Victorian Palliative and End-of-life Care Framework 2026–36

VICTORIA State Government

Department of Health

Acknowledgements

Acknowledgement of Country

The Victorian Department of Health (the department) acknowledges the Traditional Owners of the many lands and waters across Victoria and pay our respects to Elders past and present. We honour the deep and ongoing connections that First Peoples hold to Country, community, and culture.

Within palliative and end-of-life care, we recognise the cultural responsibilities, practices, and collective obligations that guide Sorry Business. These practices continue to support families, communities, and Nations in caring for loved ones; remembering those who have passed; and upholding the spiritual, cultural, and relational continuity that has existed for thousands of generations.

We acknowledge the resilience and sovereignty of First Peoples and the cultural knowledge and teachings that shape understandings of life, death, grief, and the journeys that follow. We also recognise the ongoing contributions of Aboriginal communities to the health and wellbeing of all Victorians.

We extend this respect to all First Peoples and to the families and communities who carry cultural obligations, knowledge, and care across generations.

Acknowledgement of personal experiences and sector

The department acknowledges the people, carers, families, and supporters with lived and living experiences of life-limiting illness, particularly those who have shared these experiences to inform the development of the Victorian Palliative and End-of-life Care Framework 2026–36 (the Framework). You are highly valued partners in the care journey. Your strength and generosity are deeply recognised, including as you navigate your own uncertainty and loss.

We also acknowledge the leadership and dedication of service partners in driving innovation and continuous improvement to respond to local community need. Thousands of practitioners across the sector deliver compassionate, person-centred care to every Victorian, with their contributions essential to delivering excellence in care.

Achievements across our health system are made possible by the collective commitment, effort, and advocacy of people, carers, families, volunteers, community members, researchers, health professionals, practitioners, service providers, and researchers.

Many individuals and organisations have generously shared their experiences and expertise with us. A special mention goes to Palliative Care Victoria for helping bring the sector together, and to the Health Consumers Centre at Deakin University for your commitment to the consumer voice. Your insights have shaped this refreshed Framework.

To receive this document in another format, email End-of-life Care Policy and Projects team <pallcare@health.vic.gov.au>.

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.
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A note on language and terminology

Palliative care and end of life are sensitive and deeply personal topics. The language used in the Framework has been chosen with care, noting that different communities, cultures, and families may use different terms for similar situations.

No single set of terms can capture every experience. The sections 'What is palliative and end-of-life care?' and 'Glossary' explain the terms and definitions used in the Framework. These are based on recognised standards and evidence-based practice. They are intended to provide a shared understanding – not to replace the personal or cultural language that individuals may prefer.

It is recognised that words related to dying, death, grief, and loss can evoke strong emotions and may be distressing for some. Support services are available: <www.betterhealth.vic.gov.au/health/servicesandsupport/grief-support-services#where-to-get-help>.

Contents

Minister's foreword

Our health system has transformed since the Framework was last published in 2016. To strengthen leadership and drive progress, the Victorian Government appointed Associate Professor Mark Boughey as Victoria's first Chief Palliative Care Adviser.

It is under his thoughtful guidance that this refreshed blueprint for the next 10 years has been developed, shaped strongly by the voices of the community and sector.

The refreshed Framework enables us to look ahead with confidence. It builds on what we have achieved and sets a clear direction for the decade to come. Victorians deserve the best possible care that focuses on more choice and better access to care at home, and is consistently high-quality no matter where people live and receive their care.

Dying and death are an intrinsic part of life for everyone, yet every person's end-of-life journey is as unique as the life they have lived. That is why our services must be responsive to, and honour, each person's identity, values, and choices. Care must reflect what matters to each person.

Carers, volunteers, and other community members who walk alongside people with life-limiting illness make an extraordinary impact every day. Your strength and compassion shape every Victorian's palliative and end-of-life care journey. Across Victoria, care providers and service partners continue to lead with excellence and deliver person-centred care.

Since 2016, Victoria has delivered landmark reforms that give Victorians greater choice, clarity, and confidence at the most important moments. We have strengthened advance care planning laws so more people can make their wishes known and have those wishes upheld. We are proud to have led the nation as the first state to introduce voluntary assisted dying (VAD), with other jurisdictions looking to Victoria as the model for best practice. VAD provides eligible Victorians the dignity of choosing when and with whom they spend their final moments.

Victoria can also celebrate substantial achievements in providing care closer to home. New models of home-based and community care, virtual services, and specialist care are helping more people stay in familiar surroundings, supported by a broader, more connected workforce. Continuing to embed and improve integration and experience of these models is the task ahead.

We are committed to ensuring our service system reflects community expectations. The Framework is being refreshed to ensure the service system remains contemporary, supporting continued provision of accessible, high-quality palliative and end-of-life care, and continues to offer and respect choice for Victorians at the end of life.

This is a framework for the future. It sets out 5 clear priorities to strengthen care at home, better support people and their carers and families, improve care pathways, build a capable and confident workforce, and enhance innovation and the use of data to improve care. Together, we will build a system that continues to ensure Victorians with life-limiting illness can live well, be supported well, and die the way they wish, surrounded by loved ones.

Hon Harriet Shing MP
Minister for Health
Minister for Ambulance Services
Minister for Water

Reflections from the Chief Palliative Care Adviser

As the inaugural Chief Palliative Care Adviser, the Framework is a significant and important body of work to have been part of. Focused on modernising and creating a more dynamic approach to care, I believe the Framework provides an opportunity to strengthen the service system. It recognises the many service providers contributing to care and responds to system, service, and workforce changes that can enhance care provision in meaningful and realistic ways.

Recent research shows that palliative care benefits a broad range of health conditions. Providers increasingly care for people with neurological conditions; advanced heart, liver, and lung disease; dementia; and other complex illnesses – not only cancer. This shift requires flexible and tailored care pathways, and the Framework has been designed to support this broader and more diverse population.

Care is now delivered by a wider range of providers. As care shifts closer to home, paramedics, pharmacists, aged care, and disability workers are playing a greater role, working alongside specialist palliative care teams. Technology is also transforming how care is delivered. Digital health, virtual care, and data sharing are enabling teams to collaborate more effectively; support people at home; and deliver timely, connected care. Palliative care must be part of this change, and the Framework anticipates this evolution.

Workforces are being used in new and innovative ways. New models are bolstering workforce capacity and enabling care at the top of scope. These include the expansion of nurse practitioner roles, clinicians with advanced or dual qualifications, and a focus on interdisciplinary care – all essential to meeting the needs of a growing and increasingly complex population.

Central to the Framework is the commitment to supporting people, alongside their carers and families, to remain in their homes and communities where possible including residential aged care and disability homes. By strengthening access, improving visibility, simplifying navigation, and focusing on achievable outcomes, the Framework aims to deliver compassionate, coordinated, and sustainable care leading to, and at, a person's end of life.

Mark Boughey
Associate Professor
Chief Palliative Care Adviser

Framework on a page

VISION

Victorians can access high-quality palliative and end-of-life care that meets the unique needs of each person and their carers and family. Care is provided through an integrated, responsive, and inclusive service system.

GOALS

1. Care is responsive to people's assessed needs and supports their values, preferences, and wellbeing.
2. People are cared for and, where possible, can die in their place of choice.
3. Carers and families are supported and valued as vital partners in each person's care journey.
4. Care is responsive to the needs of diverse communities and supports self-determination for First Peoples.
5. People experience high-quality and coordinated care at the right time.
6. People's care is integrated across providers and workforces, with a focus on interdisciplinary approaches.

PRIORITY DIRECTIONS	INTENT	ACTIONS		
1 Provide more care at home	Victoria is reshaping its care system so home comes first when that is a person's wish	Renew the Palliative Care Service Capability Framework to clearly outline the expectations and roles of different services	Embed best practice discharge planning, so people return home from hospital with the right supports in place	Consider best practice palliative care in-reach models for aged care and disability settings*
2 Support people's holistic needs and those of carers, families, and loved ones	A focus on wellbeing and what is most important to people approaching the end of life	Support people to make informed choices with clear and consistent information about palliative care and navigation support*	Address health service policies that might be a barrier to cultural practices around death and dying	Increase awareness of service and workforce obligations under the *Medical Treatment Planning and Decisions Act 2016*
3 Improve system interfaces and care pathways	People experience well-coordinated care and can navigate the system more easily	Implement more consistent statewide referral, admission, triage, transition and discharge criteria	Explore opportunities to strengthen the navigation and coordination role of the Victorian Palliative Care Advice Service and community-based palliative care services*	Revisit the planning and service improvement role of Palliative Care Consortia in the context of Local Health Service Networks
4 Build a capable and interconnected workforce	Coordinated palliative care delivered by a confident, interdisciplinary workforce	Increase use of 'Care Plan For the Dying Person – Victoria' to support consistent best practice	Collect better data on workforce skills, training, and distribution to inform planning	Encourage the uptake of palliative care training and skill development pathways by the broader health workforce*
5 Enhance innovation, digital capability, and use of data	Better using technology to deliver best practice care, everywhere	Undertake a palliative care data enhancement project	Develop a new palliative care data governance framework to support systematic sharing and monitoring of data	Services should increase the use of telehealth and other digital tools*

Framework actions may be subject to government funding decisions

CORE PRINCIPLES

Equity, responsiveness, choice

Safe, high-quality, person-centred care

SUCCESS LOOKS LIKE:

- Positive experiences of care and benchmarked patient outcomes
- More palliative care and more care at home in the last 100 days of life
- Equitable access, inclusive and culturally responsive care
- Peoples' care choices are known and wishes are respected
- Carers are supported and people have the information they need
- A capable interdisciplinary workforce, ensuring consistent needs assessment

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* subject to future funding decisions by government.

Introduction

Why the Framework is important

Dying is a truly universal human experience and forms part of every person's care journey. It is not only a medical or biological event, but also social, emotional and, for many people, deeply spiritual. While talking about death can feel difficult, more frequent and earlier conversations help people consider what matters most to them and receive care that reflects their needs and wishes. The Framework seeks to elevate the conversation about the end of life so more Victorians can live well with life-limiting illness, plan ahead, and die well.

Victorians want clear information and open dialogue about life-limiting illness, as well as greater influence over their palliative care choices. They also want to receive care from trusted practitioners and care providers, and have confidence that their preferences will be respected and their families supported through what can be an overwhelming and uncertain time.

Victorians want equitable access to person-centred care that reflects their values, culture, and assessed needs. People want to receive care and die in the place that feels right for them. Delivering this requires a coordinated, easy-to-navigate service system. It also depends on a compassionate, capable interdisciplinary workforce confident in having conversations about current and future palliative care needs. Strengthening the information and practical and emotional support provided to carers and families is also central.

In the last 10 years, Victoria's population has continued to grow and age, with more people reaching their 80s, 90s and beyond and living longer with chronic, progressive, and life-limiting illness. Households are also changing, shifting who people can turn to for support. This increases demand for palliative care and pressure on health, aged care, and social service systems.

As the care needs and expectations of our community grow and become more complex, we must rethink how palliative care is delivered. This means greater emphasis on improving access to care at home and in communities, more innovative models of care, and enabling technologies to support people and those who support them. The evidence is clear that these shifts, particularly in reducing avoidable hospital admissions, not only align with the needs and preferences of Victorians but also contribute to reducing health system cost pressures.

The palliative care system must also evolve in line with the big shifts that have occurred and continue to occur across the related aged care and disability service systems, and work in a more integrated and streamlined way with these services to improve people's experiences. This includes improving clarity in the services Victoria delivers, and closer collaboration with and advocacy to the Commonwealth in their areas of responsibility, including primary care.

The Framework brings all this work together. It provides a shared vision and clear priorities for how practitioners, care providers, and communities support people. It ensures that everyone can rely on compassionate, consistent, and coordinated approaches to care, no matter where they live or how they receive support.

Who the Framework is for

Victorians with life-limiting illness and those nearing the end of life

The Framework helps people take an active role in their care. It explains how services must work together to support choice, such as receiving care at home or in the community, and it includes options like advance care planning and, for some, voluntary assisted dying.

Carers, families, loved ones, and communities

The Framework guides all carers, families, loved ones, and communities. This includes those who may not see themselves as part of palliative or end-of-life care. Faith-based, cultural and community groups, and local councils all play a vital role in improving access and social connection, and raising awareness.

Clinicians and care providers

The Framework asks everyone in primary care, aged care, health, disability and human services to play their part in delivering palliative care and a good end-of-life experience for more Victorians. It calls on care providers to work together and innovate in ways that reflect regional and community needs. Specialist palliative care providers cannot meet rising demand alone – collaboration across disciplines and sectors is essential.

What is palliative and end-of-life care?

At its core, **palliative care** is an approach to care that is holistic, person and family-centred, and focused on enhancing wellbeing for someone living with life-limiting illness. It is not discussed in the Framework as something confined to a specific service model, provider, or profession.

Palliative care explicitly prioritises what matters most to the person and those caring for them, particularly when curative intent or stability for a given disease is progressively reducing. It addresses physical symptoms and causes of distress such as pain, breathlessness, and nausea. It features increased discussion about future care and end of life, as well as a greater focus on emotional, social, and spiritual needs. Palliative care can sometimes play a role in a person's care journey for years; however, it is most likely to be present in the last year or months of life.

