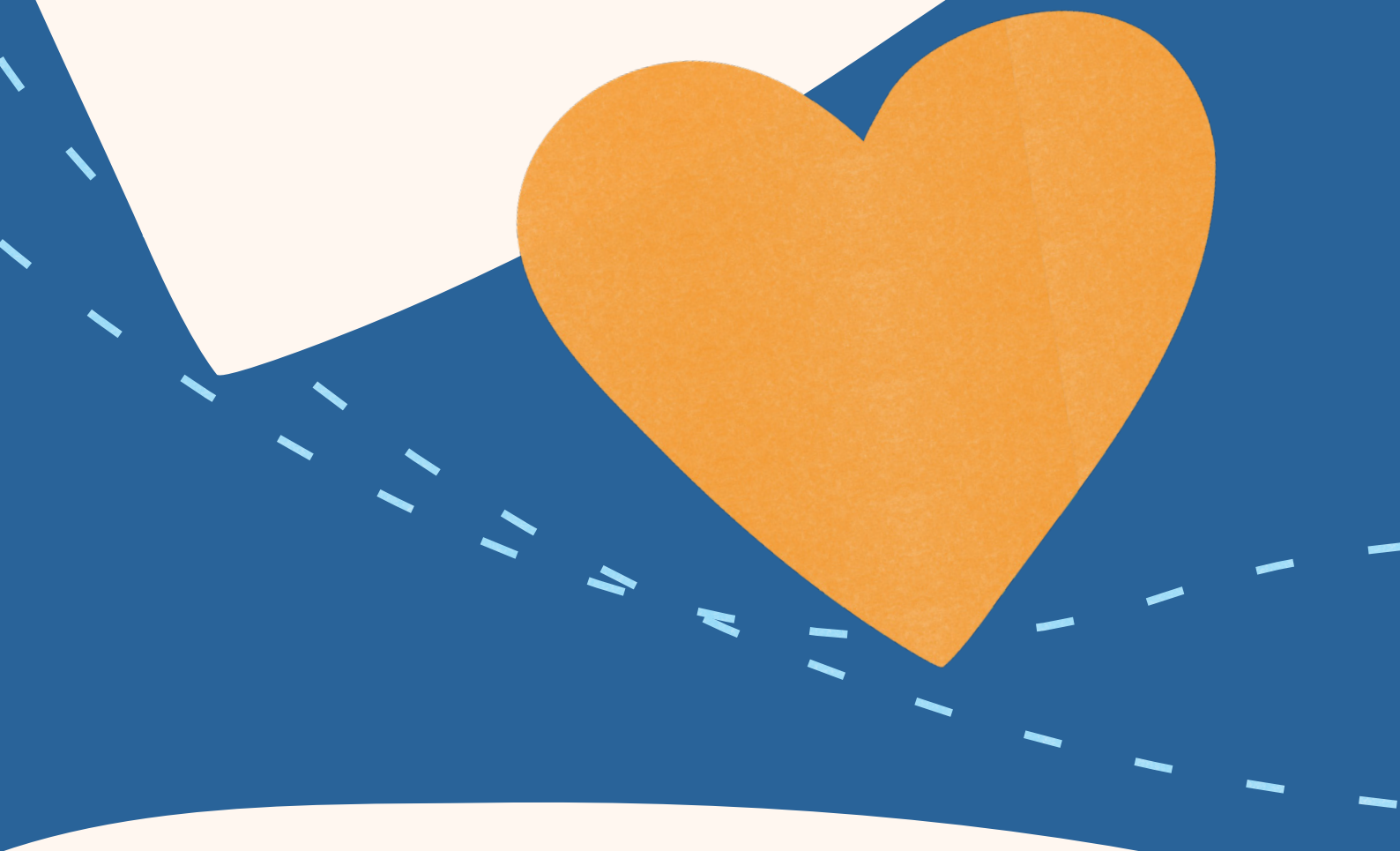
Palliative Care Victoria

State of Palliative Care in Victoria

SUMMARY REPORT
AUGUST 2026



THE UNIVERSITY OF MELBOURNE

Report developed by

A/Prof Chris Schilling, Susannah Annable, & Jack McLaughlin
Palliative Care Economics (PaCE) at The University of Melbourne

ACKNOWLEDGEMENT OF COUNTRY

Palliative Care Victoria acknowledges the Traditional Custodians of the land on which we work, the Wurundjeri Woi-wurrung people of the Kulin Nation. We pay our respect to their Elders past, present and future.

Further, PCV acknowledges Traditional Custodians of Country where palliative care services are delivered throughout Victoria, and recognises the continuing connection to lands, waters and Communities.

PALLIATIVE CARE VICTORIA'S INCLUSIVITY PROMISE

PCV is committed to creating a welcoming, safe, and respectful environment for all. We value the diversity and intersectionality that exists in our communities, and we embrace people's background, culture, faith, identity, and lived and living experiences. We promise to actively promote inclusion within the palliative care sector and the wider community.

Our commitment to diversity includes a deep respect for LGBTIQA+ people and communities, acknowledging the intersections of multiple minoritised identities that exist. This means our work towards inclusion is ongoing, as we strive to ensure our organisation is a place of safety, affirmation, and respect. We commit to advocate with, and alongside, these communities.

Executive Summary

Delivering the evidence base for Victorian palliative care

Victoria's palliative care system delivers high-quality care to people with life-limiting illness and their families. However, access remains limited, and growing demand is placing increasing pressure on services across the State.

Until now, Victoria has lacked a comprehensive understanding of who needs palliative care, who receives it, workforce capacity, how services are funded, and whether care is delivered equitably and at the right time. In order to establish a shared evidence base, this report brings together data across multiple domains including:

- Need
- Access
- Workforce
- Funding and costs
- Quality of care
- Education and training

The analysis draws on multiple complementary data sources, including the National Health Workforce Dataset, Australian Institute of Health and Welfare (AIHW) palliative care service data, Palliative Care Outcomes Collaboration (PCOC) clinical outcomes, and a bespoke linked dataset developed by the Palliative Care Economics (PaCE) team through the Centre for Victorian Data Linkage (CVDL), providing insights not previously available.

Our intent is that this report is not the end point, but the beginning of a stronger evidence base for palliative care in Victoria. While some data gaps remain, it establishes the foundation for ongoing measurement, improved data linkage and future evaluation to better inform policy, planning and investment.

Key Findings

1. **An estimated 34,457 Victorians could have benefited from palliative care in 2024.**

   Three in four Victorians who died in 2024 were estimated to require palliative care, equivalent to 34,457 people. This provides the benchmark against which access to palliative care services and unmet need are assessed.

2. **Almost 23,000 Victorians died without access to the palliative care they needed.**

   An estimated 22,889 Victorians who could have benefited from palliative care did not receive it in 2024. This equates to 63 Victorians dying each day without access to palliative care, with current specialist service capacity sufficient to meet less than 34% of estimated need.

3. **Access to palliative care is steadily improving.**

   In 2018, only 39.1% of Victorians who died received palliative care; in 2024 this had increased to 44.5%.

4. **However, it is often too late.**

   Fewer than 1 in 3 people with a cancer diagnosis receive a timely referral, defined as more than 3 months before death. For heart disease, dementia and Alzheimer's, and cerebrovascular conditions, timely access is lower at just 6%. For many, access, when it occurs at all, happens late in the disease trajectory, limiting the clinical and quality-of-life benefits palliative care is designed to provide.

5. **The number of palliative care physicians in Victoria is below both national averages and minimum service benchmarks.**

   Although the number of specialist palliative care physicians has increased since 2018, workforce growth has not kept pace with demand for palliative care services. Victoria has just 0.7 clinical specialist palliative care physicians per 100,000 population, well below the national average (1.1) and the minimum service planning benchmark (2.0). Gaps are most pronounced outside metropolitan areas, where physician supply is only one-quarter of the recommended minimum benchmark.

6. **Community palliative care funding is not keeping pace with the cost of delivering care.**

   The costs of providing community palliative care are increasing faster than both government funding and inflation. Between FY2021 and FY2025, expenditure grew by 7.0% per year, while recurrent government funding increased by just 3.7% annually.

7. **When palliative care is provided, it is provided well.**

   Palliative Care Outcomes Collaboration (PCOC) data show that Victorian palliative care services deliver responsive, high-quality care that improves or maintains patient outcomes in most cases. Our research shows that palliative care can significantly improve the quality of end-of-life care.

8. **Palliative care is underrepresented in medical training.**

   Across Victoria's three medical schools, less than 50 hours of the medical curriculum are dedicated to palliative care (<0.5% of total teaching time). There are zero mandated palliative care hours in any national medical curriculum.

