phn
GIPPSLAND
An Australian Government Initiative

Gippsland PHN

Palliative Care Needs Assessment

December 2025

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Acknowledgements

Gippsland PHN acknowledges Aboriginal and/or Torres Strait Islander Peoples as the traditional owners of country throughout Gippsland, and their continuing connection to land, water and community. We pay our respects to them and their cultures, and to elders past, present and emerging.

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We acknowledge all internal and external stakeholders that supported, contributed and helped guide the work to inform the Gippsland PHN Palliative Care Needs Assessment 2025. We recognise the contributions of those with lived and/or living experience of palliative care, their families and carers.

Disclaimer

Palliative Care

"Palliative care" is high quality health care and support for people living with a life-limiting illness and their families. Palliative care helps people to live as well as they can by managing pain and symptoms to ensure their quality of life is maintained as the illness progresses.

Palliative care identifies and treats symptoms and issues associated with life-limiting illness which may be physical, emotional, spiritual or social. Palliative care is a family-centred model of care, meaning that family and carers can also receive practical and emotional support. Palliative care is about maintaining quality of life. The aim of palliative care is neither to hasten nor postpone death. Rather, the focus is on living as well as possible, for as long as possible. (Palliative Care Australia)

Summary

Gippsland health insights

- In 2023, there was a total of 3,139 deaths in Gippsland. 1,732 were males and 1,405 were females.
- By 2030, there will be a total of 4,247 deaths, based on an average annual growth of 4.4% per year (2019-2023).
- Approximately 31% of all deaths were in Residential Aged Care Homes (RACHs) in 2023-24, (32% in Australia).
- The palliative care workforce is mostly made up of palliative care nurses, with a total of 33 FTE in 2024, or 10.6 FTE per 100,000 population, lower than 13.1 nationally.
- Rates of palliative medicine services were 50% lower per population compared to national rates in 2023-24 (131 services per 100,000 population, compared to 264 nationally).
- Rates of palliative care-related prescriptions were the fourth highest in the country and 57% higher per population compared to national rates in 2023-24 (8,537 prescriptions per 100,000 population, compared to 5,427 nationally).
- The rate of non-admitted patient palliative care was highest in Australia and 102% higher per population compared to national rates in 2023-24 (756 service events per 10,000 population, compared to 374 nationally).
- Total palliative care-related hospitalisations have increased by an average of 8% annually between 2020-21 and 2023-24.

As a result of the insights gained, Gippsland PHN will prioritise activities which support:

Suitably skilled and supported workforce across the region

- Increased ability and confidence to provide palliative care among primary healthcare professionals, including recognising signs of deterioration.
- Improved ability to provide person-centred palliative care through a multidisciplinary approach.

Equitable access to palliative care services across Gippsland

- Improved equity of access to palliative care services across Gippsland, including in Residential Aged Care Homes (RACHs).
- Appropriate services for marginalised communities, including culturally competent care for Aboriginal and/or Torres Strait Islander peoples.

Integration and coordination of primary, community and specialist palliative care services

- Appropriate, timely, accessible and clear referral pathways from primary care to specialist palliative care, including in RACHs.
- All providers can access all relevant patient information, including after hours.
- Person-centred palliative care through a holistic approach.

Community awareness and understanding of palliative care

- Improved awareness of palliative care including timely Advance Care Planning (ACP) and End-of-Life Planning.
- Increased confidence among the primary health workforce to talk about death and dying to raise awareness of palliative care.

Community voices

“I want up to date information about what palliative care services are available and how to access them.”

“I get support so I can simply focus on them [my loved one] - talk to them, hold their hand, just be there, be present.”

“I want palliative care services to support families.”

“I want us to work to sustain the workforce we have.”

“I want clear information from my palliative care team”

What We Did

Overview

Gippsland PHN's Palliative Care Needs Assessment 2025 builds on the Gippsland PHN Health Needs Assessment 2025-28 (GPHN 2025e) and incorporates learnings from the national evaluation of the Greater Choice for At Home Palliative Care (GCfAHPC) program, and local projects and evaluations 2021-25. In addition, insights from stakeholder consultations undertaken during 2025 have been included.

Population health planning is an ongoing activity at Gippsland PHN, with numerous organisational processes that support the Health Needs Assessment, including:

- Evaluation of previous assessments and supporting documents
- Purpose and Culture Governance Framework which emphasises this work as a cross-organisational and ongoing responsibility
- Internal Populational Health project team
- A Population Health Steering Committee provides strategic oversight, monitors progress and ensures involvement by teams across the organisation
- Gippsland PHN Community Advisory Committee and Clinical Council
- A Population Health Advisory Panel including external stakeholders representing service providers, universities, community, lived experience and consumers provides advice about engagement activities, resource development, co-design activities and tender evaluations
- Ongoing updates and improvement to the Gippsland Health Data Hub (GPHN 2025f) and other resources that are publicly available
- And links to other Victorian PHNs via the Victorian and Tasmanian PHN Alliance.

Stakeholder Consultation

Gippsland PHN developed a stakeholder engagement plan for the Palliative Care Needs Assessment process to ensure broad and strategic consultation occurred. Stakeholders, including groups and individuals, were consulted through a variety of mechanisms including focus groups, one-on-one meetings, interviews, a survey and emails (**Table 1**). Where possible, Gippsland PHN consulted stakeholders utilising established arrangements, including the Community Advisory Committee and Clinical Council, and other existing meetings and stakeholder engagement opportunities hosted by Gippsland PHN teams, including within the aged care sector.

Targeted palliative care consultations (GPHN 2025d) through an online survey, which included an option to share contact details for an interview, was promoted widely through Gippsland PHN communication channels and supported by the Gippsland Regional Palliative Care Consortium (GRPCC). A series of three focus groups was held, targeting Residential Aged Care Homes (RACHs), professionals and community, and family and carers. See **Table 1**. Free text responses were thematically analysed, initially separately for survey, interviews and focus groups, followed by identification of overall themes across methods.

Table 1. Stakeholder consultations informing the Gippsland PHN Palliative Care Needs Assessment 2025.

Group	Timing	Method	Summary results
Gippsland PHN Clinical Council and Community Advisory Committee	August 2025	Workshops at the quarterly meetings of the Clinical Council and the Community Advisory Committee in August 2025	Identification of health and service needs related to palliative care and suggested options to address needs
Aged care service providers and professional stakeholders, including Residential Aged Care Homes	October-November 2025	Regular online interactive partnership meetings and Community of Practice meetings Online survey Focus group with local stakeholders Interviews with interested individuals	Identification of health and service needs related to palliative care in aged care and suggested options to address needs A total of 20 survey respondents Three focus group attendees
Clinicians and other professional stakeholders, including palliative care specialist service providers	October-November 2025	Existing meetings including the Gippsland Regional Palliative Care Consortium (GRPCC) Management Group General practice and commissioned services visits Online survey Focus group with local professional stakeholders Interviews with interested individuals	Up to date intelligence about health needs, service gaps and service mapping information gathered A total of 54 survey respondents and five interviews Seven focus group attendees
Community, family and carers	October-November 2025	Online survey Focus group with local community, family and carers, including those with lived and/or living experience of palliative care Interviews with interested individuals	Up to date intelligence about health needs and service gaps gathered Total of 18 survey responses and two interviews Two focus group attendees
Aboriginal and/or Torres Strait Islander peoples	2025	A Kinaway- certified Aboriginal business was commissioned to undertake consultation with people in Gippsland identifying as Gunaikurnai and Bunurong (Liz Allen Consulting 2025)	Palliative care needs of people in Gippsland identifying as Gunaikurnai and Bunurong
Gippsland PHN	Monthly	Monthly involvement facilitated through the Planning and Commissioning Committee	A whole-of-organisation approach

Health and Service Needs Analysis

Gippsland PHN reviewed a wide range of quantitative data to understand palliative care health and service needs. This was complemented with qualitative data obtained through stakeholder consultation. Quantitative data sets analysed include:

- Australian Bureau of Statistics (ABS): Census of Population and Housing
- Australian Institute of Health and Welfare (AIHW): National Non-admitted Patient Emergency Department Care Database; National Hospital Morbidity Database; Medicare Benefits Schedule; Pharmaceutical Benefits Scheme and multiple reports
- Public Health Information Development Unit (PHIDU): Social Health Atlas of Australia
- Victorian Department of Health (DH)Victorian Admitted Episodes Dataset (VAED)
- Commonwealth Department of Health, Disability and Ageing (DHDA): HeaDS UPP workforce needs tool; National Health Workforce Dataset, Healthdirect Healthmap
- Australian Commission on Safety and Quality in Healthcare: Australian Atlas of Healthcare Variation
- Gippsland PHN: de-identified GP data extracted by Outcome Health using POLAR

The focus for service mapping was on contributing to improvements in data quality in the National Health Service Directory (NHSD), related platforms and specialised service information platforms for palliative care, including through the Gippsland Region Palliative Care Consortium (GRPCC). This approach was taken to enhance support for both providers and consumers to access up to date service information for referrals and for people seeking suitable primary healthcare for themselves.

As part of this approach, Gippsland PHN has continued to work with primary care providers including general practices, commissioned service providers and the broader health system to share the latest resources and tools and to encourage them to keep all their details in the system up to date, rather than gather local data.

For a full list of references for quantitative and qualitative data used in this report, refer to **References**.

Triangulation and Prioritisation

The process of triangulation and priority setting used by Gippsland PHN was informed by the method used in 2024 (GPHN 2025e), with some modifications. Principles included:

- Evidence-based
- Balanced and taking account of the views of priority groups
- Using transparent, fair and reasonable decision-making processes.

Health needs and service issues were identified based on available data and information, including input from key stakeholders. Potential priority areas were identified based on an assessment across quantitative data, needs expressed by community, family and carers and professional stakeholder intelligence.

Gippsland PHN worked to engage across the following stakeholders:

- Local community, health and care providers:
    - Community Advisory Committees and Clinical Council

    - Local primary, community and acute healthcare providers
    - Aboriginal Community Controlled Organisations
    - Other regional care and support providers (e.g. hospitals and aged care providers)
- Government and other entities:
    - Commonwealth Department of Health, Disability and Ageing
    - Local Victorian hospital and health services

Potential priority areas were tested in focus groups and assessed internally with a select group of Gippsland PHN employees. All input from stakeholders was brought together with quantitative data and presented to the Gippsland Population Health Steering Committee and Executive team, adding a final layer of PHN decision making.

Introduction and Background

The Greater Choice for At Home Palliative Care (GCfAHPC)) began in 2017-18 as a trial delivered by 11 PHNs with $12.6m in funding provided by the Australian Government. The program was rolled out nationally to all 31 PHNs in 2021-22 with additional funds of $37.3m. A further four years of funding with $40.1m has been provided from 2025 to 2029 to continue to embed palliative care in primary and community care. The 2025 to 2029 funding is aimed at building sustainable practices in primary care and building capacity in the community to enable people with life-limiting illness to remain at home if they wish to.

Objectives and Outcomes

It is estimated that 70% of Australians would prefer to die at home, but only 15% do so, with half of all deaths occurring in hospitals, and more than one third in residential aged care homes (RACHs), (DHDA 2025a).

The Program aims to enable people's preference for palliative and end of life care (EOLC) at home by enabling PHNs to undertake activities to meet the following four objectives:

1. Improve access to safe, quality palliative care at home and support EOLC systems and services in primary health care and community care.
2. Enable the right care, at the right time and in the right place, and reduce preventable hospitalisations.
3. Generate and use data to support continuous improvement of services across sectors.
4. Use available technologies to provide flexible and responsive care, including care after usual business hours.

The Program is intended to lead to the following key outcomes:

- Improved capacity and responsiveness of services to meet local needs and priorities.
- Improved patient access to quality palliative care services at home.
- Improved coordination of care for patients, across health care providers and integration of palliative care services in their region.

Palliative Care in Australia

Demand for palliative care services is increasing due to a growing population, an ageing population and increases in the prevalence of cancer and other chronic diseases (AIHW 2025a).

Palliative care improves the quality of life for patients of any age and their families who are facing the problems associated with life-limiting illness. It aims to prevent and relieve suffering through early identification, assessment, and treatment of pain and other physical, psychosocial and spiritual issues (AIHW 2025a). Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten nor postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

An Implementation Plan for the **National Palliative Care Strategy 2018** (DHDA 2020) identified four actions areas:

1. Access to palliative care is increased, particularly for underserved populations.
2. Collaboration and coordination of palliative care is improved.
3. Advance care plans are being prepared by people affected by life-limiting illnesses and used to facilitate shared decision-making across care settings.
4. Nationally consistent data collection mechanisms are implemented, and national public reporting is underway.

The Victorian Government is refreshing the 2016 **Victoria's end-of-life and palliative care framework** (DH 2025a), which includes the following goals, developed in consultation with community and expert representatives:

- People experience optimal end of life care.
- People's pain and symptoms are managed using quality interventions.
- People's preferences and values are recognised and respected in their end of life care.
- Carers are better supported.
- People are cared for in their place of choice.
- Where possible, people can choose to die in their place of choice.

Key recommendations from the ***Royal Commission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect*** (Australian Government 2021) relevant for palliative care included compulsory palliative care training for aged care workers, comprehensive sector funding specifically including palliative care and end of life care, a review of the Aged Care Quality Standards to regulate high quality palliative care in residential aged care, access to multidisciplinary outreach services, and a new Aged Care Act that includes the right to access palliative care and end of life care.

Palliative Care Australia's **National Palliative Care Standards** (PCA 2022a) are a set of voluntary standards, intended to guide healthcare providers to deliver high-quality palliative care for the person receiving care, their family and carers. There are two sets of Standards – one for Specialist Palliative Care and the other for

All Health Professionals and Aged Care Services. The National Palliative Care Standards for All Health Professionals and Aged Care Services are:

1. **Comprehensive assessment of needs** - Initial and ongoing assessment comprehensively incorporates the person's physical, psychological, cultural, social, and spiritual experiences and needs.
2. **Developing the comprehensive care plan** - The person, their family and carers and substitute decision-maker(s) work in partnership with multidisciplinary teams to communicate, plan, set goals of care and support informed decisions about the comprehensive care plan.
3. **Caring for carers** - The needs and preferences of the person's family and carers and substitute decision-maker(s) are assessed and directly inform provision of appropriate support and guidance about their role.
4. **Providing care** - The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan.
5. **Transitions within and between services** - Care is integrated across the person's experience to ensure seamless transitions within and between services.
6. **Grief support** - Families and carers have access to grief support services and are provided with information about loss and grief.
7. **Service culture** - The service has a philosophy, strategy, values, culture, structure, and environment that supports the delivery of person and family-centred palliative care.
8. **Quality improvement** - Services are engaged in quality improvement and research, based on best practice and evidence, to improve service provision and development.
9. **Staff qualifications and training** - Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.

An **End-of-Life Pathway** to support older people to receive care at home provides $25,000 in funding from 1 November 2025 for people diagnosed with three months or less to live, as assessed by a doctor or nurse practitioner (DHDA 2025c). The pathway is open to existing and new Support at Home participants. If the person does not already have an aged care assessment, this will be fast tracked.

Voluntary Assisted Dying (VAD) is considered out of scope of this needs assessment, however people receiving palliative care services may request VAD information and services. The Palliative Care Australia, Palliative Care and Voluntary Assisted Dying Position Statement 2022 (PCA 2022b) states that "*...people may choose to receive palliative care services throughout the VAD process."*

Deaths in Gippsland

Gippsland has a growing and rapidly ageing population, projected to have the second highest proportion of people aged 65+ of all PHN regions in Australia by 2030 (GPHN 2025e).

The total number of deaths in Gippsland in 2023 was 3,139 deaths (AIHW 2025b), see **Figure 1**. The average annual growth was 4.4% between 2019 and 2023 and if this continues, Gippsland is expected to have a total of 4,247 deaths by 2030.

