34	509	1.11%
35-44	892	1.94%
45-54	1,707	3.72%
55-64	3,557	7.74%
65-74	6,785	14.77%
75-84	12,289	26.75%
85+	19,596	42.65%
Total	45,943	100%

Note: Mortality is highly concentrated in older age groups, with individuals aged 75 and above accounting for nearly 70% of all deaths. Deaths in younger age groups (under 45) make up less than 5% combined, underscoring the strong association between advanced age and mortality.

Source: ABS Data Explorer, Australian Bureau of Statistics (June 2024 release).

Mortality is highly concentrated in older age groups, with individuals aged 75 and above accounting for nearly 70% of all deaths. Deaths in younger age groups (under 45) make up less than 5% combined, underscoring the strong association between advanced age and mortality.

Insight:

The trends suggest that palliative care demand will continue to rise sharply as the population ages, requiring SEMPHN to prioritise integrated models tailored to older cohorts, strengthen dementia and multimorbidity pathways, and embed advance care planning early in primary and aged care settings. Workforce planning and culturally responsive strategies will be critical to meet the complexity of care in this demographic.

Leading causes of death and age-standardised rates in South Eastern Melbourne

Table 7 lists the causes of death by rank and age-standardised rate (ASR) in the SEMPHN catchment. The table depicts that coronary heart disease is the leading cause of death for males and for the South Eastern Melbourne population overall, while dementia, including Alzheimer's disease, is the leading cause for females. Males exhibit higher age-standardised rates for coronary heart disease, lung cancer, and suicide, whereas females have higher rates for dementia and accidental falls.

Cancers represent 9 of the top 20 causes for both sexes. For males, prostate, lung, colorectal, pancreatic, liver, and cancers of unknown or ill-defined primary site are prominent, with prostate cancer ranking fifth and lung cancer third. For females, breast, lung, colorectal, pancreatic, ovarian, and cancers of unknown or ill-defined primary site are most common, with breast cancer ranking fifth and lung cancer fourth. Age-standardised rates for most cancer types are higher in males, except for breast and ovarian cancers, which are unique to females.

Chronic diseases such as chronic obstructive pulmonary disease (COPD), diabetes, and heart failure are the most common for both sexes but differ in rank and rate. Other than chronic diseases, suicide[4] is notably higher in males, while accidental falls and dementia are more prominent in females. COVID-19, kidney failure, and ill-defined causes are present for both, but with different ranks and rates.

In summary, cardiovascular and neurodegenerative diseases including dementia dominate mortality for both sexes in the SEMPHN catchment, with cancer contributing substantially and showing distinct sex-specific patterns.

Table 7: Causes of death by rank, sex and age-standardisation rate per 100,000 residents, SEMPHN catchment 2019-2023.

		Person		Female		Male	
Cause of death	Rank	No.	ASR	No.	ASR	No.	ASR
Coronary heart disease	1	4,768	44.6	1,885	28.90	2,883	63.40
Dementia including Alzheimer's disease	2	4,501	39.3	2,944	43.10	1,557	33.50
Cerebrovascular disease	3	2,832	25.8	1,721	26.50	1,111	24.30
Lung cancer	4	2,374	23.8	1,140	21.20	1,234	27.10
Accidental falls	5	1,750	15.6	889	13.30	861	18.60
Chronic obstructive pulmonary disease	6	1,746	16.7	856	14.60	890	19.40
Diabetes	7	1,472	13.8	659	10.60	813	17.80
Heart failure & ill-defined heart disease	8	1,453	12.9	813	12.10	640	13.80
Colorectal cancer	9	1,444	14.3	699	12.40	745	16.70
COVID-19	10	1,190	10.9	572	8.90	618	13.50
Pancreatic cancer	11	1,030	10.2	511	9.10	519	11.50
Kidney failure	12	1,025	9.2	520	7.90	505	11.00
Prostate cancer	13	1,000	9.4	-	-	1,000	21.70
Influenza & pneumonia	14	994	8.8	537	8.00	457	9.90
Other ill-defined causes	15	944	9.3	498	8.50	446	10.10
Breast cancer	16	915	9.4	910	17.40	-	-
Suicide	17	856	10.3	-	-	628	15.40
Cancer of unknown / ill-defined primary site	18	762	7.4	348	5.90	414	9.10
Cardiac arrhythmias	19	673	5.9	406	5.90	-	-
Liver disease	20	635	6.8	-	-	373	8.60
Liver cancer	-	-	-	-	-	419	9.30
Parkinson disease	-	-	-	-	-	390	8.60

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[4] Note: Suicide is not classified as a chronic condition but is included here due to its association with mental health, which is reported among chronic conditions elsewhere in this report.

Hypertensive disease	-	-	-	328	4.80	-	-
Septicaemia	-	-	-	294	4.60	-	-
Ovarian cancer	-	-	-	285	5.40	-	-

Notes: 1) Red coloured cells indicate higher ASR values and blue indicate lower ASR values; the colour gradient indicates lighter shades are closer to the middle of the scale, while darker shades represent values further towards the extremes. 2) Coronary heart disease is the leading cause of death overall and for males, while dementia (including Alzheimer's disease) is the leading cause for females. Cancers account for 9 of the top 20 causes for both sexes, with distinct sex-specific patterns (e.g., prostate cancer for males, breast cancer for females). Chronic diseases such as COPD, diabetes and heart failure are also prominent, and suicide ranks significantly higher for males compared to females.

Source: Cause of death categorised by ICD-10 chapter codes in original data for the period 2019-2023. Australian Institute of Health and Welfare. (Accessed 9 April 2025). Mortality Over Regions and Time (MORT) books [Data set].

Insight:

Coronary heart disease and dementia have the highest mortality rates in the SEMPHN catchment, with coronary heart disease leading overall and dementia the top cause for females. Cancer remains a major contributor, accounting for nine of the top 20 causes, alongside chronic conditions such as COPD and diabetes. These patterns signal the need for integrated care models that address multimorbidity, dementia-specific pathways, and cancer care, while embedding gender-tailored strategies and mental health support for conditions like suicide and accidental falls.

4.3 Epidemiology

Prevalence of chronic conditions among older adults across South Eastern Melbourne LGAs

Analysis of chronic condition prevalence among older persons across South Eastern Melbourne LGAs (rates per 1,000 population, Table 88) shows overall alignment with Victorian averages. Greater Dandenong has the highest rates for heart disease, kidney disease, lung conditions, stroke, and dementia all well above state averages. Frankston has the highest rates of mental ill-health, while Cardinia and Casey show the highest prevalence of multi-morbidity. In contrast, Port Phillip, Stonnington, and Bayside consistently report lower rates.

Top conditions of note for SEMPHN:

- Multiple LGAs have higher prevalence of heart disease and mental health compared with the State average,
- Dementia is slightly above State average with significant prevalence in Greater Dandenong and Glen Eira.
- Prevalence of kidney and lung conditions are particularly high in Greater Dandenong and Cardinia.

Some LGAs show higher rates than the State average, including Greater Dandenong (most conditions), Frankston (mental health), and Cardinia and Casey (several conditions).

Prevalence of conditions in South Eastern Melbourne are similar to those nationally, though lung conditions and heart disease are slightly less prevalent than nationally, while mental health conditions and dementia are slightly more prevalent. Greater Dandenong's has a higher chronic disease prevalence, of several conditions compared to both statewide and nationally, identifying it as a priority region.

Table 8: Older persons with chronic conditions by LGA, 2021, rate per 1,000.

LGA / Region	Heart diseases	Kidney diseases	Lung conditions	Stroke	Mental health	Dementia
Bayside	152.7	24	46.1	31.9	70.3	46
Cardinia	165.3	36.7	72.4	40.5	88.1	35.1
Casey	164.2	37.2	60.7	43.1	86.4	39.6
Frankston	156.2	33.2	60.7	33.1	98.4	42.9
Glen Eira	143.1	36.5	49	43.4	80.4	43.9
Greater Dandenong	170	40.7	78	44.1	90.9	50.3
Kingston	159.8	32.6	54.8	37.8	82.9	41.6
Mornington Peninsula	163.6	28.5	59	38.2	83.4	38.7
Port Phillip	134	25.7	45.3	30.4	77.6	33
Stonnington	139.4	24.8	39.7	30.6	65	36.8
Victoria	157.1	32.6	58.9	38.7	84.6	39.5
National	159	33	65.6	37.7	81	40.36

Notes: 1) Red coloured cells indicate higher ASR values and blue indicate lower ASR values; the colour gradient indicates lighter shades are closer to the middle of the scale, while darker shades represent values further towards the extremes. 2) Chronic condition prevalence among older persons in South Eastern Melbourne largely aligns with Victorian averages, but Greater Dandenong stands out with the highest rates for heart disease, kidney disease, lung conditions, stroke, and dementia. Frankston reports the highest mental ill-health prevalence, while Cardinia and Casey show elevated multi-morbidity. Bayside, Port Phillip, and Stonnington consistently report lower rates across most conditions.

Source: Australian Bureau of Statistics, 2021 Data and SEMPHN 2023 – 2025 Health Needs Assessment Accessed 13 November 2025.

Insight:

These patterns suggest areas where service demand may be comparatively greater. Planning implications include ensuring adequate palliative care capacity in LGAs with higher prevalence (such as Casey, Cardinia and Dandenong), reviewing resource distribution to maintain equity across the region, and continuing to monitor trends to anticipate changes in older-person health need.