9. **Looking ahead, need for palliative care will grow at double the rate of population growth and faster than projected service capacity.**

   As a result, unmet palliative care need is expected to grow by almost 5,000 people, reaching 27,872 Victorians by 2045. This would equate to 76 Victorians dying each day without access to the palliative care they need.

Table of Contents

Acknowledgements

The authors thank the members of the Steering Group for their guidance and expertise throughout the development of this report:

- Violet Platt - CEO, Palliative Care Victoria
- Jennifer Philip - Chair of Palliative Care Medicine, the University of Melbourne
- Kate Johnson - CEO, CF Together
- Alicia Barclay - Innovation and Improvement Manager, Alfred Care Group
- Leeroy William - Director of Palliative Care, South West Healthcare

Their contributions to the design, interpretation, and review of this work are gratefully acknowledged.

Foreword

Adj Assoc Prof Violet Platt
Chief Executive Officer
Palliative Care Victoria

Kelly Rogerson
Board Chair
Palliative Care Victoria

Palliative care is a fundamental component of a responsive and sustainable health system. As Victoria's population ages and the prevalence of chronic and complex illness increases, the need for high-quality, accessible palliative care continues to grow. Ensuring that every Victorian can access the right care, at the right time, regardless of where they live or who they are, remains a critical challenge for our health system.

This report, The State of Palliative Care in Victoria, has been commissioned by Palliative Care Victoria on behalf of its members, to provide a comprehensive picture of palliative care across the state. It brings together important evidence about need, access, workforce capacity, funding and equity, enabling us to better understand where the system is performing well and where further attention is required.

Importantly, this report is being released alongside the Victorian Palliative Care and End-of-Life Framework 2026-2036, reinforcing a shared commitment across government, services and communities to improve experiences and outcomes for people approaching the end of life. High-quality data is essential to that task. It enables informed planning, supports accountability and helps ensure that investment is directed to where it can make the greatest impact.

We thank the members of Palliative Care Victoria and the Palliative Care Economics Team at the University of Melbourne for their expertise, collaboration and commitment to strengthening Victoria's palliative care evidence base. Their contribution has created an important benchmark for the sector and a foundation for measuring progress over the decade ahead.

Our collective responsibility now is to translate insight into action. We hope this report will support informed discussion, encourage collaboration and contribute to a future in which every Victorian has equitable access to high-quality palliative care and end-of-life support, to be able to live, die and grieve well.

Definitions and acronyms

Term	Definition
Admitted care and the Victorian Admitted Episode Dataset (VAED)	Admitted episodes involve a formal hospital admission and occupation of an admitted hospital bed, as recorded in the VAED. For palliative care, this includes episodes in dedicated inpatient palliative care units (PCUs), as well as admitted episodes where palliative care is recorded as a secondary diagnosis (Z51.5).
Annual growth rate	The annual growth rate metric presented in this report is the compound annual growth rate. It is the mean yearly growth rate over a given period.
Emergency department presentations and the Victorian Emergency Minimum Dataset (VEMD)	Emergency department presentations are episodes of care provided to patients presenting to a hospital emergency department, as recorded in the Victorian Emergency Minimum Dataset (VEMD).
Non-admitted care and the Victorian Integrated Non-Admitted Health (VINAH) dataset	Non-admitted care refers to health care provided to patients who do not undergo a formal hospital admission or occupy an admitted hospital bed. Community palliative care and hospital-based palliative care consultancy team activity is captured as non-admitted care in VINAH.
Palliative care access and activity data	Community palliative care services, hospital-based palliative care consultancy teams, specialist palliative care services within palliative care units, and inpatient episodes where a palliative approach to care was identified through a secondary ICD-10 Z51.5 code. Exclusions: palliative care provided by general practitioners or other generalist providers.
Palliative care need	The number of persons requiring palliative care (potentially including both specialist and generalist palliative care) calculated as 75% of all deaths based on international and Australian literature. Reflects that need for palliative care varies by disease.
Palliative care workforce data	Specialist palliative care physicians and nurses working in palliative care, with metrics for headcount, full-time equivalent (FTE), clinical FTE and clinical FTE per 100,000 population, consistent Australian Institute of Health and Welfare definitions and reporting practices (see https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/palliative-care-workforce). Exclusions: generalist providers of palliative care.
Service coverage	Percentage of palliative care need that is met by current services. Calculated as the share of current workforce to nationally endorsed minimum workforce benchmarks.
Unmet palliative care need	The number of persons requiring palliative care (including both specialist and generalist palliative care) who do not receive the palliative care they need. Calculated as the difference between current and nationally endorsed minimum workforce benchmarks. Reflects the extent to which current service capacity is sufficient to meet the population's need for palliative care.

Introduction

A carer's perspective

When my mother was diagnosed with advanced cancer in regional Victoria, we had no idea what palliative care meant. We thought it meant giving up. We didn't know it could have meant six more months at home instead of in a hospital ward. We didn't know a palliative care nurse could have helped manage her pain in a way that let her sit at the kitchen table with her grandchildren. We found out too late. By the time we were referred, there were four days left.

— A Victorian carer, regional Victoria, 2026

A data and evidence hub for palliative care in Victoria

Victoria's palliative care system plays a vital role in supporting people with life-limiting illness and their families, and carers. As Victoria's population grows and ages, demand for palliative care is increasing, creating new opportunities to strengthen service planning, workforce development and equitable access across the state. Delivering on the vision of person-centred, integrated palliative care will require timely, high-quality evidence to guide policy and investment.

A longstanding challenge has been the absence of a comprehensive, integrated evidence base describing who needs palliative care, who receives it, how services are delivered, and the outcomes achieved. While valuable data exist across multiple organisations, these information sources have not typically been brought together to provide a statewide picture of palliative care.

To address this gap, Palliative Care Victoria partnered with the University of Melbourne's Palliative Care Economics (PaCE) Research Group to establish the State of Palliative Care (SOPC) program. Bringing together national collections, bespoke community palliative care data and newly linked administrative datasets through the Centre for Victorian Data Linkage, the program aims to establish an enduring evidence platform for palliative care in Victoria.

Our work is closely aligned with the Victorian Government's Palliative and End-of-Life Care Framework 2026–36[1], which identifies improved data, monitoring and governance as key priorities for the decade ahead.

This inaugural report presents a comprehensive overview of palliative care in Victoria across key domains including population need, access to care, service activity, quality and outcomes, workforce, education and training, funding and expenditure. It draws on data from the Australian Institute of Health and Welfare, the Palliative Care Outcomes Collaboration, community palliative care services and linked hospital, emergency department and outpatient datasets.

While important data gaps remain, this report represents the first step towards a sustainable statewide evidence infrastructure for palliative care. Over time, the SOPC program aims to expand the breadth of available data, refine indicators as new evidence emerges, and provide regular reporting on need, access, quality, workforce, funding, costs and outcomes. Accompanying this report is a technical report that documents the methodology underpinning each indicator and data source, ensuring the findings are transparent, reproducible and can be consistently updated over time. Together, the State of Palliative Care report and technical report establish a robust framework for monitoring palliative care in Victoria and supporting evidence-informed policy, planning and continuous improvement.

Victorians needing palliative care

Key findings

More than 34,000 Victorians could have benefited from palliative care in 2024, yet an estimated 22,889 did not receive it or received it too late. Current specialist palliative care capacity is sufficient to meet only a third of estimated need.

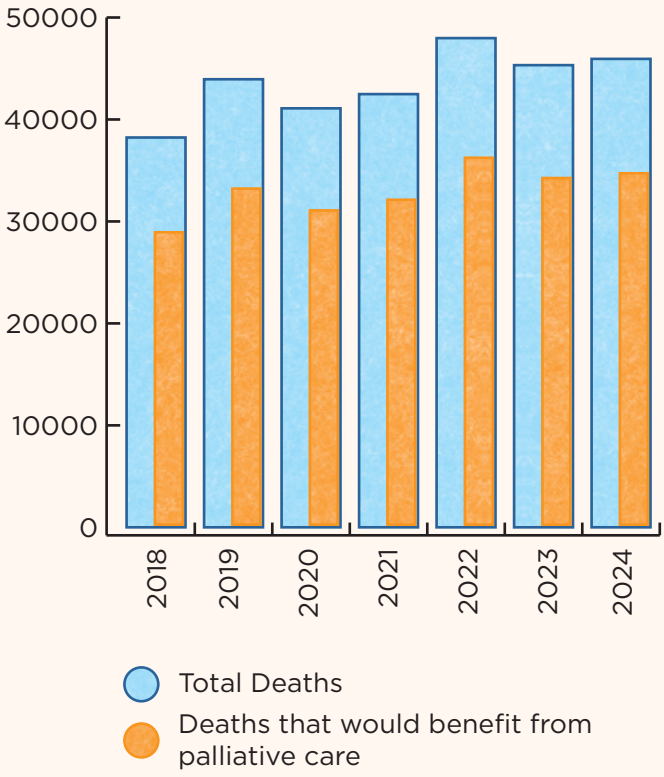
An estimated 34,457 Victorians needed palliative care in 2024

Understanding the scale of palliative care need is the foundation for all other findings in this report. It establishes the denominator: the number of Victorians whose end-of-life experience should be supported by access to skilled, compassionate, and well-resourced palliative care.