In the last year of life, when a person's health and care needs often become more complex, they are considered to be **approaching the end of life** or are receiving **end-of-life care**. This period can involve rapid shifts in condition and increased contact with multiple services. Timing can be difficult to predict, but it is the optimal phase for care planning. It is when people can connect with or strengthen supportive services, to build capability and maintain care at home wherever possible.

When it is recognised that a person is imminently dying (usually within hours, days, or sometimes a few weeks), the focus shifts to **terminal care**. This provides focused, compassionate support aimed at preparing the person and their loved ones for the death.

After a person has died, respectful **after death care** honours a person's dignity and cultural or spiritual traditions. This phase includes verification and certification of death, preparation of the body, safe management of any medications, coordination with funeral services, and assistance with practical and legal matters. The role of palliative care teams is to help families and carers understand what this period involves and what to expect.

From this point forward where the Framework uses the term palliative care it is intended to encompass end-of-life care, terminal care and after death care.

Voluntary Assisted Dying (VAD)

For some, VAD is part of their end-of-life planning. VAD provides a legal choice for eligible people in the late stages of advanced disease. VAD in Victoria has many safeguards in place to ensure that it is the person's own fully informed decision. Since the *Voluntary Assisted Dying Act 2017* commenced, most VAD applicants have also received support from a palliative care provider (79%). This shows how advance care planning, palliative care, and VAD sit alongside one another as important aspects of end-of-life care in Victoria.

Palliative care across the lifespan

Palliative care can support people and their loved ones at any stage of a life-limiting illness – from diagnosis, through to end of life, and into bereavement. Needs and preferences change over time, and care can adjust to support people during periods of stability as well as times of rapid change.

Respecting personal choice is central. People may document their wishes and appoint a medical treatment decision maker. They make choices about continuing or stopping treatment, engaging in palliative care, funeral arrangements and after death care, including organ or body donation.

Palliative care supports people at every age and stage of life – from perinatal and paediatric care through adolescence, adulthood, and older age. Care is tailored to a person's developmental and communication needs. For children, parents guide decisions with age-appropriate support, while for young adults, care is more explicitly shaped by the person's own goals and preferences, with family involvement where desired.

Emotional support, mental health, grief, and bereavement

Emotional stress, mental health challenges, grief and loss are a central consideration in supporting people living with life-limiting illness and their loved ones. Serious illness can worsen existing mental health conditions or bring new concerns, and some people may need extra emotional or psychological support.

Grief and bereavement support often begins before death, helping people and families cope with change, loss and anticipatory grief. While many rely on family and friends, others may need peer support, counselling, or referral to specialist services.

Clinicians and other workers who care for people at the end of life also need support. Self-care, seeking collegial support, and accessing debriefing and organisational resources can help reduce the risk of stress, burnout, and compassion fatigue.

Where care happens and how services work together

Palliative care in Victoria is delivered across many settings, including in people's homes, primary care, hospitals, aged care and supported residential services, and outpatient clinics.

Most people receive palliative care from their usual healthcare providers, such as general practitioners (GPs), primary care teams, aged and community services, and treating specialists. This supports choice, continuity, and care in the most appropriate, lowest-acuity setting.

Specialist palliative care teams and services are an important part of this broader landscape and is primarily the responsibility of the state health system. These are led by clinicians with more advanced training and expertise in palliative care and become involved when extra support or advice is needed, helping families navigate difficult issues and decisions, and providing direct care during times of increasing clinical complexity.

The Victorian Government funds a statewide network of specialist palliative care providers that include hospitals, community health services and community service organisations. They deliver inpatient and community palliative care; metropolitan and regional consultancy services; and statewide services, such as the Palliative Care Advice Service and the Victorian Paediatric Palliative Care Program.

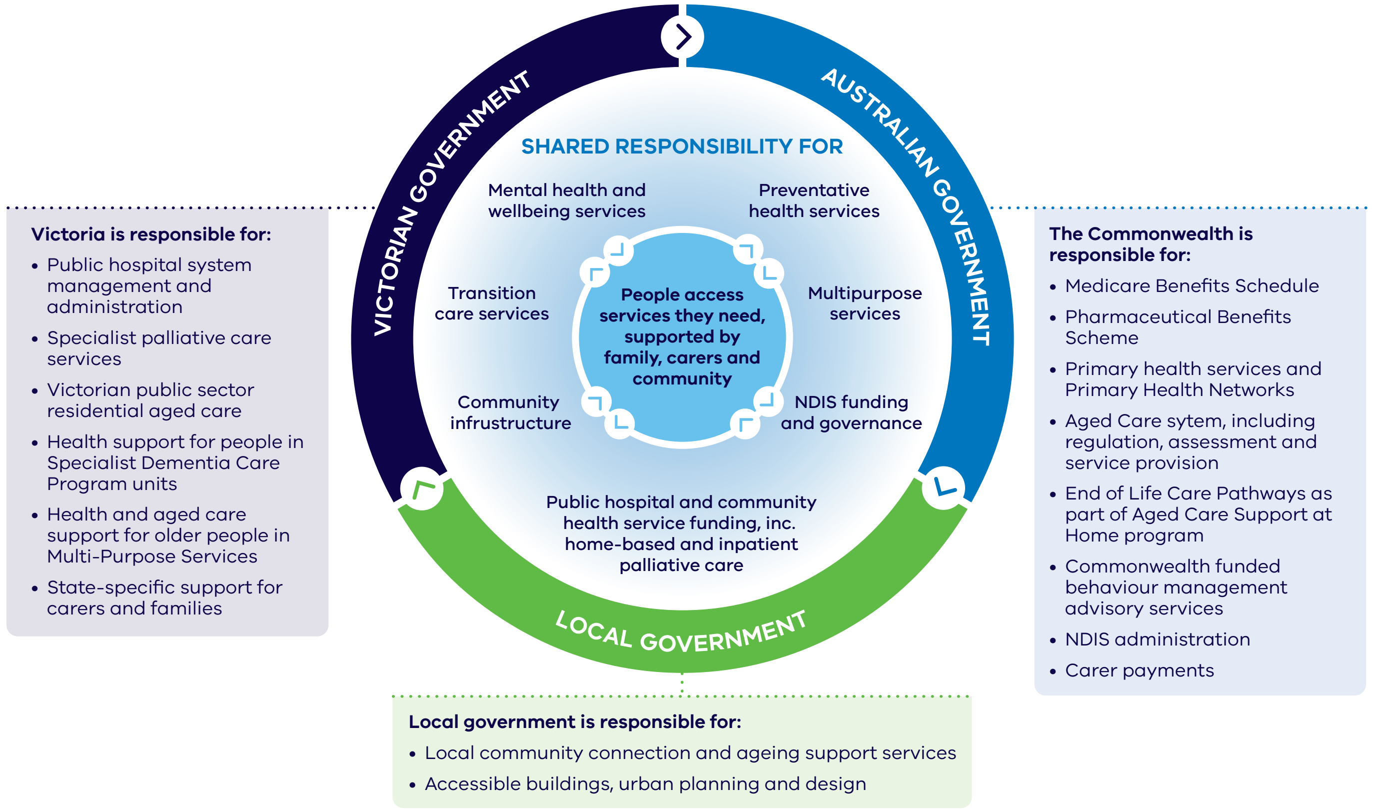
Specialist teams strengthen the system by helping people navigate to the most appropriate care, coordinate timely hospital discharge, connecting people to home-based supports and reducing avoidable hospital admissions. They mentor and guide other clinicians through advice, support for ethical decision making and strengthening organisational governance for end-of-life care.

Increasingly, care is delivered by interdisciplinary teams and shared care across providers rather than anchored to a single clinician. Palliative care works best when all parts of the system collaborate – primary care; specialist palliative care teams; and other specialist services, such as oncology, neurology and geriatrics.

A shared responsibility for palliative care

Palliative care is a diverse and complex sector, with funding and policy responsibilities shared between the Commonwealth and state and territory governments as shown below.

Figure 1: Shared responsibility for palliative care[1]



Victoria is responsible for:

- Public hospital system management and administration
- Specialist palliative care services
- Victorian public sector residential aged care
- Health support for people in Specialist Dementia Care Program units
- Health and aged care support for older people in Multi-Purpose Services
- State-specific support for carers and families

The Commonwealth is responsible for:

- Medicare Benefits Schedule
- Pharmaceutical Benefits Scheme
- Primary health services and Primary Health Networks
- Aged Care sytem, including regulation, assessment and service provision
- End of Life Care Pathways as part of Aged Care Support at Home program
- Commonwealth funded behaviour management advisory services
- NDIS administration
- Carer payments

Local government is responsible for:

- Local community connection and ageing support services
- Accessible buildings, urban planning and design

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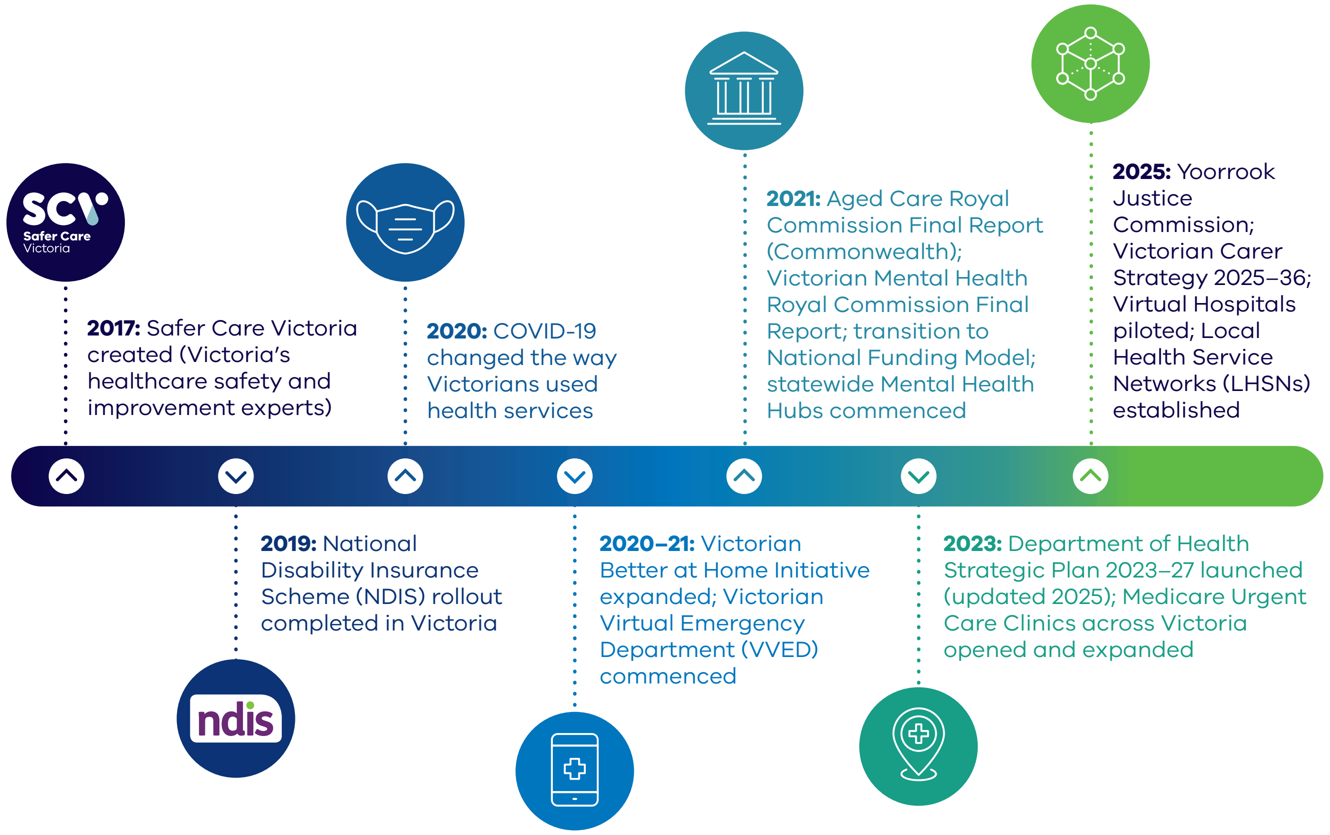
[1] Adapted from the *Joint statement to clarify the roles and responsibilities for the delivery of health care for people receiving aged care*, Commonwealth Department of Health, Disability and Ageing 2024.

A person's experience of palliative care is also shaped by supports outside formal services. Carers, family, friends, neighbours, colleagues, community members, religious congregations, and social support volunteers all play a role.

What has changed since 2016

Victoria's care system has evolved over the past decade, some key milestones are shown below.



2017: Safer Care Victoria created (Victoria's healthcare safety and improvement experts)

2019: National Disability Insurance Scheme (NDIS) rollout completed in Victoria

2020: COVID-19 changed the way Victorians used health services

2020–21: Victorian Better at Home Initiative expanded; Victorian Virtual Emergency Department (VVED) commenced

2021: Aged Care Royal Commission Final Report (Commonwealth); Victorian Mental Health Royal Commission Final Report; transition to National Funding Model; statewide Mental Health Hubs commenced

2023: Department of Health Strategic Plan 2023–27 launched (updated 2025); Medicare Urgent Care Clinics across Victoria opened and expanded

2025: Yoorrook Justice Commission; Victorian Carer Strategy 2025–36; Virtual Hospitals piloted; Local Health Service Networks (LHSNs) established

Developing the refreshed framework

What's new in the Framework?