Patterns in palliative care-related hospitalisations by diagnosis and PHN

Analysis of primary palliative care hospitalisations in South Eastern Melbourne (see **Table 9** 9 below) shows a stable trend for cancer-related admissions, decreasing slightly from 6.5 to 6.4 per 10,000 population between 2022–23 and 2023–24. In contrast, non-cancer admissions increased significantly from 4.1 to 4.9 per 10,000 population—a 19.5% rise—indicating growing demand for palliative care beyond oncology. Compared to Victorian and national averages (see Appendix item C), South Eastern Melbourne remains below overall rates, but the gap for non-cancer care is narrowing, suggesting emerging pressure on local services.

Table 9: Trends in cancer and non-cancer palliative care hospitalisation rates per 10,000 population 2022 – 2024 FY.

Primary palliative care hospitalisations				
	Cancer hospitalisations per 10,000 population		Non-cancer hospitalisations per 10,000 population	
PHN[5]	2022-2023	2023-2024	2022-2023	2023-2024
SEMPHN	6.5	6.4	4.1	4.9
EMPHN	6.9	7.1	6.6	6.7
NWMPHN	6.1	6.0	7.4	7.0
Victoria	7.1	7.1	6.9	7.2
National	10.0	10.3	10.7	11.1

Note: Cancer-related palliative hospitalisations in South Eastern Melbourne remain stable (6.5 to 6.4 per 10,000), while non-cancer admissions rose by nearly 20% (4.1 to 4.9 per 10,000), signalling growing demand for palliative care beyond oncology. Despite this increase, South Eastern Melbourne rates remain below Victorian and national averages, though the gap for non-cancer care is narrowing.

Source: Australian Institute of Health and Welfare. (2025). Palliative care services in Australia 2025: Data tables (Primary Health Networks - palliative care services).

Insight:

The sharp increase in non-cancer cases requires targeted investment in multidisciplinary teams, community-based models, and integration with aged care and chronic disease management. An inability to address this could lead to service bottlenecks and inequities in access. (See Appendix item C for detailed breakdown by PHN and primary diagnosis).

Age-specific trends in palliative medicine service utilisation

Although service utilisation rates for 2022–2023 are unavailable, the 2023–2024 data reveal clear patterns. South Eastern Melbourne's overall service rate is 868 per 100,000 population, which is significantly lower than the Victorian average (2,204 per 100,000) and the national average (13,124 per 100,000). This indicates a comparatively smaller footprint of palliative medicine activity in the region. Age distribution follows expected trends: the 75+ cohort dominates service use, with rates far exceeding younger groups, while the 55–74 group is the next largest segment. Middle-aged adults (35–54) account for a modest share, and utilisation among those under 35 remains negligible (see Appendix Item F for detailed data table).

Insight:

The local region faces similar demographic drivers of palliative care demand as other PHNs, but at a lower intensity. However, the data is unable to illustrate whether this is due to genuinely lower demand for palliative care services compared to other PHNs, or whether this is due to lack of

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[5] Throughout this PCNA, the analysis focuses on SEMPHN and surrounding metropolitan PHNs most similar in demographic and service profile, rather than all Victorian PHNs, to ensure a meaningful comparison.

supply, and therefore ‘hidden’ demand. Further insights are provided as part of stakeholder consultation. Planning should anticipate continued growth among older cohorts and rising complexity of care. Workforce and resource allocation strategies should therefore prioritise capacity for high-intensity care in later life stages.

Age-specific trends in palliative care prescriptions utilisation

Analysis of palliative care-related medication use in South Eastern Melbourne between 2022–2024 shows stable to modest growth across most age groups, with slight increases in prescription rates and prescriptions per person (see Appendix item H). For example, in the 75+ age group, the prescription rate rose from 22,505.9 to 24,440.1 per 100,000 population, while prescriptions per person remained steady at around 3.0. Similarly, the total prescription rate increased from 34,983.0 to 37,010.9 per 100,000, indicating a gradual rise in overall medication use. These changes, while not dramatic, are practically significant given the aging population and the complexity of palliative care needs.

Compared to other PHNs, South Eastern Melbourne’s prescription rates are slightly lower than North Western Melbourne but broadly aligned with Eastern Melbourne. The South Eastern Melbourne total prescription rate of 37,010.9 per 100,000 is less than Victoria’s prescription rate (275,903.7 per 100,000) and the national prescription rate (1,401,913.7 per 100,000).

Insight:

The trend suggests growing demand driven by older cohorts, with the 75+ group consistently accounting for the largest share of prescriptions. This implies increasing resource allocation challenges, particularly in medication supply, workforce capacity, and coordination of care for complex cases. Planning should prioritise geriatric palliative care services, medication access, and integration with community-based supports to meet rising needs.

Trends in primary and other palliative care hospitalisation

Between 2020–21 and 2023-24, South Eastern Melbourne recorded consistently lower rates of palliative care hospitalisations compared to Victorian and national averages (see

Table *10* and

Table 11 For primary palliative care hospitalisations (i.e. hospital admissions where the recorded care type is palliative care, indicating that palliative care was the main purpose of the admission), South Eastern Melbourne increased modestly from 10.2 per 10,000 in 2020–21 to 11.2 per 100,000 in 2023–24. This growth is slower than Victoria overall and significantly below the national trend (from 19.5 to 21.7 per 100,000). Among Victorian PHNs, South Eastern Melbourne remains the lowest, with Eastern Melbourne showing the strongest growth (from 12.0 to 13.8 per 100,000) and North Western Melbourne peaking at 13.9 per 100,000 before declining to 13.0 per 100,000 (see Appendix item D for more detail)

For other palliative care hospitalisations (i.e. hospital admissions where a diagnosis of palliative care is recorded, but the care type is not classified as palliative care, meaning palliative care was provided as part of broader treatment rather than being the primary reason for admission), South Eastern Melbourne rates fluctuated but ended slightly higher (from 20.3 to 21.5 per 100,000). This is comparable to the Victorian average (from 20.3 to 21.7 per 100,000) and higher than the national rate (from 15.9 to 18.6 per 100,000). Regional variation is evident: Eastern Melbourne peaked at 21.6 before dropping to 20.5 per 100,000, while North Western Melbourne grew steadily from 17.4 to 19.0 per 100,000.

Table 10: Rate of primary palliative care hospitalisations per 10,000 population from 2020 - 2024 FY.

Rate of primary Palliative Care Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	10.2	10.7	10.6	11.2
EMPHN	12.0	12.5	13.5	13.8
NWMPHN	12.5	13.9	13.4	13.0
VIC	13.4	13.9	14.1	14.3
National	19.5	19.9	20.6	21.7

Note: South Eastern Melbourne consistently records the lowest primary palliative care hospitalisation rates among Victorian metro PHNs, increasing modestly from 10.2 to 11.2 per 10,000 between 2020–21 and 2023–24. Growth is slower than Victoria overall and significantly below the national trend (19.5 to 21.7 per 100,000).

Source: Australian Institute of Health and Welfare. (2025). Palliative care services in Australia 2025: Data tables (Primary Health Networks - palliative care services).

Table 11: Rate of other palliative care hospitalisations per 10,000 population from 2020 – 2024 FY.

Rate of other Palliative Care Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	20.3	21.8	21.1	21.5
EMPHN	20.3	21.1	21.6	20.5
NWMPHN	17.4	18	18.4	19
VIC	20.3	21.2	21.2	21.7
National	15.9	16.9	17.8	18.6

Note: South Eastern Melbourne's rate of other palliative care hospitalisations rose slightly from 20.3 to 21.5 per 10,000, aligning closely with Victorian averages and remaining above national rates. Regional variation persists, with EMPHN peaking at 21.6 per 10,000 population before declining, and NWMPHN showing steady growth.

Source: Australian Institute of Health and Welfare. (2025). Palliative care services in Australia 2025: Data tables (Primary Health Networks - palliative care services).

Insight:

South Eastern Melbourne's relatively low primary palliative care hospitalisation rates and moderate growth relative to other PHNs suggest a need to explore service accessibility and community-based care models, while its higher rates for other palliative care hospitalisations indicate ongoing reliance on hospital-based services.

Palliative medicine attendances and case conference activity across PHNs

Across the 2022 - 2024, palliative care activity in South Eastern Melbourne has remained broadly stable, with subtle shifts in service patterns. Palliative medicine attendance rates (i.e. the proportion of people receiving specialist palliative medicine consultations) show minimal movement, indicating that overall reach is steady. However, the intensity of care per patient is increasing, as reflected in a higher number of services delivered to each individual. For example, the average services per person rose from 7.5 to 8.1, an 8% increase, suggesting more interventions per patient rather than more patients overall (see Appendix item E).

South Eastern Melbourne shows a mixed trend in palliative medicine case conferences between the two years. Case conferences (i.e. case conference is a multidisciplinary meeting involving at least one palliative medicine specialist and other formal care providers to coordinate and plan care for a patient receiving palliative care.) declined slightly, while discharge case conferences grew modestly, suggesting a shift in focus toward discharge planning. Overall, more people were reached, but the total volume of services delivered fell slightly, and service intensity per person dipped marginally. Participation in conferences appears to have dropped out entirely or is no longer reported. Compared to Victoria and national averages, South Eastern Melbourne's activity remains far lower in both reach and service delivery, indicating a much smaller scale of engagement. While Victoria also saw a slight overall decline, national figures remain substantially higher and more stable, highlighting a significant gap between South Eastern Melbourne and broader benchmarks (Appendix item E).

Palliative care activity in the SEMPHN catchment has remained broadly stable, but the patterns suggest a shift in service delivery priorities. While palliative medicine attendance rates indicate steady overall reach, the increase in service intensity per patient points to a growing focus on more comprehensive care for each individual rather than expanding access to new patients. In contrast, case conference activity shows mixed movement: community conferences declined slightly, while discharge conferences grew, signalling an emphasis on discharge planning and transition management. The absence of participation data may reflect reduced engagement or reporting gaps, which could impact care coordination quality.