Deaths by LGA are shown in **Figure 2**, with most deaths in Latrobe, accounting for 27% of all Gippsland deaths in 2023; followed by East Gippsland (19%), Baw Baw (16%), Wellington (15%), Bass Coast (14%) and South Gippsland (10%). The fastest annual growth in the number of deaths was in Baw Baw (7.7%), followed by Bass Coast (6.1%).

Figure 1. Annual deaths in Gippsland by sex, 2019 to 2023 (AIHW 2025b).

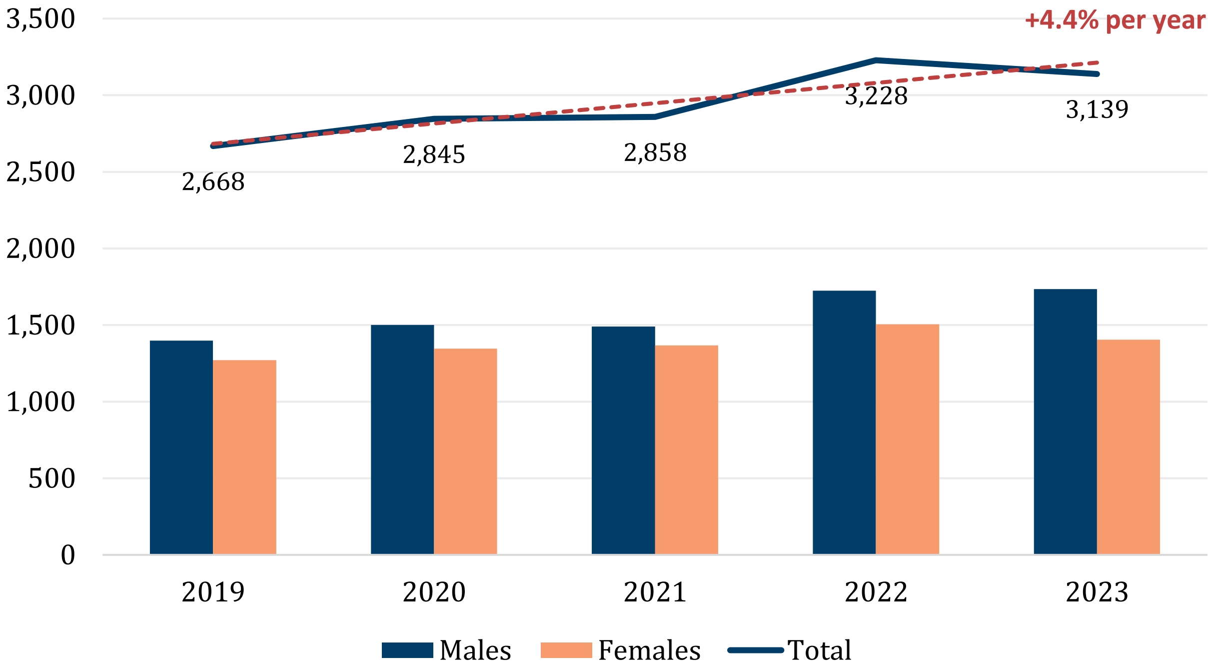
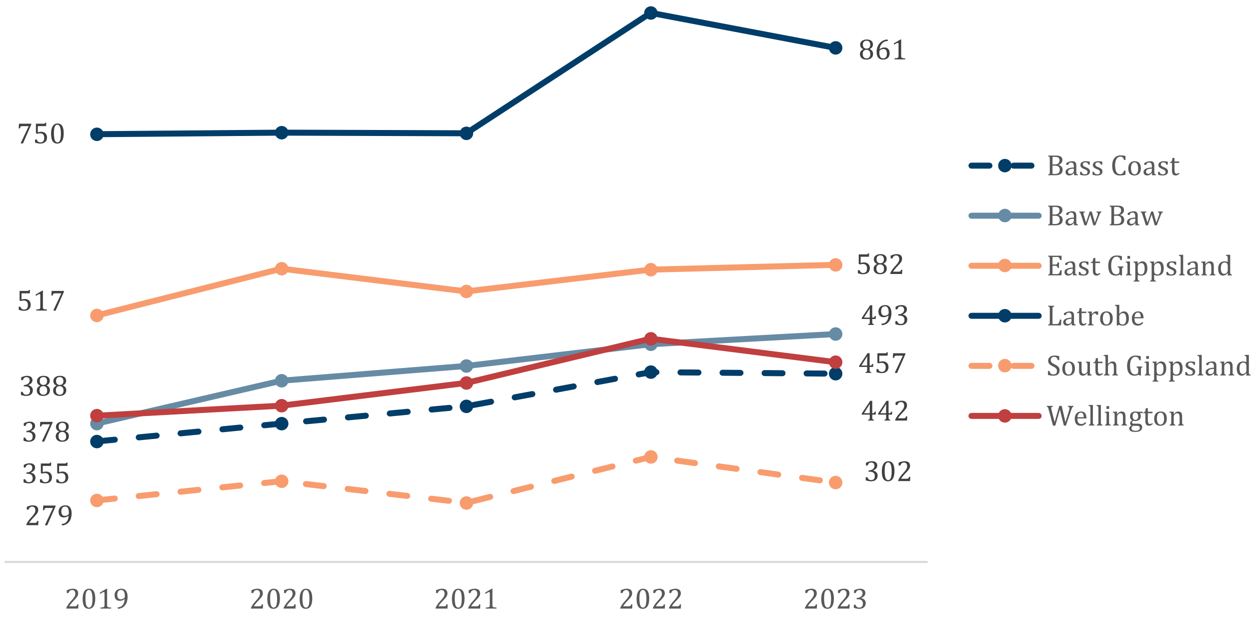


Figure 2. Number of total deaths by LGA, 2019-2023 (AIHW 2025b).



In 2023-24, there were a total of 963 deaths for people living in permanent residential care across Gippsland, accounting for 84.6% of all exits (AIHW 2025c). It is estimated that almost a third (31%) of all deaths in Gippsland were in RACHs in 2023-24, based on death data from 2023 (AIHW 2025b). This is similar to 32% of deaths across Australia occurring in RACHs.

Palliative Care Access and Outcomes

Overview

The Australian Institute of Health and Welfare have defined measures to help drive improvements in the palliative care sector (AIHW 2024a). These measures were developed to track if 'people affected by life-limiting illnesses get the care they need to live well' and are in alignment with the broad goals of the national Strategy (DHDA 2020). Some key findings based on data from the Palliative Care Outcomes Collaboration Dataset (PCOC), are available related to palliative care phases. A palliative care phase is a clinically meaningful period in a patient's condition, and they include stable, unstable, deteriorating and terminal phases. Findings based on national data from 2018 and 2022 include (AIHW 2024a):

- Most of the measures indicate palliative care experiences were better among older people than among younger people.
- Pain improved or remained at a low level for 71% of palliative care phases after intervention
  - Similar for males and females
  - Higher among people with a non-malignant diagnosis (77% compared to 68% among people with a malignant diagnosis)
- Psychological and spiritual problems improved or remained at a low level for 79% of palliative care phases.
- 8% of people received a potentially non-beneficial treatment at the end of life. Potentially non-beneficial treatments may include interventions like chemotherapy, pathology and imaging, which are unlikely to provide comfort, prolong life or improve quality of life. These interventions were less common among older people and were variable by condition (lowest for dementia).
- Family and carer problems improved or remained low for 74% of phases.
- 12% of people had a potentially preventable hospitalisation in their last three months of life.
- 21% of people who received specialist palliative care received it at least three months before they died.

Access to palliative care for marginalised communities

Palliative Care Australia’s National Palliative Care Standards for All Health Professionals and Aged Care Services (PCA 2022a), highlights how person-centred care is essential for all palliative care. However, it is even more crucial for people who experience marginalisation and may face additional systemic barriers to accessing palliative care, especially if they are part of more than one marginalised group (PCA 2022a), including those described below.

Aboriginal and/or Torres Strait Islander peoples

Culturally responsive care is needed to plan palliative care in partnership with communities to respect cultural practices and appropriate language around death and dying, including for the family and kinship group (PCA 2022a).

People living with a mental illness

People living with a mental illness are more likely to also have poorly managed physical needs and may have multiple and complex needs. A partnership approach with mental health services can help alleviate this (PCA 2022a).

People living with addictions or substance abuse disorders

Challenges around medication can arise and there are frequently multiple and complex additional needs (PCA 2022a).

People living with dementia

Challenges for people living with dementia include decision-making so the person's needs can remain the primary focus after they are no longer able to make their own decisions. Symptoms like pain can often present behaviourally and are at risk of not being well managed (PCA 2022a).

People who live in prison custody

Little is known about the needs of people who die while in prison. The need is likely to increase over time as the population ages (PCA 2022a), and as people who have contact with the justice system often experience multiple and complex health needs (GPHN 2025e).

People with disability

Providing palliative care for people living with disability often requires coordination of care across multiple providers, including disability support services. Alternative methods of communication may be required, supported by disability workers and/or digital supports (PCA 2022a).

People experiencing homelessness or at risk of homelessness

Partnership models are often required to meet the needs of people experiencing homelessness or at risk of homelessness due to a lack of ongoing, safe and secure housing combined with multiple and complex needs (GPHN 2025e).

Multicultural communities

People in multicultural communities may be unfamiliar with the concept of palliative care and the services available to them, including access to interpreters and the funding/payment method of these services (PCA 2022a).

LGBTIQA+

LGBTIQA+ people continue to face stigma and poor experiences when seeking healthcare and this includes palliative care. Planning and decision-making can be delayed or avoided if a person's chosen family is not recognised (PCA 2022a).

Children and young people

The needs for infants, children and young people are different to that of adults and will change over time due to the developmental stage of the child and the needs of family and carers (PCA 2022a).

The Palliative Care Australia Paediatric Palliative Care National Action Plan (PCA 2022c) describes how paediatric palliative care has similarities with adult palliative care, including an expectation that the care is person-centred and includes a multidisciplinary model of care. However, there are important differences, including:

- The family has an increased role in decision making and care.
- A substantial number of children have non-malignant conditions, many of which are specific to childhood.
- Life-limiting conditions in children can be extremely rare and sometimes there is no definitive diagnosis.
- Perinatal palliative care may be provided alongside the antenatal care that a mother receives from the obstetric team.
- Predicting a prognosis can be difficult and deterioration can be episodic and unpredictable.

- A child’s ability to communicate and understand varies according to their age or stage of development and underlying condition.
- The provision of education and play is essential.
- There may be financial life-changing costs to families when parents withdraw partially or completely from the workforce to become caregivers.
- Siblings are vulnerable.
- The death of a child can lead to prolonged, or even lifelong grieving.

Residential Aged Care Homes (RACHs)

Older people living in RACHs need support to receive high quality palliative care and have access to the same range of community and inpatient-based services available to people residing in their own homes. This includes access to support from general practitioners and from specialist palliative care services as needed (PCA 2022a).

There is limited data about palliative care needs among people living in RACHs. Based on national data from 2021-22, 2.0% of people in permanent residential aged care with an Aged Care Funding Instrument (ACFI) appraisal had a need for palliative care (AIHW 2025a). At entry, 3.5% were appraised as having a need for palliative care compared to 6.0% of all exits. These appraisal data have limitations as the ACFI tool was only used between 2018 and 2022 and focuses on the cost of care related to end of life care. Findings included (AIHW 2025a):

- Death was the most common cause of exiting RACHs, accounting for 95% of exits for people appraised as requiring palliative care, compared to 85% for those not appraised as requiring palliative care.
- Cancer was listed as the first condition on the appraisal for 21% of people appraised as requiring palliative care, compared with 3.7% for those not appraised as requiring palliative care.
- There were shorter stays for people appraised as requiring palliative care (50% exited within 8 weeks), compared to those not appraised as requiring palliative care (8% exited within 8 weeks).

The new **Aged Care Act** commenced 1 November 2025, and the Federal Government has released a suite of resources to support Aboriginal and Torres Strait Islander people receiving Support at Home services (DHDA 2025d).

National Greater Choices for At Home Palliative Care Evaluation

A national evaluation of the GCfAHPC program is in progress with a midpoint report published in June 2025 (DHDA 2025a). The midpoint review was informed by available data including from AIHW and PHNs, a desktop review, PHN consultations (focus groups, workshops and surveys) and case studies. The evaluation approach was aligned with the GCfAHPC Evaluation Framework and the program logic is included in Appendix 1. Key findings were reported for five activity streams (**Figure 3**).

Figure 3. Categories of PHN activities (DHDA 2025).

A summary of the findings for each category of activity reported in the national evaluation midpoint report (DHDA 2025a) and a summary of Gippsland activity during 2021-2025 is provided in **Table 2** below**.**

Table 2. Summary of findings in the national midpoint evaluation (DHDA 2025a) by category of activity, and a summary of Gippsland PHN activity 2021-25 (GPHN 2025a).

Category of PHN activity (total of 31 PHNs)	Sub-category / examples of activity	Summary of evaluation findings (DHDA 2025a)
1. Workforce Education and Awareness (n=31)	Primary care workforce capability through education and training, resources or clinical connections	Significant uptake by PHNs and increased knowledge and intention to improve was demonstrated.
	GP Quality Improvement (QI)	Positive outcomes for ACP, but few PHNs did this activity.
	RACHs, including awareness of palliative care and Advance Care Planning (ACP)	Increased knowledge, and intention to improve and change practice demonstrated.
2. Awareness in the Community (n=26)	Examples include death cafes, resources, workshops and Compassionate Communities events	Increased knowledge and awareness of palliative care demonstrated. Data collection more difficult for these activities.
3. Palliative Care Medicines (n=7)	Increased availability via pharmacists, anticipatory prescribing	PHN activities suggest improved access to palliative care medications, but few PHNs did these activities.

Category of PHN activity (total of 31 PHNs)	Sub-category / examples of activity	Summary of evaluation findings (DHDA 2025a)
4. Priority Populations (n=16)	Examples include work related to improved support for priority populations and upskilling of providers	Work with partner organisations is crucial to success. Limited evidence so far but showing promise.
5. Coordination and Integration (n=21)	Service mapping and pathways	HealthPathways data showing varying impact.
	Models of shared care, including networking initiatives	Limited evidence to date.

🟩 Positive impacts shown (tentative)
🟩 Insufficient data to show impact

General conclusions from the midpoint evaluation report included (DHDA 2025a):

- There is significant uptake nationally in PHN-driven palliative care education and awareness workshops by a wide range of health professionals.
- The importance of partnerships and collaboration to deliver successful program activities continues to be highlighted.
  - A broad range of partnerships with third-party organisations were noted, including non-government organisations, local service providers, health professionals, peak industry bodies and community groups.
  - Partners for community awareness activities include:
    - Peak bodies.
    - Non-government organisations.
    - Local government and local public health catchments.
    - Community service providers (e.g. bereavement councillors).
    - Local Health Districts/Local Health Networks (including RACHs).
- Projects with the potential for greater impact often include longer-term planning, sustained efforts, pilots and trials, or PHNs working together towards shared goals.
  - As an example, projects in Regional Victoria and Metro Brisbane, where PHNs have collaborated to engage with stakeholders over long periods of time and combined resources to provide financial incentives.
- Targeting General Practice quality improvement continues to remain a gap for PHNs with only eight activities occurring overall in this space. Barriers include workforce shortages in general practice which limits ability to implement Quality Improvement projects (DHDA 2025a).

Evaluation data collection tools included:

- Death Literacy Index (DLI) data to measure workforce knowledge, skills, confidence and intention to change practice (DHDS 2025a).

Workforce Education and Awareness

Examples of education and training topics for the primary health workforce from the National Evaluation of the Greater Choice for At-Home Palliative Care Program, include:

- Advance Care Planning (ACP)
- local palliative care pathways
- support for carers
- identifying signs that a patient’s health is deteriorating, and/or approaching end of life
- opioid prescription and administration in the home, and
- planning, preparing and organising end of life care in the home setting (RACHs and in the community).