This report adopts a population-level, needs-based approach based on international and Australian literature, estimating that 75% of all projected deaths involve a need for palliative care.[2, 3] Applied to the 45,943 Victorians who died in 2024, this yields an estimated 34,457 people who could benefit from palliative care each year.

From 2018 to 2024, deaths in Victoria have grown at a compound annual growth rate of 3.1% each year, outpacing annual population growth of 1.4% over the same period. Deaths from conditions with a strong need for palliative care continue to rise. In 2024, 12,466 deaths (27.1% of all deaths) were due to malignant cancers, and 3,838 (8.4%) were due to dementia, including Alzheimer's disease.

Figure 1: Victorian deaths and need for palliative care, 2018-2024



Standardised death rates (which adjust for differences in age structure across populations to enable meaningful geographic comparison) are higher in rural and remote areas compared with major cities, suggesting differences in mortality burden across geographic regions. In Victoria, rates increase from 5.0 per 1,000 population in major cities to 5.6 in inner regional areas and 5.9 in outer regional areas.

Table 1: Victorian standardised death rates by remoteness, 2024

Remoteness area	Standardised death rate
Major cities	5.0
Inner regional Victoria	5.6
Outer regional Victoria	5.9
Victoria	**5.2**

Almost 23,000 Victorians who died in 2024 didn't receive the palliative care they needed

Understanding unmet need for palliative care is critical for effective service planning and policy development, and for ensuring that people who could benefit from palliative care are able to access it. There is no single, universally accepted measure of unmet need, and direct measurement requires information not only on who receives palliative care, but also on the timing, intensity, appropriateness, and outcomes of care. In practice, unmet need is often estimated indirectly using a range of approaches, including comparisons between potential need and service utilisation, analysis of access patterns, or assessment of service capacity relative to demand.[4]

For this State of Palliative Care report, we adopt a service-capacity approach to estimating unmet need at the population level.[4] Specifically, we compare the available specialist palliative care workforce with nationally endorsed minimum service planning benchmarks. This approach provides an estimate of the extent to which current service capacity is sufficient to meet population need. While it does not identify unmet need at the individual patient level, it offers a practical and transparent method for assessing service shortfalls and monitoring changes in access to specialist palliative care over time.

Using this definition, we estimate that 22,889 Victorians who died in 2024 could have benefited from palliative care but did not receive it. This equates to 63 Victorians per day dying without access to palliative care. While service coverage has expanded, growth in capacity has not kept pace with rising mortality and increasing demand for palliative care. As a result, current service capacity is sufficient to meet only a third of the State's estimated need, leaving a substantial gap between population need and available services.

Table 2: Victorian unmet palliative care needs, deaths and coverage, 2018-2024

	2018	2019	2020	2021	2022	2023	2024	Annual Growth Rate
Service coverage	29.3%	31.3%	33.3%	33.6%	34.8%	32.7%	33.6%	2.3%
Unmet need, deaths	20,281	22,643	20,542	21,151	23,483	22,883	22,889	2.0%

Victorians accessing palliative care

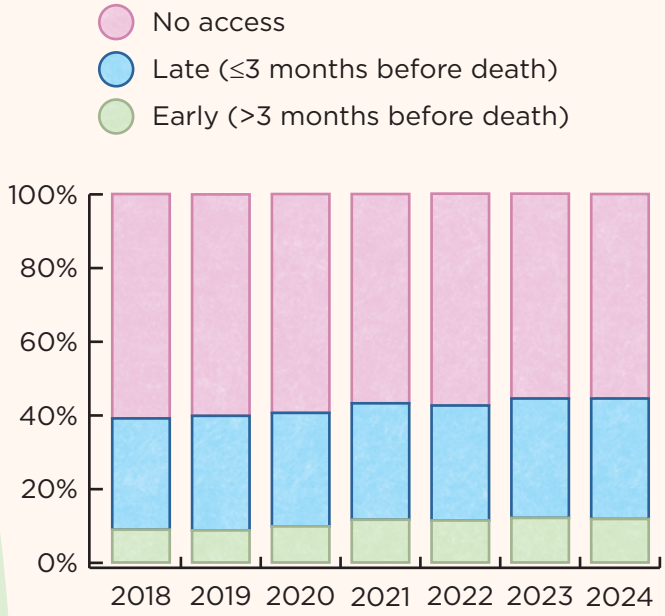
Key findings

Fewer than 1 in 3 people with a cancer diagnosis receive a timely referral. For heart disease, dementia, and neurodegenerative conditions timely referral is lower at just 6%.

Access to palliative care has steadily improved but timely access remains limited

Across Victoria in 2024, 44.5% of people who died accessed palliative care services, up from 39.1% in 2018. This steady increase is a welcome improvement, but access still falls well short of the best available evidence that suggests 75% of decedents would have benefited from palliative care. In 2024, access to timely palliative care, broadly classified as at least 3 months before death, was limited to less than 11.8% of Victorian decedents, limiting the clinical and quality-of-life benefits palliative care is designed to provide.

Figure 2: Palliative care timing by year, Victoria 2018–2024



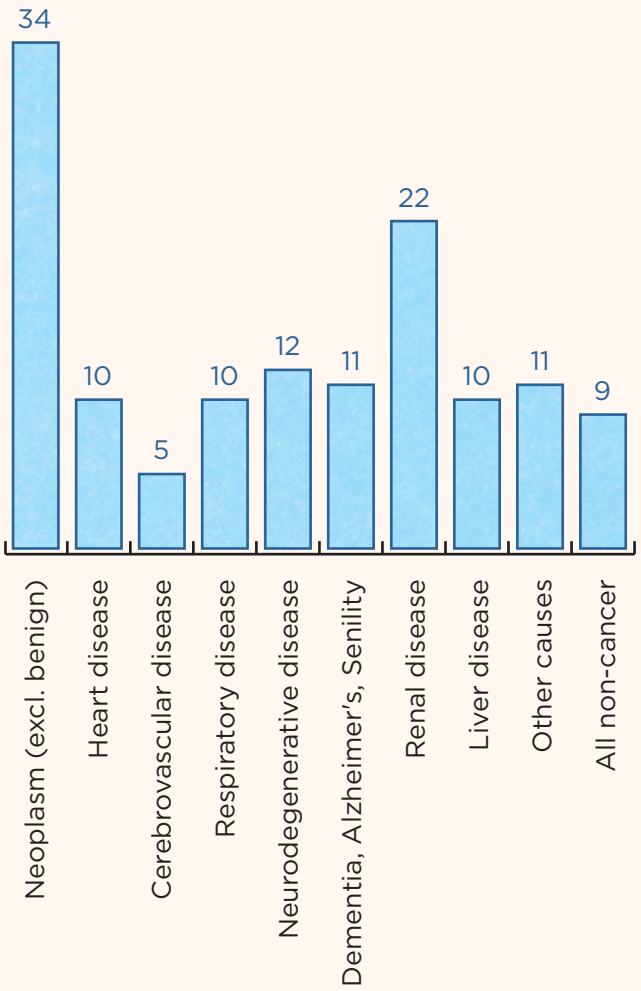
Palliative care is delivered by a range of specialist and generalist providers across the health system. In this report, access includes care provided by community palliative care services, hospital-based palliative care consultancy teams, specialist palliative care services within palliative care units, and inpatient episodes where palliative care was identified through a secondary ICD-10 Z51.5 code. A limitation of these data is that they do not capture palliative care provided by general practitioners or other generalist providers and therefore may underestimate overall access to palliative care.

The median time from first referral to death was just 16 days, unchanged since 2018, indicating that many Victorians continue to access palliative care only in the final days of life.