Insight:

Compared to Victoria and national benchmarks, South Eastern Melbourne data indicates that the PHN operates at a much smaller scale, with significantly lower reach and service volumes. This gap highlights potential challenges in meeting broader system expectations and suggests opportunities to strengthen multidisciplinary collaboration and expand access to case conferencing as part of integrated palliative care.

Palliative care related medication utilisation trends

Between 2022–23 and 2023–24, South Eastern Melbourne's overall pain relief medication usage rate rose by 4.2% (3395.1 to 3539.1 per 100,000) which is slightly above the national increase of 3.8% (3245.9 to 3370.8 per 100,000), Eastern Melbourne's 2.4% increase (3044.0 to 3118.2 per 100,000), and similar to North Western Melbourne's 4.5% increase (3284.2 to 3433.0 per 100,000). South Eastern Melbourne also remains above the Victorian average for pain relief provision (see Appendix item G for full data). Within pain categories (i.e. anti-inflammatory, opioids and other analgesics), South Eastern Melbourne saw a small decline in anti-inflammatories, a modest rise in opioids, and a notable increase in other analgesics. These patterns were broadly consistent with national trends. Outside pain relief, South Eastern Melbourne recorded an increase in psychological medications, far exceeding other PHNs, and a moderate rise in neurological drugs. Gastrointestinal prescribing fell slightly, while respiratory medications dropped steeply compared to other regions.

Insight:

South Eastern Melbourne faces growing overall demand, a shift toward non-opioid analgesics and psychological support, and a distinctive pattern of reduced respiratory care. Resource planning should prioritise mental health and complex symptom management alongside sustaining pain relief capacity.

5. Stakeholder consultations

5.1 Consultation process

Consultations for the PCNA occurred with various stakeholders across the region in November 2025. This process included:

- ACP providers
- Health Network Palliative Care Units
- Community Palliative Care Providers
- General Practice staff
- Southern Metropolitan Region Palliative Care Consortium

While a rapid consultation process was undertaken to inform this needs assessment, SEMPHN is committed to working with palliative care stakeholders in the region on the implication of this PCNA, and in particular, how the needs of the community can be addressed through targeted activities and workplans.

5.2 Emerging themes

Demand for palliative care is outpacing resources

Stakeholders reported that demand for palliative care services, across inpatient, community and outpatient settings continues to grow significantly, identifying that referrals have increased by 20-30% in the last 3-5 years. This increase is driven by an ageing population and rising complexity of care needs (i.e. comorbidity and cultural and religious beliefs). There are indications that referral volumes to both community and specialist palliative care services are increasing (see section 4.2 of this report) and can be expected to increase further with increasing demand for palliative care for both cancer and non-cancer related conditions. Stakeholders reported a perceived significant increase in primary diagnoses of referred patients from cancer to dementia and other non-malignant conditions.

Stakeholders perceive that while demand for palliative care has grown, funding and workforce capacity have not kept pace. "*[Our] concern is the ageing population and how to manage with such small FTE and operational capability*"[6]. This widening gap means services often operate reactively rather than proactively. Many referrals occur late, often within 24 to 48 hours of death. Delayed engagement with palliative care limits the ability to plan and provide care according to patient preferences, particularly for those wishing to remain at home or in the community.

Importantly, stakeholders report a trend toward tightened service eligibility and greater prioritisation of acute, unstable complex cases, particularly cancers, due to constrained capacity. Community

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[6] Community Palliative Care Provider

palliative care teams also reported receiving more complex and unstable patients than in previous years, leaving fewer resources available to support patients earlier in their trajectory. This creates a cycle where only those in crisis are seen, reinforcing late referral patterns and limiting opportunities for proactive symptom management, anticipatory planning and ACP.

Stakeholders emphasised that without targeted investment and scalable service models, these gaps will persist, leading to greater inequities in access and increasing strain on both families and the health system.

Insight:

These patterns suggest that SEMPHN may need to consider strategies that address both scale and complexity of care. Without investment in scalable models and workforce capacity, services risk remaining reactive therefore limiting opportunities for early engagement and equitable access.

Fragmented systems and poor coordination undermine continuity of care

Stakeholders expressed that fragmentation between hospitals, GPs and community providers remains a significant challenge. Premature hospital discharges often cause patients to cycle between services "*with clients bouncing between home and hospital due to unclear service pathways and limited community supports*."[7] Further, stakeholders indicate that families face delays and confusion because information is not consistently shared and responsibilities for each stage of care are unclear. These gaps lead to missed referrals, duplicated work (such as repeated unnecessary hospital presentations) and considerable stress for those navigating a complex system. Stakeholders described "*huge communication gaps*"[8] between providers, with discharge planning practices varying significantly between hospitals and written plans not always provided to families.

Confusion between private and public service options adds further complexity. Stakeholders suggested several practical ideas including shared care models where GPs and specialists' alternate visits *("this works well in diabetes and maternity care")*[9], virtual referral pathways to streamline processes and regional navigator roles to guide patients and families through services. A central navigation resource supported by a dedicated liaison or 'navigation champion' was also suggested to decode hospital discharge information and ensure timely access to care.

Insight:

The level of fragmentation indicates that SEMPHN could explore mechanisms to improve integration and navigation across hospitals, GPs, and community providers. Shared-care protocols, central navigation supports, and clearer discharge processes may help reduce duplication and improve continuity for patients and families.

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[7] Clinical Manager - Nursing
[8] General Practice Manager & Manager of Palliative Care Consult Nurse team
[9] Manager Palliative Care Consultancy

Strengthening GP engagement is essential for improving care

GPs are critical to early identification, medication management and ACP, yet their involvement in palliative care remains limited. Stakeholders reported that time pressures, limited financial incentives for services such as home visits and hesitancy around prescribing palliative medicines such as opioids have impacted engagement with care supports that facilitate palliative and EOLC. Stakeholders felt that GPs were more difficult to engage around activities such as after-hours visits and certification of death certificates. Further, palliative care providers report that ACP documentation completed in primary care is often incomplete or not suitable for upload. Where education is provided to build GP capability in palliative care, knowledge is not always retained given many GPs see only a small number of palliative care patients each year, limiting their opportunities to apply knowledge in practice. These gaps are considered to contribute to late referrals to specialist palliative care and reactive models of care.

Strategies suggested by stakeholders to address these issues include expanding the role of practice nurses (i.e. by training them as ACP facilitators or as providers of palliative care education and health literacy) and introducing palliative care micro-learning to build confidence and capability across the primary care workforce. Strengthening GP engagement remains essential to support proactive care and reduce reliance on crisis-driven interventions.

Insight:

Limited GP involvement suggests SEMPHN may need to focus on building capability and confidence in primary care to support proactive palliative care. Strategies such as expanding practice nurse roles and introducing flexible education models could help address gaps in ACP, medication management, and timely referrals.

Cultural and linguistic barriers limit equitable access to palliative care services

Stakeholders consistently raised concerns about cultural and linguistic barriers that restrict access to palliative care. For example, there are regions within the South Eastern Melbourne that have a high proportion of palliative clients from non-English speaking backgrounds, yet interpreter services are not funded, forcing providers to rely on bilingual staff or telehealth interpreters.

Stakeholders suggest that cultural misunderstandings about palliative care have led to late or inappropriate referrals, sometimes without client consent. Ensuring cultural and religious practices around death and dying are honoured is an area that stakeholders report is an emerging area of carer stress.

First Nations engagement in palliative care remains minimal even though First Nations people represent an estimated 0.8% or approximately 12,000 of the population in the South Eastern Melbourne region (South Eastern Melbourne Primary Health Network, 2024). Stakeholders perceive that there are no explicit cultural or linguistic strategies developed to support First Nations communities in accessing culturally relevant palliative and EOLC. There was a perception that current service models are not tailored to cultural needs or designed to build trust. Without targeted approaches, there are reduced opportunities for First Nations people to access timely palliative care and ACP, which contributes to persistent health inequities.

Stakeholders emphasised that culturally responsive models and funded interpreter services are essential to improve equity and trust with their community.

Insight:

These patterns suggest SEMPHN may need to consider strategies that embed cultural responsiveness into service design and commissioning. This could include funding interpreter services, co-designing models with CALD and First Nations communities and building workforce capability to address cultural beliefs and practices around end-of-life care.

Community awareness and death literacy remain low

Despite previous awareness campaigns, misconceptions about palliative care continue to limit engagement and delay planning. Stakeholders indicated that many families struggle to navigate complex service systems, which increases reliance on providers for coordination. Confusion about the distinction between specialist and generalist roles often results in inappropriate referrals and missed opportunities for early intervention. Service providers expressed that end-of-life planning conversations are frequently crisis-driven and occur too late, reducing the ability to align care with patient preferences.

General practice stakeholders expressed that many patients and families misunderstand what palliative care involves and often associate it only with imminent death. These misconceptions lead to reluctance to engage early, reducing opportunities for advance care planning. Education gaps exist for both patients and carers about responsibilities, referral pathways, and available support, and health professionals also need clearer guidance on when and how to recommend palliative care.

While recent ACP promotion has improved awareness, it has also created capacity challenges, with some services reporting waitlists extending to March 2026. This demand has forced providers to scale back external education efforts. Stakeholders identified opportunities to better manage these capacity challenges in the future. It was suggested that future strategies could prioritise greater awareness about having these ‘difficult’ values-based discussions earlier in the care journey. The importance of having conversations with consumers about what ACP would look like for them was emphasised, noting that these are "difficult conversations" and that referrals are sometimes made to ACP services due to being worried about raising the topic.