Awareness in the Community

Community activity topics included:

- Palliative and end of life care considerations
- Advance Care Planning (ACP)
- Booklets for specific population groups
- People living with dementia and their carers
- Compassionate Communities events. It was noted that there may be a high reliance on community members if no local service provider can support. In some PHNs, this was seen as best suited to be led by local government or peak bodies.
- Train the Trainer workshops

Palliative Care Medicines

Palliative Care Medicines refer to those listed in the **National Core Community Palliative Care Medicines List** (PCA 2025a). They include four medicines for use by home-based palliative patients in the terminal phase who require urgent symptom relief. The list was developed to improve access to these medications in the community to manage terminal symptoms in uncomplicated palliative care patients. PHN activities have included:

- Collaborations between PHNs, general practitioners and community pharmacists for end of life care to improve timely access to palliative care medicines for patients. This has included the creation of public maps of community pharmacies stocking the medications.
- Anticipatory prescribing initiatives where injectable or sublingual medications are prescribed to a person with a life-limiting illness in preparation for a time when a person needs them. This can be in RACHs or in the community, supported by pharmacies and prescribers.
    - The IMPREST system can be made available in RACHs to help manage palliative care medications to ensure a 'ward stock' of palliative care medicines on site.
- Education and training, including webinars to increase awareness among pharmacists, GPs and community nurses.

Priority Populations

Activities targeted to priority populations were identified in several PHNs and all included work with partner organisations, including ACCOs, non-government organisations (NGOs) and technology organisations. The partnerships were seen as critical to ensure local knowledge and trusted relationships. Initiatives to support priority populations have included education and training and development of resources, including in language, and to improve cultural safety.

Priority populations identified across PHNs included:

- Aboriginal and/or Torres Strait Islander peoples
- Multicultural communities
- People living with a disability
- People experiencing homelessness
- LGBTIQA+ people
- People living with dementia and their carers and support people
- People with Motor Neurone Disease (MND) due to rapid progression of disease and significant impact on daily living and family and carers (MND Australia 2025)

Coordination and Integration

Activities in the Coordination and Integration category look to improve palliative care access, coordination and navigation in their regions. Almost all PHNs worked with a partner organisation to implement coordination and integration activities, including health service providers, both in the primary and acute setting, peak bodies, consumer groups, RACHs, NGOs, ACCOs and multicultural community groups or organisations. Activities included the following:

- Service mapping and local directories.
- Pathways information for GPs and other clinicians to access clinical management guidelines, local referral options and resources.
- Decision support tools for appropriate referrals.
- Multidisciplinary approaches to help health professionals develop partnerships to optimise systems, processes and outcomes for palliative care patients.
- Models of shared care. For example, end of life care coordination model for primary care and improved palliative care services in RACHs, including Advance Care Planning, anticipatory planning, recognising deterioration and the provision of high-quality, person-centred palliative care. Digital solutions were trialled by two PHNs but both were ceased.
- Networking and other methods of bringing providers together to improve patient care.

Gippsland Greater Choices for At Home Palliative Care 2021-25 projects

The GCfAHPC program at Gippsland PHN was informed by an Advisory Group with representatives from local hospitals, RACHs, the Gippsland Region Palliative Care Consortium (GRPCC), the Gippsland Palliative Care Consultancy Service and a Bush Nursing Centre (GPHN 2025a). A Steering Committee included representation from the Pharmacy Guild, GRPCC, the Gippsland Palliative Care Consultancy Service and a community advisor. In addition, program development and implementation was supported by a Victorian and Tasmanian Community of Practice (CoP), made up of PHN representatives, and attendance at GRPCC Consortium Management Group meetings.

A needs assessment informed project activity and additional activities included:

- An evaluation framework was developed – see Appendix 2.
- A palliative care education, training and resources review.
- Service mapping activities.

A summary of activities during the 2021-25 period using the categories in the national evaluation (DHDA 2025a) shows activity across the five categories (GPHN 2025a):

1. **Workforce Education and Awareness** activities included:
    a. Education and training including:
        i. Four webinars for general practice (35 attendees in total).
        ii. Four bush nursing and remote nursing sessions (21 attendees in total).
        iii. 13 workshops for Registered Nurses (RNs) in residential aged care (108 attendees in total, representing 77% of all RACHs in Gippsland), where topics included ACPs and the timing of palliative care.
    b. Development of a **GP Palliative Care Quality Improvement (QI) Toolkit** in collaboration with Murray PHN and Western Victoria PHN (Regional Victorian PHN Collaborative 2025).
    c. Palliative Care Nurses Australia (PCNA) conference grants to six nurses across six general practices.
    d. Incentive payments to support health providers to attend Program of Experience in the Palliative Approach (PEPA) and/or Indigenous Program of Experience in the Palliative Approach (IPEPA) education sessions were offered but did not have any applicants, likely due to short lead times.

2. **Awareness in the Community** activities included:
    a. ''Live the Life You Please'' community screenings of a local film to raise awareness of palliative care. There were 11 screenings across Gippsland including follow up discussion with local palliative care service providers.
    b. Three community roadshow events saw a total of 94 attendees; the majority were community members. All attendees who completed an evaluation (n=43) reported they had learnt something new (GRPCC 2024b). The events were developed and delivered in conjunction with Palliative Care Advisory Service (PCAS), Voluntary Assisted Dying (VAD) Care Navigators, Ambulance Victoria (AV) and local community palliative care teams.
    c. Community grants to increase awareness of palliative care options and pathways offered to 13 organisations to promote palliative care education and awareness activities within their communities.

3. **Palliative Care Medicines** activities included:
    d. IMPREST implementation in RACHs to support improved access to 'ward stock' of palliative care medicines, supported by GRPCC and a health service.
    e. A planned mapping project of pharmacies stocking palliative care medicine did not go ahead.

3. **Priority Populations** activities included:

An Aboriginal and/or Torres Strait Islander palliative care consultation was undertaken by a Kinaway- certified Aboriginal business. The consultation identified palliative care needs of people in Gippsland identifying as Gunaikurnai and Bunurong. Key themes based on community feedback were identified in an interim report (Liz Allen Consultancy 2025):

- **Culturally Safe and Compassionate Palliative Care**
    - Community members described a lack of cultural safety and compassion in hospitals, particularly in Melbourne-based facilities.
    - Reports of racism, poor communication, and minimal support during times of loss.
    - Families need culturally aware hospital staff, especially Aboriginal Liaison Officers (ALOs), to assist during crises.
- **Need for Aboriginal-Led Resources and Supports**
    - Strong desire for access to an Aboriginal palliative care community worker.
    - Resource suggestions included: (i) an Aboriginal-specific hotline for palliative support, (ii) a user-friendly information booklet tailored to Aboriginal families explaining available resources and processes, and (iii) an updated Aboriginal Community Directory ("Black Pages") with accessible services and contacts.
- **Poor Coordination Between Hospital and Community-Based Care**
    - Families face challenges post-discharge, such as:
        - Lack of medication, follow-up care, and understanding of care plans.
        - No clear communication or support from hospitals when returning home.
        - Transport difficulties in bringing family members home to receive care.
    - Calls for a "two-pronged care approach" linking hospital and community health services.
- **Infrastructure Gaps**
    - Too few palliative care beds in East Gippsland and a lack of family accommodation.
    - Community sees an urgent need for a dedicated hospice facility in the region.
- **Inadequate Support from Government Systems**
    - Centrelink and aged care services were seen as culturally misaligned and difficult to access.
    - Families noted insufficient carers' payments, lack of respite options, and minimal clinical support.
    - Limited understanding and application of Advance Care Planning among community members.
- **Community-Led Education and Engagement**
    - Strong interest in:
        - Short video resources to inform families about available support.
        - Ongoing community workshops to build understanding of palliative care processes.
        - Incorporating discussions into existing groups.
- **Broken Trust with Mainstream Services**
    - A history of poor experiences has led to broken trust with mainstream health providers.
    - Community wants collaborative partnerships with culturally competent services.
    - Interest in working with churches and local organisations to strengthen community-led solutions.

4. **Coordination and Integration** activities included:

a. A General Practice Referral Form to facilitate referrals to community palliative care has been integrated into general practice management software (Medical Director and Best Practice). It has been trialled by two practices.

c. A Palliative Care in Aged Care Referral Pathways Review project resulted in updated palliative care referral pathways in residential aged care with localised pathways for each LGA.

d. Gippsland Pathways updates are planned for phase 2, including inclusion of the General Practice Referral Form and updated links to key sources for clinical resources such as the CareSearch palliative care knowledge network.

GP Palliative Care Quality Improvement (QI) Toolkit

A report by the **Regional Victorian PHN Collaborative** (2025) describes an evaluation of the project. It notes that the literature confirms early Advance Care Planning (ACP) and palliative care discussions:

- reduce unnecessary hospital interventions
- enhance quality of life
- enable personalised care planning.

The Collaborative was made up of the three regional Victorian PHNs who worked jointly on a quality improvement toolkit for general practice. The project included two stages:

Stage 1 – a regional toolkit was developed based on a North Western Melbourne PHN toolkit. There was a focus on data auditing strategies to increase timely identification and care coordination of patients' unmet needs, including support materials.

Stage 2 – a 12-month intervention with 17 general practices, including five Gippsland general practices. The project included palliative care-focused Plan-Do-Study-Act QI activities, pre and post-Death Literacy Index and After Death Audit surveys, and education modules on the Program of Experience Palliative Approach (PEPA). Practices were supported through an outreach facilitation led by project staff across each PHN.

Evaluation findings showed increased palliative care competency in general practice and that the model is scalable for broader adoption:

- 79% implemented new palliative care models, with plans to sustain them
- Increased use of existing care planning models in the Medicare Benefits Schedule (MBS) ensuring financial sustainability and workflow alignment, including General Practice Management Plans (GPMP), 75+ Health Assessments and Domiciliary Medication Management Reviews (DMMR)
- Recall systems led to an increase in Advance Care Planning (ACP) conversations and documentation of end-of life preferences and goals of care
- 69% reported increased confidence in using Supportive and Palliative Care Indicators Tool (SPICT) or the Surprise Question ("*Would I be surprised if this patient died in the next 12 months*?")
- Significant improvement in death literacy and factual knowledge
- The pilot had broader impacts on practice culture, promoting more integrated and patient-centered care.

In conclusion, the partnership model was described as successful and the project as a scalable model suitable for broader adoption.

Service System

Palliative care is provided in almost all settings where health care is provided, including neonatal units, paediatric services, general practices, acute hospitals, residential and community aged care services, and generalist community services (AIHW 2025a). A distinction is commonly made between care provided in hospitals, including hospices, and care provided in the community, including in the patient's home or in Residential Aged Care Homes (RACHs).

Expenditure on palliative care in Gippsland, in 2022-23, shows more than $11 million was spent on admitted patient palliative care compared to $0.7 million on non-admitted palliative care (AIHW 2025a).

The Gippsland Regional Palliative Care Consortium (GRPCC 2025a) is an alliance of 14 member agencies that provide inpatient and/or community palliative care for the residents of Gippsland. It is supported by the Victorian Government, and its role is to help deliver and facilitate end of life care and palliative care across the Gippsland region.

Gippsland Regional Integrated Cancer Services (GRICS) is funded by the Victorian Department of Health to ensure local people diagnosed with cancer have access to integrated, person-centred services. The Gippsland Regional Cancer Services Plan includes an action to improve integration of palliative care in treatment decision making (GRICS 2025).

Palliative and end of life care in the Gippsland community is supported by 100 General Practitioner clinics, 54 Residential Aged Care Homes (RACHs) and Supported Independent Living Houses (GPHN 2025b).

In Gippsland, there are seven funded specialist community palliative care services (GRPCC 2025a):

- Bairnsdale Regional Health Service (BRHS)
- Bass Coast Health (BCH
- Central Gippsland Health (CGH)
- Gippsland Lakes Complete Health (GLCH)
- Gippsland Southern Health Service (GSHS)
- Latrobe Community Health Service (LCHS)
- West Gippsland Healthcare Group (WGHG)

In addition, generalist palliative care and end of life care is delivered by (GRPCC 2025a):

- Omeo District Health
- Orbost Regional Health
- South Gippsland Hospital
- Yarram and District Health Service
- Maryvale Private Hospital
- Neerim Health
- Bush nursing services (five in East Gippsland and one in Wellington)

There are 11 designated palliative care inpatient beds in Gippsland, located at (GRPCC 2025a):

- Bairnsdale Regional Health Service (1)
- Bass Coast Health (1)
- Central Gippsland Health (2)
- Gippsland Southern Health Service (1)
- Latrobe Regional Health (4)
- West Gippsland Health Service (2)

The region is supported by the Palliative Care Consultancy Gippsland (PCCG) based at Latrobe Regional Health (LRH 2025a). The PCCG provides specialist consultation to health professionals, palliative clients and their families/carers throughout the Gippsland region.

Services and supports funded by the Victorian Government include:

- Victorian Palliative Care Advice Service for everyone in Victoria
- Victorian Virtual Specialist Consults (VVSC) supports general practitioners, nurses, allied health professionals and other primary care.

The National Palliative Care Coordination (NPCC) project notes approximately 70% of specialist palliative care referrals originate from acute hospitals, with only 7% initiated by GPs. This can result in unmet care needs, increased hospitalisations, and limited access for non-cancer patients requiring palliative care support. The GenPal tool is a structured palliative care needs assessment and decision support tool, to identify patients who may benefit from early palliative care to support early identification of palliative care needs in general practice and ensure timely, needs-based referrals to specialist palliative care services.

Palliative Care Workforce

The National Health Workforce Dataset includes information about palliative medicine physicians and palliative care nurses (including only nurses whose principal job area is palliative care). National data from 2023 reveals that (AIHW 2025a):

- 64% of palliative care specialist and 92% of palliative care nurses were women.
- There were around twice as many palliative medicine physicians in major cities compared to regional areas; 1.5 Full Time Equivalents (FTE) per 100,000 population, compared to 0.8 / 0.6 FTE per population in inner / outer regional areas and none reported for remote or very remote areas.
- The rate of palliative care nurses was highest in inner regional areas (14.8 per 100,000 population) and lowest in very remote areas (3.7 per 100,000 population).
- More than half of palliative medicine physicians and palliative care nurses worked in a hospital setting (75% and 49%, respectively).
- Annual growth in FTE rates per population was 5.0% for palliative medicine specialists and 0.8% for palliative care nurses.

A national palliative care workforce survey conducted online in 2024 had 1,400 respondents working across different health and aged care settings where palliative care is provided (PCA 2025b). Some key findings included:

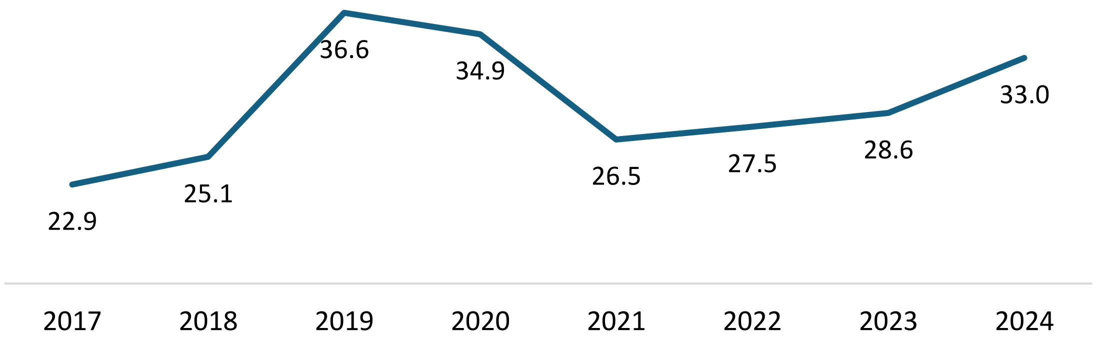
- 96% of primary care workers agreed early discussion of palliative care is critical, while only 11% agreed their service had adequate resources to support this.
- 90% of respondents reported increasing demand for palliative care in the previous year, compared to 72% among the primary care workforce.
- 83% reported the aged care service they work for provided palliative care to all residents who needed it.
- A need for improved remuneration opportunities for palliative care in primary care was highlighted and suggestions included:
    - A new practice-level payment to remunerate palliative care, including advance care planning, developing goals of care, referrals and covering activities undertaken by primary care multidisciplinary teams that are not currently billable to Medicare.
    - Further guidance for general practice about the use of existing longer consultation items (Level C, D and E) to be more explicit about their relevance to palliative care.
    - Additional funding for home visits, after-hours care (in-person and via telehealth), and shared care arrangements with specialist palliative care teams.