Victoria's 2016 End of Life and Palliative Care Framework was an important response to the Victorian Parliamentary Inquiry into End of Life Choices and was informed by extensive community consultation to understand what matters most to people at the end of life. It prioritised working with communities to deliver the right care at the right place by focusing on people and outcomes.

At its heart, this refreshed 2026–36 Framework supports people's palliative care choices and recognises that accessible and compassionate palliative care is foundational to this. It sets a clear agenda for the next decade of reform that builds on the 2016 Framework. It sets the system up to respond to Victoria's changing needs by:

- better integrating palliative care into major changes across health, aged care, disability, and mental health and wellbeing systems, and ensuring it is embedded in mainstream policy
- making care at home the new normal by modernising the service system and strengthening the enablers that make home-based care work and reduce preventable hospital transfers
- putting carers front and centre, so they are seen not only as supporters but as people with their own needs
- encouraging a whole-of-community approach that mobilises both clinical teams and social networks around the person, adapting as needs change
- driving earlier conversations about palliative care and future planning, so people have the information they need to make informed, confident choices
- delivering consistent care assessments and clear, coordinated pathways that make it easier for people and carers to move through and across services
- setting clearer expectations of specialist palliative care teams and partners, so the small specialist workforce can work to full scope and support interdisciplinary practice
- setting more explicit expectations around data, information, and evidence to drive innovation, improvement, and better planning for the service system of the future.

The refreshed vision and goals and new priority directions recognise substantial shifts in demand, community expectations, and care delivery across sectors. Together, they provide a shared approach for equitable, inclusive, and world class care. Each priority direction outlines key challenges to be addressed, signals the reform aspiration and identifies practical actions for system improvement.

Consultation and engagement

In the Victorian Cancer Plan 2024–28, the Government committed to co-designing a renewed vision for palliative care with consumers and the sector 10 years on from the launch of the last Framework. This Framework delivers on that promise.

The Framework refresh used a targeted, multifaceted engagement process that ran from May to November 2025. This built on extensive community consultation undertaken for the 2016 Framework.

The engagement explored the lived experience of Victorians with life-limiting illness, their families and carers, and the Victorian palliative care service system that supports them. It has informed an updated vision and goals that reflect today's needs, honour what Victorian's previously said mattered most, as well as identifying priority opportunities for change to shape a modern service system. These conversations looked back at what has been achieved and forward to the evidence and emerging trends that will shape future needs in Victoria and Australia more broadly.

Figure 2: Targeted, multi-faceted engagement in 2025

Consumer engagement	**Sector engagement**	**Expert interviews**
Deep dive workshops with **36 consumers** with lived experience of the Victorian palliative care service system	**4 online forums** with Palliative Care Victoria and 80 funded palliative care sector representatives, and **invited submissions** from 29 aligned sector partners	**Targeted interviews** with representatives from key organisations and peak bodies, and researchers

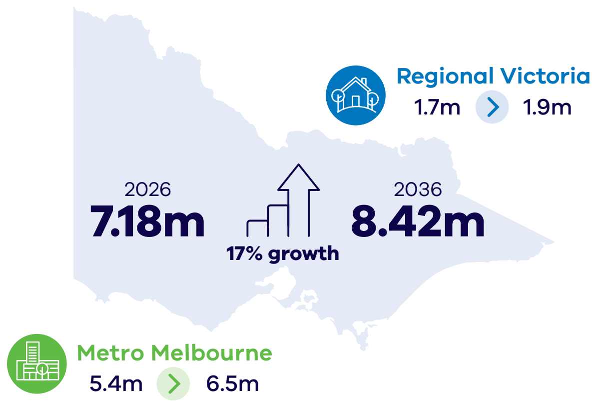
Looking back, it is important to recognise the significant disruption caused by the COVID 19 health emergency. COVID-19 affected palliative care in unique ways, including how people accessed care and restricting the presence of loved ones at the time of death. These challenges deeply shaped people's experiences of care, dying, and bereavement. This disruption also meant that some work planned under the 2016 Framework is yet to be fully realised, despite shared commitment.

Indeed, the pandemic changed the Victorian healthcare system in unexpected ways. There were also some positive changes, including acceleration of digital and flexible care models, creating space for innovation.

Looking ahead – Victoria's profile 2026–36

Communities across Victoria are changing, shaping future demand for palliative care. Shifts in population and household profiles calls for a rethink of care models and strengthening of social and support networks. While not everyone with a serious illness will need palliative care, understanding demand is essential to building a modern system that can respond earlier and well.

OUR POPULATION IS GROWING AND CHANGING



Our multicultural communities are ageing, with increasing need for culturally responsive care.

Metropolitan Melbourne is home to about 75% of Victorians, and will see the largest population rise.

VICTORIANS ARE AGEING[1]

There are more people aged 65 years and older (up 26%).

This group is arguably the largest cohort living with serious illness, signalling **rising demand** for palliative and end-of-life care, and highlighting a need to plan for future demand.

AGE	2026	% CHANGE	2036
0–20	1.69m	10%	1.85m
21–64	4.26m	18%	5.03m
65–84	1.07m	20%	1.29m
85+	0.16m	60%	0.26m

TYPE	2026	% CHANGE	2036
Family with children	1.19m	18%	1.41m
Family without children	0.75m	21%	0.90m
Lone person household	0.74m	17%	0.87m
Group and other household	0.15m	19%	0.18m

HOUSEHOLDS ARE CHANGING[1]

The number of households will grow by 19% and there will be greater diversity in household types.

This underscores the need to rethink the concept of 'loved ones' and 'community' to provide support at home.

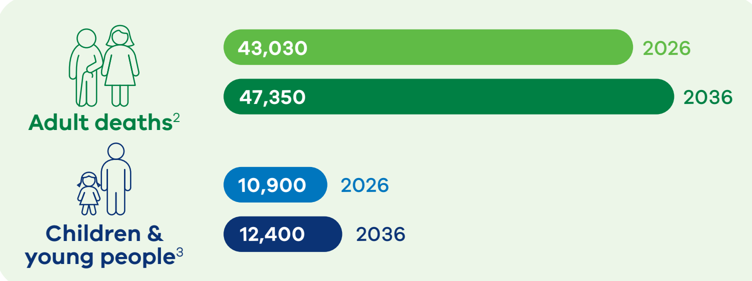
"There appears to be a positive association between living with someone or having a family carer and dying at home." OECD

PROJECTED PALLIATIVE CARE NEED

This is an estimate that helps plan ahead for services, noting not every person will require targeted services.

Around **85%** of adult palliative deaths are in people aged 65 years and older.

Around 68% resided in metro Melbourne.



Sources:

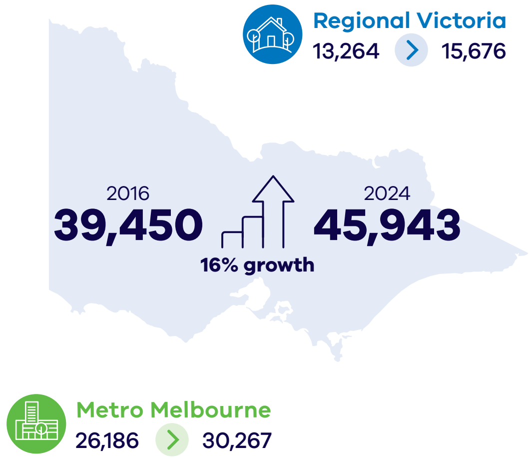
1. Department of Transport and Planning Victoria 2023, Victoria in Future 2023.
2. Department of Health Victoria 2025, internal projections using data from the Victorian Registry of Births, Deaths and Marriages.
3. Paediatric Palliative Care Australia and New Zealand 2024, *Paediatric Palliative Care Need in Australia Report.*

Looking back – Where Victorians died 2016–25

Understanding where people with life-limiting illness are cared for and die will help design a modern, responsive system that supports more care at home and honours people's preferences.

DEATHS (ALL CAUSES, ALL AGES) from 2016–2024[1]

Estimated to reach 57,000 by 2036



Not all deaths are predictable (e.g. accidents), and not everyone experiences illness in a way that means they choose palliative care.

Around 68% of all adult deaths occur in metropolitan Melbourne

AGE AT DEATH[2]	2016	2024
0–19	**1.0%**	**0.9%**
20–39	**2.4%**	**2.4%**
40–64	**13.3%**	**12.6%**
65–84	**41.0%**	**41.5%**
85 and older	**42.3%**	**42.7%**

END OF LIFE CARE TRAJECTORIES[3]

These pathways show typical illness progression.

Frailty and organ failure often appear less in the data because they may not be recorded as the main condition when people have multiple health issues.

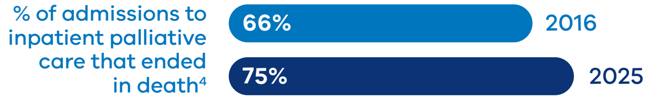
END OF LIFE CARE CATEGORY	% OF DEATHS
Malignant neoplasm (cancer)	**62%**
Frailty (dementia and Parkinson's Disease)	**23%**
Organ failure (heart and liver failure, COPD)	**15%**

WHERE PEOPLE DIE IN HOSPITAL[4]

Most people die in acute care.

For people who die in acute or palliative care, the average length of stay is 9 days.

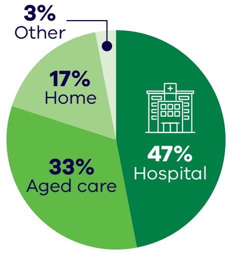
ALL HOSPITAL DEATHS	2016	2025
Inpatient palliative care	**33%**	**38%**
Acute care	**62%**	**59%**
Other hospital areas	**5%**	**3%**



WHERE PEOPLE ARE DYING[5]

The number of people dying at home has remained steady. Just under half of Victorians with palliative care needs die in hospital, mostly older Victorians.

Around 85% of all hospital deaths occur in public hospitals.



Sources:

1. Department of Transport and Planning Victoria 2023, *Victoria in Future 2023*.
2. Australian Bureau of Statistics 2024, Deaths, Australia.
3. Australian Institute of Health and Welfare 2024, *Palliative care and health service use for people with life-limiting illness*.
4. Department of Health Victoria 2025, service activity data (excludes deaths in Ambulances and ED).
5. Department of Health Victoria 2025, internal projections using data from the Victorian Registry of Births, Deaths and Marriages.

Population and changing households

Victoria's population is growing and ageing, with a rapid increase in people aged 85 years and over who typically need more support with daily living. Regional areas may experience these pressures more intensely due to population profiles, while Melbourne will see higher overall volumes. At the same time household structures are shifting towards more people living alone, in couples without children, or in shared households. There are an increasing number of individuals who do not have family or carers and are isolated. As informal carers get older and become less available, the demand for formal services will increase. In response, services will need to recognise broader support networks, including friends and community, and be more coordinated and flexible.

Growing demand for palliative care

Demand for palliative care is rising across all ages, reflecting both the growing number of people living with complex, life limiting conditions and those dying with them. Palliative care responds to a person's needs and experience of illness rather than diagnosis, but particular diseases still shape palliative care demand. Children and young people have different illness patterns from adults, with genetic and neurological conditions more common in infancy and cancer more prevalent in adolescence. Adult demand is increasing as more people live longer with dementia,[2] neurological conditions, and advanced heart, lung and kidney disease. Improved cancer survival[3] also means that more people, including younger adults and families, live with complex social needs. They also require support over longer periods, particularly during transitions from paediatric to adult services.

Deaths

Deaths in Victoria are gradually increasing by around 1–2% each year and are estimated to reach around 57,850 by 2036 – almost all in adults. While a small cohort, the death of younger Victorians has a profound impact, causing significant emotional distress for families and communities. Around 97% of deaths are people aged 40 years and over, this large group has more consistent healthcare and palliative care needs. Most people die aged 65 years and over, where frailty, dementia, and complex multiple chronic conditions are more common. Regional areas have higher death rates per population, metropolitan areas have a greater volume. While not all deaths are predictable or require palliative care these trends reinforce the need for good planning for home-based care.

Place of death

A new tick box on Victorian death certificates introduced in 2019 records whether people die at home, in aged care, in hospital or elsewhere, providing better data to plan for services. Early results show that the proportion of adult deaths occurring at home has remained stable at around 17–18%, with gaps still evident in data for children and young people. Despite strong community preferences for home-based end-of-life care, hospitals continue to be the most common place of death. This highlights a persistent challenge and underscores the importance of strengthening and expanding home-based palliative care to better align care with people's needs and preferences.

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[2] The number of older Victorians living with dementia is projected to rise from 113,900 in 2026 to 142,670 by 2036.

[3] The 5-year survival rate for cancer is now at 73% with more than 350,000 Victorians living with a cancer diagnosis.

Deaths in hospital

Public hospitals remain a major setting for end-of-life care in Victoria. Hospital deaths are increasing around the same rate as overall deaths, and hospital admissions ending in death remain steady at 0.8%. People aged 65 years and over account for just over 80% of hospital deaths. Over half of patients admitted to inpatient palliative care die within four days, reflecting stronger referral pathways and increasing complexity. Around 60% of hospital deaths occur in acute beds under usual treating teams (such as oncology or cardiology units), rather than in dedicated palliative care beds. This highlights the need for strong specialist palliative care consultancy, broad uptake of end of life care tools, earlier conversations about preferences and to plan for care at home, and support for rapid discharge where possible.