Similarly, stakeholders felt that there were opportunities to improve consumer and carer capability in the use of tools that enable self-completion of ACP documents. Stakeholders noted successful experiences delivering awareness and demonstration initiatives through the University of the Third Age (U3A), where consumers were guided on how to self-complete ACP documents. Participants would complete the documents independently and then return to the provider for review or further support. From the provider perspective, however, it was noted that identification of which applicants are best suited for self-completion was challenging.

These approaches could help reduce reliance on clinician-led processes and improve confidence among patients and carers.

Insight:

Low community awareness and persistent misconceptions about palliative care delay early engagement and completion of ACPs. Prioritising education for consumers, carers and clinicians, alongside scalable ACP strategies, could improve death literacy and enable timely planning to prevent further demand pressures and growing inequalities.

Carer support and burden on families

Stakeholders emphasised that while most families prefer home-based palliative care, this option often becomes unsustainable due to the substantial physical, emotional, and financial burden placed on carers.

Carers are frequently required to navigate the complexity of coordinating physical health needs and health systems while supporting psychosocial challenges and managing their own emotional wellbeing. Limited access to respite, allied health services and knowing where to go for emergency support contribute to carer fatigue. Access to respite care and knowing how and where to access support is essential for carers to maintain basic routines, reduce stress, avoid burnout, recover, maintain their own health. General practice stakeholders described situations where people have been discharged from hospital with no definitive plan, experiencing information overwhelm and missing the 'what next' and a plan, explaining that end of life care discussion often gets pushed down the priority list for carers who are managing complexity in the moment.

Stakeholders reinforced this carer experience, highlighting that strengthening supports for carers is essential to sustain home-based care and improve patient outcomes. Stakeholders recognised that although increasing access to respite services is essential, providing targeted education on symptom management also creates opportunities to embed psychosocial supports earlier in the disease trajectory. An example of this is patient fatigue. Some clinical tools (like the Symptom Assessment Scale) recognise that while fatigue may not distress the patient in the terminal phase, it can be a significant concern for carers. Identifying carer distress about fatigue can be recorded and addressed in the care planning process. Grief, patient safety concerns and cultural complexities and managing their own physical and emotional wellbeing are other areas that contribute to carer stress.

Providing the opportunity to pre-emptively identify known areas that place additional strain on the carer role builds capacity for carers to have a 'toolkit' of knowledge and resources available ahead of when they might need them. Improving carers capacity may reduce or delay escalation of carer burnout. Ultimately, carer fatigue and burnout can have a role in undermining patient preferences and contribute to otherwise avoidable hospitalisations. Investing in early capacity building and supports for carers will have a downstream impact on improving service coordination and reduce health system costs.

Insight:

Carer burden threatens the sustainability of home-based palliative care and patient preferences. Investment in early capacity building, education and access to respite services can prevent burnout, avoid unnecessary hospitalisations, and improve patient outcomes.

Palliative care focus on cancer, leaving non-malignant conditions underserved

There were indications from stakeholders that current palliative care pathways remain biased towards cancer diagnosis and that non-malignant diagnostic conditions (e.g. dementia, advanced frailty, disabilities and other chronic conditions) are underserviced or have disproportionate access to palliative care settings. People experiencing non-malignant and chronic conditions with variable disease trajectories often experience longer, more complex but often stable disease progression. They may receive management support for their conditions for longer at home and in the community without being referred to specialist palliative care services until much later in their disease progression. This may mean they the palliative care services they receive are more reactive in nature, rather than planned. The increased ability to receive care management for these non-malignant disease presentations may be due to improved supportive therapies and improvements in aged care funding meaning that disease progression and symptom control may be improved, however, it may also result in this patient cohort having a level of 'invisibility' to the broader system.

When these consumers do present to palliative care, they are often more complex. Stakeholders provided the example of dementia often going unrecognised as a palliative condition, delaying conversations about goals of care and ACP until deterioration and crisis occurs. Community palliative care service providers reported greater numbers of late or missed referrals for non-malignant conditions and that they were seeing increasing referrals for non-malignant conditions such as dementia, noting that these 'add complexity' both due to the nature of the condition and the stage of disease progression. The issue is often not that the person is not receiving a referral to palliative care services, but that anticipatory planning for EOLC is not occurring to the same degree as for cancer-related diagnoses.

Increasing the focus on opportunities to build early intervention and anticipatory planning capability for non-malignant presentations may serve to reduce gaps in equitable access and facilitate access earlier in the disease trajectory. Improving workforce awareness and understanding around early intervention, anticipatory planning and care plan management for non-malignant conditions could include:

- Recognition of key clinical decision points to trigger discussion or actions associated with palliative care access and planning.
- Locally available services that provide support for disease progression (i.e. pharmacies that stock core palliative care medicines).
- Building interprofessional networks to improve informal care coordination.
- Improving clarity of protocols for service access and eligibility for palliative care services.
- Differentiating early-journey support from rapid response at terminal phases to manage capacity and avoid indiscriminate referral growth.

While the addition of funding mechanisms to support proactive engagement with palliative care services for non-malignant diagnosis may aid in the uptake of workforce development opportunities, many primary care providers may only identify a need for education around palliative care when it becomes a core issue in their patient population. Looking at data from practices and RACHs may aid the identification of people who could benefit from early help and planning. Practices may be able to use this data to recall patients for early intervention opportunities. Giving more support at the practice and RACH level may also help improve access to care, especially for people with non-malignant conditions.

Insight:

Current palliative care pathways disproportionately focus on cancer, leaving people with non-malignant conditions underserved and often referred late. Early intervention and anticipatory planning for non-malignant conditions could be improved through workforce education, clearer protocols, and proactive data use.

Technology-enabled palliative care service models are seen as a practical and accessible option.

A range of approaches to the delivery of care including in-clinic, home and site visits, and phone-based consultation were discussed throughout the consultation. Stakeholders reported a growing interest in the adoption of virtual models such as Hospital in the Home and Virtual ED both among providers and in terms of consumer uptake and perceived acceptability. The increasing use of these virtual approaches to delivery of care is being driven by the economics of time and increasing costs of face-to-face care. There is a recognition that people are becoming increasingly comfortable with receiving care in the home using technology. This technology driven uptake in models of care for palliative services may serve to support the increasing delivery of home-based care. Stakeholders noted that the outcome of this shift towards people becoming more comfortable and accepting of receiving palliative care at home and in the community may drive a greater consumer expectation for being able to access home-based palliative care services. Providers expressed that when coupled with growth in services that enable improved home-based care there are potential challenges with this shift in expectation towards home-based care. With greater number of people being able to facilitate dying at home, there will be an associated rise in demand for home-based specialist palliative care services during end-of-life disease phases. Leveraging digital solutions will be essential to meet rising demand and sustain home-based care.

Gaps in funding, digital infrastructure and workforce capability continue to constrain implementation of virtual models of care. Providers felt that while virtual care could improve reach and efficiency, success was dependent on investment in reliable technology, workforce training and integration with existing referral pathways.

Stakeholders expressed that non-virtual models care such as such as nurse-led clinics and shared care models with GPs could improve workforce capacity and ‘were promising’, however, the structural and funding support required to scale these approaches were a limiting factor. Providing the example of ACP not being within the core role of the practice nurse. yet being a role that could quite readily be performed by a practice nurse. This suggests a discussion about whether ACP could or should be embedded as a responsibility for practice nurses, indicating consideration of a nurse-led approach to

ACP. Embedding ACP into role descriptions and broader workforce engagement in ACP, which could occur in nurse-led models is an opportunity where workforce capacity could be improved through shift in models of service delivery.

Insight:

Virtual and nurse-led models offer a pathway to meet growing demand for home-based palliative care, but SEMPHN may require strengthened technology and workforce capacity to avoid service gaps and inequitable care.

Workforce shortages and system-wide capacity gaps limit the delivery of timely, coordinated palliative care.

Stakeholders emphasised that workforce limitations extend beyond primary care and affect the entire palliative care system. Community palliative care providers expressed that many factors associated with a need for palliative care services (ageing population, increase referral numbers, rising complexity) also increased strain on the workforce and felt that demand for services, especially home-based services, often outstripped supply. Shortages and reliance on small clinical teams by many service providers limit the ability to meet rising demand.

Changing workforce characteristics impact knowledge retention and sector capacity, both in primary care settings and the sector more broadly. Stakeholders perceived that there were many GPs in the region retiring, resulting in reduced availability of primary care services. Similarly, it was noted that there are few GPs who do home-visits in the region, limiting supports for people who may be homebound due to disease progression. It was expressed that the limitations of confined full-time equivalent (FTE) staff and absence of activity-based funding constrain service delivery and community engagement.

Stakeholders provided examples of a range of models in use in PHN regions across Australia that may offer opportunities to improve workforce capacity in the region. Providing examples such as co-commissioned trials of virtual support models, clinic diversion pathways, and shared resources across community palliative care services. The Nurse Practitioner ElderCare model in South Australia was provided as an example. In this approach, the Nurse Practitioner (NP) works autonomously and has the expertise to support referral to other health professionals, and access to medical advice as required. The NP may take on specialist support roles including provision of clinical advice to residents, promoting ACP, facilitation of 'Needs Rounds' - identify those who are deteriorating, participation in palliative care case conferences with residents and carers and education and mentoring of staff.

These extended scope of practice and navigator roles were identified as a strategy to improve coordination between hospitals, community teams and families, ensuring timely referrals and reducing fragmentation of care. Providers stressed that sustainable funding and clear protocols are essential to embed these workforce innovations and deliver equitable, high-quality palliative care.