Table 3: Median days from first referral to death, Victoria, 2018-2024

Time	2018	2019	2020	2021	2022	2023	2024
Median days from first referral to death	16	14	15	16	16	17	16

Figure 3: Median days from first referral to death for each disease, Victoria, 2023



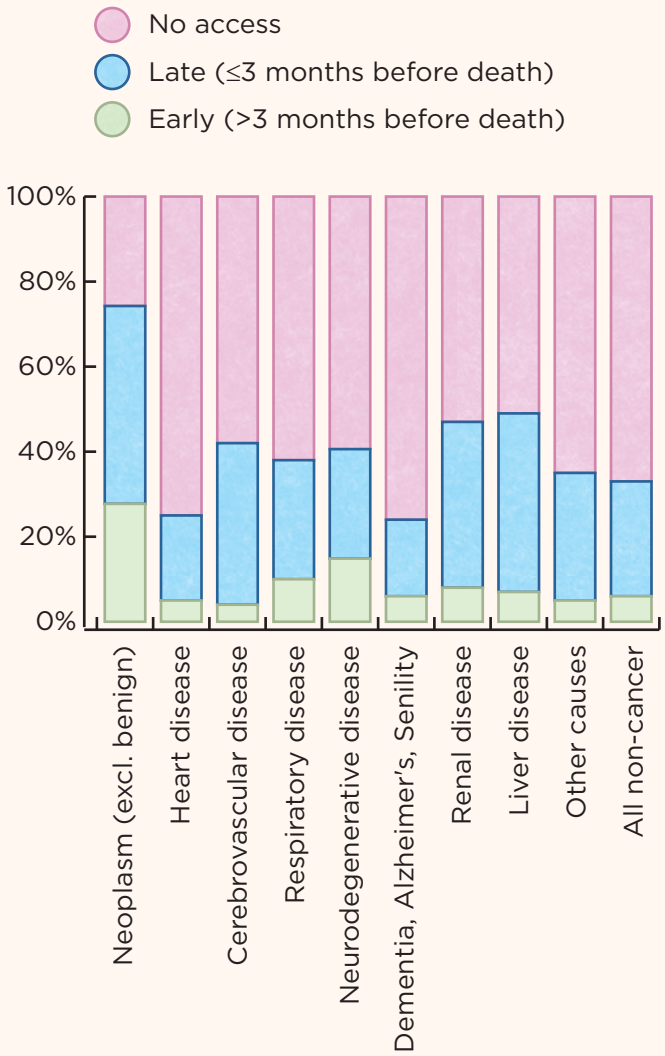
Access to palliative care varies by underlying condition

The proportion of Victorians receiving palliative care varies substantially by the condition from which they are dying. Neoplasms (cancers excluding benign tumours) have historically had the highest rates of palliative care access, reflecting the longstanding association between oncology and palliative care pathways. In 2023, 74.4% of Victorians who died from cancer accessed palliative care, but less than 3 in 10 accessed in a timely manner.

However, the majority of Victorians who die each year do not die of cancer. They die of heart disease, cerebrovascular disease, respiratory failure, neurodegenerative conditions, and dementia — conditions for which palliative care is also beneficial, but clinical recognition and referral rates are materially lower. Just over 3 in 10 Victorians who died of causes other than cancer accessed palliative care, and only 6% received access in a timely manner. Over the last 7 years, the overall rates of access have improved by less than 1% each year.[5]

However, access remains limited: fewer than one in four Victorians dying with dementia receive palliative care, and only one in twenty access it early enough to realise its full benefits. As the number of people dying with dementia continues to grow, there is a significant opportunity to build on existing awareness campaigns[6] to improve timely access to palliative care for this increasingly important patient group.

Figure 4: Palliative care access timing by disease group. Victoria 2023

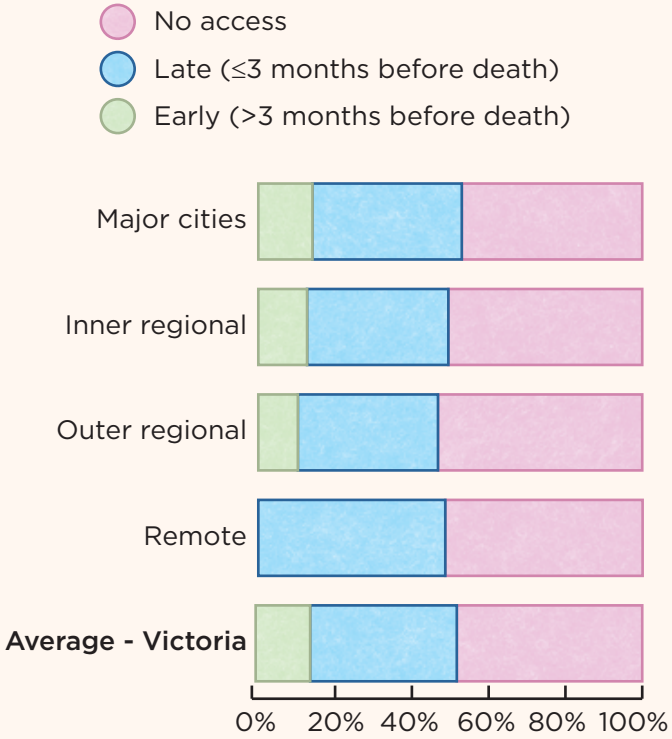


Dementia is now a leading cause of death in Victoria. Palliative care plays a vital role in supporting people living with advanced dementia, helping to maintain quality of life, manage distressing symptoms, and providing emotional and practical support to families and carers. The best available evidence suggests around 80% of people with dementia would benefit from palliative care.

People in regional and rural areas are less likely to access palliative care than those living in major cities

Access to palliative care declines with increasing remoteness, in both overall rate and timeliness. Overall access falls from 53% in major cities to 46.9% in outer regional areas, while early access (>3 months before death) falls from 14.1% to 10.3% across the same categories, indicating that Victorians outside major cities are not only less likely to receive palliative care, but less likely to receive it early.

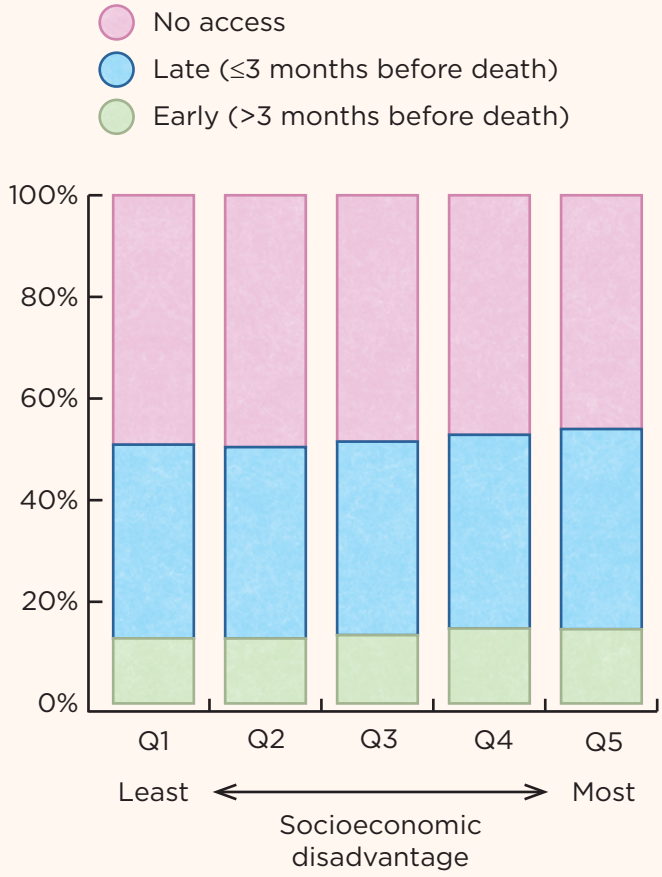
Figure 5: Palliative care access timing by remoteness, Victoria 2024



Access to palliative care is broadly consistent across levels of socioeconomic disadvantage

Using the Index of Relative Socio-Economic Disadvantage (IRSD), this report tracks palliative care access across five quintiles from least to most disadvantaged. The socioeconomic gradient in Victoria demonstrates a slightly increasing rate of access as disadvantage increases: access to no palliative care ranges from 46.0% in the most disadvantaged quintile to 49.1% in the least disadvantaged. Early access displays the same trend with the most disadvantaged receiving more early access.