Vision and goals

The Framework's vision and goals represent the Victorian community's aspiration and the outcomes they want to see from the palliative care system. These have been developed in consultation with the community and sector, informed by expert input and best practice evidence.

Vision

Victorians can access high-quality palliative and end-of-life care that meets the unique needs of each person and their carers and family. Care is provided through an integrated, responsive, and inclusive service system.

Goals

1. Care is responsive to people's assessed needs and supports individual values, preferences, and wellbeing.
2. People are cared for and, where possible, can die in their place of choice.
3. Carers and families are supported and valued as vital partners in each person's care journey.
4. Care is responsive to the needs of diverse communities and supports self-determination for First Peoples.
5. People experience high-quality and coordinated care at the right time.
6. People's care is integrated across providers and workforces, with a focus on interdisciplinary approaches.

Core principles

- Equity, responsiveness, choice
- Safe, high-quality, person-centred care

The Framework also adopts and weaves through the 9 guiding principles for safe and high-quality end-of-life care as identified in the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.[4] This document was endorsed by all Australian governments as the best practice approach to caring for people who are at the end of life.

A rights-based approach is embedded throughout the framework, in line with the Victorian *Charter of Human Rights and Responsibilities Act 2006*. This reflects an ongoing commitment to ensuring people receive the quality of care, safety, respect, and choice that they are entitled to.

Outcome measures

High-level outcome measures have been identified to track progress toward Framework goals. These build on the 2016 measures and reflect what Victorians told us matters most. A refreshed outcomes framework, supported by a monitoring dashboard, will help track progress over time and provide transparency on how the system is performing. Palliative care system data needs and opportunities for improvement are discussed further under priority direction 5.

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[4] National Consensus Statement – 9 guiding principles: 1. Be person-centred and include family and carers; 2. Align with values, needs and wishes; 3. Provide people with information they can understand; 4. Consider cultural, spiritual and psycho-social needs; 5. Include qualified, experienced and multi-disciplinary care; 6. Ensure the right to refuse medical treatment; 7. Not be burdensome or harmful; 8. Not offer unreasonable hope; and 9. Continue after a person has died.

System success will be measured by:

- more people spend most of their last 100 days at home
- more people access palliative care in the last 100 days of life
- evidence of people's care preferences and advance care planning documents in patient records
- people and carers experience high-quality, inclusive care
- more people, carers, and families receive the information they want and need
- increased use of validated, standardised assessment and guidance tools by practitioners
- evidence that care is delivered by a capable, interdisciplinary workforce, reflected in team mix, specialist involvement, and collaboration across professions
- more equitable access to palliative care across regions and population groups
- benchmarked patient outcomes, such as timely access to care, responsive care, acknowledgement of people's preferences, and people's involvement in decision making about their care.

Priority directions

Priority direction 1 – Provide more care at home

Victoria is reshaping its care system so home comes first when that is a person's wish

The Victorian Government is committed to helping more people receive care closer to home. Being cared for at home supports people to live well in familiar surroundings, stay connected to family and community, and maintain their independence. For many people, care at home can reduce stress, reduce avoidable hospital visits, and support continuity of care, particularly for older people or as care needs increase over time.

There are many places that people call home, and the palliative care system must be able to reach into all of them. Home may be a private residence, residential aged care, disability accommodation, supported housing, group homes, and retirement villages. For some, housing may even be temporary or insecure. Many core elements of palliative care – triage, assessment, referral, and symptom management and support – can be delivered safely in the home.

A wide range of practitioners support people every day and make home-based care possible. All can embed a palliative approach in their care, with specialist teams providing consultation and shared-care support when additional expertise is needed. This means that effective home-based care requires strong system partnerships that enable coordination, supported by comprehensive assessment, care planning, and multidisciplinary practice.

The Victorian Government has strengthened home-based care across the health system through key priorities such as the Better at Home initiative and the Virtual Hospital pilot. These initiatives show what is possible when services are designed around home. Specific projects such as the We are Ambulance Victoria Engaged (WAVE) project support stronger connections with paramedics and community-based palliative care teams.

While community palliative care shares common care principles, some service elements can vary, such as access to support after-hours. Community palliative care teams work alongside general nursing, personal care, and other in-home supports. These other supports are essential for meeting daily care needs, supporting carers and families, and preventing avoidable hospital admissions. Ensuring other practitioners and the community are clear on the role of specialist palliative care teams is essential to a well-functioning service system.

Hospitals are also expanding their palliative care models that reduce time spent in hospital. These include Planned Rapid Discharge, Admitted Care at Home, and Hospital in the Home. Inpatient palliative care is still an important option for people with complex needs or when a hospital stay can help prevent a crisis. Together, these models strengthen choice and improve flexibility, ensuring people receive care in the setting that best meets their needs.

The Commonwealth Government has also invested in initiatives such as Greater Choice for At Home Palliative Care Program and the Comprehensive Palliative Care in Aged Care Measure (co-funded with the Victorian Government). Both aim to build palliative care capacity with our primary health and aged care partners. Reforms flowing from the new *Aged Care Act 2024* also focus on older people remaining at home for longer. For example, the new End-of-Life Pathway under the Support at Home program provides up to $25,000 to help a person in the last 3 months of life to be cared for at home. Ensuring this pathway works seamlessly with Victorian health and specialist palliative care teams will be an important area of focus.

Effective home based care is what the community expects. These collective efforts provide a strong foundation for the future. The next step is to embed, consolidate, and better integrate these initiatives so they operate as a coordinated, reliable system of care. Modernising the palliative care service system to align with these broader system reforms will enable more Victorians to remain at home for as long as possible, or die at home if that is their wish.

What the evidence tells us

Services for those dying of chronic illness need to be reoriented so that they focus more on people's wishes to die at home and in homelike settings, rather than in institutions.

– Swerissen and Duckett, 2015

Caring for people in their last year of life requires significant resources. Around 8% of Australian healthcare expenditure supports end-of-life care. The average annual cost per person is 14 times higher in the final 12 months of life, with hospital admissions making up most of the cost.

– Australian Institute of Health and Welfare, 2022

Challenges in the current system

- Uneven population, illness, and service patterns across Victoria mean more sophisticated planning is needed to support equitable access to care at home for all Victorians.
- Inconsistencies across Victoria in who gets home-based care, what it looks like, when it is available, and after hours support create challenges in delivering consistent care.
- Palliative care is essential, but care at home models are not uniformly keeping pace with innovation, changing service structures, or community expectations.
- Gaps in hospital discharge planning can lead to risk-aversion, missed opportunities, and underutilisation of community-based care.
- Funding for care at home and in the community does not always reflect service demand or the complexity of people's care needs, including Medicare rebates for longer consultations and home visits, which are central to GP delivery of palliative care.
- Care at home is affected by an evolving policy and regulatory environment, and palliative care risks falling behind other forms of care if new opportunities are not taken up.
- Coordinated and integrating state-based services and access to Commonwealth programs is complex, and improving alignment is critical for the experience of people, their families and carers.

Quotes from the 2025 engagement

'It would be good to have access equitable and uniform across the state, including after hours.'

– Palliative care clinical manager, Regional health service

'While there are some similarities in service model features across providers, there is variability in service offerings, particularly within residential aged care home in-reach.'

– Project partner

'Is it realistic to expect a smaller service to have all the resources, or are we better off … working collaboratively or using technology to allow services to have access to skills?'

– Metropolitan community palliative care provider

'Strategic commissioning incentivises earlier intervention, joined-up care, and care in the lowest acuity setting that is clinically appropriate.'

– Project partner

Opportunities for change

- Set clear statewide standards for publicly funded palliative care services so all Victorians can access the same core offering, with clear pathways to additional supports.
- Expand flexible community-based and home-based models to provide timely, coordinated support and reduce unnecessary hospital use. Responsive options include specialist community-based teams; hospital-in-the-home; and planned rapid discharge models, with outpatient support for people already receiving treatment in this setting.
- Strengthen sector collaboration across regions, with metropolitan and regional services supporting rural communities through outreach, virtual care, and secondary consults.
- Strengthen collaboration with the Commonwealth to create clearer referral pathways and consistent models of care that enable state-based services to better and more consistently support residents in aged care and disability homes.
- Undertake a broader review of how palliative care fits with other care at home to better embed palliative care, strengthen pathways, and improve how services interface to enhance people's experiences.

Actions

1.1 Renew the Palliative Care Service Capability Framework to outline the expectations and roles of all services, including primary care, so that people experience well-coordinated support no matter where they receive it.

1.2 Embed best practice discharge planning for palliative care patients, so people return home from hospital with the right supports in place to help them stay there.

1.3 Consider best practice palliative care in-reach models for aged care and disability settings, so specialist palliative care services are reaching people in any type of home. [subject to future funding decisions by government]

Priority direction 2 – Support people's holistic needs and those of carers, families, and loved ones

A focus on wellbeing and what is most important to people approaching the end of life

Victorians living with serious illness deserve inclusive, personalised, and trauma informed care that reflects their values and identity. Life-limiting illness affects more than physical health – it brings profound impacts for people and those close to them.

Quality palliative care is life optimising and supports the whole person. It strengthens emotional wellbeing, cultural identity, and spiritual or religious practice, and helps people stay connected to family, community, place, and routines. Palliative care honours each person's definition of a good life, supporting people with clear care planning and accessible services. Some people need minimal support and die peacefully at home. Others require care for weeks, months, or years. This variation is one of the biggest challenges for providers.

Some Victorians are less likely to receive palliative care that meets their needs, including people in regional and rural areas; First Peoples; multicultural communities; LGBTIQA+ communities; people with disability, and those experiencing mental illness, homelessness, and non-cancer conditions. Victoria is taking steps to close these gaps through initiatives such as the Aboriginal Palliative Care Program, but more can be done. There is a strong body of Australian work to draw on, along with the dedicated efforts of many providers, and sector partners, to systematically build a more inclusive palliative care system.

Carers are essential partners in home-based care, and their own needs must be recognised. The Victorian Carer Strategy 2025–35 affirms the government's commitment to recognising the uniqueness of each caring role and care experience. Engaged, informed, supported, and confident carers are an essential enabler for more people remaining at home for longer. Carers can face significant personal, family, and financial pressures, and their wellbeing must be supported through regular assessment, practical help, emotional support, and flexible respite when needed.

Communities also make home-based care possible. Friends, neighbours, volunteers, community members, and organisations offer companionship, reduce isolation, and support families through grief. It is also noted that there is a small but increasing cohort of people who do not have nearby family supports. Practical tools, such as the Palliative Care Social Prescribing Service Model and flexible volunteer programs, help build networks of care that complement formal services. As our population ages and household structures change, providers must adapt to broader definitions of 'loved ones' and emerging community support networks.

People, families, and communities need timely, clear information about what good palliative care looks like, how to plan, what to expect, and how to help. Information must be easy to find and use so it reduces uncertainty, supports choices aligned with people's values and wishes, and builds confidence. Normalising earlier, honest, and sensitive conversations about palliative care and the advance care planning process also enhances choice and improves quality of care. It helps people find care that is right for them and reduces fear, stigma, and last-minute decision-making.

The VIctorian Government is committed to supporting people's end-of-life care choices, demonstrated by delivering major reforms arising from the 2016 Parliamentary Inquiry into End of Life Choices. Key achievements that are providing a foundation for improvement include Victoria's End of Life and Palliative Care Framework 2016, the *Medical Treatment Planning and Decisions Act 2016*, and the *Voluntary Assisted Dying Act 2017* (with amendments taking effect in 2027). Health services are also embedding advance care planning into routine practice. The Victorian Office of the Public Advocate provides advice and decision-making support when needed.

National reforms will also further strengthen people's choice and control. The *Aged Care Act 2024* upholds autonomy, dignity, and culturally respectful care, including equitable access to palliative care for older people receiving aged care supports.

We only get one chance to support a good death for each person. Care must be equitable, respectful, and aligned with each person's needs and wishes. Dignity at the end of life is a fundamental human right.

What the evidence tells us

Deaths among multicultural Victorians are projected to increase by 28% over the next decade, compared with 8% for other Victorians. This increase primarily reflects that Victoria's population of older, culturally diverse residents is growing, and creates a clear opportunity to strengthen culturally responsive, multifaith end-of-life care.

– Victorian Department of Health, 2025

Health care professionals and carers report different perspectives on the initiation and timing of conversations regarding palliative care. Conversations about palliative care are often carer led, and late in the illness progression potentially indicating a hesitancy on behalf of health care professionals to initiate early conversations.

– Commonwealth Department of Health, Disability and Ageing 2023

Most people recognise that advance care planning can help others make decisions if they can't (82%), and many are willing to talk about it (73%). However, far fewer take action: only a third have started planning, and even fewer have discussed their wishes (20%), appointed a substitute decision maker (13%), or completed an advance care directive (6%).

– Advance Care Planning Australia, 2025

'It is imperative that governments better understand Aboriginal and Torres Strait Islander ways of approaching health and ageing well as a continuum that encompasses dying well. This includes better understanding the end of life needs and how they can support culturally safe palliative care'.