Insight:

Workforce shortages and changing dynamics across the palliative care system are creating significant gaps in service delivery, particularly in home-based care. Without sustainable funding and innovative workforce models, there is a risk of worsening inequities in access to palliative care, leaving vulnerable patients without timely and coordinated care.

VAD legislative reforms will reshape demand, workforce requirements and governance across palliative care.

The Voluntary Assisted Dying Amendment Bill was introduced to the Victorian Parliament in 2025 following a five-year review of the state's VAD laws (Parliament Victoria, 2025). Proposed changes include:

- Removing the 'gag clause' to allow clinicians to raise VAD with patients.
- Adjusting residency and prognosis eligibility criteria.
- Shortening the timeframe between first and final VAD requests.
- Expanding authorised practitioners to include nurse practitioners and registered nurses.

These reforms aim to improve access and flexibility within Victoria's VAD framework, with significant implications for palliative care planning and workforce development (Parliament Victoria, 2025).

Anticipated changes in VAD legislation will increase demand on palliative care and ACP services and place additional pressure on the workforce. Stakeholders raised concerns about the need for clear protocols and governance frameworks as well as culturally sensitive approaches to manage this transition.

Clinicians will require specialised training and confidence to navigate complex ethical and legal issues, particularly when supporting diverse communities. Integration with ACP processes is essential to avoid duplication and ensure patient preferences are respected. Planning for legislative impacts now, including funding and accountability measures, will help services remain responsive and deliver safe and equitable care aligned with patient values.

Insight:

The recent VAD reforms may intensify demand for palliative care and ACP services, making it critical for SEMPHN to strengthen workforce readiness, governance, and culturally responsive practices to ensure safe and equitable patient-centred care.

6. Service mapping

Palliative care in the South Eastern Melbourne catchment is delivered through a mix of specialist inpatient units, community and home-based specialist care teams (Hospice and outreach specialist services), regional coordination services. The region includes seven specialist inpatient services within public and private hospitals: Calvary Bethlehem, Cabrini Malvern, Monash Health McCulloch House, Casey Hospital, The Alfred and Peninsula Health's Palliative Care Centre. Four multidisciplinary community providers deliver specialist care at home: Palliative Care South East, Peninsula Home Hospice, Calvary Bethlehem Outreach and Cabrini Home-Based Palliative Care. One regional body, the Southern Melbourne Region Palliative Care Consortium, provides coordination and workforce support.

There are no standalone hospices in the region. All hospice-style beds are located within hospital settings. The total dedicated specialist bed capacity is approximately 71 across Bethlehem, Cabrini, McCulloch House, Casey Hospital and Peninsula Health, although Peninsula Health's exact number is not publicly reported.

Table 1112 provides an overview of specialist palliative care services across the South Eastern Melbourne catchment and nearby areas, outlining each provider's location, service types, local government areas served, referral pathways and available capacity.

Table 11: Palliative care service map for South Eastern Melbourne catchment and near surrounds

Service provider	Location	Primary service type	Other service types	LGAs served	Referral source / intake	Capacity
Palliative Care South East	80 Victor Crescent, Narre Warren VIC 3805	Community palliative care (specialist home-based)	Multidisciplinary home visits; carer support; advice to GPs & providers	Casey; Cardinia; Greater Dandenong; Kingston (parts)	Referrals via intake team – GP, hospital, specialist, RACH & self-referral (phone & form)	Community only – no inpatient beds
Peninsula Home Hospice (PHH)	327–331 Main Street, Mornington VIC 3931	Community palliative care (specialist home-based)	Bereavement support; education; respite via Peninsula Health Hospital when needed	Frankston; Mornington Peninsula; Kingston (parts)	Referrals via Consultmed / referral form – GP & other health professionals	Community only – no inpatient beds
Calvary Health Care Bethlehem	476 Kooyong Road, Caulfield South VIC 3162	Specialist palliative care (public hospital)	32-bed inpatient unit; consultancy; day centre;	Bayside; Glen Eira; Port Phillip; Stonnington;	Referrals to Access & Intake – GP / specialists / hospital teams	32 inpatient palliative care beds

			education services	Kingston (parts)		
Cabrini Health – Malvern	181–183 Wattletree Road, Malvern VIC 3144	Private specialist palliative care	18-bed inpatient unit; home care; consultancy to GPs & providers	Bayside; Glen Eira; Port Phillip; Stonnington; Kingston (parts)	Referrals via GP / specialist / hospital team	18 inpatient palliative care beds
The Alfred (Alfred Health)	55 Commercial Road, Melbourne VIC 3004	Specialist palliative care (hospital consult service)	Outpatient clinic; consultancy across hospitals; community outreach; advance care planning	Bayside; Glen Eira; Port Phillip; Stonnington; Kingston (parts)	Referrals via Alfred guidelines – GP, specialist, hospital referrals	No fixed dedicated palliative beds (consult service model)
Monash Health – McCulloch House	246 Clayton Rd, Clayton VIC 3168	Specialist palliative care (inpatient hospice unit)	16-bed hospice unit; 5-bed palliative unit at Casey Hospital; consultancy	Casey; Cardinia; Greater Dandenong; Kingston (parts)	Referrals via treating healthcare professional; transfer or admission	21 total palliative beds (16 + 5)
Peninsula Health – Palliative Care Centre	125 Golf Links Road, Frankston VIC 3199	Specialist palliative care (public inpatient)	Consultancy; outpatient clinic; community interface via PHH	Frankston; Mornington Peninsula; Kingston (parts)	Referrals via Pen Health ACCESS & guidelines – GPs and hospital clinicians	Bed numbers not public (operational unit)
Southern Melbourne Region Palliative Care Consortium (SMRPCC)	140–154 Sladen Street, Cranbourne VIC 3977	Regional coordination & workforce planning (non-clinical)	Education & training; RACH support; regional service collaboration	Bayside; Glen Eira; Port Phillip; Stonnington; Casey; Cardinia; Greater Dandenong; Frankston; Mornington Peninsula; Kingston (parts)	Not a referral service – contact for projects / education / regional coordination	No clinical capacity (no beds)

As mentioned in SEMPHN's 2024 Needs Assessment, the region also contains 493 general practices, 155 residential aged care facilities, 410 pharmacies and two Aboriginal Community Controlled Health

Organisations, which play a key role in referral pathways and continuity of care post-discharge (South Eastern Melbourne Primary Health Network, 2024).

Figure 2 provides a map of the Palliative Care Services across the South Eastern Melbourne catchment as of September 2023.

Figure 2 - Palliative Care Services across the South Eastern Melbourne catchment as of September 2023

7. Recommendations and opportunities

Drawing together the quantitative analysis and rich stakeholder insights, this section outlines a practical roadmap for how SEMPHN may work to strengthen access to high-quality palliative care across the region over the next one to three years (2026 – 2029). The recommendations are grounded in clear signals from the data – a rapidly ageing population, high burden of chronic and life-limiting illness, lower palliative utilisation than state and national benchmarks, and culturally diverse considerations – as well as what clinicians and service providers told us about challenges and opportunities on the ground. They are designed to be actionable, scalable and aligned with the GCfAHPC priorities, focusing on workforce capability, community awareness, medicines access and improved support for priority populations. Together, they provide a sequenced set of next steps to guide commissioning, partnership and advocacy efforts to build a more coordinated, person-centred and equitable palliative care system.

Table 13: Recommendations and Opportunities

Recommendation	Why (Evidence & Rationale)	GCfAHPC Impact Area Alignment
7.1 Plan to strengthen primary-care-led ACP and early identification (with practice nurses as ACP facilitators in high-need LGAs such as Casey, Greater Dandenong, Mornington Peninsula).	• A primary-care-led approach to ACP is essential given the rapid ageing of the South Eastern Melbourne population and the steady increase in multimorbidity. • The population aged 65+ has grown substantially, and referrals are often occurring very late, sometimes within 24–48 hours of death. This limits the ability to plan care in line with patient preferences and reduces the effectiveness of community-based care. • General practitioners remain the most appropriate place for early ACP and the identification of palliative needs, yet their capacity is constrained by time pressures, inconsistent	Workforce education and awareness; community awareness; Medicines (anticipatory prescribing & ACP)

	training, retention and low confidence in opioid prescribing and ACP demand currently exceeds workforce capacity. • A strengthened model would include normalising values-based ACP in general practice, expanding the role of practice nurses as ACP facilitators, embedding micro-learning for GPs and practice staff, and piloting after-hours or virtual ACP clinics. • A stronger generalist palliative framework across primary care would help shift practice from reactive to proactive identification and improve symptom management earlier in the trajectory.	
7.2 Work to build culturally responsive and equitable palliative care initiatives and models (CALD & First Nations advisory group, co-designed models, funded interpreting, bilingual roles in priority LGAs.)	• The South Eastern Melbourne region has LGAs with some of the highest proportions of CALD residents in Victoria (e.g., Casey, Greater Dandenong, Glen Eira), yet interpreter services are not readily accessible and cultural misunderstandings often lead to delayed or inappropriate referrals. • Stakeholders reported that in some communities' death is taboo, and palliative care is perceived as hastening death. • First Nations engagement is minimal despite significant regional populations, indicating gaps in culturally safe and trusted pathways. • A culturally responsive model would include co-design with CALD leaders and Elders, multilingual and culturally tailored resources, additional funding for interpreter support, bilingual	Priority populations; community awareness; workforce education (building cultural capability)

	clinician roles where appropriate, and culturally adapted death literacy initiatives. • Without these strategies, CALD and First Nations communities will continue to face inequitable access, lower awareness and reduced confidence in palliative care services.	
7.3 Design and develop integrated pathways for non malignant conditions (such as dementia, frailty, COPD, heart failure and other non-cancer conditions).	• Hospitalisation data shows that around two-thirds of palliative care admissions relate to non-cancer conditions, yet stakeholders note that current pathways remain heavily cancer-focused and dementia, in particular,” is rarely recognised as a palliative condition” until very late, despite being the leading cause of death for women and increasing sharply with age. • People with dementia experience long periods of decline, complex symptom needs and fragmented care across settings. • Meanwhile, chronic respiratory disease, heart failure and multimorbidity are common across South Eastern Melbourne LGAs and increase symptom burden and planning needs. • Integrated pathways should include clear eligibility criteria based on function rather than diagnosis, strengthened partnerships with memory clinics and gerontology services, dementia-inclusive ACP clinics and facilitate training across primary care and aged care to recognise palliative trajectories earlier. • This will ensure people with non-malignant conditions receive equitable and timely palliative support.	Workforce education & awareness; Priority populations