In Gippsland, in 2024, there was an estimated total of three palliative medicine physicians, (DHDA 2025b), stable since 2023, but numbers are too small to be reliable.[1] The total FTE of palliative care nurses was 33.0, and this is higher than 2023 but lower than in 2019 and 2020, see **Figure 4**. The palliative care nurse distribution by LGA reveals that the lowest FTE per population was identified in Bass Coast, noting limitations of small numbers.[1] East Gippsland had the highest palliative care nursing FTE per population in Gippsland, slightly higher than the rate across Australia. See **Figure 5**.

---

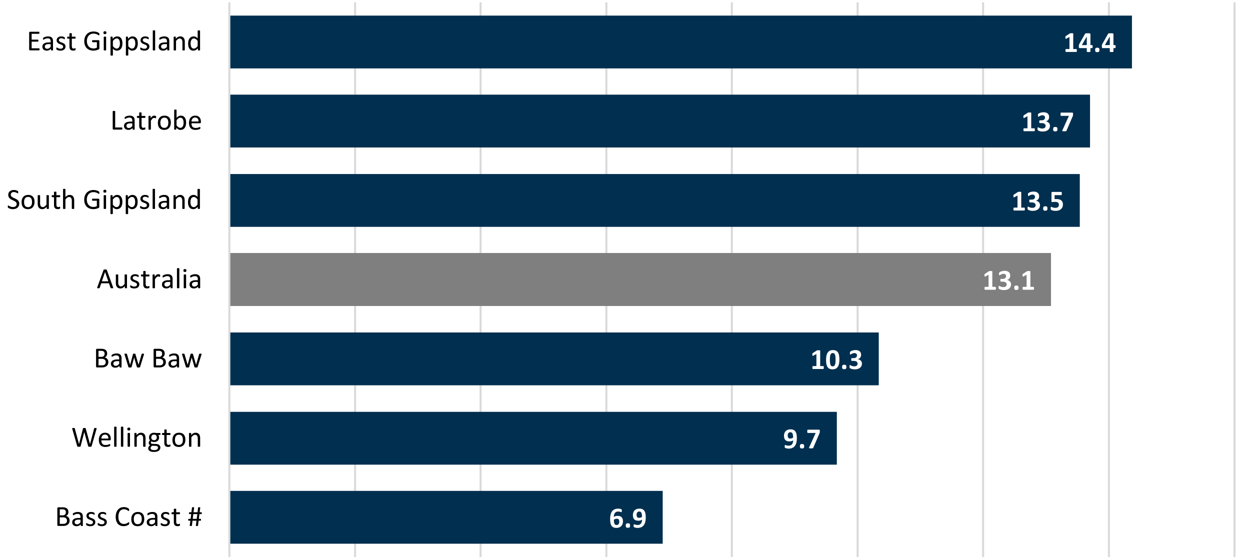
[1] Note that due to the sensitive nature of the data, the Health Workforce Data Tool applies perturbation to all figures between 0 and 3. This means any figure between 0 and 3 may have a true value anywhere between 0 and 3.

Figure 4. Palliative care nurses as Full Time Equivalents (FTE)* working in Gippsland, 2017 until 2024 (DHDA 2025b).



* Based on job area as nurse, working in registered profession

Figure 5. Palliative care nurses as FTE* per 100,000 population by LGA, 2024 (DHDA 2025b).



* Based on job area as nurse, working in registered profession

\# Equal to or less than 6.9 FTE per 100,000 population. Note that due to the sensitive nature of the data, the Health Workforce Data Tool applies perturbation to all figures between 0 and 3. This means any figure between 0 and 3 may have a true value anywhere between 0 and 3. The reported rate was based on 3 FTE palliative care nurses in Bass Coast in 2024.

Many other professional groups are crucial in the provision of palliative care services, especially in rural and regional areas where there are fewer palliative medicine physicians and palliative care nurses per population. This includes general practitioners, other medical specialists, social workers, occupational therapists, physiotherapists, pharmacists and other allied health professionals. In addition, a palliative care team may also include Aboriginal and/or Torres Strait Islander health workers, medical imaging professionals, radiation therapists, personal care workers and grief counsellors (PCA 2022a). However, existing national data sources do not accurately capture the extent of palliative care services provided by these health professionals.

Gippsland Consultation Findings from 2025 Survey

Respondents

A 2025 online survey recorded a total of 72 responses with all Gippsland LGAs represented, see **Figure 6**. Overall, 75% of respondents were professionals and 25% were community members or carers, family members or other support people, see **Figure 7** for a more detailed distribution by category. The 'Other' category was selected by nine respondents, all were professionals including practice manager, social worker, counsellor, local government worker, pharmacist and palliative care support worker.

Figure 6. Survey respondents by LGA, n=72 (GPHN 2025d).

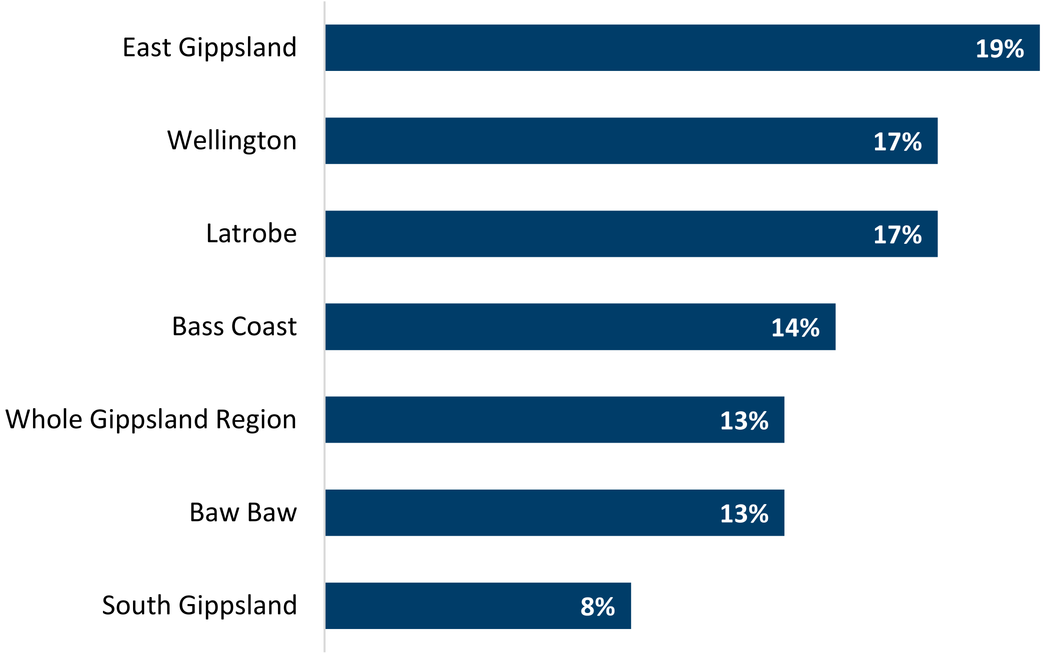
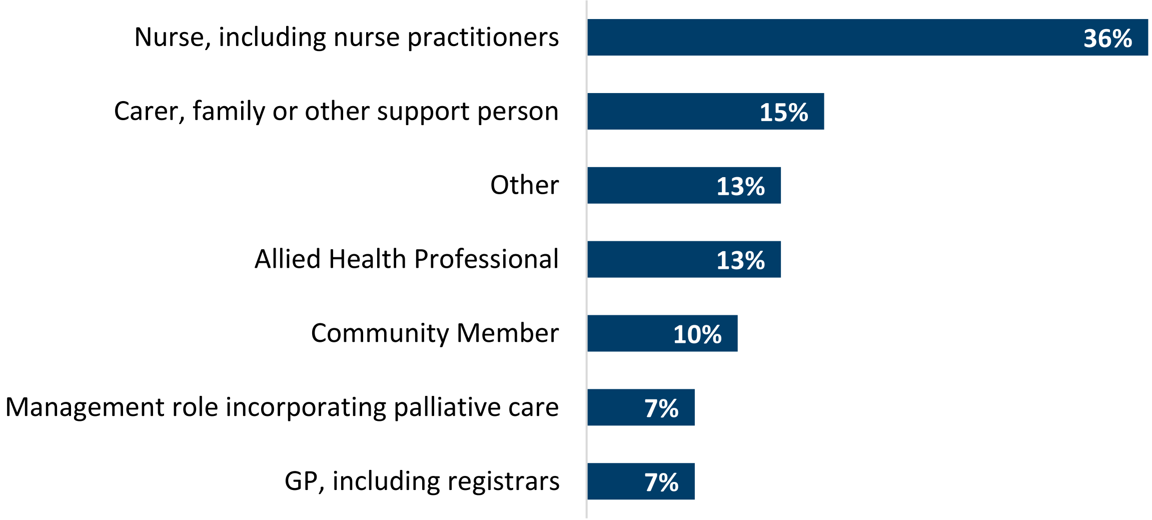


Figure 7. Survey respondents by category, n=72 (GPHN 2025d).



Professionals were asked about their work setting and multiple responses were possible. Total respondents with a role in the below settings were:

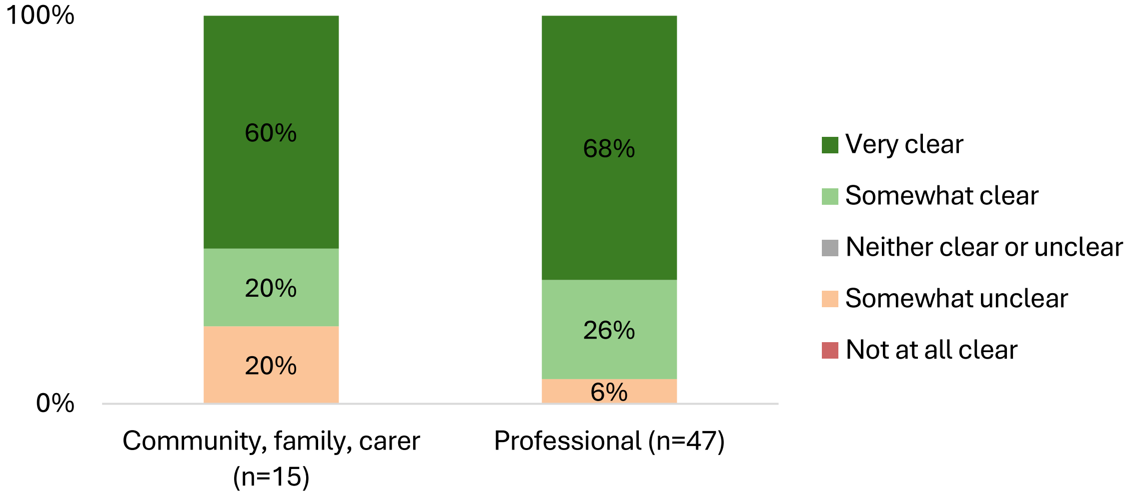
Table 3. Work setting for professional respondents, n=49 (GPHN 2025d).

Setting of work role/s related to palliative care	Number	Percent
Acute care (hospital)	14	29%
Residential Aged Care Home	20	41%
Primary care	19	39%
Other	13	27%

Awareness about palliative care and end of life care

Professional survey respondents had greater awareness about the difference between palliative care and end of life care, compared to community, family and carers, see **Figure 8.**

Figure 8. Response distribution for the question: How clear are you about the difference between Palliative Care and End of Life Care? (GPHN 2025d).



Qualification related to palliative care

Twenty-one professional respondents reported having a qualification related to palliative care (open-ended question): 11 respondents had a postgraduate qualification, six reported work experience, three had completed a relevant short course and one had undertaken self-directed learning. Other professionals did not answer or noted they had no qualification related to palliative care.

Twenty-six professional respondents suggested training related to palliative care would support them in their role. Suggestions were themed:

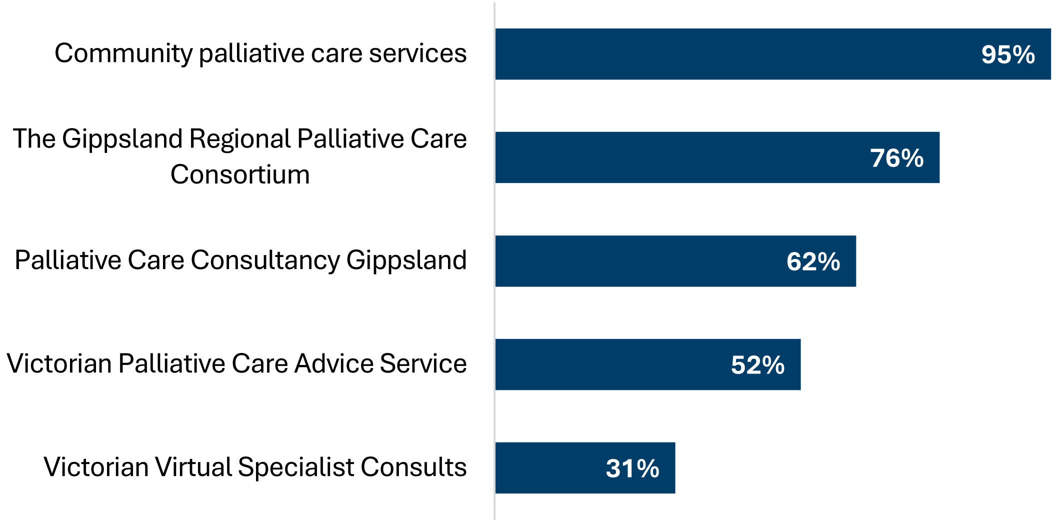
- General palliative care (6 respondents)
- Referral pathways (4)
- Medication (3)
- Symptom management (3)
- Clinical supervision (2)
- Postgraduate course (2)
- Other suggestions from one respondent: bereavement, counselling, person-centred palliative care and a multi-disciplinary approach.

Awareness of services and support options

Among professional respondents, 26% did not know how to refer to community palliative care services (n=46), and this included GPs.

Professional respondents were most aware of community palliative care services, see **Figure 9.** There was least awareness about the Victorian Virtual Specialist Consults, which is a relatively new service. Additional services and supports listed under the 'Other' category included: palliative care services from local hospital, Care Search, Palliative Care Nurse Practitioner and the Carer Gateway.

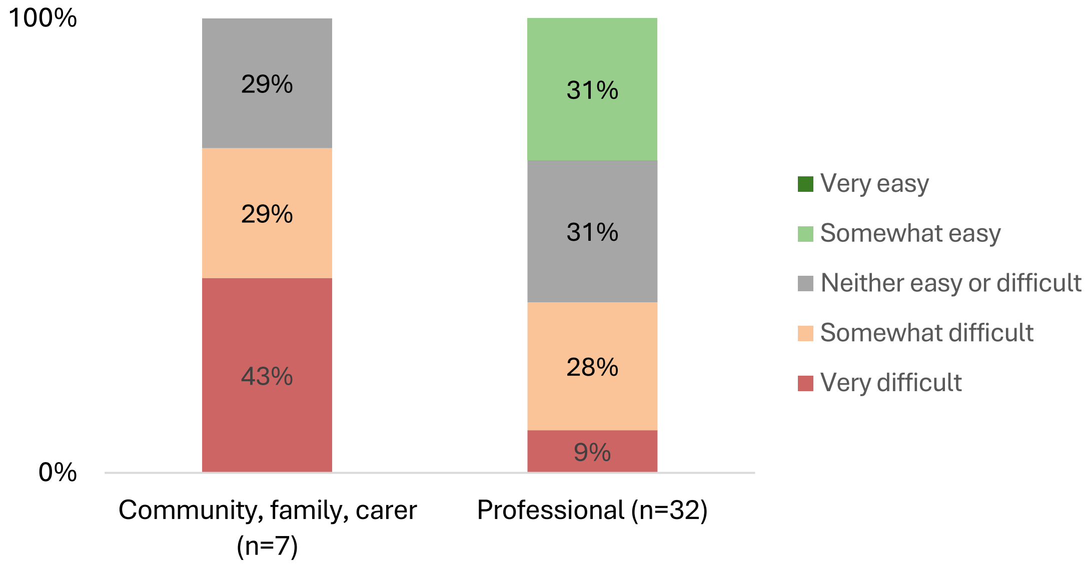
Figure 9. Awareness of palliative care support services among professional respondents, n=42 (GPHN 2025d).