Figure 6: Palliative care access by socioeconomic disadvantage (IRSD quintile), Victoria 2024

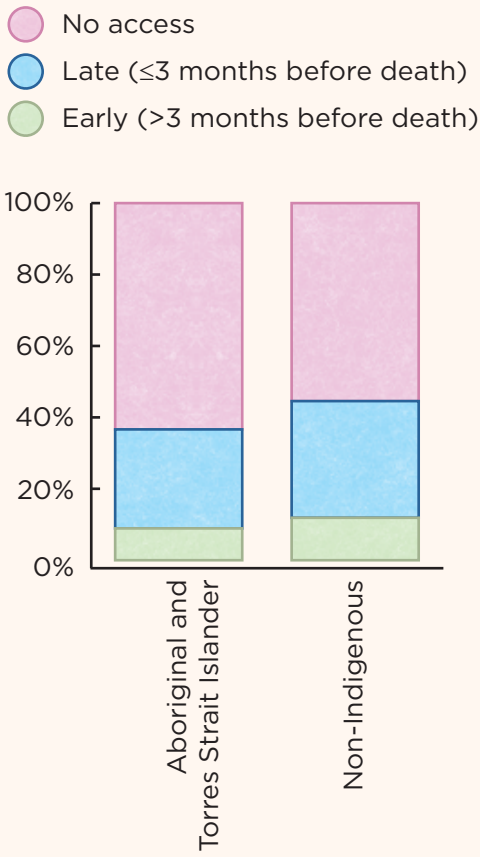


Access to palliative care is lower among Aboriginal and Torres Strait Islander Victorians

Aboriginal and Torres Strait Islander Victorians have lower rates of access to palliative care than non-Indigenous Victorians, both overall and in terms of timeliness. In 2024, 63.6% of Aboriginal and Torres Strait Islander Victorians who died received no palliative care, compared with 55.5% of non-Indigenous Victorians, and early access (more than three months before death) was achieved by only 8.6% compared with 11.8%.

These findings are consistent with the recognition in Victoria's Palliative and End-of-Life Care Framework 2026–36[1] that First Peoples are among those least likely to receive palliative care that meets their needs. While Victoria is taking steps to close these gaps through initiatives such as the Aboriginal Palliative Care Program, more can be done and building a more inclusive system will require sustained effort from providers, sector partners, and government alike.

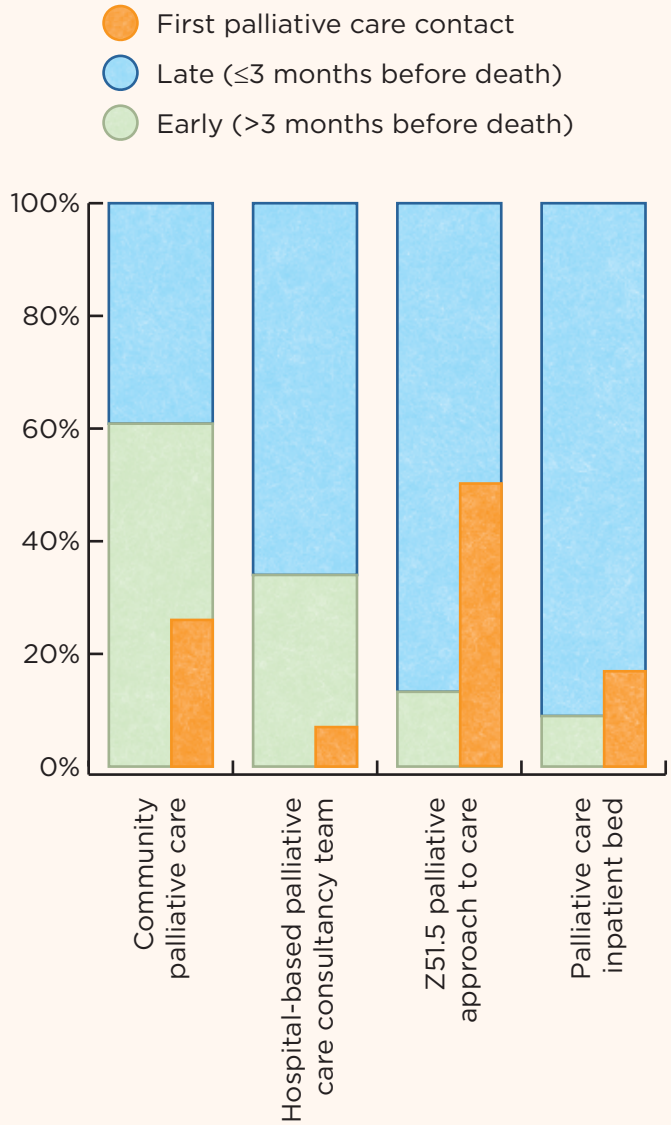
Figure 7: Palliative care access by Indigenous status, Victoria 2024



For one in two people, palliative care begins in hospital via a palliative approach to care during an acute admission

Additionally, 16.9% of those who accessed palliative care in 2024 had their first contact with the palliative care system via admission to an inpatient palliative care bed. Only one in four people first accessed palliative care through a community palliative care service.

Figure 8: Palliative care type for first referral, 2024



Outcomes and Quality

Key findings

When palliative care is provided, it is provided well. In general, Victorian palliative care services deliver responsive, high-quality care that improves or maintains patient outcomes in the majority of cases.

PCOC data highlight strong patient-reported outcomes from palliative care

The Palliative Care Outcomes Collaboration (PCOC) collects standardised clinical assessment data from participating services at each phase of a patient's episode of care. Biannual outcome reports benchmark performance against nationally endorsed standards across domains including symptom management, timeliness of care, and responsiveness to urgent clinical need.

PCOC data for the July–December 2025 period, the most recent available, covers 13,802 patients across 55 Victorian services, encompassing 34,895 palliative care phases across inpatient and non-admitted settings.[7]

Process outcome performance

Victorian inpatient services performed strongly on process outcome metrics. Timely commencement of care was particularly high, with 96.6% of patients commencing care within two days of being ready, against a benchmark of 90%. Inpatient services also met all anticipatory care benchmarks, reflecting consistent clinical management of patients with well-controlled symptoms at phase start.

Non-admitted service performance fell below benchmark on several measures, including timely commencement (77.1%) and responsiveness to urgent need (87.9%). Performance on breathing problem management (93.9%) was a notable strength, exceeding the benchmark across both settings.

Responsive care measures, assessing the proportion of patients with moderate to severe symptoms at phase start who achieve absent to mild symptom levels by phase end, were more challenging across both inpatient and non-admitted services, consistent with the clinical difficulty of managing complex or refractory symptoms.

Patient outcome performance

The patient level outcomes identify whether patients are better off after receiving palliative care. They show the proportion of phases in which the outcome improved or remained at a low level. In the inpatient setting, Victoria met the benchmark on all outcomes. Victorian patients had improved or consistently low distress from pain symptoms for 66.6% of palliative care phases. The same trend of improvement was consistent across all outcome domains, including distress from psychological and spiritual problems, family and carer problems, and other symptoms.

In the non-admitted setting, both patient- and clinician-assessed pain symptoms improved or remained low for less than 60% of phases, below the benchmark. Other symptom outcomes met the benchmark for the proportion of phases in which they improved, except for nausea. As such, for most people receiving palliative care in outpatient settings, these outcomes improve significantly; however, there remains room to improve pain management.

✓	Benchmark met
✗	Benchmark not met
^	**PCPSS (Palliative Care Problem Severity Score):** a clinician-rated tool scoring severity of problems across four domains — pain, other symptoms, psychological/spiritual, and family/carer — on a 0 (absent) to 3 (severe) scale.
*	**SAS (Symptom Assessment Scale):** a patient- or proxy-rated tool scoring distress from seven symptoms — pain, fatigue, nausea, breathing problems, bowel problems, appetite problems, and difficulty sleeping — on a 0 (no distress) to 10 (worst possible distress) scale.