7.4 Improve navigation, coordination and shared-care across the palliative care system (e.g., centralised hub/ palliative care liaison roles linked to hospitals, GPS and community providers)	• Stakeholders cited fragmentation between hospitals, general practice and community providers remains a major cause of stress for families and inefficiency for providers. • Stakeholders frequently described "huge communication gaps", premature discharges, inconsistent handover information, unclear role delineation and families being left without written plans or understanding of what services are available leaving families "cycling between home and hospital". • Qualitative data show that palliative care service utilisation remains significantly lower in South Eastern Melbourne than Victorian and national averages, suggesting that navigation barriers may limit access. • Coordinated regional navigation, consistent discharge protocols, shared-care arrangements between specialists and GPs, and standardised referral processes may reduce duplication and ensure smoother transitions. • A dedicated liaison or navigation "champion" role could support families understand hospital discharge notes, access medicines and equipment, and ensure timely community follow-up—especially in disadvantaged LGAs where navigation capacity is lowest.	Community awareness; Workforce awareness
7.5 Explore and trial ways to enhance access to palliative medicines and symptom management (with community	• Data shows that palliative medicine use is dominated by pain relief (41%), yet neurological and psychological medications are dispensed at significantly lower rates than Victorian benchmarks. However, medication prescribing is symptom-	Workforce education and awareness; community awareness

pharmacies, GPs and community palliative teams).	driven, and pain relief can also address psychological or other distress. Further information would be needed to determine whether this reflects gaps in managing symptoms such as agitation, breathlessness, delirium, or psychological distress. • Stakeholders noted variable confidence among GPs in prescribing opioids and poor access to after-hours hours medical support, leading families to call emergency services when a patient dies outside usual service hours. • Developing a “palliative-ready pharmacy network”, standard anticipatory prescribing bundles, improving prescriber confidence through micro-learning and providing after-hours telehealth support may improve the safety and timeliness of symptom control, and ensure timely access to key medicines in high need LGAs. This is essential for enabling home-based care and reducing avoidable hospitalisations.	
7.6 Explore ways to strengthen carer support to sustain home based care (e.g., education, psychosocial support, linkage to respite and practical supports).)	• Evidence shows that carers often shoulder substantial emotional, physical and clinical demands, particularly in LGAs such as Casey, Greater Dandenong and the Mornington Peninsula where physical assistance needs among the 65+ population are highest. • Stakeholders described carers shouldering substantial physical, emotional and financial burden, often without structured respite or after-hours backup, leading to avoidable hospitalisations and breakdown of home-based care. • Expanding respite, providing structured carer education on symptom management and medicines, embedding	Community awareness; priority populations; access to palliative medicines.

	psychosocial support and linking carers to financial or housing assistance where required may help sustain care at home, align with patient preferences and reduce acute demand.	
7.7 Invest in short and long term opportunities to grow and upskill the workforce (including nurse-led models across priority LGAs)	• Stakeholders report workforce limitations are pervasive across specialist, generalist and community settings and note that high turnover among nurses and palliative care workforce undermines continuity of care. • Specialist services are at capacity, forcing them to prioritise only the most complex and unstable cases—contributing to a cycle of late referrals. • Evidence from other jurisdictions (e.g., Hospital in the Home) shows nurse-practitioner led models may safely extend reach, support RACHs and GPs and may offer a scalable solution for increasing capacity while maintaining quality. Piloting and scaling nurse-led models in high-need LGAs may increase capacity without relying solely on scarce specialist physicians. • Stakeholders also emphasised the value of micro-learning, structured capability frameworks and embedding palliative modules into onboarding processes for community and aged-care staff. • Developing advanced practice nurse roles, establishing shared-care models with GPs and creating clear capability frameworks would help address rising demand and complexity.	Workforce education and awareness

7.8 Explore and trial ways to expand digital and virtual care for home-based palliative support (telehealth reviews, virtual case conferences, and remote ACP support, prioritising outer-urban LGAs).	• Non-admitted palliative care for 75+ grew by ~50% in one year, reflecting a shift toward community-based care. Yet South Eastern Melbourne still has much lower service rates than Victoria and nationally, alongside geographic challenges and travel burden in certain LGAs. • Stakeholders expressed interest in Virtual ED/Hospital in the Home and telehealth models but cite infrastructure and integration gaps. Piloting initiatives such as virtual care platforms, integrated with navigation and ACP, may extend reach into outer-urban and high-disadvantage areas and support home-based management of complex symptoms, potentially reducing hospitalisations.	Workforce education and awareness; Community awareness (through virtual education); Improve access to palliative care medicines (through virtual review and prescribing)
7.9 Explore ways to strengthen data, evaluation and prepare for VAD legislative changes	• Data for palliative care is fragmented across ABS, AIHW, POLAR, PCOC and hospital systems, making it difficult to track local needs or measure change. • Service utilisation across South Eastern Melbourne remains below Victorian and national averages, yet the drivers of this variation are not fully understood. • Legislative changes to Victoria's VAD framework will also require robust governance, workforce training and integrated ACP processes. Stakeholders expressed concern about protocols, cultural sensitivity and workload implications. • SEMPHN is well placed to support training, ethics/governance guidance and alignment of VAD conversations with ACP and palliative pathways, particularly	Workforce education; Community awareness; Priority populations

	for CALD and First Nations groups where beliefs about VAD and end-of-life care may be complex and sensitive. • Establishing and trialling a regional palliative care dashboard, data-sharing agreements and an evaluation working group may enable SEMPHN to benchmark progress, identify inequities, prepare for legislative impacts and publish an extract of meaningful insights to guide future planning.	

Appendices

Appendix 1: Stakeholders consulted

Table 14: Stakeholder Consultation

Stakeholder Group	Organisations participated	Date Consulted	Purpose
Community Palliative Care Providers	• Palliative Care South East • Peninsula Home Hospice • Calvary Bethlehem	11 November 2025	To understand current strengths, challenges, and coordination needs within community-based palliative care, while exploring emerging trends, service gaps, and workforce capability to identify opportunities for collaboration and integration.
Advance Care Planning Providers	• Alfred Health ACP Unit • Monash Health ACP Unit • Peninsula Health ACP Unit	13 November 2025	To explore how ACP is currently implemented across the South Eastern Melbourne region, identify barriers and enablers to consistency and accessibility, and understand workforce capacity and community awareness to improve coordination.
Consortium	• Southern Metropolitan Palliative Care Consortium members	18 November 2025	To explore diverse approaches to community-based palliative care within consortium member organisations, assess how these models integrate with primary care and specialist services, and collaboratively identify emerging trends, service gaps, and workforce capacity challenges.

Health Network Palliative Care Units	Acute palliative care teams from: • Alfred Health • Monash Health	20 November 2025	To understand hospital-based palliative care models, examine integration with community services, and identify emerging trends, gaps, and workforce capacity to enhance continuity of care and patient experience.
General Practice and Practice Managers	• North Road Medical	21 November 2025	To understand how GPs are currently involved in palliative care, explore practical approaches to supporting patients and families in the community, examine how referral pathways and collaboration with specialist services work in practice, and identify emerging trends, service gaps, and workforce challenges from a primary care perspective

Appendix 2: Quant data analysis tables (i.e. PCSiA, ABS, PCOC)

Appendix item A - Average distribution of hospitalisations based on age 2022-2024 FY

		Admitted Patient Palliative Care (NHMD)									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2022-2023	SEMPHN	18.0	0.6	50.0	1.2	317.0	7.2	1529.0	48.2	3184.0	265.0
	EMPHN	16.0	0.6	40.0	1.0	341.0	8.1	1494.0	47.1	3525.0	277.1
	NWMPHN	24.0	0.7	65.0	1.1	502.0	9.4	1832.0	61.1	3601.0	373.2
	Vic	66.0	0.7	192.0	1.1	1604.2	9.0	7235.1	53.2	14504.5	287.4
	National	919.5	2.3	925.0	1.4	6466.0	9.4	31953.9	58.4	60119.8	302.8
2023-2024	SEMPHN	16.0	0.5	53.0	1.2	362.0	8.0	1748.0	54.4	3222.0	256.3
	EMPHN	7.0	-	37.0	0.9	328.0	7.7	1661.0	51.9	3398.0	258.6
	NWMPHN	20.0	0.6	65.0	1.0	467.0	8.4	2057.0	67.1	3714.0	368.6
	Vic	62.0	0.8	202.0	1.1	1556.0	8.5	8056.0	58.6	14853.0	282.6
	National	908.0	2.2	1045.0	1.5	6840.0	9.8	34810.0	63.0	62403.0	300.6