Care coordination and integration

Among professional survey respondents, 37% rated their experience in navigating care across primary, community and specialist palliative care as difficult, see **Figure 10.** Among community respondents, 72% found it difficult and no one found it easy.

Figure 10. Response distribution for the question: How easy is it to navigate between primary, community, and specialist palliative care providers? (GPHN 2025d).



Improving access to palliative care services and supports at home

Survey respondents were asked to rank six possible options for improving access to palliative care services and supports at home. Among community, family and carers, the top ranked option was improved integration of community and specialist services, see **Figure 11.** Among professionals, the top ranked option was improved understanding of palliative care / end of life care among professionals.

Figure 11. Ranking order of provided options for the question: What do you think will be most important to improve access to palliative care services and supports at home? (GPHN 2025d).

Additional options added by respondents:

- Improved communication between primary, acute, community and aged care services. This includes feedback / general updates on referrals sent.
- Improved support for existing workforce.
- Recognise and plan for remote area access.
- Increased funding to provide services and supports at no cost, particularly for younger clients.
- One or more hospices in Gippsland or increased dedicated hospital beds.
- On-call after hours nursing support.

> *“Work to sustain the workforce we have, by creating pathways to specialty services, supporting the staff with good leadership, funding and access to clinical supervision to guide their care and careers.” (Nurse)*

Navigating between primary, community, and specialist palliative care providers

Key themes from responses to the survey question: Please share more about your experiences with navigating between primary, community, and specialist palliative care providers”. Arranged by most frequently mentioned themes:

- Importance of effective communication / **coordination** between services to meet patient needs
- Gaps in **service availability and access**, including capacity of community-based services
- **Unclear pathways** impacted by lack of process
- **Medical focus** on curative issues leads to lack of timely support
- **Lack of understanding** of palliative care (not end of life care) in the community

> *"My observation is that, when a person is within acute inpatient care, the linkage to palliative care is not smooth; mainly because of the hospital focus on curative issues…" (Community member)*
>
> *"When my husband required palliative care the doctor and nurses guided me through" (Community member)*
>
> *"Sometimes it is hard to find the contact numbers and to know when referral is appropriate and at which level" (GP)*
>
> *"Sometimes metro services are slow with information and do not understand regional service capacity and travel distances." (Nurse)*
>
> *"… there is often strong resistance from the patient and family who fail to understand the concept: that is, they see it as equivalent to terminal care." (Community member)*

Barriers in Residential Aged Care Homes

Key themes from responses to the survey question: Are you aware of any barriers in accessing palliative care for people living in Residential Aged Care Homes? Arranged by most frequently mentioned themes:

- Gaps in **service availability and access**, including RACHs not serviced by community palliative care services in some areas
- **Unclear pathways**
- **Workforce issues**, including capacity and capability
- **Late referrals**, often associated with workforce capability
- Resistance from patient or family due to **lack of awareness**
- **Access to medication**

> *"…[mum] only started palliative care at my insistence the day before she died. … she was very unwell and in pain …. She suffered terribly." (Allied health professional)*
>
> *"Challenges with current waitlist within our local community pall care service." (Allied health professional)*
>
> *"Relying on staff recognising the deterioration of their residents." (Community member)*

Barriers to accessing community palliative care

Key themes from responses to the survey question: Are you aware of any barriers in accessing community palliative care? Arranged by most frequently mentioned themes:

- Gaps in **service access and availability**
- **Workforce issues**, including capacity and capability
- **Unclear pathways**
- **Lack of communication between services**
- A **lack of community awareness**, leading to family/client resistance
- Late referrals
- Financial barriers
- Access to medication

> *"[The pathways are unclear…] Usually, it is felt that they fall outside of these consultancies and should be managed by either their GP or Residential In Reach, when specialist palliative care is the more appropriate option." (GP)*

"Hospital were quite unsupportive … keen to discharge him before we as a family could get set up to support him at home and even discuss how we would or could support him through end of life care, which was then around the clock care for 2 weeks. This caused high levels of distress and anxiousness for the whole family to be thrown entirely unprepared into that situation without discussion or choice." (Carer, family member)

"My mother also had to pay for all her services which was stressing as she didn't have an income and was told she had to go on jobseeker while waiting for DSP as no more sickness benefit. Often, she went without necessities to pay for her medication and services." (Carer, family member)

"…many people in the general public have a fear of palliative care. They think it means death will occur soon if they accept." (Counsellor)

"We do have patients who have to wait for palliative care services in the community in order to leave hospital, or don't have often enough access to services in the community to meet their needs." (Nurse)

Populations with the greatest challenges accessing community palliative care

Key themes from responses to the survey question: Are there specific groups of people within the community who tend to encounter more challenges when trying to access palliative care services? Arranged by most frequently mentioned themes:

- Socially isolated people with no family or carer
- Aboriginal and/or Torres Strait Islander peoples
- Multicultural background
- Low socio-economic status, unable to advocate for themselves
- Homeless / at risk of homelessness
- Anyone unprepared (low awareness/denial)
- Limited digital capacity
- Mental health challenges
- Locations where services are unavailable
- Younger than 65 years
- Disability, including intellectual
- Dementia

"People with no supports at home or can't drive to collect meds" (Nurse)

Suggestions

- Upskilling of primary care practice nurses to take on a palliative approach role.
- Support for a Palliative Care Nurse practitioner model for support in RACHs and community.
- Grief and bereavement support.
- Regular specialist palliative care visits in RACHs.
- Dementia palliative pathway in RACHs.
- Sub-regional specialist palliative care models.
- Strengthened psychosocial supports for families.
- Palliative care software, used across providers.
- Free subcutaneous end of life medications.
- Up to date 'directory' of clinical resources, including ELDAC (End of Life Directions for Aged Care)

"There is huge gap with supporting family with the grief and understanding the end of life process. It is confronting watching a loved one die in front of you; however, you know this is inevitable. When the

loved one dies you are left with so much sadness and knowing your life will always be different. Support with understanding these emotions and how to deal with the grief would be ideal." (Carer, family)

"Have regular visits from palliative care team with staff from facilities and residents but also include family members." (Nurse)

"Assistance with moving dementia residents to a palliative pathway. Often it is not viable option for a resident with profound dementia to be treated in hospital. A palliative pathway with set ceilings of treatment, ideally onsite [at RACH]." (Nurse)

"The regional specialist palliative care model that has been developed … provides significant value by fostering collaborative partnerships that enhance the quality of care. By integrating efforts in symptom management through Nurse Practitioners (NP) and addressing psychosocial and caregiver needs via Social Welfare, we have effectively reduced duplication of services for clients and their families. This approach not only strengthens our presence in regional areas but also complements and enhances the capabilities of existing care teams, ultimately leading to more comprehensive and coordinated care and support." (Support worker, palliative care)

"More home visiting palliative care counsellors are needed to support families as well as social workers within community pall care teams. The psychosocial aspects are always underfunded and yet they are often the reason patients and families are suffering - emotional distress secondary to advanced illness, making symptom burden worse." (Counsellor)

"An integrated, IT based software (Pal Care) would allow services to better plan and communicate the care needs of the patient and their family." (Nurse)

Service Utilisation

National insights

A mix of specialist palliative care services is often used in the last year of life. Nationally, in 2019-20, 80% of people received inpatient care, 26% outpatient consultations and 23% had consultations with palliative care specialists/physicians through MBS claims.

People aged under 65 years accounted for around a quarter of all palliative care-related service events recorded at episode-level in 2023-24 (AIHW 2025a):

- 25% of primary palliative care service events.
- 28% of medical consultations for palliative care.
- 25% of allied health and/or clinical nurse specialist interventions for palliative care.
- 26% of total palliative care-related service events.

It has been estimated that 41% of people in need of palliative care received specialist palliative care in their last year of life based on data from 2019-20 (AIHW 2024b). Other insights included:

- While current evidence suggests at least three to four months of specialist palliative care provides the maximum benefit, this occurred for only 20% of people who received specialist palliative care services. In contrast, 49% of people received their first specialist palliative care service in the last two weeks of life and 13% in the last three to four weeks.
- Those who received specialist palliative care were younger than the population not receiving specialist palliative care.
- People dying from cancer were more likely to receive specialist palliative care; for the population in need of palliative care, those dying of cancer were at least 5 times as likely to have Medicare-recorded consultations with palliative care specialist physicians than people dying from other causes (21% versus less than 4%).
- Conditions with the lowest proportion receiving palliative care were dementia, heart disease and respiratory diseases (based on underlying cause of death).
- The likelihood of receiving specialist palliative care was greater for people living in major cities (compared to regional areas) and for those in socioeconomically advantaged areas (compared to disadvantaged).

General practice

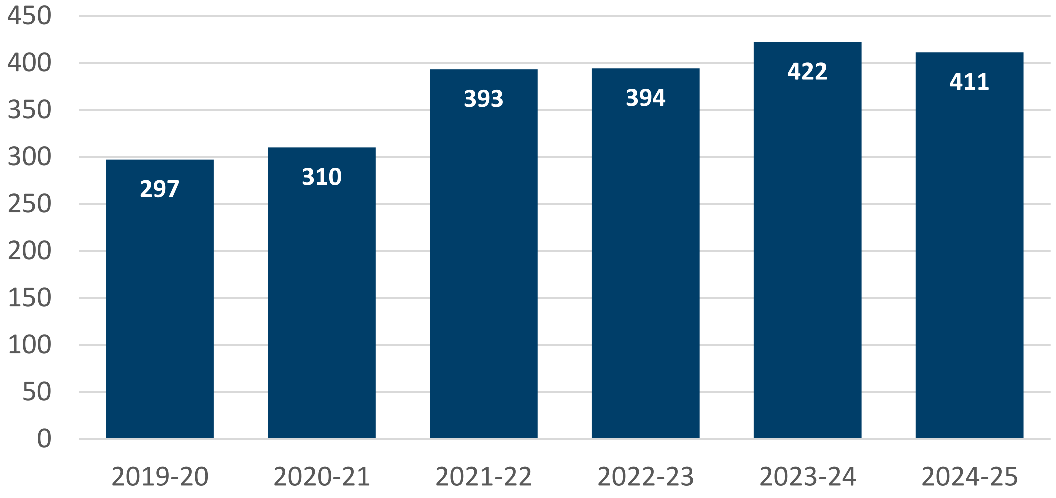
According to the BEACH (Bettering the Evaluation and Care of Health) survey, about 1 in every 1,000 GP encounters was palliative care related in 2015-16 (AIHW 2025a). Of these, 90% were for patients aged 65+ and 5% were for patients aged under 55 years.

The number of Gippsland general practice patients with a new palliative care diagnosis and/or referral over six years 2019-20 to 2024-25 is shown in **Figure 12** (GPHN 2025c). In the past four years, the numbers have been relatively steady around 400 patients per year.

Of 1,552 patients with a new palliative care diagnosis over six years 2019-20 to 2024-25 (GPHN 2025c):

- 53% were female; 47% male
- 90% were aged 65 years or older (46% were 85+ years)
- 6% were under 55 years
- 1% were recorded as Aboriginal and/or Torres Strait Islander

Figure 12. Number of general practice patients with a new palliative care diagnosis and/or referral, by financial year 2019-20 until 2024-25 (GPHN 2025c).



It should be noted that palliative care is not a medical diagnosis in its own right and there are no palliative care-specific MBS items that can be used by GPs who may be providing palliative care (AIHW 2025a). Therefore, the general practice activity reported above as related to palliative care is likely to be an underestimate of actual activity.

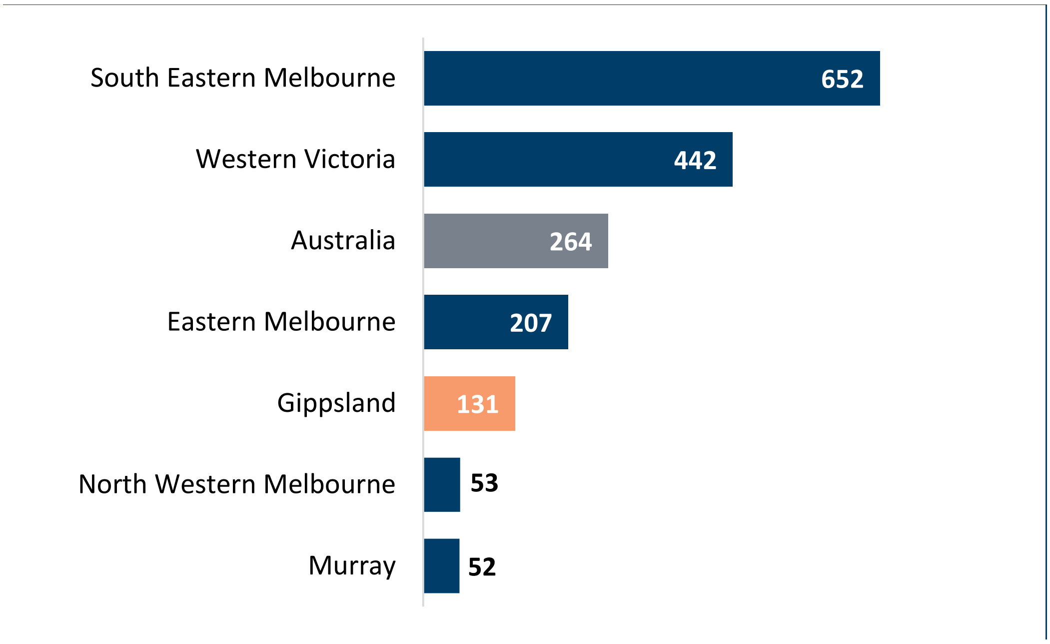
Palliative medicine specialists

Palliative medicine attendances/consultations and case conferencing provided by palliative medicine physicians/specialists can be subsidised through available MBS item numbers (AIHW 2025a).National data on Medicare-subsidised services for 2023-24 shows that there were more than twice the number of palliative medicine services provided per population in major cities (259 palliative medicine consults per 100,000 population) compared to outer regional (111) or remote locations (90); there were 195 services per 100,000 population in inner regional areas.

Gippsland rates of palliative medicine services were 50% lower per population compared to national rates (131 services per 100,000 population, compared to 264 nationally), (AIHW 2025a). See **Figure 13**. In total, 61 Gippsland residents received an average of 6.6 MBS subsidised palliative medicine services in 2023-24.

Nationally, the number of MBS-subsidised palliative medicine services has declined by 4.9% per annum between 2018–19 and 2023–24 (AIHW 2025a); however, the data may suggest palliative medicine specialists are increasingly using other MBS items when attending to palliative care patients.

Figure 13. Rate of Medicare subsidised palliative medicine services per 100,000 population, by Victorian PHN and compared to Australia, 2023–24 (AIHW 2025a).