– Report from the Interim First Nations Aged Care Commissioner, 2024

Challenges in the current system

- Open discussions about palliative care can appear difficult as they may seem to conflict with active treatment, but the two can co-exist. Earlier conversations about the end of life with people, their carers and families can enable more effective planning, including for care at home.
- Outcomes from advance care planning conversations are not always translated into recognised medical treatment decision makers or formal advance care directives. This means that peoples' wishes are not always clearly documented, understood, and respected.
- There are inequities in access to and experiences of palliative care. Fear of stigma and concerns about whether services will be culturally safe and inclusive can lead some people to delay or avoid care, leading to poorer outcomes and increased distress for loved ones.
- Care must reflect the natural complexity and nuance in people's lives. Peoples' intersecting identities shape their experience of illness, dying, and death. Equity and inclusion depend on recognising this diversity.
- Grief and bereavement needs vary. Some people rely on existing social networks, and others need specialist support – yet services remain inconsistent and are often mismatched to need.

Quotes from the 2025 engagement

'Carers often feel invisible, unsupported, and overwhelmed, impacting their wellbeing and the sustainability of care at home.'

– Project partner

'I think being genuine and not being scared to show empathy for anyone. I think it's that real human connectedness that anyone can sort of empathise with as much as possible.'

– Consumer

'Accessible public information on palliative care, advance care planning and death literacy empowers more Victorians to make informed choices about how and where they die. It also helps carers and loved ones to better understand those choices and the values behind them.'

– A Victorian peak body representative

Opportunities for change

- Embed earlier, routine palliative care and future planning conversations into standard care for every person with serious illness, supported by increased clinician confidence and capability in having these conversations.
- Provide clear, staged information to support effective conversations– what palliative care is, what to expect, and how to plan – through a single, trusted source available in multiple formats and appropriately tailored for key audiences such as multicultural communities and First Peoples.
- Better reflect the voices and insights of people with lived experience and carers to help improve care for those who use the service system.
- Embed trusted tools for holistic needs assessment to guide consistent, confident decisions to ensure care aligns with each person's unique needs, and connects them to the right support.
- Commit to culturally responsive care by co-designing approaches and services that respect and reflect diverse values, traditions, and needs.

Actions

2.1 Support people to make informed choices with clear and consistent information about palliative care and navigation support. [subject to future funding decisions by government]

2.2 Address health service policies that may be a barrier to cultural practices around the end of life so that people and their carers and families are supported to approach dying and death in a way that aligns with their values and beliefs.

2.3 Increase awareness of service and workforce obligations relating to advance care directives under the *Medical Treatment Planning and Decisions Act 2016* so that people can have confidence that their wishes will be known and respected.

Priority direction 3 – Improve system interfaces and care pathways

People experience well-coordinated care and can navigate the system more easily

People with serious illnesses often see many different care providers. Effective care relies on clear communication, defined roles, and strong, trusted relationships between providers and clinicians. When services are fragmented or resources are stretched, coordination becomes harder. An integrated system is essential for smooth, consistent care. Every part of the system must work together, linking specialist teams, primary care, aged care, disability, and community services.

Effective partnerships are essential to support people as they transition across the care system to maintain continuity of care: children and young people to the adult system, and people between settings, providers, and sectors. Strengthening partnerships between treating teams and specialist palliative care teams can also prevent avoidable admissions through earlier or more timely support. Over time, stronger partnerships may also help to reduce the pattern of around half of all Victorians dying in hospital despite strong community preferences to die at home.

Victorian research clearly shows that engaging earlier with palliative care teams builds trust and leads to better outcomes. People who engage earlier are more likely to have advance care planning documents in place and are more likely to die outside hospital. They are also less likely to have multiple emergency presentations or hospital admissions. Currently, Australians aged 40 years and over typically see a palliative medicine physician at least 6 months after seeing their disease-specific specialist. Earlier engagement means thinking differently about specialist palliative care – not just as a referral for terminal care, but as dynamic support that people can move in and out of as their needs change.

Victorian consumers report it can be difficult to navigate to the right care. It is important that both the community and other providers understand the tasks of palliative care and the role of providers. Responding to increasing demand will require greater clarity around the roles and responsibilities of specialist palliative care teams and when to engage them. Clearer expectations will improve coordination, ensure smoother transitions, and navigate people to the right care the first time.

The Victorian Government is committed to strengthening collaborative care as close to home as possible. Many providers play a role in delivering integrated, reliable care. These include hospitals, palliative care providers, Ambulance Victoria, community pharmacies, primary care, disability services, mental health services, and Residential In-reach teams, and many others. The Local Health Service Networks, established in 2025, will support health services and their partners to coordinate care more effectively. Stronger regional governance, inclusive of palliative care, will drive integration, support consistent care, and strengthen accountability.

Virtual care is improving system interfaces. The Victorian Virtual Emergency Department helps people receive care in place, including enabling palliative discussions in aged care homes. The Victorian Palliative Care Advice Service provides statewide specialist support to all Victorians: health, primary care, aged care, and other providers, as well as the general public. Many community-based providers and consultancy services also provide a navigation and coordination role for their local area, meaning it is important to consider any duplication and unnecessary effort in directing people to the right care.

Early Victorian work on mapping patient journeys has informed national models such as the Cancer Care Optimal Care Pathways. Victoria will build on these learnings to refine care pathways so people, carers, and families experience consistent, coordinated palliative care. Improving pathways and interfaces, and engaging specialist palliative care teams earlier, will help create a more connected and coordinated system for all Victorians.

What the evidence tells us

The bi-annual national data reported by the Australian Institute of Health and Welfare (2024) highlights several important insights about how Victoria's end-of-life care system is performing.

Equity of access to specialist care

Nationally, cancer accounts for 1 in 2 adult deaths but these patients have disproportionately better access to palliative care physicians compared to patients with other health conditions.

Timely access to specialist care

16.5% of Victorians who died with a life-limiting illness saw a palliative care physician at least 3 months before death – lower than the national average of 20.9%, showing this is an area for focus in Victoria.

Quality care

8.6% of Victorians who died with a life-limiting illness received at least one non-beneficial treatment in a public hospital at the end of their life. Research based on clinical audit would suggest that this in an underestimate.

Coordinated care

10.5% of Victorians who died with a life-limiting illness had a potentially preventable hospitalisation in the last 3 months of life – while better than the national average of 11.9% there remains opportunity for improvement

Challenges in the current system

- When expectations about the role of specialist palliative care are unclear, referrals may be not the best fit, late, or not made at all. This can make it harder for people to receive the right support at the right time, and can impact their care experience.
- Victoria's palliative care system is complex, which can make it hard to follow people through their care journey and provide consistent support as they move between providers and settings. This can affect the system's ability to coordinate care around a person's changing needs.
- Viewing specialist palliative care teams only as terminal care means other providers can miss chances for earlier support, and limited understanding of its wider role makes shared care partnerships harder to put in place.
- Meeting people's assessed needs requires stronger links between palliative care services, state led health, mental health and social services as well as the critical enablers in areas of Commonwealth responsibility such as aged care and disability supports and income support for people and carers.
- There is a variety of validated, trusted tools that can support prognostication and identification of need, and greater uptake is required to support smoother movement across the system.
- People with deteriorating conditions often require rapid, short-term personal care and nursing services in addition to palliative care support. Eligibility tied to age, diagnosis, housing, and other criteria results in unequal access.

Quotes from the 2025 engagement

'In terms of navigation, I think it's having healthcare professionals who know the patient really, really well, and being able to flag options early on.'

– Consumer

'A refreshed framework should seek to support a strong culture of collaboration and connection within and between primary, hospital, allied health, palliative, and aged care sectors to support more timely and appropriate referrals for palliative and end-of-life care.

– A Victorian peak body representative

'System strengths in compassion and holistic care are undermined by structural constraints, including fragmentation. Families and patients experience uncertainty, distress, and lack of confidence when trying to understand or navigate the system.'

– Project partner

Opportunities for change

- Be clear on what specialist palliative care teams deliver and what other care partners contribute, so more care can be provided in place. It is not just about specialist palliative care services and workforces doing more.
- Provide clear pathways between paediatric and adult palliative care and leverage specialist teams in advisory roles to improve navigation, integration, and access to care closer to home.
- Meet rising demand through better enabling effective shared-care models, for example between GPs and specialist palliative care services, or community-based and hospital-based palliative care services. These should be linked to patient need, with clear criteria for timing and intensity.
- Improve the certainty of when to involve specialist palliative care through consistent pathways, using trusted, consensus-based tools and escalation criteria to ensure timely access.
- Strengthen regional governance and partnerships so specialist palliative care, primary care, mental health, aged care, and community services collaborate effectively, with clear roles.

Actions

3.1 Implement more consistent statewide referral, triage, and admission criteria, including transition and discharge trigger points, so that people have a more streamlined experience moving through their care journey.

3.2 Explore opportunities to strengthen the navigation and coordination role of the Victorian Palliative Care Advice Service and community-based palliative care services, so that people and their carers and families are better connected to the right care at the right time. [subject to future funding decisions by government]

3.3 Revisit the role of Palliative Care Consortia in planning and service improvement in the context of the Local Health Service Networks, so that people receive consistently well-planned care closer to home that reflects both local needs and statewide priorities.

Priority direction 4 – Build a capable and interconnected workforce

Coordinated palliative care delivered by a confident, interdisciplinary workforce

People nearing the end of life are already supported by a broad and diverse workforce operating across multiple settings and sectors. This includes aged care staff, paramedics, pharmacists, Aboriginal health workers, allied health professionals, disability and community care workers, interpreters, spiritual and pastoral care workers, and more. In primary care, GPs and nurses support people from early diagnosis through to terminal care and bereavement support.

Each practitioner group has a unique role in the service system; all need to be comfortable and confident in recognising palliative care needs and having honest and sensitive conversations with people, carers and families about the end of life.

Specialist palliative care teams include doctors, nurses, and other practitioners working across hospitals, community health services, and non-government organisations. Senior registered nurses make up most of this workforce, with a small but growing number of nurse practitioners. Around half of palliative care providers do not directly employ a palliative medicine physician, instead accessing medical expertise through consultancy teams. Allied health professionals operate as a shared workforce. Volunteers embedded within service models also provide valued practical and emotional support to people, carers, and families.

Since 2018, the Victorian Government has funded the Palliative Medicine Training Program. This valuable initiative has gradually expanded specialist medical capacity and supported other doctors to complete advanced training. Nurse practitioner training has also strengthened care, particularly in regional areas. Victoria is now developing paramedics as independent practitioners.

Broader workforce capability is steadily growing with more doctors now holding advanced or dual training, including rural generalists, geriatrics, cancer care, and general medicine[5] Around 17% of cancer nurses also now have a speciality in palliative care. Despite this progress, workforce supply and capability are not keeping up with overall demand and within specific clinical streams including dementia and other non-malignant conditions. While palliative care can be personally rewarding it can also be emotionally demanding. A continued focus is required on training pipelines, retention strategies, role optimisation and access to supervision and professional support.

Each part of the workforce has different training needs. A tiered capability model is required, with most workers needing core palliative care skills. Primary care teams, other specialist clinicians, and aged care nurses will need more advanced capabilities, while specialist palliative care teams continue providing expertise for more complex care. This structured approach will build a more interconnected and capable workforce. A range of Commonwealth funded, high-quality education and training programs are available to help build to support workforce uplift and should be systematically embedded across services.[6]

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5. Advanced Specialised Training from the Australian College of Rural and Remote Medicine (ACCRM) and the Clinical Foundation in Palliative Medicine from the Royal Australian College of Physicians (RACP).
6. End of Life Essentials, Palliative Care Curriculum for Undergraduates (PCC4U), the general and indigenous Program of Experience in the Palliative Approach (PEPA and iPEPA) and End of Life Law for Clinicians.

Consistent assessment of need and use of validated clinical tools can support earlier identification of palliative care needs and appropriate escalation across settings. These tools can assist practitioners to recognise when specialist palliative care input is required and support clear decision-making and more reliable coordination of care. A key example that can be adopted across sectors is the Care Plan for the Dying Person–Victoria, which provides a standardised, system-wide approach to end-of-life care across hospital and community settings. It supports early recognition of dying, guides timely review of care, and helps document a person's wishes. Wider use and more consistent uptake will support workforce confidence and ensure best practice.

What the evidence tells us

In 2023, healthcare staff across Australia, including close to 80 Victorian practitioners, provided insights into their experience in providing palliative care. Some key insights were:

- Around 2/3 of practitioners reported low or average confidence in their knowledge of legal rights and responsibilities around palliative and end of life care.
- Around 1/2 of practitioners reported low or average confidence in coordinating community-based palliative care.
- Around 1/2 of medical specialists' report confusion about who is responsible for care.

Top 5 information needs

60%	60%	52%	47%	44%
Myth-busting – debunking misconceptions around palliative care	**Conversation coaching**	**Information on Allied Health support**	**Best-practise palliative care treatments**	**Understanding regulatory and legal framework**
Content to explicitly challenge and empower health care professionals conversations.	Improve and ease difficult conversations.	Increased awareness of resources across ecosystem.	Increased understanding of what care to provide. Palliative care professionals have the greatest need.	Increased confidence that they are doing the right thing. One third have ethical issues arising from care.