		Non-admitted Patient Palliative Care (NHMD)									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2022-2023	SEMPHN	187.0	6.4	717.0	16.5	3411.0	77.1	15388.0	485.0	21644.0	1801.7
	EMPHN	164.0	6.0	622.0	15.3	5281.0	125.9	19175.0	603.9	31554.0	2480.4
	NWMPHN	306.0	8.8	677.0	11.1	5104.0	95.7	16434.0	547.8	19500.0	2021.2
	Vic	873.0	9.6	2871.1	16.3	21233.5	118.6	86747.7	638.0	112217.9	2223.5
	National	7003.0	17.4	10813.0	16.5	70275.8	102.2	298702.8	545.6	375765.9	1892.6
2023-2024	SEMPHN	230	7.8	1,116	24.5	5,524	122.2	21,747	676.3	33,823	2691

		Non-admitted Patient Palliative Care (NHMD)									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2023-2024	EMPHN	168	-	993	23.1	6,238	145.5	27,706	865.9	51,192	3896.2
	NWMPHN	350	9.8	1,052	16.1	6,381	115	24,329	793.3	37,702	3741.4
	Vic	1,135	14.8	4,011	21.6	25,320	138	113,796	827.8	171,440	3261.3
	National	7,042	17.4	11,966	17.2	78,436	111.8	351,739	636.6	473,393	2280.7

		All patient Palliative Care									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2022-2023	SEMPHN	205.0	7.0	767.0	17.7	3728.0	84.3	16917.0	533.2	24828.0	2066.7
	EMPHN	180.0	6.6	662.0	16.3	5622.0	134.0	20669.0	651.0	35079.0	2757.5
	NWMPHN	330.0	9.5	742.0	12.1	5606.0	105.1	18266.0	608.9	23101.0	2394.4
	Vic	939.0	10.3	3063.1	17.4	22837.7	127.5	93982.8	691.3	126722.3	2510.9
	National	7922.5	19.7	11738.0	17.9	76741.8	111.6	330656.7	603.9	435885.7	2195.3
2023-2024	SEMPHN	246.0	8.4	1169.0	25.6	5886.0	130.2	23495.0	730.7	37045.0	2947.3
	EMPHN	175.0	-	1030.0	24.0	6566.0	153.2	29367.0	917.8	54590.0	4154.8
	NWMPHN	370.0	10.4	1117.0	17.1	6848.0	123.4	26386.0	860.3	41416.0	4110.0
	Vic	1197.0	15.6	4214.0	22.7	26876.0	146.5	121852.0	886.4	186293.0	3543.8
	National	7950.0	19.6	13011.0	18.7	85276.0	121.6	386549.0	699.6	535796.0	2581.3

Appendix item B - Average distribution of socioeconomic status for hospitlisations and service events 2022 – 2024 FY

		Admitted Patient Palliative Care (Socioeconomic area) (per 10,000 pop)				
Year	PHN	1	2	3	4	5
2022-23	SEMPHN	29.3	35.5	27.6	29.6	34.8
	EMPHN	67.7	41.7	34.9	30.7	34.7
	NWMPHN	40.3	34.6	29.1	26.6	30.0
	Vic	44.8	40.0	33.2	29.3	33.4
	National	47.3	43.9	37.7	31.9	33.1
2023-24	SEMPHN	33.0	33.9	29.1	29.5	36.1
	EMPHN	69.2	35.6	34.5	29.7	34.8
	NWMPHN	37.7	33.8	31.1	26.8	32.6
	Vic	44.2	42.0	35.1	28.8	34.3
	National	47.5	45.9	39.7	32.6	34.2

		Non-admitted Patient Palliative Care (Socioeconomic area) (per 10,000 pop)				
Year	PHN	1	2	3	4	5
2022-2023	SEMPHN	267.5	384.5	259.9	239.7	217.5
	EMPHN	549.6	339.2	378.0	321.1	391.6
	NWMPHN	267.6	199.2	267.4	183.3	197.7
	Vic	403.5	420.5	346.2	266.3	282.4
	National	368.0	349.4	303.5	217.9	235.6
2023-2024	SEMPHN	383.7	518.0	354.8	365.0	343.7
	EMPHN	754.6	535.2	576.0	469.5	574.7
	NWMPHN	448.5	321.1	394.9	290.3	323.4
	Vic	519.3	580.8	455.7	376.4	414.2
	National	414.6	430.3	351.1	260.9	285.6

		All Admitted Patient Palliative Care (Socioeconomic area) (per 10,000 pop)				
Year	PHN	1	2	3	4	5
2022-2023	SEMPHN	205.0	7.0	767.0	17.7	3,728.0
	EMPHN	180.0	6.6	662.0	16.3	5,622.0
	NWMPHN	330.0	9.5	742.0	12.1	5,606.0
	Vic	939.0	10.3	3,063.1	17.4	22,837.7
	National	7,922.5	19.7	11,738.0	17.9	76,741.8
2023-2024	SEMPHN	205.0	7.0	767.0	17.7	3,728.0
	EMPHN	180.0	6.6	662.0	16.3	5,622.0
	NWMPHN	330.0	9.5	742.0	12.1	5,606.0
	Vic	939.0	10.3	3,063.1	17.4	22,837.7
	National	7,922.5	19.7	11,738.0	17.9	76,741.8

Appendix item C – Palliative care-related hospitalisations, by Primary Health Network (PHN) and principal diagnosis, 2022-24 FY

		Primary palliative care hospitalisations					
Year	PHN	Primary palliative care hospitalisations Cancer No.	Primary palliative care hospitalisations Cancer %	Primary palliative care hospitalisations Cancer Hospitalisations per 10,000 pop	Primary palliative care hospitalisations Non-cancer No.	Primary palliative care hospitalisations Non-cancer %	Primary palliative care hospitalisations Non-cancer Hospitalisations per 10,000 pop
2022-2023	SEMPHN	1044.0	0.6	6.5	660.0	0.4	4.1
	EMPHN	1066.0	0.5	6.9	1013.0	0.5	6.6
	NWMPHN	1149.0	0.5	6.1	1391.0	0.5	7.4
	Vic	4752.9	0.5	7.1	4644.9	0.5	6.9
	National	26031.9	0.5	10.0	27849.9	0.5	10.7
2023-2024	SEMPHN	1049.0	0.6	6.4	803.0	0.4	4.9
	EMPHN	1119.0	0.5	7.1	1064.0	0.5	6.7
	NWMPHN	1182.0	0.5	6.0	1384.0	0.5	7.0
	Vic	4855.2	0.5	7.1	4967.6	0.5	7.2
	National	27473.9	0.5	10.3	29534.9	0.5	11.1

Appendix item D – Palliative care-related hospitalisations, by Primary Health Network (PHN), 2020–21 to 2023–24 FY

Number of Primary Palliative Care Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	1,633	1,706	1,704	1,852
EMPHN	1,867	1,912	2,079	2,183
NWMPHN	2,339	2,580	2,540	2,566
VIC	8,882	9,204	9,398	9,823
National	50041	51342	54096	57845

Rate of Primary Palliative Care Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	10.2	10.7	10.6	11.2
EMPHN	12.0	12.5	13.5	13.8
NWMPHN	12.5	13.9	13.4	13.0
VIC	13.4	13.9	14.1	14.3
National	19.5	19.9	20.6	21.7

Rate of Other Palliative Care Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	20.3	21.8	21.1	21.5
EMPHN	20.3	21.1	21.6	20.5
NWMPHN	17.4	18	18.4	19
VIC	20.3	21.2	21.2	21.7
National	15.9	16.9	17.8	18.6

Rate of Palliative Care Related Hospitalisations				
PHN	2020-2021	2021-2022	2022-2023	2023-2024
SEMPHN	30.5	32.6	31.8	32.7
EMPHN	32.4	33.5	35.1	34.3
NWMPHN	30.0	31.9	31.9	32.0
VIC	33.7	35.1	35.3	36.0
National	35.4	36.8	38.4	40.3

Appendix item E – MBS-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists and people receiving them, by Primary Health Network (PHN), 2022-2024 FY

		Palliative medicine attendances								
		Attendance in a consulting room or hospital			Attendance in other settings			Palliative medicine attendances Subtotal		
	PHN	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person[10]
2022-2023	SEMPHN	68.4	516.1	7.5	0.7	1.3	1.9	68.9	517.4	7.5
	EMPHN	-	175.9	-	-	-	-	34.6	176.4	5.1
	NWMPHN	14.6	42.9	2.9	-	2.9	6.1	15.0	45.8	3.1
	Vic	123.6	1,182.9	16.7	21.7	94.8	12.2	220.1	1,278.8	30.2
	National	861.9	5,283.8	111.1	147.6	292.1	36.0	1,153.0	5,868.8	136.0
2023-2024	SEMPHN	67.8	552.8	8.2	0.6	0.7	1.1	68.1	553.5	8.1
	EMPHN	-	183.9	-	-	1.2	-	34.0	185.1	5.4
	NWMPHN	-	47.9	-	-	1.7	-	16.1	49.6	3.1
	Vic	124.3	1,114.3	18.2	25.2	144.1	9.4	212.0	1,381.8	33.7
	National	854.9	4,892.9	98.2	107.7	276.9	31.4	1,171.2	6,206.6	135.3

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[10] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