Figure 9: Casemix-Adjusted Outcomes - Inpatient Setting, July–December 2025

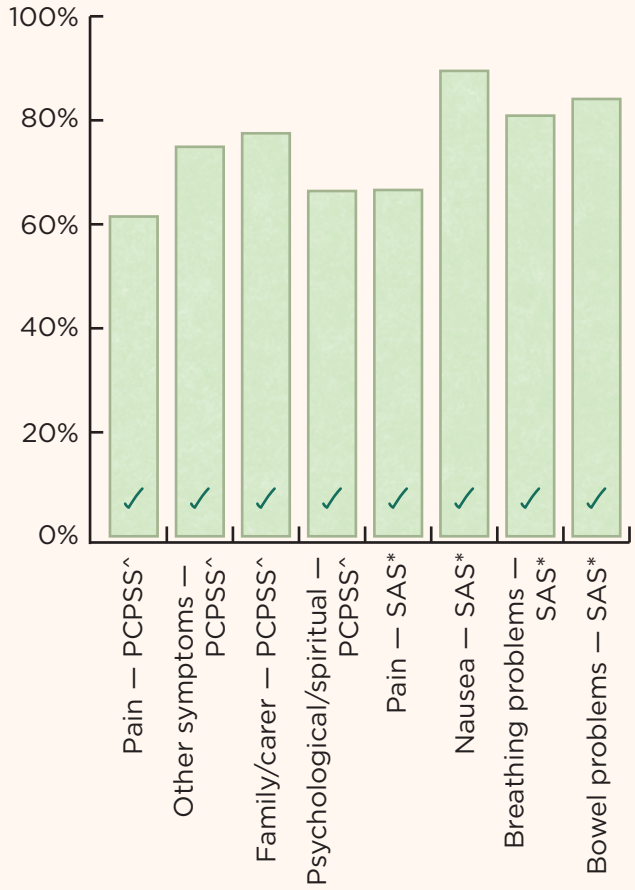
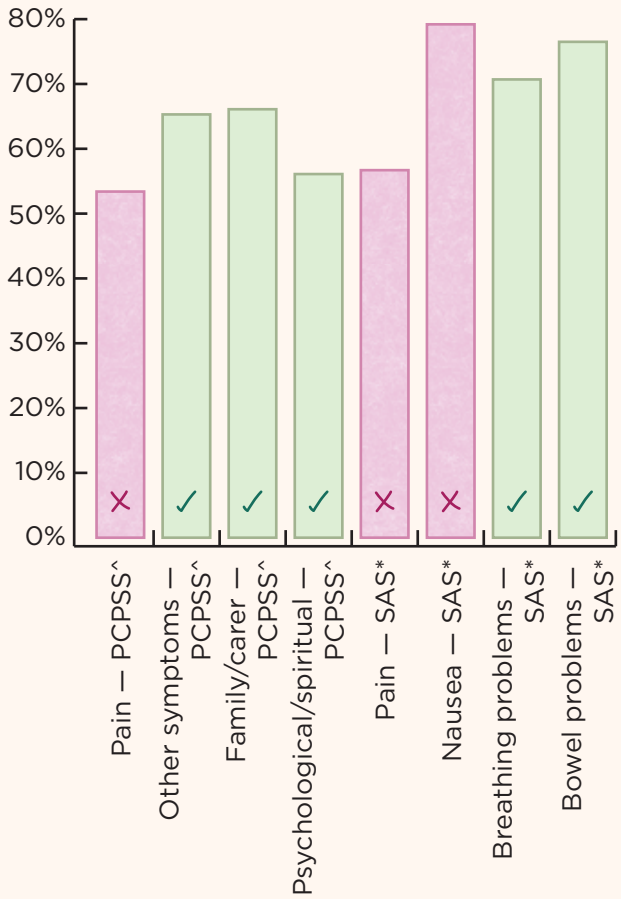


Figure 10: Casemix-Adjusted Outcomes Non-Admitted Setting, July–December 2025



Palliative care can improve the quality of end-of-life care

Quality of end-of-life care can be assessed using established indicators derived from administrative data.[8, 9, 10] Positive indicators include the presence of an advance care plan and dying outside an acute hospital bed, while potentially burdensome or low-value care indicators include two or more emergency department presentations in the last 30 days of life, receipt of chemotherapy in the last 30 days of life, and prolonged hospitalisation near the end of life. These indicators have primarily been developed and validated in cancer populations, so the results presented here are for cancer decedents only.

In 2024, only 33.0% of cancer decedents died outside an acute hospital bed, and just 16.7% had an advance care plan. More than a quarter had two or more acute hospitalisations in the last 30 days of life, and 1.6% had a long stay acute hospitalisation of more than 14 days in their final 30 days.

Apart from increases in the recording of an advance care plan, trends in the other metrics have remained relatively stagnant over the last 7 years, indicating the ongoing opportunity to improve the quality of end-of-life care.

Palliative care provides a clear avenue to do that. Recent Victorian research found that those who accessed palliative care early rather than late had 25% less chance of multiple emergency department presentations, 42% less chance of multiple acute hospitalisations and almost 50% less chance of chemotherapy in the last 30 days of life.[11]

Table 4: Quality of end-of-life care, cancer decedents, by year, Victoria 2018–2024

Palliative care timing	2018	2019	2020	2021	2022	2023	2024	Annual Growth Rate
Died outside acute hospital bed	30.5%	31.9%	38.8%	37.9%	37.8%	35.6%	33.0%	1.3%
Two or more ED presentations (final 30 days)	9.8%	9.4%	8.6%	9.1%	9.2%	10.6%	12.6%	4.3%
Two or more hospital admissions (final 30 days)	27.8%	26.4%	24.3%	24.5%	24.3%	23.6%	25.9%	-1.2%
Long stay hospitalisation (final 30 days)	1.4%	1.2%	1.2%	1.2%	1.5%	1.5%	1.6%	2.3%
Inpatient chemotherapy (final 30 days)	11.0%	10.4%	10.0%	10.0%	9.9%	9.2%	9.9%	-1.7%
Advance care plan at death	12.8%	14.7%	14.6%	14.9%	16.2%	16.9%	16.7%	4.5%

Palliative care service activity

Key findings

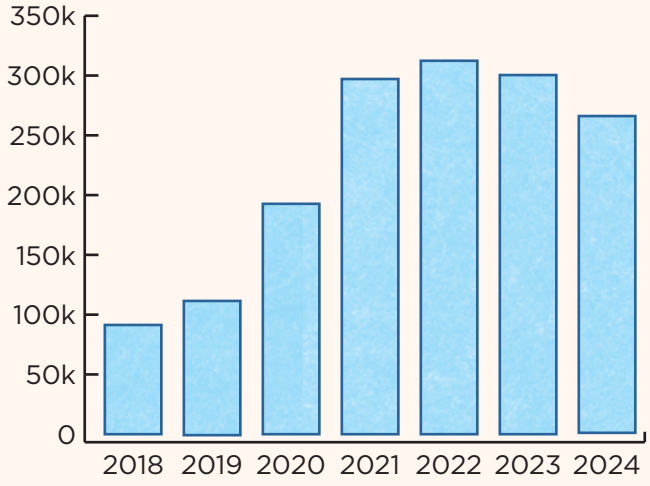
The volume of hospital-based activity has increased over the past 7 years, whilst community palliative care contacts have declined from pandemic-era highs.

Activity data show that Victorian palliative care services have delivered a substantial increase in service activity from 2018 to 2024. Admissions to palliative care units rose from 7,120 to 9,482, while inpatient episodes coded as a palliative approach to care increased from 18,108 to 22,969. While community palliative care contacts increased significantly from 91,374 in 2018 to 264,958 in 2024, this may reflect changes to the reporting capture in the administrative dataset which occurred during the first few years of this period. The later years of reporting are likely to provide a clearer view of community palliative care activity moving forward. The decline in community contacts over the final 3 years of the period, may reflect a combination of reductions from pandemic-era highs, which saw more people remain in their community, and ongoing capacity constraints hindering the delivery of care in the community.

These trends indicate that the system is delivering more palliative care in hospital settings and through hospital-based palliative care consultants than it was seven years ago. However, the volume of palliative care contacts in the community has reduced.

This section describes the volume of palliative care activity delivered across Victoria, providing an indication of current system capacity and how it has changed over the past seven years. This system-level perspective complements the preceding section, which focused on patient-level access to palliative care. The activity measures reported include palliative care episodes, palliative approach to care (Z51.5) episodes, hospital-based palliative care consultancy team visits, and community palliative care contacts. A limitation is that these data do not capture palliative care activity provided by generalist healthcare providers.

Figure 11: Victorian palliative care activity, 2018-2024

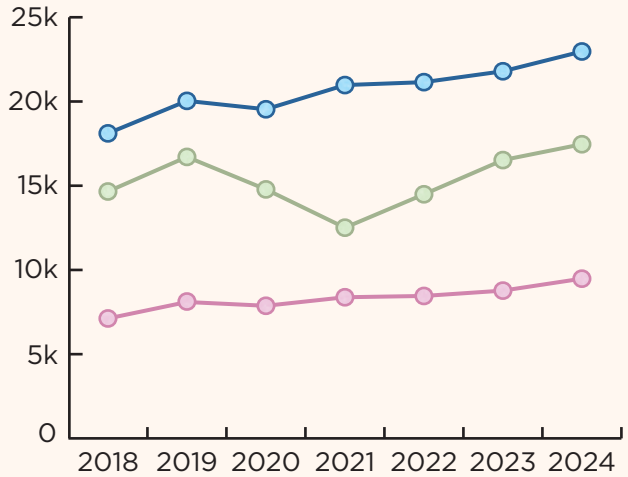


Community palliative care contacts^+

Activity is one years' worth, attributed to the year in which the person died.

^ Community palliative care is reported in VINAH data, which has undergone reporting and activity/funding changes from 2018 through 2021, consequently the activity in those years is likely to be an underrepresentation of the true activity.

\+ Palliative care is identified at the episode level, there are numerous contacts per episode, which includes in-person and telehealth contacts.