– Commonwealth Department of Health, Disability and Ageing, 2023

Challenges in the current system

- Demand for palliative care is rising, and the specialist workforce is small and not evenly distributed across the state. Future needs cannot be met by specialist workforce growth alone. Capability must be strengthened across the whole system so specialist expertise can be used in the most targeted and efficient way.
- Planning is constrained by limited visibility of existing palliative care skills and capacity across services and sectors. Funding for specialist palliative care does not always reflect the workforce composition and mix of disciplines needed in different regions. Better workforce insight—covering roles, location, and capability—would support smarter planning and fairer access.
- While medical specialisation pathways are well established, clearer development pathways are needed for palliative care nurses and allied health. There is a need to build capacity and a way to connect with palliative care sub-speciality expertise. Paediatrics is an example, but other areas need similar support such as gerontological nurses.
- General practitioner capability in palliative care is growing, but most GPs work in the private sector and are not consistently connected to public palliative care services. Better integration and recognition would improve coordination and continuity of care.
- Variation in access to workforce and support services (e.g. personal care, nursing) across different accommodation settings makes it harder for some people to remain at home or in the community. More equitable models are needed to support choice and consistency of care.

Quotes from the 2025 engagement

'We expect everyone to do palliative care but don't provide enough leadership or education to do it.'

– Palliative care service provider

'Important to understand there are nuances with people receiving care as well as nuances within the workforce with discrete needs with respect to education and support.'

– National disability service provider

'The quality of palliative care provided to residents in aged care is directly linked to the knowledge and competence of the GP clinician.'

– National aged care provider

'Many health care professionals regularly provide care to people with serious illness yet with few exceptions they receive no formal training in palliative care (including how to communicate effectively).'

– Palliative care researcher

Opportunities for change

- Promote palliative care as a rewarding career to attract and retain a strong workforce, while expanding culturally responsive training and clear development pathways across all sectors.
- Enable flexible, interdisciplinary specialist palliative care teams with clear roles and optimal composition, supporting clinicians to work to their full scope and deliver high-quality care, for example nurse prescribing.
- Support models of care with advanced and dual-trained clinicians to help meet growing palliative care demand, especially in regional Victoria. Provide structured leadership and mentoring from specialist palliative care teams.
- Enable participation by palliative care specialists in multidisciplinary team meetings using virtual platforms, prioritising cases, sharing documentation and adopting flexible team structures.
- Ensure models of care support sectors with high workforce turnover. Provide coaching at the time of need and embed flexible palliative care approaches to help workers identify and respond to end of life needs for people, carers and families.

Actions

4.1 Increase use of 'Care Plan for the Dying Person–Victoria' to support consistent best practice across the system, so that people receive high quality care no matter who is providing it.

4.2 Collect better data on workforce skills, training and distribution to enable best use of existing resources and grow capability so the increasing palliative care needs of Victorians can continue to be met into the future.

4.3 Encourage the uptake of palliative care training and skill development pathways by the broader health workforce. [subject to future funding decisions by government]

Priority direction 5 – Enhance innovation, digital capability, and use of data

Better using technology to deliver best practice care, everywhere

Strengthening data and digital capability across the Victorian palliative care system will support a modern approach to care that can continue to meet people's needs. Better insights into care will enable smarter planning, give clinicians timely information for decision making, and help providers innovate and work together more effectively. Enhancing digital care, improving access to high quality data, and supporting innovation and evaluation will ensure the system continues to adapt and improve over time.

Victoria has comprehensive palliative care activity data for some settings and has continued to make improvements by updating key health datasets and death certificates. These changes will help us better understand place of death, people's care preferences, clinical urgency, and people's experience of care. However, information gaps remain, hindering progress and adequate resourcing across the system, particularly for palliative care outpatient and consultancy interactions.

Understanding people's care journey and outcomes remains complex given people can cross multiple settings over time, and noting the split in state and Commonwealth data responsibilities. National work led by the Australian Institute of Health and Welfare, including the Palliative Care and End-of-life Care Information Priorities 2022 and the National Palliative Measures 2024 are closing some reporting gaps. Key sector representatives and Victoria are active partners in this work. These early steps are laying the groundwork for lasting change, providing opportunities to better bridge system learning across Australian jurisdictions.

Poor visibility of the breadth of care provided in the community, including by GPs through the Medicare system or navigation and coordination activities delivered by community-based palliative care providers, remains a challenge to be addressed.

Aligning planning with the Local Health Service Network clinical planning processes and priorities will help create a more connected system that responds to community expectations. Working closely with Primary Health Networks and sector partners will ensure services respond to community need. This creates an opportunity to design care that genuinely reflects community expectations, including for carers, First Peoples and other priority groups. A clearer picture of who needs care, where best to receive it, and where gaps remain is critical.

Digital innovation is also transforming how Victorians access care. The Victorian Virtual Care Strategy 2023 is expanding access to services. Initiatives such as the Safer Care Victoria Assisted Self Management pilot 2025 show how people with chronic conditions can use self-monitoring to actively participate in their care and stay well at home. A stronger digital presence in palliative care will make support easier to access, especially for people who want to remain at home. Virtual consultations and online teamwork can enable better sharing of specialist expertise. This will provide faster support, reduce avoidable hospital visits, strengthen help for carers, all while boosting service capacity.

Victoria's providers and researchers are showing strong leadership and dedication to improving palliative care. Participation in the national Palliative Care Outcomes Collaborative is helping to lift care quality. Victorian clinicians also developed the internationally validated RUN-PC Triage Tool which is now improving clinical prioritisation of palliative care patients. However, neither are used universally across the state. Earlier intervention models such as the Care Plus Model are also showing positive impacts but there are opportunities to increase scale. Many other innovations are emerging across the state. Supporting research, innovation, translation, evaluation and sharing of insights are essential for an effective learning system.

What the evidence tells us

The gaps in national data are likely to impact service planning and monitoring as the sector evolves in response to changing demand. With the increasing recognition of palliative care and end-of-life care as a key social and health issue, the development of comprehensive national information to inform policy and program development is essential.

– National Palliative Care and End-of-life care Information Priorities Document, AIHW 2022

Challenges in the current system

- Emerging models and best practices are not always systematically evaluated or shared, making it harder for the service system to scale, embed and sustain continuous improvement.
- Siloed reporting, gaps in palliative care data quality and coverage, along with fragmented data collections limit the ability to generate reliable insights on people's care journey, outcomes and equity of access. This reduces visibility of need and resourcing across the system.
- Fragmented digital systems and limited interoperability make real-time data sharing and coordination difficult, reducing clinical decision support and limiting system-wide insights. Uneven adoption of virtual care highlights the need for consistent and effective integration.
- Complex patterns of service use and split responsibilities between the Commonwealth and Victorian government make it difficult to understand care pathways. There is also complexity in generating insights into where innovations or improvements are having the greatest impact.

Quotes from the 2025 engagement

'Siloed, non-integrated systems block interoperability and benchmarking, undermining accurate cost capture and the alignment of funding to activity. The path to a resilient community palliative care service system includes extending shared data platforms and integration – digital transformation.'

– Project partner

'Improve electronic records/information sharing across all the disjointed health networks. A colossally large number of person-hours (paid and unpaid) are wasted every day to chase correspondences between individual public health networks.'

– Palliative Medicine Physician

Opportunities for change

- Use shared, system-focused measures to drive improvement across the system, such as patient experience and outcomes, time spent at home in the last 100 days of life, reduced hospital admissions and non-beneficial treatments.
- Strengthen collaborative learning by systematically identifying, evaluating, scaling and sharing innovative care models and best practice. This will turn evidence into action and build capability across the sector.
- Invest in data linkage to unify fragmentated palliative care data into an action-focused framework that informs decisions and insights for continuous improvement. Capture the full scope of palliative care activity and outcomes across all settings to guide planning and improve quality, which links effort to measurable outcomes.
- Boost virtual care and digital tools to improve access and coordination—delivering 24/7 support. Give clear guidance on what to use, when, and how, so choices lead to better outcomes.
- Work with the Commonwealth to close data and reporting gaps, improve visibility of unmet need and preferences, support equitable models of care, and strengthen awareness and engagement with communities and priority groups.

Actions

5.1 Undertake a palliative care data enhancement project to improve visibility of the full range of service delivery across the system and to better meet the needs of all Victorians.

5.2 Develop a new palliative care data governance framework to support systematic sharing and monitoring of data to drive improvement, so that all Victorians can benefit from innovations in service delivery.

5.3 Services should increase the use of telehealth and other digital tools to improve service capacity and accessibility for people, their families and carers. [subject to future funding decisions by government]

Conclusion

Victoria's population is growing, ageing and becoming more diverse, increasing demand for responsive and inclusive palliative care. Changing household structures mean services must look beyond traditional carer-centric assumptions and strengthen broader community supports.

Community expectations are changing. People want community-based care that supports people, carers and families including strategies to reduce avoidable hospital admissions when death is imminent. At the same time, people are living longer with life-limiting conditions and can experience extended periods of stability before their condition deteriorates again. As a result, palliative care must shift from linear referral pathways to flexible, dynamic models that allow people to move in and out of services as their needs change.

Several significant enablers will help support this shift including:

- Earlier, routine conversations so people's wishes are known, they feel prepared for care at home and are supported by trusted clinicians and loved ones.
- Clearer, more consistent information that builds on existing community understanding and improves how the health system explains palliative care to people.
- More responsive models such as parallel care pathways, building palliative care capacity within other disciplines, and flexible ways to bring specialist palliative expertise into other teams.
- Explicit escalation pathways to specialist palliative care teams and strong shared care models so people spend more of their last 100 days at home.
- More use of self-monitoring and other digital tools to improve access for people, carers and families, supporting independence and enabling rapid escalation when required.

Victorian and Commonwealth system reforms are also creating new opportunities for people to stay well at home for longer. New funding and care models are strengthening the role of primary and community care and supporting new approaches to shared care. Together, these reforms mean palliative care must evolve in step with the broader system.

Victoria is building a more responsive, integrated health system. Realising this shift requires stronger integration across disciplines, genuine partnership models, clear triggers for palliative conversations, and consistent pathways to specialist involvement. These changes will help people experience seamless, coordinated care wherever they receive support

Victoria's focus is a workforce that is well-designed, interconnected, supported, and sustainable. Strengthening capability, role clarity and confidence across the whole service system is essential to deliver palliative care at scale. This will complement the expertise of Victoria's specialist palliative care teams and clinicians by ensuring specialist input is used where it adds most value.

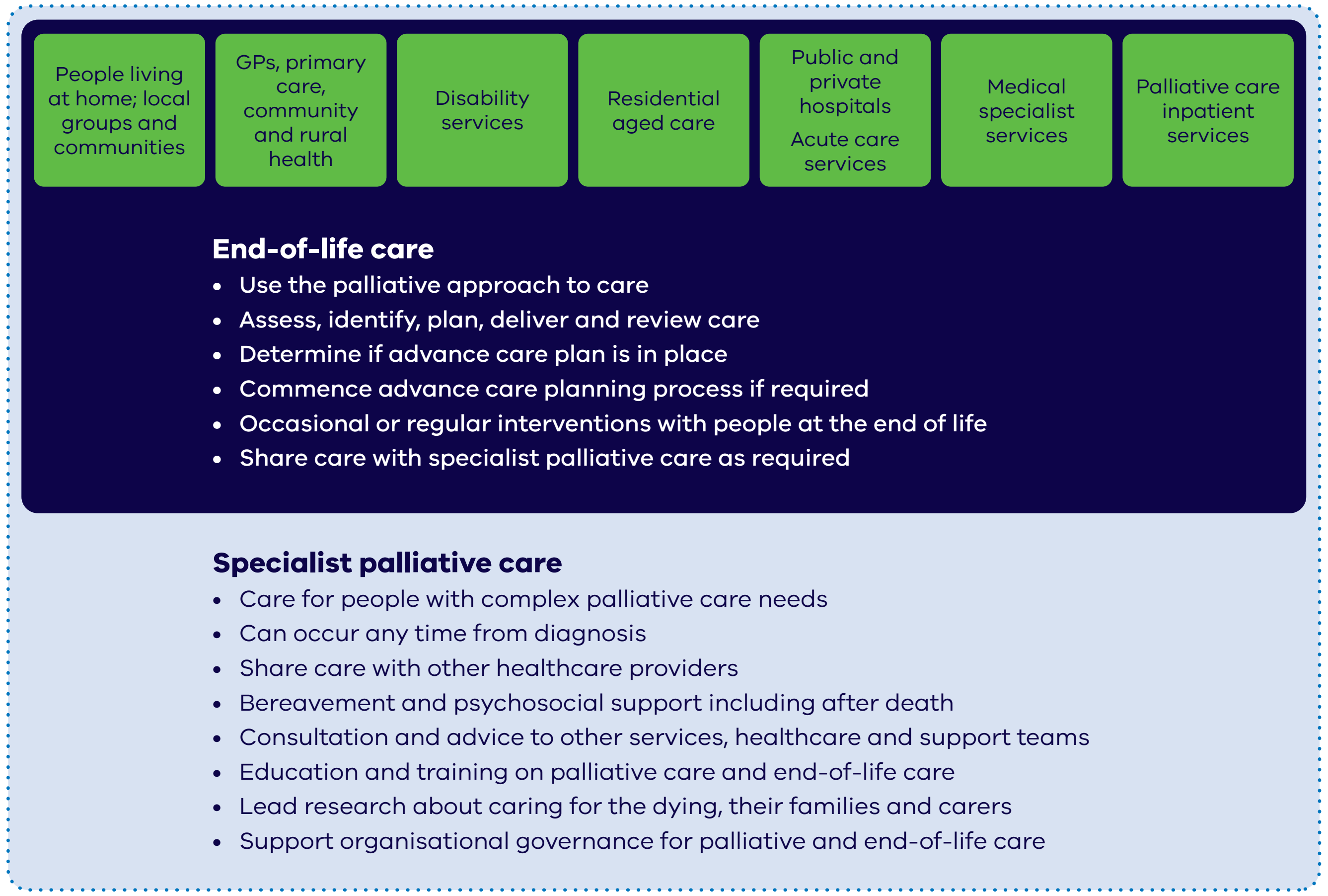
The future of palliative care in Victoria is modern, locally responsive models that keep pace with population change. These models must strengthen community-based care and embed digital and virtual options as everyday practice.