		Palliative medicine case conferences														
		Organise and coordinate a community case conference			Participate in a community case conference			Organise and coordinate a discharge case conference			Participate in a discharge case conference			Palliative medicine case conferences Subtotal		
	PHN	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person[11]
2022-2023	SEMPHN	21.3	24.0	1.1	-	-	1.0	30.3	61.9	2.0	-	13.8	1.7	49.1	100.0	2.0
	EMPHN	3.4	3.7	1.1	-	-	-	9.6	17.9	1.9	-	-	-	12.2	23.6	1.9
	NWMPHN	1.0	1.4	1.4	-	0.8	-	1.2	3.3	2.8	-	-	-	2.5	5.5	2.2
	Vic	39.6	51.3	6.4	5.7	7.0	2.1	45.4	89.3	8.1	9.0	13.8	1.7	88.6	171.1	11.4
	National	155.1	163.1	16.1	261.9	324.4	19.6	205.0	329.8	29.1	34.7	60.0	13.4	590.4	957.1	43.0
2023-2024	SEMPHN	20.1	21.7	1.1	-	-	-	32.1	64.2	2.0	-	-	-	52.4	98.5	1.9
	EMPHN	2.8	3.3	1.2	-	-	-	8.8	17.1	1.9	-	-	-	12.1	22.1	1.8
	NWMPHN	0.8	0.8	1.0	-	-	-	1.2	1.8	1.6	-	-	-	2.5	3.2	1.3

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[11] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

	Palliative medicine case conferences														
	Organise and coordinate a community case conference			Participate in a community case conference			Organise and coordinate a discharge case conference			Participate in a discharge case conference			Palliative medicine case conferences Subtotal		
PHN	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person[12]
Vic	33.6	45.0	6.6	2.0	2.4	1.2	45.5	88.5	7.0	-	-	-	85.2	155.1	9.8
National	129.2	185.1	19.4	232.4	295.2	14.7	199.7	315.8	25.7	16.3	28.8	9.8	562.6	879.5	42.3

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[12] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

		Total Palliative medicine attendance and case conferences Total		
	PHN	Rate (people per 100,000)	Rate (services per 100,000 pop)	Services per person[13]
2022-2023	SEMPHN	238.7	1,234.5	24.9
	EMPHN	59.8	397.6	10.0
	NWMPHN	34.2	102.6	18.5
	Vic	553.6	2,889.1	88.8
	National	3,409.5	13,279.3	404.3
2023-2024	SEMPHN	241.1	1,291.5	22.4
	EMPHN	57.8	412.8	10.4
	NWMPHN	20.6	105.1	6.9
	Vic	527.8	2,931.1	85.8
	National	3,274.0	13,080.8	376.9

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[13] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 5 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

Appendix item F – MBS-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists and people receiving them, by Primary Health Network (PHN) and age group, 2022-2024 FY

		MBS-subsidised palliative medicine attendance and case conference services provided														
		15 - 34			35 - 54			55 - 74			75+			Total		
		Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person[14]
2022-2023	SEMPHN	-	-	-	21.3	127.9	-	133.4	1,035.0	-	697.6	5,030.8	-	852.3	6,193.7	-
	EMPHN	-	2.4	-	12.1	58.4	-	53.1	364.4	-	268.3	1,319.9	-	333.5	1,745.0	-
	NWMPHN	-	2.8	-	6.6	33.6	-	42.8	137.3	-	133.0	375.0	-	182.4	548.8	-
	Vic Average	1.6	5.1	-	40.0	261.6	-	401.6	2,323.1	-	1,768.1	10,303.4	-	2,211.3	12,893.2	-
	National Average	18.4	191.9	-	305.6	2,293.7	-	2,579.4	12,673.6	-	10,009.7	46,607.2	-	12,913.1	61,766.5	-
2023-2024	SEMPHN	-	12	-	24	142	-	122	818	-	722	5,910	-	868	6,882	-
	EMPHN	-	4	-	-	52	-	54	393	-	276	1,361	-	330	1,809	-
	NWMPHN	-	2	-	-	25	-	45	128	-	155	497	-	200	651	-
	Vic Average	3	17	4	24	269	10	358	2,045	31	1,819	12,137	35	2,204	14,469	79

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[14] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 6 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx.

		MBS-subsidised palliative medicine attendance and case conference services provided														
		15 - 34			35 - 54			55 - 74			75+			Total		
		Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person	Rate (people per 100,000 pop)	Rate (services per 100,000 pop)	Services per person[15]
2023-2024	National Average	25	156	40	339	1,894	61	2,550	12,653	131	10,210	47,868	116	13,124	62,571	348

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[15] Total services per person is calculated by dividing the total number of services provided by the total number of people in the dataset. This represents the average number of services delivered per individual. The full 2023 - 24 dataset can be found in table 6 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx.

Appendix item G – Palliative care-related medications from PBS Palliative Care Schedule and people receiving them, by Primary Health Network (PHN) and medication group, 2022-2024 FY

		Palliative care-related medications rate of service per 100,000 population							
		Pain Relief				Gastrointestinal	Neurological	Respiratory	Psychological
	PHN	Anti-inflammatory and antirheumatic products, non-steroids	Opioids	Other analgesics and antipyretics	Subtotal pain relief	Gastrointestinal Subtotal	Neurological Subtotal	Respiratory Subtotal	Psychological Subtotal
2022-2023	SEMPHN	1039.6	1172.3	1183.2	3395.1	400.1	587.7	35.7	55.5
	EMPHN	860.6	1080.6	1102.7	3044.0	449.4	695.4	31.7	48.0
	NWMPHN	910.0	986.7	1387.5	3284.2	410.9	565.7	22.0	40.4
	Vic	1036.6	1507.4	1396.2	3245.9	419.3	612.5	29.3	47.5
	National	958.3	1570.3	1486.5	3245.9	N/A	N/A	N/A	N/A
2023-2024	SEMPHN	1005.6	1200.7	1333.0	3539.1	391.8	624.7	22.2	68.6
	EMPHN	780.2	1106.7	1231.3	3118.2	473.9	746.5	26.2	52.3
	NWMPHN	862.5	995.5	1575.2	3433.0	405.3	570.1	16.6	40.4
	Vic	1191.8	1152.9	1177.5	614.6	933.6	1675.5	1102.3	360.2
	National	906.6	1614.9	1728.4	3370.8	N/A	N/A	N/A	N/A

Appendix item H – Palliative care-related medications from PBS Palliative Care Schedule and people receiving them, by Primary Health Network (PHN) and age group, 2022-2024 FY

		MBS-subsidised palliative medicine attendance and case conference services provided																	
		0 - 14			15 - 34			35 - 54			55 - 74			75+			Total		
		Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person[16]
2022-2023	SEMPHN	43.8	67.8	1.5	598.1	1,059.8	1.8	1,376.4	3,179.4	2.3	2,857.2	8,170.0	2.9	7,653.2	22,505.9	2.9	12,528.7	34,983.0	11.4
	EMPHN	45.6	73.4	1.6	537.8	946.3	1.8	1,195.9	2,753.6	2.3	2,451.3	6,642.1	2.7	7,904.0	23,002.2	2.9	12,134.6	33,417.6	11.3
	NWMPHN	44.9	86.8	1.9	496.6	858.6	1.7	1,408.0	3,127.7	2.2	3,611.9	10,353.4	2.9	9,949.3	29,425.1	3.0	15,510.8	43,851.7	11.7
	Vic	310	627	12	3,998	7,327	11	9,556	24,662	15	19,281	59,150	18	52,533	166,389	19	85,678.5	258,154.6	75.2
	National	1,249	2,570	60	16,887	30,498	56	43,501	112,842	79	94,590	298,376	97	259,342	862,553	102	415,568.5	1,306,838.5	394.7
2023-2024	SEMPHN	41.1	68.0	1.7	574.1	1,025.1	1.8	1,395.9	3,177.1	2.3	2,936.7	8,300.6	2.8	8,145.4	24,440.1	3.0	13,093.2	37,010.9	11.5
	EMPHN	45.1	64.8	1.4	488.9	889.6	1.8	1,162.5	2,814.0	2.4	2,374.0	6,807.2	2.9	8,265.5	24,461.5	3.0	12,336.0	35,037.1	11.5

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[16] Total prescriptions per person is calculated by dividing the total number of prescriptions provided by the total number of people in the dataset. This represents the average number of prescriptions delivered per individual. The full 2023 - 24 dataset can be found in table 8 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 8 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

		MBS-subsidised palliative medicine attendance and case conference services provided																	
		0 - 14			15 - 34			35 - 54			55 - 74			75+			Total		
		Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person	Rate (people per 100,000 pop)	Rate (prescriptions per 100,000 pop)	Prescriptions per person[17]
2023-2024	NWMPHN	45.7	85.0	1.9	463.8	793.2	1.7	1,363.5	3,081.0	2.3	3,720.7	10,811.6	2.9	10,414.9	32,106.1	3.1	16,008.6	46,876.9	11.8
	Vic	314	613	11	3,825	7,070	11	9,481	25,168	16	19,434	61,726	19	54,776	181,327	20	87,829.8	275,903.7	76.7
	National	1,176	2,590	64	16,180	30,434	58	43,154	115,135	82	95,684	311,204	100	270,882	942,551	107	427,076.1	1,401,913.7	411.5

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[17] Total prescriptions per person is calculated by dividing the total number of prescriptions provided by the total number of people in the dataset. This represents the average number of prescriptions delivered per individual. The full 2023 - 24 dataset can be found in table 8 of the AIHW data found here: https://www.aihw.gov.au/getmedia/ce4d3cb1-8639-42fc-b253-d8d7a2f58f00/PCSiA-2025-Non-admitted-patient-palliative-care-data-tables.xlsx. The full 2022 - 23 dataset can be found in table 8 of the AIHW data found here: https://www.aihw.gov.au/getmedia/7906ad4c-5b30-48bd-afc4-426c96c1bc31/pcsia-may-2025-phn-palliative-care-services-data-tables.xlsx

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