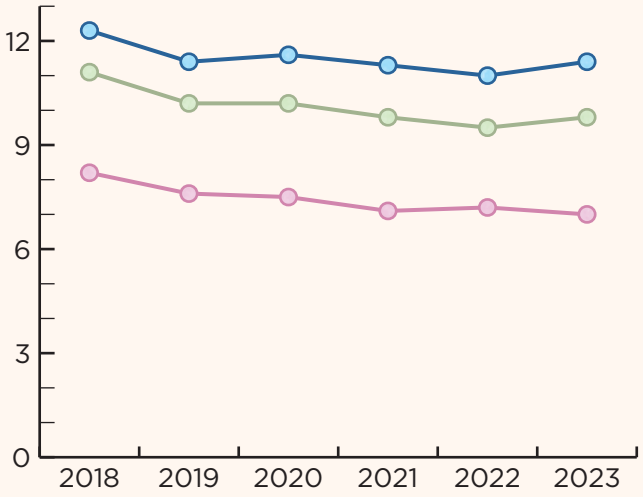
Palliative approach to care (Z51.5)

Hospital-based palliative care consultancy team

Admission to palliative care unit

Whilst the number of admissions to a palliative care unit has increased over time, the average length of stay in the unit has been reducing. In 2023, the average length of stay in a palliative care unit in Victoria was 9.8 days, down from 11.1 days in 2018. Those who died of cancer had an average length of stay of 11.4 days in 2023, compared with 7.0 days for non-cancer deaths.

Figure 12: Average length of stay (days) in a Victorian palliative care unit, 2018-2023



Neoplasm (excl. benign)

Total

Non-cancer

Specialist palliative care workforce

Key findings

While the number of specialist palliative care physicians has increased since 2018, Victoria has just 0.7 clinical specialist palliative care physicians per 100,000 population, well below the national average (1.1) and the minimum service planning benchmark (2.0).

The current Victorian specialist palliative care workforce

The number of specialist palliative care physicians working in clinical roles in Victoria increased from 38 FTE in 2018 to 51 FTE in 2024. However, population growth meant that physician supply increased only modestly, from 0.6 to 0.7 FTE per 100,000 population over the same period. This remains well below both the current national average of 1.1 clinical FTE per 100,000 population and the expert consensus minimum service planning benchmark of 2.0 FTE per 100,000 population.

Table 5: Victorian specialist palliative care physician clinical FTE, 2018–2024

	Clinical FTE	Clinical FTE per 100,000
2018	38	0.6
2019	43	0.6
2020	44	0.6
2021	46	0.6
2022	53	0.8
2023	48	0.8
2024	51	0.7
Annual growth rate	**5.0%**	**2.6%**

The number of nurse FTEs working clinically in a palliative care role increased from 760 to 943 from 2018 to 2024, resulting in an increase of 11.8 to 13.6 FTE per 100,000 population.

Table 6: Victorian specialist palliative care nurse clinical FTE, 2018–2024

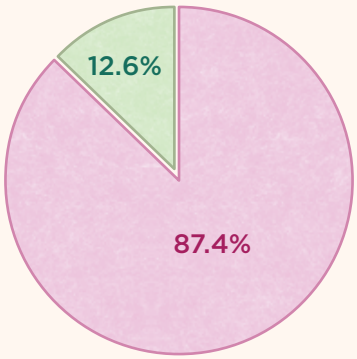
	Clinical FTE	Clinical FTE per 100,000
2018	760	11.8
2019	787	12
2020	860	13
2021	819	12.5
2022	879	13.3
2023	897	13.2
2024	943	13.6
Annual growth rate	**3.7%**	**2.4%**

The palliative care workforce is concentrated in major cities and inner regional Victoria

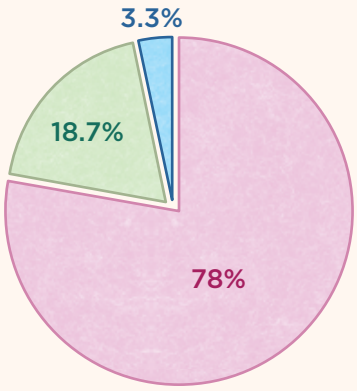
Workforce distribution remains heavily concentrated in metropolitan areas. More than 87% of specialist palliative care physicians and 78% of specialist palliative care nurses are located in major cities. Outer regional, rural and remote areas are serviced by the palliative care nurse workforce, with no palliative care physicians outside of inner regional Victoria.

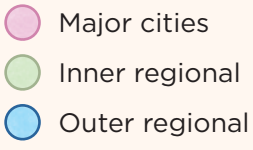
Figure 13: Victorian specialist workforce by remoteness classification, 2024

Physician specialist %



Nurse specialist %

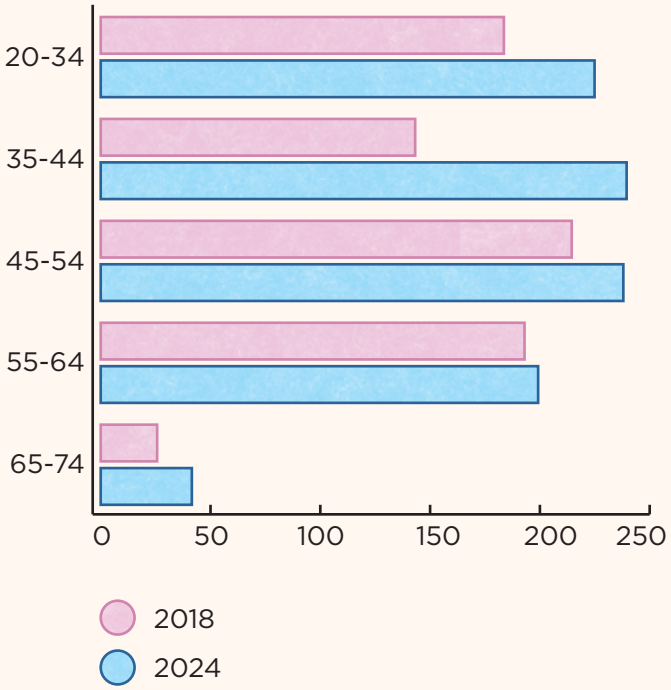




There is a growing proportion of palliative care nurses in younger age groups

The age profile of the Victorian palliative care workforce is becoming younger. Between 2018 and 2024, the proportion of palliative care nurses aged 45 years or younger increased from 40% to 48%, mirroring national trends. A younger workforce helps to build an ongoing pipeline of capacity and reduce near-term losses due to retirement. It also highlights the growing importance of workforce development, supervision, and retention strategies to support a less experienced workforce.

Figure 14: Population pyramid figure for Victorian nurses, 2018 vs 2024



Palliative care education and training

Key findings

Palliative care is under represented in medical training. Palliative care represents less than 0.5% of medical degree program time at all three Victorian universities. There are zero mandated palliative care hours in any national medical curriculum.

Victorian Medical School data shows just 0.5% of training time is spent on palliative care

Table 7: Palliative care education and training in Victorian medical schools

University	Degree	Est. Program Hours	Est. PCC4U Hours	% of Total
University of Melbourne	MD (graduate entry)	8,500 – 9,500	~45–50	~0.5%
Deakin University	MD (graduate entry)	8,500 – 9,500	~45–50	~0.5%
Monash University	BMedSci/MD (undergrad)	11,000 – 12,000	~45–50	~0.4%

Palliative care education in Victorian medical schools is estimated to account for less than 0.5% of total program time, with no mandated requirements in the national medical curriculum.

Medical training represents an important upstream policy lever, influencing clinicians' capacity to identify, manage, and refer patients with palliative care needs throughout their careers. While all Victorian medical schools include core palliative care content and are supported by the Palliative Care Curriculum for Undergraduates (PCC4U), current exposure, approximately 45–50 hours over four to five years, may limit opportunities for students to develop confidence and competence in palliative care skills across a range of clinical settings, including general practice, emergency medicine, oncology, cardiology, and aged care. As a result, some graduates may enter the workforce with limited preparation for recognising and responding to palliative care needs. Given the growing demand for palliative care and the substantial proportion of deaths involving a palliative trajectory, there is an opportunity to strengthen undergraduate training.

Beyond medicine: The nursing and allied health gap, >90% of specialist workforces are nurses with no pre-registration training

In Victoria, nurses and allied health professionals are frequently the primary point of care for patients nearing end of life, particularly in rural and regional settings, yet there are no mandated minimum requirements for palliative care education or clinical exposure in these training pathways.

This creates a significant system gap, as nurse specialists constitute over 90% of the specialist palliative care workforce, but pre-registration training does not ensure consistent capability in end-of-life care.