Above all, the system must support a small, skilled specialist workforce to work at the top of scope within strong interdisciplinary teams. This must be backed by a broader care system with the understanding, knowledge and confidence to deliver core palliative care services appropriately and to initiate conversations about future care. Building this wider capability helps ensure people receive safe, high-quality care at home and in their communities.

By strengthening partnerships and improving pathways across providers and specialties, Victoria can build a more connected palliative care system. Clearer roles and earlier specialist involvement will support smoother transitions. This is the foundation of a modern, person-centred palliative care system for all Victorians.

Appendices

End-of-life care across the service sectors (from the 2016 Framework)



End-of-life care

- Use the palliative approach to care
- Assess, identify, plan, deliver and review care
- Determine if advance care plan is in place
- Commence advance care planning process if required
- Occasional or regular interventions with people at the end of life
- Share care with specialist palliative care as required

Specialist palliative care

- Care for people with complex palliative care needs
- Can occur any time from diagnosis
- Share care with other healthcare providers
- Bereavement and psychosocial support including after death
- Consultation and advice to other services, healthcare and support teams
- Education and training on palliative care and end-of-life care
- Lead research about caring for the dying, their families and carers
- Support organisational governance for palliative and end-of-life care

Resources in Victoria

End of life and palliative care information at better health website, <www.betterhealth.vic.gov.au>.

Victorian Office of the public advocate, <https://www.publicadvocate.vic.gov.au/medical-treatment>.

Palliative Care Victoria, <https://www.pallcarevic.asn.au/>.

Department of Health palliative care program, <https://www.health.vic.gov.au/end-of-life-care/palliative-care-program>.

Safer Care Victoria, Palliative Care Resources, <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/palliative>.

Other related frameworks and plans

Department of Health, Department of Health Strategic Plan 2023–2027 <https://www.health.vic.gov.au/our-strategic-plan-2023-27>.

Department of Health, Victorian Cancer Plan 2024–2028 <https://www.health.vic.gov.au/victorian-cancer-plan>.

Department of Health, Virtual Care Strategy 2023 <https://www.health.vic.gov.au/victorian-virtual-care-strategy/overview>.

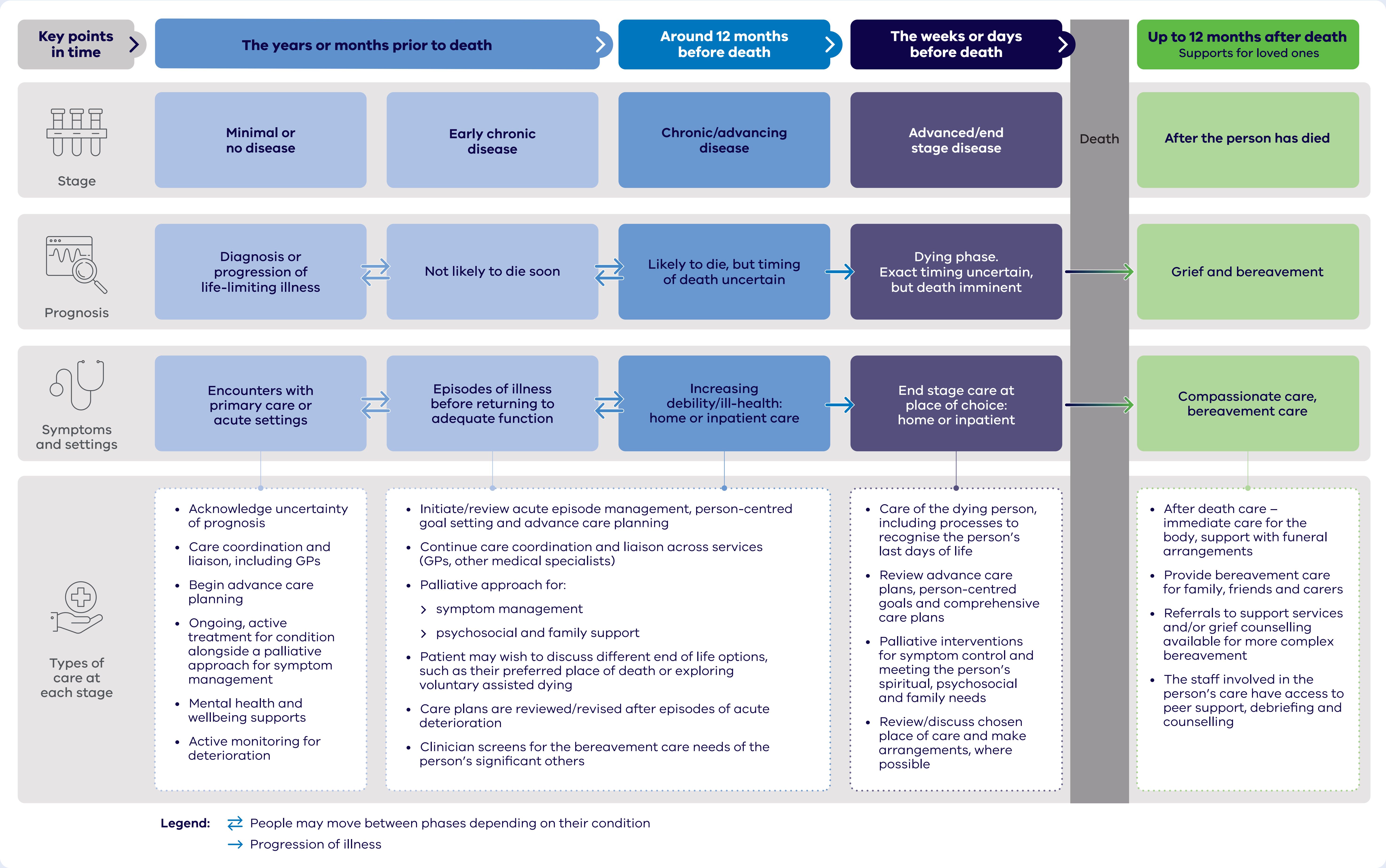
Department of Health, Victorian Health Workforce Strategy 2024 <https://www.health.vic.gov.au/victorian-health-workforce-strategy>.

Department of Families, Fairness and Housing, Victorian Carer Strategy 2025–2035 <https://www.dffh.vic.gov.au/publications/victorian-carer-strategy-2025-2035>.

Safer Care Victoria, Care Plan for the Dying person – Victoria <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/palliative/care-plan-for-the-dying-victoria>.

Safer Care Victoria, Palliative (end of life) neonatal care <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/neonatal/palliative-end-of-life-neonatal-care>.

The disease spectrum: The stages of care and triggers at different points in time



Key points in time	**The years or months prior to death**		**Around 12 months before death**	**The weeks or days before death**		**Up to 12 months after death** Supports for loved ones
Stage	**Minimal or no disease**	**Early chronic disease**	**Chronic/advancing disease**	**Advanced/end stage disease**	Death	**After the person has died**
Prognosis	Diagnosis or progression of life-limiting illness ⇄	Not likely to die soon ⇄	Likely to die, but timing of death uncertain →	Dying phase. Exact timing uncertain, but death imminent →		Grief and bereavement
Symptoms and settings	Encounters with primary care or acute settings ⇄	Episodes of illness before returning to adequate function ⇄	Increasing debility/ill-health: home or inpatient care →	End stage care at place of choice: home or inpatient →		Compassionate care, bereavement care
Types of care at each stage	• Acknowledge uncertainty of prognosis • Care coordination and liaison, including GPs • Begin advance care planning • Ongoing, active treatment for condition alongside a palliative approach for symptom management • Mental health and wellbeing supports • Active monitoring for deterioration	• Initiate/review acute episode management, person-centred goal setting and advance care planning • Continue care coordination and liaison across services (GPs, other medical specialists) • Palliative approach for: › symptom management › psychosocial and family support • Patient may wish to discuss different end of life options, such as their preferred place of death or exploring voluntary assisted dying • Care plans are reviewed/revised after episodes of acute deterioration • Clinician screens for the bereavement care needs of the person's significant others		• Care of the dying person, including processes to recognise the person's last days of life • Review advance care plans, person-centred goals and comprehensive care plans • Palliative interventions for symptom control and meeting the person's spiritual, psychosocial and family needs • Review/discuss chosen place of care and make arrangements, where possible		• After death care – immediate care for the body, support with funeral arrangements • Provide bereavement care for family, friends and carers • Referrals to support services and/or grief counselling available for more complex bereavement • The staff involved in the person's care have access to peer support, debriefing and counselling

Legend:
⇄ People may move between phases depending on their condition
→ Progression of illness

What to expect from advance care planning at different points in time

Advance care planning allows you to clearly express your preferences to inform future medical treatment and care, in the event you become unable to participate in those decisions in the future.

Key points in time	**The years or months prior to death**		**Around 12 months before death**	**The weeks or days before death**	Death
Stage	**Minimal or no disease**	**Early chronic disease**	**Chronic/advancing disease**	**Advanced/end stage disease**	
People may be prompted to initiate ACP discussions after...	• Regular GP health check • Completion of will • Admission to a hospital • Death of a loved one	• GP visit for the condition • Diagnostic procedure • Episodes of illness related to the chronic condition • Admission to a residential care facility	• Relapse of their condition • Progression of disease or cessation of treatment • Multiple hospital admissions due to advancing illness	• Rapid deterioration of their condition • Significant progression of disease • Hospital admissions due to symptom distress in last stage of life	
As part of these ACP discussions, you might...	• Identify if an advance care plan already exists • Start thinking and talking about your values and goals • Consider appointing a substitute decision-maker as medical power of attorney	• Identify your values, beliefs and preferences for care • Record these preferences as a written advance care directive (legally recognised document)	• Identify your treatment and care preferences, and any preferred outcomes **Once it is in effect**, your advance care plan will: • Clearly inform clinical decision-making; and • Any disease-specific goals of care will align with and support your plan.	At this stage, your advance care plan will: • Inform specific goals of care; and • Inform the care and support of family, friends and carers, both before and after death.	

What palliative care was delivered in Victoria 2016–25

The Victorian Government funds a statewide network of specialist palliative care providers, including statewide services such as the Victorian Palliative Care Advice Service, inpatient (admitted) palliative care services, community palliative care services, and metropolitan and regional consultancy services. The Victorian Government also funds palliative care consortia to foster collaboration and networking for service providers delivering palliative care in each region.

SPECIALIST INPATIENT PALLIATIVE CARE (PUBLIC)[1,2]

Admission numbers

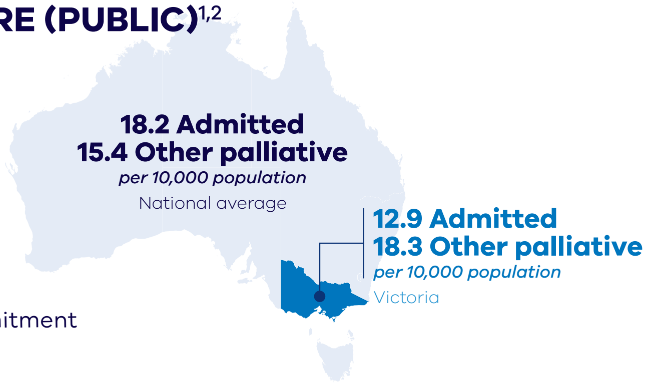
2% annual growth

7,636	2016
9,285	2025

Average length of time in hospital

2% annual decline

2016 12.0 days > 2025 9.5 days



18.2 Admitted
15.4 Other palliative
per 10,000 population
National average

12.9 Admitted
18.3 Other palliative
per 10,000 population
Victoria

People are spending less time in admitted care, reflecting the Victorian Government's commitment to improve access to care outside hospital.

COMMUNITY PALLIATIVE CARE[1]

Number of referrals

7% annual growth

12,599	2016
21,204	2025

Number of contacts

3% annual growth

482,207	2016
618,158	2025

Referral numbers are higher than the number of new clients accepted each year after clinical review.

TOP SOURCES OF REFERRAL

Inpatient palliative care[1]
is strongly connected to public hospital and community palliative care services

Other public hospital teams	30%
Public hospital medical units	25%
Community palliative care	22%
Hospital-based palliative care teams	13%
Other sources	10%

Community palliative care[1]
has many different types of referrers

Hospitals	29%
Specialist	17%
Other health professional service	14%
GP	14%
Aged care	9%
Community based services	5%
Other	3%
Hospital palliative care services	3%
ED/Ambulance	0%

EXPERIENCE OF CARE, 2024[3]

Question: *'Overall, how would you rate the support you received from your palliative care service?'*

Community palliative care

Clients	Carers	Bereaved carers
97%	93%	90%

Inpatient palliative care

Patients	Carers
98%	98%

These consumer responses indicate that overall, most people rate their experience of palliative care services as either 'good' or 'very good'.