Palliative care-related medications

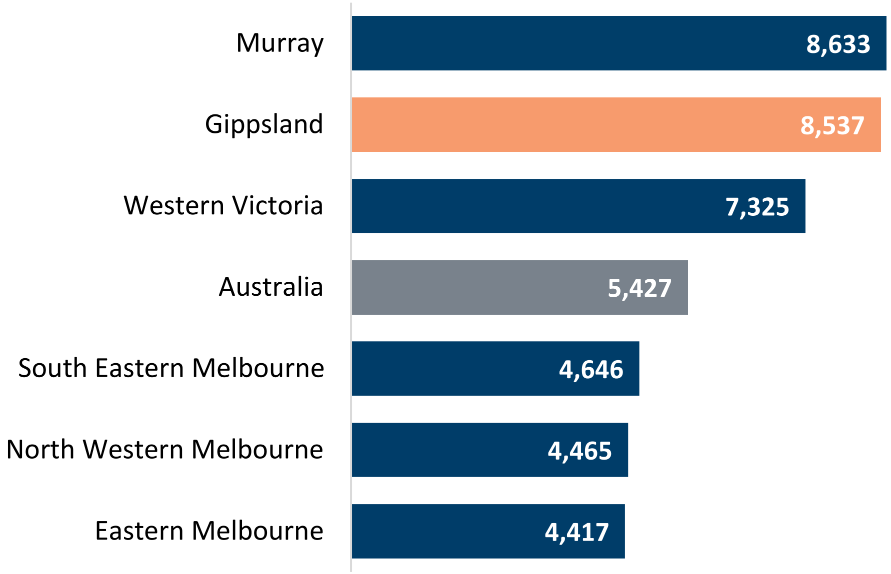
Data in this section are based on information related to palliative care-related prescriptions from the Palliative Care Schedule under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) (AIHW 2025a).Note these data do not capture all medications prescribed for palliative care purposes, as some palliative care medicines (for example, morphine) are prescribed from the General Schedule. There was a 59% increase in palliative care related prescriptions between 2016-17 and 2023-24. National data for 2023-24 shows that:

- 79% of palliative care-related prescriptions were for pain relief; and
- general practitioners prescribed 90% of palliative care-related prescriptions.

Gippsland rates of palliative care-related prescriptions were the fourth highest in the country and 57% higher per population compared to national rates in 2023-24 (8,537 prescriptions per 100,000 population, compared to 5,427 nationally) (AIHW 2025a). See **Figure 14**. Of a total 26,278 prescriptions in 2023-24:

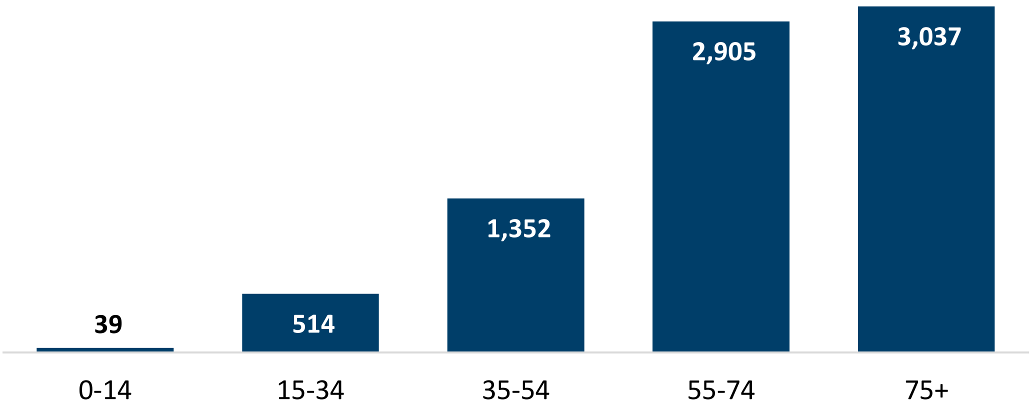
- 80% were for ‘Pain relief’ and of these, 53% were ‘Opioids’; 28% ‘Other analgesics and antipyretics’ and 18% were ‘Anti-inflammatory and antirheumatic products, non-steroids’
- 10% ‘Neurological’
- 8% ‘Gastrointestinal’
- 1% ‘Respiratory’ and
- 1% ‘Psychological’

Figure 14. Rate of palliative medicine prescriptions per 100,000 population, by Victorian PHN and compared to Australia, 2023–24 (AIHW 2025a).



In total, 7,847 Gippsland residents were prescribed a palliative care-related medication in 2023-24; 39% were aged 75 years or older. See **Figure 15**.

Figure 15. Number of Gippsland residents prescribed a palliative care-related medication by age group, 2023-24 (AIHW 2025a).



Non-admitted patient palliative care

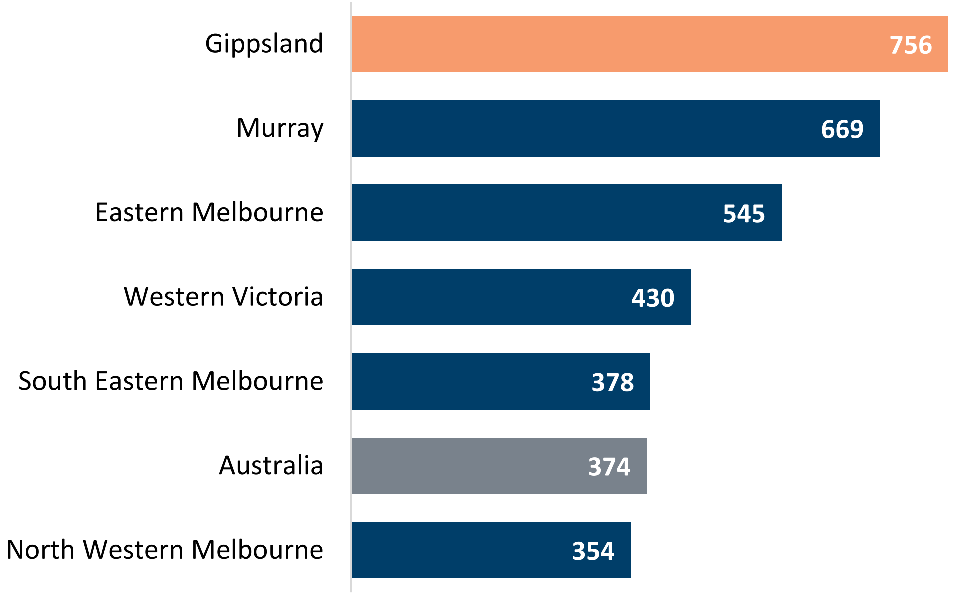
The Gippsland rate of non-admitted patient palliative care was highest in Australia and 102% higher per population compared to national rates in 2023-24 (756 service events per 10,000 population, compared to 374 nationally) (AIHW 2025a). See **Figure 16**. Non-admitted services include palliative care service events provided in the public hospital system without a hospital admission, including allied health and clinical nurse specialist interventions.

There was a total of 23,264 service events for Gippsland residents in 2023-24, and of these:

- 53% were for people aged 75+ (51% nationally), and
- there was a lower rate per population for the lowest socio-economic areas (191 service events per 10,000 population in the lowest quintile compared to 756 for the total population). Nationally, rates were higher for lower quintiles.

Due to changes in data definitions, trends over time are not available.

Figure 16. Rate of Non-Admitted Palliative Care per 100,000 population, by Victorian PHN and compared to Australia, 2023–24 (AIHW 2025a).



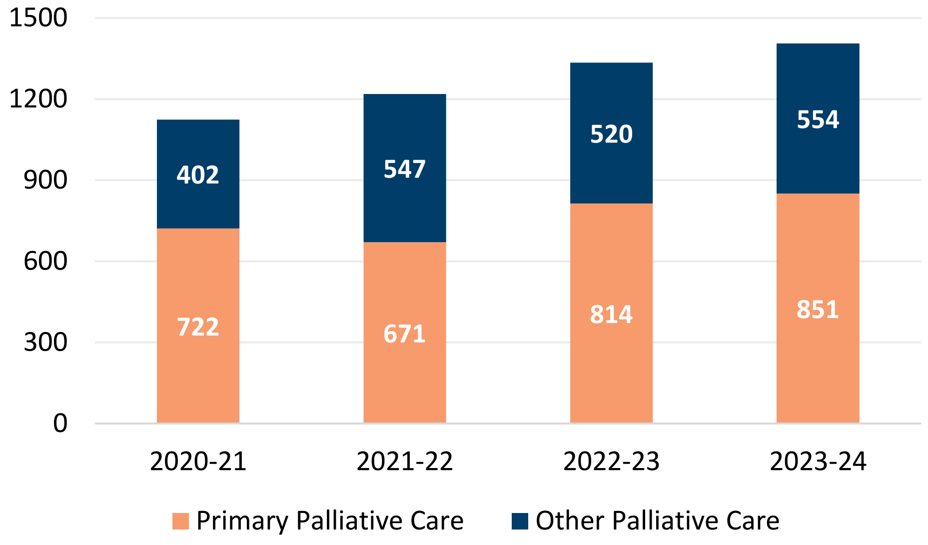
Hospital admissions

Palliative care-related hospitalisations can be divided into two groups depending on how they are identified in the hospital data (AIHW 2025a):

1. primary palliative care hospitalisations: hospitalisations with a recorded care type of palliative care, and
2. other palliative care hospitalisations: hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

In Gippsland, total palliative care-related hospitalisations have increased by an average of 8% annually between 2020-21 and 2023-24. See **Figure 17.** The national growth rate was 6% annually.

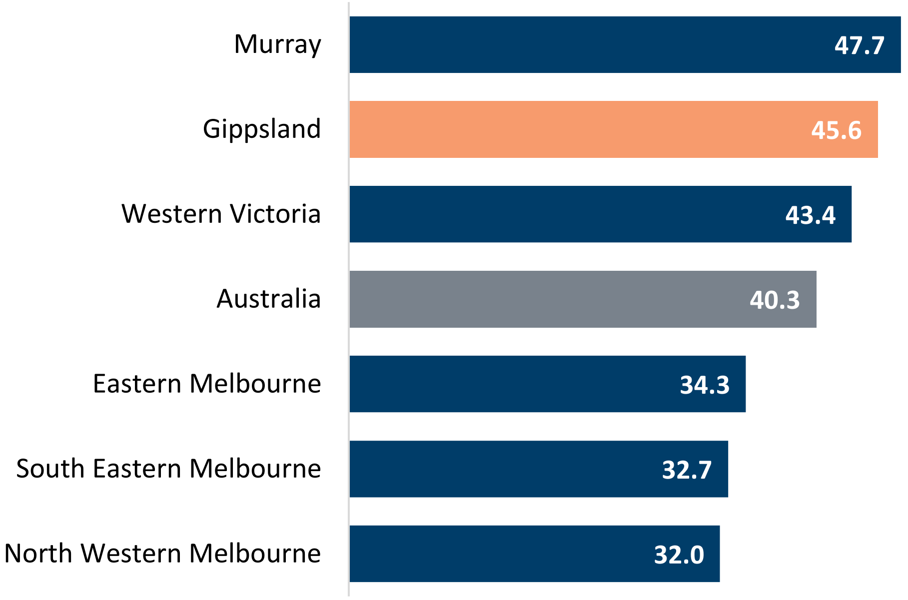
Figure 17. Number of palliative care-related hospitalisations for Gippsland residents, 2020-21 to 2023–24 (AIHW 2025a).



In 2023-24, there was a total of 1,405 palliative care hospital admissions for Gippsland residents (AIHW 2025a). The rate in Gippsland was 45.6 hospitalisations per 10,000 population, higher than nationally (40.3 per 10,000 population), and second highest of Victorian PHNs. See **Figure 18**. Among these hospital admissions:

- 56% were for people 75+ (59% nationally),
- 37% had a principal diagnosis of cancer (40% nationally), and
- there was a higher rate per population for the lowest socio-economic areas (67 admissions per 10,000 population in the lowest quintile compared to 46 for the total population). This rate was among the top 25% among Australian PHNs.

Figure 18. Rate of total palliative care-related hospitalisations per 10,000 population, by Victorian PHN and compared to Australia, 2023–24 (AIHW 2025a).



Based on an analysis of primary palliative care hospital admissions for Gippsland residents by Gippsland PHN (DH 2025b), 2019-20 until 2024-25 (n=4,604), it was found that:

- **Aboriginal and/or Torres Strait Islander peoples**: There was an increased proportion of admissions from 1.0% in 2019-20 to 2.5% in 2024-25.
- **Preferred language**: A majority had English as preferred language (99.2% of admissions), with top other languages Italian, Greek, Dutch, German and Mandarin. An additional 11 languages were identified by a small number of people. An interpreter was required for 0.3% of admissions.
- **Aged 65 years or older**: 81% of admissions were for people aged 65+, and of these:
    - 92% had no ACAS (Aged Care Assessment Service) involvement; 4% had completed an ACAS assessment; others had no data or were incomplete. [2]
- **Hospital location**: 95% of admissions were to a Gippsland hospital, and top hospitals outside Gippsland were Monash Medical Centre [Clayton], Casey Hopsital, Golf Links Road Rehabilitation and PCU, Austin Hospital and Peter MacCallum Cancer Institute.
- **Length of stay**: The average length of stay was 6.6 days in hospital; 23% of admissions were for an overnight or shorter stay.
- **Discharge location**: 69% of admissions resulted in the patient dying; 18% went home (private); 7% to a Residential Aged Care Home (RACH) and 4% to acute hospital care.

The rates of primary palliative care hospitalisations for Gippsland residents vary between a low of 9 per 10,000 population in Baw Baw to 37 in Latrobe, see **Figure 19.**

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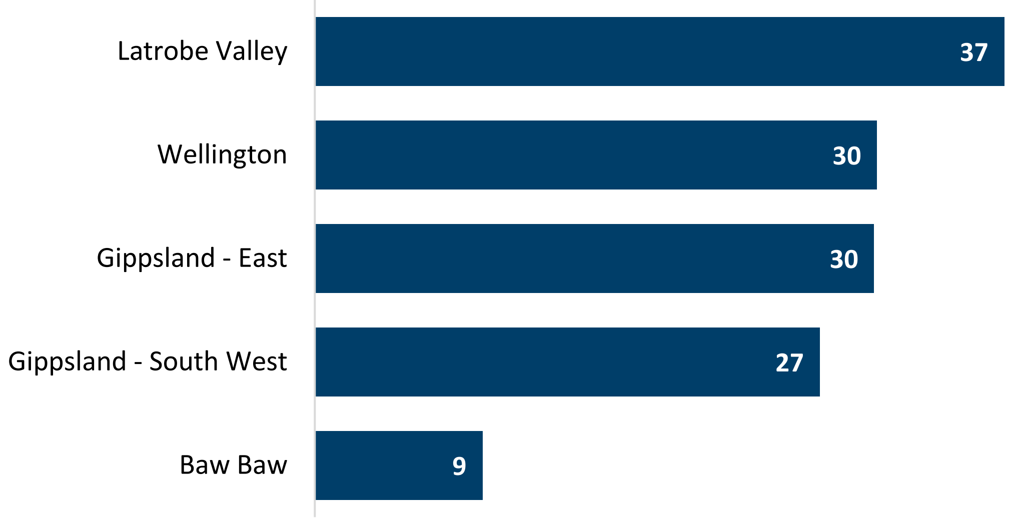
[2] Note that the RAS (Regional Assessment Service) is not included here. A change to the Single Assessment System (SAS) occurred on 9 December 2024, merging the ACAS (Aged Care Assessment Service) and the RAS.

Figure 19. Rate of primary palliative care-related hospitalisations per 10,000 population*, by residential sub-region (Statistical Area 3), 2024-25 (DH 2025b).



* Using June 2024 Estimated Resident Populations (ABS 2025)

Palliative Care Consultancy Gippsland (PCCG)

The Palliative Care Consultancy Gippsland (PCCG) is a multidisciplinary team which provides an outpatient clinic, education and support, on call services and regional visits, including by medical consultants, Nurse Practitioners (NPs) and social workers. In 2023-24 (LRH 2024) there was a total of 703 referrals and 5,583 patient contacts. The distribution of referrals by client LGA shows that:

- 50% were from Latrobe
- 15% were from Wellington
- 9% Baw Baw
- 9% East Gippsland
- 9% Bass Coast
- 7% South Gippsland

Advice and recommendations for symptom control and management was the predominant contact reason.

Based on 3,139 total deaths in Gippsland in 2023 (AIHW 2025b), and total referrals to the PCCG of 703 in 2023-24 (LRH 2024), it can be estimated that approximately 22% of all deaths in Gippsland were referred to the PCCG.