Community palliative care costs and funding

Key findings

While community palliative care expenditure grew by 7.0% per year between FY2021 and FY2025, recurrent government funding increased by just 3.7% per year, widening the gap between the cost of delivering services and available funding.

A comprehensive picture of the costs and funding of palliative care services across Victoria is not currently available. As a first step towards addressing this evidence gap, this report presents expenditure and funding data for community palliative care providers. These results should not be interpreted as representing the full costs or funding of palliative care across Victoria.

There has been a divergence between costs and funding for community palliative care

Community palliative care expenditure in Victoria reached $50.1 million in FY2025, increasing at an annual rate of 7.0% from 2021 to 2025. This exceeds general inflation and reflects growth in both workforce and service delivery costs. Labour costs accounted for 82% of total expenditure in FY2025 and increased at an annual rate of 7.8%.

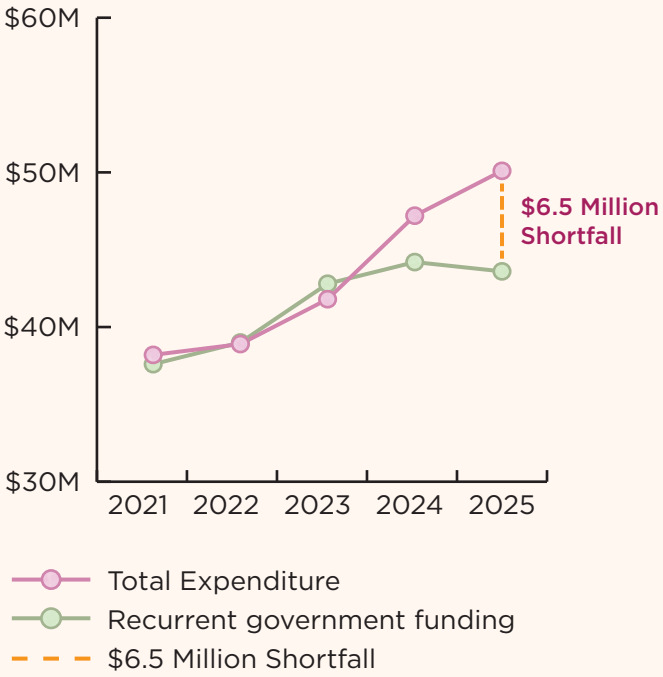
As labour represents the largest component of expenditure, changes in workforce costs are likely to be an important contributor to overall expenditure growth. Potential drivers include wage growth, enterprise bargaining outcomes, and the costs associated with recruiting and retaining palliative care staff, particularly in rural and regional areas.

The data are drawn from a bespoke Palliative Care Victoria (PCV) survey developed to better understand and harmonise financial and activity reporting across community palliative care providers. The survey achieved a response rate of 88% of providers. While this high response rate suggests that reported trends are broadly representative of the sector, total expenditure and funding estimates are likely to be conservative as they do not capture all providers. Over time, we aim to work with providers and funders to establish comprehensive, routine reporting of palliative care costs and funding across Victoria, improving the evidence base for service planning and policy development.

Over the same period, recurrent government funding for community palliative care services increased at an annual rate of 3.7%, reaching $43.6 million in FY2025. Funding growth was substantially lower than expenditure growth.

In addition, average recurrent government funding per accepted referral declined by 2.1% over the period, suggesting that funding growth has not matched growth in service activity or expenditure.

Figure 15: Community palliative care recurrent funding vs total expenditure, FY2021–FY2025



Looking ahead

Key findings

By 2045, under current policy settings, almost 76 Victorians each day will die without access to the palliative care they need.

Demand for palliative care in Victoria is expected to grow strongly, increasing by over 24,500 people to reach 59,047 by 2045

Victoria's ageing population will see demand for palliative care grow far faster than overall population growth. From today until 2045, deaths are projected to increase by 2.6% per year, more than double the 1.3% per year increase in population. As a result, more than 59,000 Victorians will require palliative care.

Growth in the specialist palliative care workforce will not keep up with demand under a business-as-usual scenario

Under business-as-usual conditions, the Victorian specialist palliative care physician workforce is projected to increase to 1.5 clinical FTE per 100,000 population by 2045. Despite this growth, physician supply would remain below the current minimum service planning benchmarks. Shortfalls are projected to persist in rural and regional areas, where workforce supply already falls well below recommended levels.

In contrast, the specialist palliative care nursing workforce is projected to remain largely unchanged on a per-100,000 population basis over the next two decades. Given projected growth in palliative care need, stagnant nursing workforce capacity is likely to constrain service delivery and place increasing pressure on the existing workforce.

Unmet palliative care need will grow, reaching almost 28,000 Victorians unable to access palliative care by 2045

As palliative care need grows faster than service capacity under a business-as-usual scenario, unmet palliative care need is expected to grow by almost 5,000 people, reaching 27,872 Victorians by 2045. This would equate to 76 Victorians per day dying without access to palliative care. While service coverage has expanded, growth in capacity has not kept pace with rising mortality and increasing demand for palliative care.

Table 8: Population growth, palliative care need and unmet need projections, 2024 to 2045

	2024	2045	Change	Annual Growth Rate
Population	6,981,352	9,165,222	2,183,870	1.3%
Deaths	45,943	78,729	32,786	2.6%
Palliative care need	34,457	59,047	24,590	2.6%
Unmet palliative care need	**22,889**	**27,872**	**4,983**	**0.9%**

References

1. Department of Health Victoria 2026, Victorian Palliative and End-of-Life Care Framework 2026–36, Victorian Government, Melbourne.
2. Luc, I., Dadich, A. and Laurence, C., 2026. Estimating the need for palliative care services in Australia by 2042. BMC Palliative Care.
3. Murtagh, F.E., Bausewein, C., Verne, J., Groeneveld, E.I., Kaloki, Y.E. and Higginson, I.J., 2014. How many people need palliative care? A study developing and comparing methods for population-based estimates. Palliative medicine, 28(1), pp.49-58.
4. Johansson T, Diggle MFJ, Finucane A, et al. Defining and measuring unmet palliative care needs among people with life-limiting illness: A scoping review of international evidence. Palliat Med. 2026;40(4):448-471. doi:10.1177/02692163261416279
5. van der Steen, J.T., Radbruch, L., Hertogh, C.M.P.M., de Boer, M.E., Hughes, J.C., Larkin, P., Francke, A.L., Jünger, S., Gove, D., Firth, P., Koopmans, R.T.C.M., Volicer, L.; European Association for Palliative Care (EAPC) (2014). White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care. Palliative Medicine, 28(3), 197–209. doi: 10.1177/0269216313493685.
6. Dementia Australia. Palliative Care. Dementia Australia, 27 Nov. 2025, https://www.dementia.org.au/living-dementia/care-options/palliative-care. Accessed 2 July 2026.
7. Barnaba A, Clapham S, Draper K, Fonseka S, Futcher T, Kaltner M, Rand J. Patient Outcomes in Palliative Care – Victoria State Report, July to December 2025. Palliative Care Outcomes Collaboration, Faculty of Science, Medicine and Health, University of Wollongong; 2026.
8. Earle, C. C., Park, E. R., Lai, B., Weeks, J. C., Ayanian, J. Z., & Block, S. Identifying potential indicators of the quality of end-of-life cancer care from administrative data. J Clin Oncol. 2003;21:1133-1138.
9. Grunfeld, E., Urquhart, R., Mykhalovskiy, E., Folkes, A., Johnston, G., Burge, F.I., Earle, C.C. and Dent, S. Toward population-based indicators of quality end-of-life care. Cancer. 2008;112:2301-2308
10. Grunfeld, E., Lethbridge, L., Dewar, R., Lawson, B., Paszat, L.F., Johnston, G., Burge, F., McIntyre, P. and Earle, C.C. Towards using administrative databases to measure population-based indicators of quality of end-of-life care: testing the methodology. Palliat Med. 2006;20:769-777.
11. Schilling, C., Wawryk, O., Collins, A., Sundararajan, V., Le, B.H. and Philip, J. Early Palliative Care and Quality of End-of-Life Care for People With Terminal Cancer, Victoria, 2018–2023: A Retrospective, Population-Based Cohort Study. Medical Journal of Australia 224.1 (2026): e70128.

Palliative Care Victoria

State of Palliative Care in Victoria

SUMMARY REPORT
AUGUST 2026

Palliative Care Victoria
L2/182 Victoria Parade, East Melbourne VIC 3002
T 03 9662 9644
E info@pallcarevic.asn.au
www.pallcarevic.asn.au

The University of Melbourne
Grattan Street, Parkville, VIC 3010
T 13 MELB (13 6352) or +61 3 9035 5511 (International)
www.unimelb.edu.au