Sources:
1. Department of Health Victoria 2025, Service activity data
2. Australian Institute of Health and Welfare 2024, Palliative Care Services in Australia
3. Department of Health Victoria 2024, Victorian Healthcare Experience Survey data
4. Department of Health Victoria 2026, Service activity data
5. National Health Workforce Data Tool, 2025

VICTORIAN PALLIATIVE CARE ADVICE SERVICE[1]

Over 5,200 calls
received by VPCAS since mid-2020 to end 2025

VPCAS is staffed by experienced clinicians with **specialist** palliative care training

80% Most callers are **first time users** of the VPCAS

Callers are made up of:

Family, friends	Clinicians	Other
45%	47%	8%

Who seek advice for:

- Symptom management and medication
- Service locations, referral
- After hours guidance

VICTORIAN VIRTUAL EMERGENCY DEPARTMENT[4]

Of all calls to the VVED in 2024–25 a total of **1,488 calls** were palliative care-related, mostly from aged care homes (75%)

PALLIATIVE CARE WORKFORCE[5]

Palliative medicine physicians

74% growth

50	2016
87	2024

Paediatric palliative medicine physicians

0% growth

3	2016
3	2024

Palliative care nurses

21% growth

989	2016
1,193	2024

Notes:
1. Clinicians employed and working in Victoria.
2. Includes all nurses who report working in palliative care and not just those employed in Victorian palliative care services.
3. The workforce data does not capture other practitioners in our funded palliative care service system.

Victoria's specialist palliative care services

The Victorian Palliative Care Advice Service is staffed by specialist clinicians and operates daily from 7am to 10pm. The service helps all Victorians navigate palliative care with confidence.

- **Current picture:** Since launching in May 2020, the service has had steady year on year growth and strong reach across the state. Caller survey responses indicate that without it, some callers would not know what to do (16%) or would turn to emergency services such as 000 or hospital care (21%). This demonstrates the service's valuable role in providing timely, appropriate, and effective palliative care support.

Inpatient (admitted) palliative care services are available in select hospitals across Victoria for people with advanced illness or more complex needs. Hospital teams can provide intensive help to stabilise health, manage symptoms, and improve comfort. This type of care acts as a safety net when care at home is no longer possible.

- **Current picture:** Victoria has fewer inpatient palliative care admissions compared with the national average, with specialist palliative care beds accounting for just 0.4% of all hospital admissions. This reflects Victoria's strong focus on care at home whenever possible. New approaches are shortening hospital stays and giving people more options to stay at home, such as planned rapid discharge, admitted care at home, and hospital-in-the-home. More consistent access to flexible models will mean less time in hospital and improved experiences of care. At the same time, Victoria has a higher than the national average for the 'other palliative care hospitalisation types' which reflects palliative care provided in other parts of the hospital such as on the acute ward.

Community palliative care services are central to Victoria's care at home system and have been for over 20 years. Providers help people remain at home with compassionate, proactive support. Community palliative care provides home-based, family-centred specialist consultancy services, including telehealth options, after hours client and carer support, bereavement support, and sometimes aids and equipment.

- **Current picture:** Referrals to community palliative care are growing, particularly in Melbourne. While referrals have increased by 7% annually, growth in accepted clients is comparatively modest at 3% annually. This increase reflects higher demand and a growing number of referrals that do not meet acceptance criteria or are duplicate referrals. These inappropriate referrals add pressure to services, can delay access to suitable care, and may discourage people from seeking help again if they are not accepted the first time around. Clients who are accepted often have more complex needs, requiring longer, more intensive support and stronger service collaboration.

Metropolitan and regional consultancy services and earlier intervention outpatient models provide specialist advice and direct care, enabling interventions that prevent avoidable admissions, timely bedside support, and rapid discharge. Regional teams extend this capability across rural areas to support more home-based care, through either direct care or secondary consultations with other clinicians.

- **Current picture:** Availability of consultancy services varies significantly across Victoria. Some areas have 7-day specialist coverage and some have more limited coverage, particularly in regional areas. These differences do not necessarily reflect community needs. Further, some gaps in data collection make it hard to fully understand service demand and delivery.

Statewide services include the Victorian Paediatric Palliative Care Program and Very Special Kids, which support children and young people; MND Victoria, which provides comprehensive, multidisciplinary palliative support for people with motor neurone disease; Grief Australia, which delivers the statewide specialist bereavement service; and the Aboriginal Palliative Care Program, which promotes collaboration between mainstream palliative care providers and Aboriginal Community Controlled Organisations. Palliative Care Victoria, as a statewide service provides community awareness, cultural community and volunteer engagement, and the statewide directory of palliative care services to assist in navigation and understanding of palliative care across the Victorian community. Palliative Care Victoria also provides telephone support to community members and the sector, receiving an average of 285 calls per year.

Victorian Virtual Emergency Department (VVED)

In 2024–25, the VVED received 1,488 calls related to palliative or end-of-life care, representing around 0.6% of all calls to the VVED. Nearly all palliative care related calls came from residential aged care homes (75%). Of these calls, around 9% were from Ambulance Victoria infield paramedics attending the residential aged care home. A further 19% of all calls were from Ambulance Victoria infield paramedics in the community and 3% were self-referral to the VVED. The VVED provides support for end of life discussions and acute medication management, including interim prescriptions, and ensures continuity of care with primary providers, Residential In Reach services, and community palliative care teams.

Workforce

Victoria benefits from a skilled, committed, and compassionate specialist palliative care workforce. Specialist doctors and nurses deliver vital care across hospitals and the community. However, the workforce is small, unevenly distributed, and shared across multiple providers in complex ways. Most specialist staff are based in metropolitan Melbourne, leading to capability gaps in some regions.

There is likely more capacity in the system, with some doctors and nurses being dual-qualified or having advanced training and expertise in palliative care. Workforce data available through the National Health Workforce Data (NHWD) tool does not distinguish nurse practitioners, and may overestimate public sector capacity, as some palliative care nurses work in private or community organisations. Current data also does not reflect the diversity of clinicians, practitioners, and care workers who support people at the end of life.

Patient experiences and outcomes

Consumer voice is captured via **Victorian Palliative Care Experience Surveys**. These surveys align with Safer Care Victoria's Partnering in Healthcare Framework. They focus on what matters to consumers: communication, inclusion, shared decisions, personalised care, and quality of care. People using palliative care services report that they are consistently treated with fairness, respect, and dignity. The results also show clear opportunities to strengthen shared decision making and improve conversations about care options, including how family and loved ones are involved.

The **Palliative Care Outcomes Collaborative (PCOC)** is a voluntary national initiative that helps improve clinical care and outcomes. Many, but not all, Victorian providers currently participate. PCOC's 20 patient and clinician reported measures show that Victorian providers perform strongly in timely care, urgent symptom response, and anticipatory support for mild symptoms. There is scope to strengthen responsive care for people with moderate to severe symptoms, noting some symptoms persist even with best practice.

Glossary

Actively dying (terminal phase)[6]	The terminal phase of life, where death is imminent and likely to occur within hours or days, or occasionally weeks.
Advance care planning[6]	A process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions. Registered and non-registered health practitioners have a role in advance care planning and require capability to facilitate these conversations effectively. The National Quality Standards for aged care, general practice and health services all promote advance care planning. Individuals can also choose to engage in advance care planning with other non-health practitioners, and friends or family.
Advance care directive[6]	A voluntary, person-led document completed and signed by a competent person that focuses on an individual's values and preferences for future care decisions, including their preferred outcomes and care. Advance care directives are recognised by specific legislation (statutory) such as the Victoria's *Medical Treatment Planning and Decisions Act 2016* or under common law (non-statutory). They come into effect when an individual loses decision-making capacity.
Bereavement[30]	Refers to the time after the death of a person with whom there has been an enduring relationship.
Capability framework[24]	A tool that describes the requirements within specific clinical streams to provide progressively higher (more complex) levels of care in terms of the scope of service, skills, experience and capacity of the workforce, the infrastructure and equipment requirements and clinical support services.
Carer[6]	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal, chronic or mental illness), or because they are frail and aged. An individual is not a carer merely because they are the spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care.
Child and young person[14]	A child is an individual aged 0 to 17 years. A young person is an individual aged 18 to 21 years.
Consumer[46]	Consumers include people, families, carers and communities who are current or potential users of health services.
Diversity[6]	The varying social, economic and geographic circumstances of consumers who use, or may use, healthcare services, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.
End of life[6]	The period when a person is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of persons with chronic or malignant disease, or very brief in the case of persons who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.
End-of-life care[6]	Includes physical, spiritual and psychosocial assessment, and care and treatment delivered by healthcare workers. It also includes support of families and carers, and care of the patient's body after their death. People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with: • Advanced, progressive, incurable conditions. • General frailty and coexisting conditions that mean that they are expected to die within 12 months. • Existing conditions, if they are at risk of dying from a sudden acute crisis in their condition. • Life threatening acute conditions caused by sudden catastrophic events. This describes the care delivered to people with progressive, incurable illness to live as well as possible until they die. It allows the supportive and palliative care needs of both the patient and their family to be identified and met using the palliative approach to care for approximately the last 12 months of life.
Equity in healthcare[47]	Equity in healthcare means that all people receive care of equal quality that is safe, effective and is responsive to their individual needs, culture, language, ability, experience and preferences. This does not mean that everyone receives the same care, but rather that all persons have their healthcare needs equally well met, including through removing differences in the quality, safety and accessibility of opportunities, services and rights between groups of people.

Family[6]	The term family includes people identified by the person as family. This may include people who are biologically related, however it may not. People who joined the family through marriage or other relationships, such as kinship, chosen family, street family for those experiencing homelessness, friends, and pets may be identified by the person as family.
Healthcare worker[6]	A person working in health, community or aged care settings. This includes registered health practitioners, other health practitioners, carers. Support staff in these settings (such as those in administration or cleaning) are not considered healthcare workers in this consensus statement.
High-quality care[46]	High-quality care is safe, timely, effective, efficient, equitable and person-centred care. Where each element is defined as: • Safe – actively prevent avoidable harm. • Timely – reduce wait times and other harmful delays in diagnosis and treatment and ensure employees have timely access to critical resources. • Effective – deliver appropriate and connected care in the right way at the right time, with the right outcomes, for every consumer. • Efficient – eliminate avoidable waste, including waste of time, equipment, supplies, ideas, and energy.
LGBTQIA+	This refers to people who identify as lesbian, gay, bisexual, transgender, intersex, queer, and asexual people often referred to collectively as the LGBTQIA+ community.
Life-limiting illness[19]	A person with life-limiting illness may die prematurely. This term is often used for people living with a chronic condition that may seem life-threatening but can continue for many years or even decades.
Life-threatening illness[19]	This refers to a person with life-limiting illness who is likely to die prematurely. Often used when referring to children or adults who have an illness with a poor prognosis and their life span may be considerably shortened.
Non-beneficial treatment[6]	Interventions that will not be effective in treating a person's medical condition or improving their quality of life. Non-beneficial treatment may include interventions such as diagnostic tests, medicines, artificial hydration and nutrition, intensive care, and medical or surgical procedures. Non-beneficial treatment is sometimes referred to as futile treatment, but this is not a preferred term.

Palliative approach to care/ palliative care[55]	An approach to care that improves the quality of life of people and their families facing life-limiting illness by preventing and relieving suffering. It involves early identification, and assessment and treatment of pain and other problems (physical, psychosocial, and spiritual).
Palliative care consultancy[19]	Working with the client's treating team, palliative care consultancy provides specialist insight, advice and support for both clients and families, and other healthcare providers. This can be hospital, community based or virtual care or phone support.
Person-centred care[6]	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients. Person centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Also known as patient centred care or consumer centred care.
Priority populations (2016 Framework)[19]	Aboriginal and Torres Strait Islanders, people in rural areas, LGBTQIA+ community, people from culturally and linguistically diverse communities, Forgotten Australians, people with conditions other than cancer and those with a disability, a mental health condition or who are homeless. Forgotten Australians refers to orphaned child migrants who arrived in Australia during the 1920s – 1960s. The Prime Minister offered a formal apology to this group in 2009, and they have become known as 'Forgotten Australians'.
Quality of care[6]	The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people centred.
Shared decision-making[6]	A discussion and collaboration between a person and their healthcare worker that brings together the person's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person. The person may also be the parents for a child, or the Medical Treatment Decision Maker (MTDM) for an adult who has lost capacity.

Specialist palliative care[30,39]	Services with a dedicated focus on palliative care and delivered or overseen by a clinician with advanced training and expertise in palliative care. These services provide direct care for people with complex needs and support navigation to the most appropriate care. They mentor and guide other clinicians and care workers to deliver the palliative approach to care. This support includes consultation, education, clinical advice, assistance with ethical dilemmas, and strengthening organisational governance for end-of-life care.
Voluntary Assisted Dying (VAD)[25]	VAD is an option for some people in the late stages of advanced disease. If assessed as eligible, a doctor can prescribe medication that will bring about their death. A person's decision to ask for VAD must be: • voluntary (the person' own decision) • consistent (the person makes three separate requests) • fully informed (the person is well-informed about their disease, treatment and palliative care).

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