Models of Care and Tools

Selected models of care and tools with potential to improve access to palliative care at home were identified based on a brief literature review and consultation findings. The selected models and tools detailed below are already used in parts of Gippsland and/or have the potential to be transferrable to other parts of the region or additional settings within the region:

- **’Palliative Care Needs Rounds’ in RACHs** (GPHN 2024a). West Gippsland Healthcare Group (WGHG) has commenced monthly Palliative Care Needs Rounds in RACHs after an internal review of referral pathways. The model at WGHG includes a Palliative Care Nurse Practitioner and Clinical Nurse Consultants. The Palliative Care Needs Rounds are based on a Calvary Health Care model (Calvary 2025). The impacts of anticipatory planning to meet any unmet palliative care and end of life care needs are expected to lead to decreases in hospital transfers.
- A **Telephone Triage Tool** (GPHN 2024a) was developed by GRPCC (2019) and is currently in use in the community palliative care setting. The tool provides nurses with prompts, and guides assessment and communication with a doctor in responding to palliative care symptoms. Adapting the tool for use in RACHs could improve assessment and communication of palliative care symptoms for nurses working in aged care.
- **caring@home** is a core National Palliative Care Project funded by the Australian Government. The resources produced are applicable Australia-wide and freely available. They were developed for carers and families, health professionals and for clinical services.
- **PalCare** PMS (Patient Management System) is a dedicated system for palliative care, suited to provide a shared data platform across community palliative care services and specialist consultancy teams. It is in use by the Palliative Care Consultancy Service Gippsland, including a referral form which can be accessed by primary care providers. Expanded functionality to enable a shared data platform across Gippsland providers, including community palliative care services and in-patient settings has the potential to improve continuity of care and patient outcomes, including in the after-hours period. A broader roll-out, supported by the Victorian Department of Health has occurred in other Victorian regions, including Hume (GPHN 2025d).
- A pilot of a **Clinical Supervision model** for palliative care nurses to improve professional development and support is planned for Gippsland. The model is based on an ACT Health framework (ACT Health 2023) and was localised in response to an identified need for nurses who work in palliative care to receive additional professional supports to prevent burnout.
- A **PEPA|IPEPA Victoria - collaboration with Ambulance Victoria** (PCV 2025) highlights how targeted education can equip paramedics to deliver compassionate, informed care to people on a palliative journey. The collaboration included online learning and clinical placements. Ambulance Victoria can be an especially important service in rural and remote regions where access to specialist palliative care services remains limited.
- **Compassionate Communities** has a vision that every person in Australia is supported by a compassionate, connected, and confident community, through illness, death, and grief. Its foundation is community support for family and carers who provide 95% of the care for someone who is dying and notes that death is not a medical event.

Professional Stakeholder Perspective

Gippsland PHN stakeholder consultations included meetings with key stakeholders, an online survey, interviews and focus groups to inform the palliative care needs assessment. Summary themes were identified (GPHN 2025d):

Community awareness and understanding of palliative care:

- People often don't understand what palliative care is.
- Many people in the community are afraid to talk about death and dying. Community awareness events are needed so people can talk if they want to.

> *"We are a death denying society".*
>
> *"…people think you are supposed to die in hospital and are surprised about dying at home which most want to." (Nurse)*
>
> *"People are afraid to die so don't want to do ACP [Advance Care Planning]" (Nurse)*

Rural and regional areas rely on generalist service providers to provide palliative care:

- District nursing services are essential to provide palliative care in the home, especially after-hours, but capacity is limited.
- Areas not supported by a funded specialist palliative care service can be less equipped to provide high quality care.
- Service providers funded for specialist palliative care across the region can be Traralgon-centric and few supports reach more remote areas.

There are significant barriers for people aged less than 65 years in accessing palliative care:

- Access to funding is challenging, including to support travel, equipment and support at home.
- Early palliative care needs are associated with chronic disease among younger people with a higher proportion in areas experiencing disadvantage or environmental exposures leading to conditions such as mesothelioma.
- There are few social supports and a reliance on community-based initiatives.
- Support for younger families can be harder to manage, including due to work commitments and childcare.

Importance of person-centred care to support care at home:

- A lack of communication skills is a big gap and essential for person-centred care.
- Lack of awareness about resources and support for family and carers to help when supporting a dying person. Often the carer is an elderly partner who is also unwell.
- When more unwell people remain at home, it will inevitably lead to emergency department presentations, and there is a need to prepared for this.
- Importance of identifying socio-economic barriers, including social isolation, and availability of a suitable home for palliative care. Factors impacting availability of a suitable home can include family violence, inability to safely manage medication due to family members with drug issues, homelessness or risk of homelessness, lack of physical space and/or financial security.

> *"Good clinicians know how to talk to extract what is most important." (Nurse)*

Integration and coordination of primary, community and specialist palliative care services:

- A lack of patient management system to enable sharing of clinical information in a timely and secure way.
- A lack of standardisation of information, competencies and procedures.

- Variable communication methods for different services make transfer of relevant patient information challenging, especially for urgent referrals.
- Community palliative care service providers who are linked to a health service also incorporating a hospital facilitates coordination through shared records.
- Fragmentation due to varying policies and procedures can be a problem.
- Patients with complex conditions need to access specialist care from metropolitan Melbourne and communication with local providers is often patchy.
- Collaboration in local areas is often great despite limited workforce.
- It can be hard to "*pull in the GPs*" to allow collaboration due to limited planning, access and funding.
- Advance Care Plans are not used in ED/ICU.
- There can be a complete focus on curative medicine by specialists which can be in contrast to GP perspective, making care coordination challenging.

"People often don't understand that their treatment is no longer aimed to cure." (Nurse)

"… everything is paper-based…" (Professional focus group)

Early identification of palliative care needs and deterioration are essential for high quality care:

- Identification of deterioration in patients is essential to provide good symptom management and avoid urgent after-hours care needs.
- Consider ACPs as a mandatory part of 75+ health assessments. This could assist in planning and preparing, but there is a need for funding through Medicare and systems to make them available.
- Many doctors and nurses lack the skills and experience to enable early identification of palliative care and end of life care needs.
- Communication skills are essential to enable conversations with patient and family.

"… a reluctance to start and have the conversation." (RACH focus group)

"Readiness of family and client - often not on the same page…" (Professional focus group)

Suitably skilled and supported workforce across the region:

- Retention and recruitment of palliative care workforce limits availability.
- There is a need for upskilling generalist doctors and nurses to improve access to palliative care.
- There is a need for more specialist palliative care nurses.
- It is demanding to work in palliative care and professional supports are needed to prevent burnout.
- Gippsland has an ageing specialist palliative care workforce.
- The aged care sector has high staff turnover with ongoing needs to upskill new staff.
- There is a reliance on migrant workers, including in RACHs and GPs, and they require support for their transition to work in Australia's healthcare system, noting some countries don't have palliative care.

"A strong need to support our staff across the board!" (Nurse)

"Education and capacity building for generalists is a huge issue. They need the ability to identify end of life and capacity to have difficult conversation with family and client." (Professionals focus group)

Limited capacity of specialist palliative care services:

- Delays to access specialist support can occur, leading to end of life support being prioritised, and a potential inability to take early referrals.
- There is limited access in rural and remote areas, in part due to capacity and the time required for travel and overnight stays for the more remote areas of Gippsland.

- Limited access leads to complex cases being held by non-specialist service providers while waiting to access specialist services.
- Access to equipment can be challenging due to a requirement for occupational therapy assessment and limited funding.

"Need availability of staff so someone can be around when people are dying (even if weekend or after hours)." (Nurse)

"If we referred all to palliative care they couldn't get a service as there isn't enough funding." (Nurse)

Gaps in service availability:

- It is challenging for general practices to provide after-hours and on call support due to part time work, reduced home visits by GPs and doctors not living locally.
- There is a need for additional dedicated palliative care inpatient beds and/or hospice.
- Limited access to bereavement support, especially for those at risk of complex grief.
- There is one VAD navigator at LRH. Health professionals can be fearful of those discussions and the legislative requirements.

Uncertainty about referral pathways and available services and supports:

- There is a lack of knowledge and understanding of available palliative care services and supports.
- Varying referral pathways in different parts of Gippsland can cause confusion.
- A need to ensure new doctors and nurses working in Gippsland can access information about local referral information.

"A lack of understanding of the system - are community nurses the same as the ones in hospital?" (Professional)

There are challenges related to timely access to medication:

- Timely prescribing can be a barrier, and the patient can end up in hospital if there is no access in the community.
- Some GPs are not comfortable with prescribing palliative care medications, which can be due to lack of education and/or cultural or personal beliefs.
- Partnerships and communication between prescriber and pharmacists are helpful.
- A need for standing orders for drugs to use as PRN (pro re nata, or as needed) and this is not always in place. A clinician confident in identifying deterioration to start administering is also required.
- Not all pharmacies stock palliative care medications.
- Access to 'imprest stock' medications which are not prescribed for a specific individual and are available after hours or in emergencies, including in RACHs and rural and remote locations is essential for timely supply when needed.

"Patient had PRN morphine, but they were not given any as nurses didn't pick up that patient needed the meds" (GP)

Priority populations for improved access to palliative care:

- There is variable access to palliative care in RACHs, often related to a lack of palliative care staff and awareness which can result in very late referrals. In addition, people spend less time in RACHs now, meaning they often have higher care needs.
- Aboriginal and/or Torres Strait Islander people are under-represented in palliative care and are more likely to present to an ED. This is likely related to a lack of culturally appropriate care.
- Appropriate care for LGBTIQA+ is still a need. This includes care that is safe, inclusive, and affirming.

- Lower socio-economic areas are under-serviced, which forces people into hospital when they need support.
- People who are isolated and lacking informal supports.

The healthcare system can be a barrier to implementing reforms:

- The new End-of-Life Pathway may result in added pressure on the system, both in primary care where GPs will be responsible for the assessment required to access the pathway, and in specialist palliative care services who will not be provided with additional funding.
- There is a disconnect between NDIS and palliative care services.
- Changes to aged care funding raises concern that some people currently supported with packages may need to be supported by primary care due to increases in costs of services.
- Palliative care in aged care is now embedded in guidelines, but some do not have the workforce and are unable to provide adequate support.
- Service providers want a sustainable plan, not projects, and may be reluctant to support short term initiatives.
- A need for improved data to show need and advocate for money.

> *"Palliative care has bad data and perhaps it is about better data. Lots of levels involved and it is hard to understand the data with many services involved …." (Nurse)*

Enablers for improved palliative care in RACHs were identified:

- Continuity of care improves with a regular GP or general practice.
- Subregional education programs and community of practice meetings support promotion of referral pathways, including for Residential in Reach (GPHN 2024a).
- New Aged Care Quality Standards implemented in 2025 require RACHs to provide information related to accessing specialist palliative care, including for family and carers. Updated referral pathways and tools can support this organisational process to meet the standard (GPHN 2025d).
- Awareness about palliative care support options including the Palliative Care Advice Service (PCAS), the Victorian Virtual Emergency Department (VVED) and the Palliative Care Consultancy Gippsland after hours palliative care support arrangements (GPHN 2024a and GPHN 2025d).
- Credential NPs to work across multiple hospitals and RACHs to enable streamlined palliative care and end of life care across providers (GPHN 2025d).
- Regular NP visits to RACHs are very useful to support case conferences. (GPHN 2025d)

> *"VVED has been helpful." (RACH professional)*

Enablers and opportunities for improved palliative care in the community:

- Practice nurses could speak to patients prior to GP appointments to provide background. This is currently not funded by Medicare but could support the roll out of the new End-of-Life Care pathway.
- Consider elderly patient navigators in general practices.
- Build a model of flagging 'frequent presenters' in GP practices and train nurses / navigator to pilot a support role. They don't need to be palliative care specialists, but they do need good communication skills, including the ability to complete ACPs and prepare for a potential referral to palliative care.
- An expanded role for Ambulance Victoria based on new guidelines (Ambulance Victoria 2025).
- Additional MBS items to cover phone calls and other coordination activities would improve access.
- Having a close relationship with a GP helps people learn about palliative care gradually.
- Encourage completion of ACPs early when in good health.
- A need for improved death literacy in the community.

“The discussion around palliative care being referred to and framed as supportive care, not just end of life care, will impact how I discuss this with clients as relevant.” (Healthcare professional)

“Family is key.“ (GP)

“GP is the key – they will need to know when it is time – see deterioration…” (Nurse)

“We still feel uncomfortable with death and dying so conversations don’t happen, and people become excluded from palliative care as a result.” (Professionals focus group)

“… we all have a terminal condition. [ACP] is much easier when death isn’t imminent. Not everyone will want to do it but with encouragement people get it done early.” (Professionals focus group)

“Need a prominent person to advocate and increase awareness.” (Nurse)

Community, Family and Carer Perspective

Main themes were identified from Gippsland PHN consultations with community, families and carers during a 2024 Community Roadshow (GPHN 2024b) and multiple methods in 2025, including the Gippsland PHN Community Advisory Committee, a survey, interviews and a focus group (GPHN 2025b and GPHN 2025d):

Community awareness and understanding of palliative care:

- A lack of awareness about the importance of pre-planning while still well.
- A lack of knowledge of local palliative care services, what they can do for you, how they work together and where to get information.
- Community events about death, dying and planning usually attract a lot of interest, demonstrating a need for community events.

> *"... if people believe that it [palliative care] is just those last few weeks of life, then they're probably missing a whole lot of opportunities." (Community member)*
>
> *"I've noticed that as soon as anything's done or mentioned on palliative, people run away from it in droves. It's sort of like, no, it's not me, it's not the end yet" (Community member)*

There is a lack of knowledge about palliative care among health professionals:

- Medical specialists can be reluctant to declare a patient is palliative, and this becomes a barrier to access those services and supports. Preparation is not possible, and they end up going straight to end of life care.
- The number of trained palliative care nurses working in the community is limited.
- A lack of appropriate conversations with the patient and family in acute services leads to distress and inability to prepare for at home support post-discharge.

> *"…pity GPs don't know more about dementia." (Carer)*

There is a lack of access to palliative care services across the Gippsland region:

- Funded specialist community palliative care services are not available in several more rural and remote communities.
- After-hours and on call support is not available or limited in many locations, including GPs and specialist palliative care services.
- It can be challenging to access support from the Palliative Care Consultancy Gippsland across the whole region.
- No local access to a palliative care inpatient bed in some areas.
- Access to geriatricians and other specialist services in the region is limited.
- A local hospice facility in Gippsland is needed, or alternative access to a facility with a homely environment where family can visit.

There is uncertainty about pathways to palliative care and related service options:

- People don't know what is out there unless they are told.
- There is a lack of awareness and knowledge about Voluntary Assisted Dying (VAD) and related pathways.
- The role of Ambulance Victoria in palliative care is unclear.
- A lack of access to GPs who can prescribe medicinal cannabis or alternative pathways.

Socio-economic barriers to accessing palliative care:

- Access to transport can be challenging and limits access to services and supports not available locally.
- Costs of home support services can be a barrier, especially for people younger than 65 years or unable to access Support at Home funding.
- Concerns about rising costs of home care services and ability to access required support within budget.
- People with a multicultural background need additional supports, for example, they may go back to using their first language and struggle to communicate.
- People with low literacy skills and/or no computer skills miss out on accessing services and supports.

"People can't find the information if they don't have a computer." (Carer)

A lack of care coordination and integration:

- Paper-based or verbal information sharing for referrals is still occurring, leading to disjointed records across providers and family and carers can become responsible for coordination.
- Appropriate community-based services are not always arranged prior to discharge from hospital.
- Coordination is more challenging during the weekend and after-hours.
- Adequate communication with family and carers to prepare both practically and emotionally after a hospital stay or when deterioration happens is sometimes lacking.
- Examples of inconsistent or conflicting advice from different providers, including about medication and doses, leading to poor symptom management and pressures on the family.
- Some services do not share information on My Health Record, including pathology test results, leading to repeated tests.

"Felt shamed when … Drs saying different things about meds and made family cry as thinking they were doing the wrong things" (Family member)

"Mum's wishes and family were not considered…" (Family member)

There is a lack of person-centred care including support for physical, emotional, spiritual and social care needs, including for family:

- Service providers can focus solely on physical needs, such as pain management, while neglecting or lacking resources to support other needs.
- Family and carers can be left feeling unsupported and overwhelmed with practical tasks and unable to prepare for the death.
- A family member described the contrast between two deaths:

"In the case of my stepdad, in his last days we were focussed on the practical and medical, the logistics, the medication, the problems, the physical, not the emotional, or the engagement and the connection. In the case of Dad, we could simply focus on him - talk to him, hold his hand, just - be there, be present, and hopefully even though there wasn't a lot of consciousness in the last couple of days and hours, hopefully he knew, felt it, and was comforted." (Family member)

"…we linked into Community Palliative Care, and they were great however did not have resources to support families." (Family member)

Enablers for accessing palliative care in the community:

- Knowing what is available.

- Telehealth appointments can save travel time and money.
- Access to resources and courses to learn more for carers.
- Practical ideas about everyday items that can assist. For example, a watch can monitor health and falls, and this can give incidental respite.
- Carer groups are a great resource.
- Assistance with accessing funding is hugely valuable.

> *"…the GP attended and had an office at the RACH for appointments onsite weekly." (Family member)*
>
> *"...there almost needs to be some kind of a shopping list to say this is available, what might help you? Um, because it's really hard otherwise to just come up with, you know, I know as a carer, you know, somebody says what will help." (Carer)*
>
> *"[The palliative care service] advocated and it felt like they were on our side and what was best for mum and family." (Carer)*

The **Latrobe Health Advocate** identified palliative care as a priority area based on findings from community engagement in Latrobe in 2019. A report (Latrobe Health Advocate 2024) identifies progress against the five reform priority areas:

1. Empowering people in Latrobe to die in their place of choice and offering places to choose from.
    a. Limited progress with availability of a hospice and/or a home-like environment in hospital.
2. Latrobe communities experiencing a system that works in harmony with their needs.
    a. System reform is underway to improve access and a more unified model of care.
3. Latrobe as the epicentre for those who have the heart for palliative care.
    a. Importance of supporting the palliative care workforce, including volunteers.
4. Latrobe communities benefiting from a public health approach that brings death and dying out from the shadows.
    a. Limited progress with awareness of palliative care and death with support for grief and bereavement.
5. Contemporary governance brings health services and communities together to share their collective expertise.
    a. Limited progress with structures where health services and communities come together.

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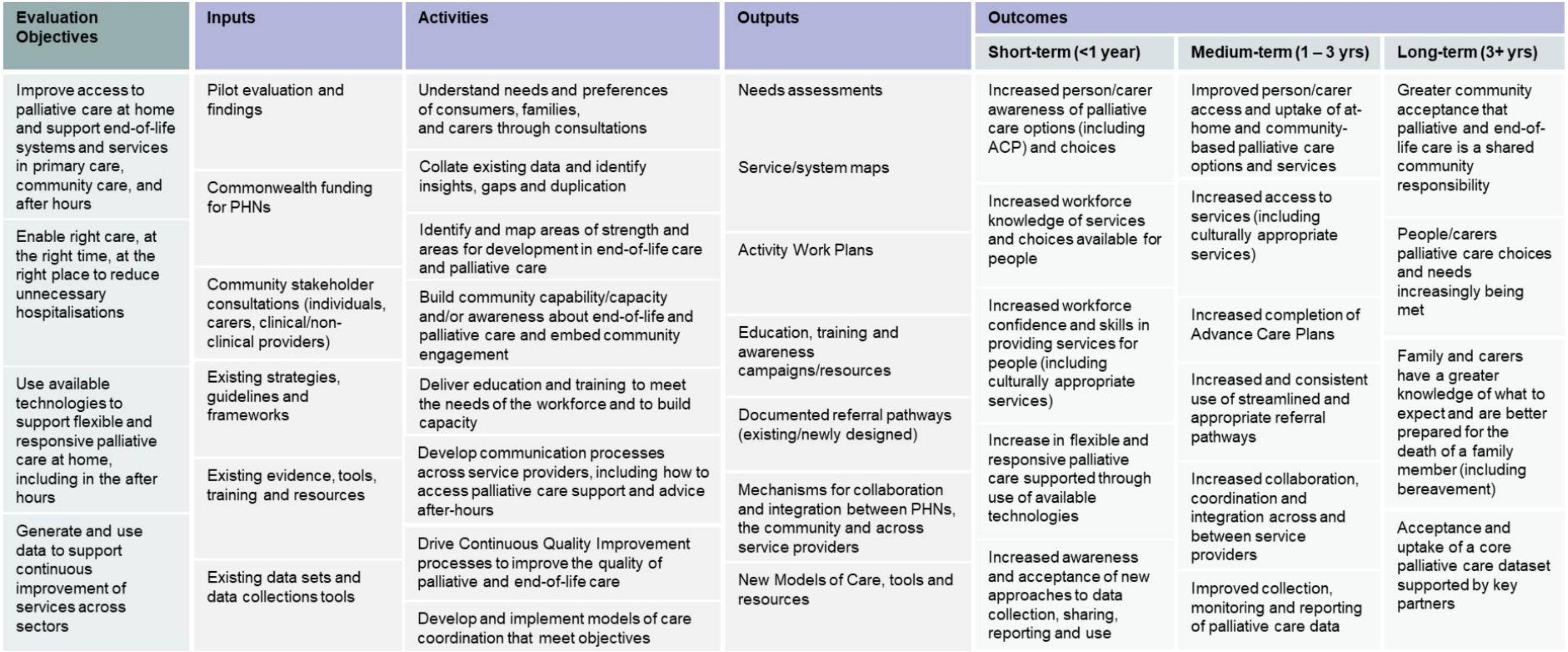
Acronyms

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACAT	Aged Care Assessment Team
ACCO	Aboriginal Community Controlled Organisation
ACD	Advance Care Directive
ACP	Advance Care Planning
AIHW	Australian Institute of Health and Welfare
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AOD	Alcohol and Other Drugs
BCH	Bass Coast Health
CALD	Culturally and Linguistically Diverse
DFFH	Department of Families, Fairness and Housing (Victoria)
DH	Victorian Department of Health
DHDA	Department of Health, Disability and Ageing (Commonwealth)
DLI	Death Literacy Index
ED	Emergency Department
ELDAC	End of Life Directions for Aged Care
EMR	Electronic Medical record
EOLC	End of Life Care
GCfAHPC	Greater Choice for At Home Palliative Care
GP	General Practitioner
GPHN	Gippsland Primary Health Network
GRICS	Gippsland Region Integrated Cancer Services
GRPCC	Gippsland Region Palliative Care Consortium
GSHS	Gippsland Southern Health Service
GWH	Gippsland Women's Health
FTE	Full Time Equivalent
HNA	Health Needs Assessment
IPEPA	Indigenous Program of Experience in the Palliative Approach
LGA	Local Government Area
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual
LHA	Latrobe Health Advocate
LHN	Local Health Network
LRH	Latrobe Regional Health
LOTE	Language Other Than English
MARAM	Multi-Agency Risk Assessment and Management
MBS	Medicare Benefits Schedule
MHR	My Health Record
MMM	Modified Monash Model
MPHWP	Municipal Public Health and Wellbeing Plan
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NPSM	National Psychosocial Support Measure
PCOC	Palliative Care Outcomes Collaboration
PBS	Pharmaceutical Benefits Scheme

PCA	Palliative Care Australia
PCV	Palliative Care Victoria
PDSA	Plan-Do-Study-Act
PEPA	Program of Experience in the Palliative Approach
PHN	Primary Health Network
PHIDU	Public Health Information Development Unit
PIP	Practice Incentive Payment
PIP QI	Practice Incentives Program Quality Improvement
PIR	Partners in Recovery
POLAR	Population Level Analysis and Reporting
PPH	Potentially Preventable Hospitalisations
PSP	Psychosocial Support Program
QI	Quality Improvement
RACH	Residential Aged Care Homes
RWAV	Rural Workforce Agency Victoria
SA3	Statistical Area 3
SEIFA	Socio-Economic Index for Areas
SES	Socio-Economic Status
SHS	Shared Health Summary
VAD	Voluntary Assisted Dying
VAED	*VAED Victorian Admitted Episodes Dataset*

Appendix 1 – Program Logic, National Evaluation of the Greater Choices for At Home Palliative Care Program (DHDA 2025a)



Evaluation Objectives	Inputs	Activities	Outputs	Outcomes		
				Short-term (<1 year)	Medium-term (1 – 3 yrs)	Long-term (3+ yrs)
Improve access to palliative care at home and support end-of-life systems and services in primary care, community care, and after hours	Pilot evaluation and findings	Understand needs and preferences of consumers, families, and carers through consultations	Needs assessments	Increased person/carer awareness of palliative care options (including ACP) and choices	Improved person/carer access and uptake of at-home and community-based palliative care options and services	Greater community acceptance that palliative and end-of-life care is a shared community responsibility
Enable right care, at the right time, at the right place to reduce unnecessary hospitalisations	Commonwealth funding for PHNs	Collate existing data and identify insights, gaps and duplication	Service/system maps	Increased workforce knowledge of services and choices available for people	Increased access to services (including culturally appropriate services)	People/carers palliative care choices and needs increasingly being met
Use available technologies to support flexible and responsive palliative care at home, including in the after hours	Community stakeholder consultations (individuals, carers, clinical/non-clinical providers)	Identify and map areas of strength and areas for development in end-of-life care and palliative care	Activity Work Plans	Increased workforce confidence and skills in providing services for people (including culturally appropriate services)	Increased completion of Advance Care Plans	Family and carers have a greater knowledge of what to expect and are better prepared for the death of a family member (including bereavement)
Generate and use data to support continuous improvement of services across sectors	Existing strategies, guidelines and frameworks	Build community capability/capacity and/or awareness about end-of-life and palliative care and embed community engagement	Education, training and awareness campaigns/resources	Increase in flexible and responsive palliative care supported through use of available technologies	Increased and consistent use of streamlined and appropriate referral pathways	Acceptance and uptake of a core palliative care dataset supported by key partners
	Existing evidence, tools, training and resources	Deliver education and training to meet the needs of the workforce and to build capacity	Documented referral pathways (existing/newly designed)	Increased awareness and acceptance of new approaches to data collection, sharing, reporting and use	Increased collaboration, coordination and integration across and between service providers	
	Existing data sets and data collections tools	Develop communication processes across service providers, including how to access palliative care support and advice after-hours	Mechanisms for collaboration and integration between PHNs, the community and across service providers		Improved collection, monitoring and reporting of palliative care data	
		Drive Continuous Quality Improvement processes to improve the quality of palliative and end-of-life care	New Models of Care, tools and resources			
		Develop and implement models of care coordination that meet objectives				

Appendix 2 – Gippsland Evaluation Framework 2021-25, Greater Choices for at Home Palliative Care Project Final Report (GPHN 2025a)

Inputs	Activities	Outputs[1]	Impacts -Short term (<1yr)	Outcomes – Medium term (1-3yrs)
Funding **Governance Framework:** • Clinical Advisory Group • Project steering Committee • Community advisors **Gippsland PHN** **Health Services** **Project Partners:** • Gippsland Palliative Care Consortium • Gippsland Palliative Care Consultancy Service • Latrobe Health Advocate • GRICS • Community	Develop an understanding of the current system: • Identify and map existing palliative care services across Gippsland. • Palliative Care Needs assessment	1 Service system map developed 2 Needs assessments completed and local barriers identified.	3 Areas of opportunity to strengthen local palliative care service delivery are identified and used to inform a model of care.[2] 4 Increased knowledge base of palliative care service in the primary and acute sectors.[3]	5 Adaptive and responsive approaches/solutions to identified local barriers were developed and promoted.[2] 6 Increased understanding of scope of palliative care practice in Gippsland across primary, acute and palliative care providers.[3]
	Key Stakeholder Engagement • Establish the Gippsland Project Advisory Group and Steering Committee to ongoingly support improvements • Develop Communications and Stakeholder Engagement Plan	7 Project Advisory Group and Steering Committee developed	8 Collaboration with relevant stakeholders.[4]	9 Increased collaboration and coordination across and between existing primary, acute and palliative care providers. [4] 10 Improved coordination of care for patients across health care providers.[4, 5,13,14]
	Patient/Carers and community awareness and access	11 Community Awareness Campaign and resources identified (or developed) and promoted # resources developed # resources distributed Reach of distribution	12 Increased provision of quality information related to palliative care planning and choices to patients/carers.[5,12 ,13,14] 13 Families and carers have access to bereavement support services and are provided with information about loss and grief (Standard 6). [5,13,14] 14 Increased access to palliative care supports early, and information to better understand the demands of palliative care at home.[5, 12,13,14]	15 Increased patient/carer awareness of palliative care options (including ACP), palliative care service in the home and choices. [5, 12,13,14] 16 Improved patient/carer access and uptake of community-based and at-home palliative care options and support services. [5,13,14]
	Access to Core Palliative Care Medicines • Landscape map pharmacies without Core Medicines List (CML) in Gippsland • Establish collaborative agreements for the stockpile of palliative care medicines	17 Mapping completed 18 Agreements between providers and pharmacies are developed 19 Pain management guidelines to ensure pain management reflects symptom management, and local process for access of medications are developed and promoted	21 Greater awareness of pathways and mechanisms to support access to palliative care medicines in the Gippsland region. [3] 22 Increased health professional knowledge of palliative care medications or therapies for the treatment of symptoms, including best practice pain management procedures and how and when to prescribe palliative care medicines – and confidence to prescribe when needed. [3]	23 Improved access to and prescribing of Palliative Care medicines to reduce unnecessary hospitalisation.[6]

Inputs	Activities	Outputs[1]	Impacts -Short term (<1yr)	Outcomes – Medium term (1-3yrs)
		20 Guidelines in place for advanced dispensing		
	Residential Aged Care Facilities (RACFs) • IMPREST establishment in RACFs • Needs Assessment in RACFs to develop recommendations; scope for use of triage tool and develop a model of palliative care needs rounds • Implement recommendations in RACFs	24 Needs assessments completed 25 Recommendations implemented in RACFS		
	Technology and Digital health • Mapping of current DH tools • Use Capacity Tracker for improving timely access to medications • Pilot use of remote patient monitoring tool in home settings	26 Mapping completed 27 Model of care identified or developed 28 Pilot plan developed	29 # of acute and primary providers using the model[3,10,11] 30 Broadened reach, awareness and uptake of the new model among stakeholders. [3,10,11]	31 Available technologies are in use to support flexible and responsive palliative care at home, including in the afterhours.[9,10,11] 32 Evaluation of trialled model of care and how it can further support future local health needs.[9,10,11]
	Health professional education and training • Review access to palliative care education, training and resources for community and workforce and develop recommendations • Develop and co-design Regional Palliative Care Toolkit collaboratively with Murray PHN and Western Vic PHN. • Deliver a collaborative 12-month outreach facilitation intervention programme directed at improving the quality of general practice-based primary care services, using the co-designed toolkit • Deliver GP palliative Care webinar series • Review, update and promote relevant HealthPathways.	33 # of primary and acute palliative care stakeholders participating in the development and review of Health Pathways 34 # Health Pathways updated 35 # Health Pathways developed 36 Metrics of palliative care related Health Pathways usage 37 # education sessions delivered 38 # health professionals attending	39 Increased and consistent use of streamlined and appropriate referral pathways (e.g., HealthPathways)[8] 40 Greater health professional awareness of the availability of existing palliative care support services, how to access and when to use them. [3] 41 Increased health professional confidence and competence in the having palliative care conversation and providing information to patients, including how to support families who are palliative caring[3] 42 Increased awareness of the need to refer patients to palliative care support services early[3]	43 Staff and volunteers are appropriately qualified, are engaged in continuing professional development, and are supported in their roles (Standard 9). [3]