phn EASTERN MELBOURNE

An Australian Government Initiative

Palliative Care Needs Assessment

15 December 2025

Acknowledgement

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present EMPHN is committed to the healing of country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

Disclaimer

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Executive summary

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

Methodology

This PCNA draws on a mixed-methods approach combining quantitative and qualitative evidence. Quantitative analysis used population, mortality, hospitalisation, primary care, aged care and service utilisation data, focusing on trends from 2013–2024 (mortality) and 2019–2025 (service and workforce indicators). Data were analysed at an EMPHN and LGA level to identify trends, geographic variation and equity gaps. A consumer and carer survey was used to provide direct insight from service users and carers, adding depth to understanding palliative care needs across the region. Complementary qualitative insights were obtained through targeted consultations held in November–December 2025, with stakeholders across residential aged care homes (RACHs), ACP providers, specialist and community palliative care services, in-reach and advice services, GPs and primary care representatives. Stakeholder input was thematically analysed and triangulated with quantitative findings to validate patterns, explain observed variation and identify feasible, system-level opportunities for improvement.

EMPHN's PCNA Key Findings

The EMPHN palliative care system is under intensifying pressure. A rapidly ageing and culturally diverse population, rising chronic disease, increasing multimorbidity and uneven service distribution are driving demand growth that is outpacing current workforce, funding and digital capability.

Below provides a consolidated summary of the PCNA findings, key drivers of demand and considerations for palliative care services in the EMPHN catchment.

- **Demographic change is accelerating demand complexity and widening inequities.** Rapid population ageing, growing cultural diversity and rising multimorbidity are increasing palliative care needs and complexity. These shifts also create a clear opportunity to strengthen culturally responsive models and targeted outreach to improve equity for CALD, First Nations and outer-region communities.
- **Disease patterns are shifting toward chronic, progressive and non-malignant conditions, intensifying care needs**. Rising dementia, frailty and chronic organ failure are driving more complex, long-term care needs. Earlier identification and referral present an opportunity to reduce avoidable symptom burden, improve quality of life, and better align care with patient goals.
- **Demand and acuity are rising faster than system capacity, creating widening gaps in timely care**. Rising referrals, greater multimorbidity and strong preference for home care exceed current workforce and service capacity; non-admitted activity is growing fastest. This

trend provides an opportunity to rebalance services toward community-based, multidisciplinary and flexible models of care.

- **Workforce pressures underscore the importance of capability building and shared-care models.** Workforce shortages, uneven skills and emotional burden affect consistency of care. At the same time, there is strong potential to expand generalist palliative care capability across primary care, aged care and community settings, supported by specialist expertise.
- **Digital fragmentation highlights a clear opportunity to improve safety and coordination through better information-sharing.** Hybrid paper–electronic systems and inconsistent digital adoption result in incomplete access to ACPs and care plans, particularly during transitions of care.
- **Late access and after-hours gaps presents an opportunity for improvements in comfort, carer support and system efficiency.** Limited after-hours support, medication access barriers, and persistent stigma lead to delayed symptom relief and high carer burden.
- **Urban-centric service distribution reveals priority areas for targeted growth and outreach.** Most specialist services are concentrated in inner LGAs, leaving growth corridors reliant on outreach and unable to access timely, complex or inpatient care.
- **Specialist palliative care is accessed too late**: Most people receive specialist palliative care close to death, particularly those with non-cancer conditions, limiting opportunities for early symptom management, advance care planning and coordinated support for families and carers.

Summary of insights

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

Table 1: Summary of insights for EMPHN's Palliative Care Needs Assessment 2025

A rapidly growing, ageing and culturally diverse population shaping future palliative care demand.
Population trends in the Eastern Melbourne region reveal significant growth and ageing, with the total population projected to rise by 26% to 1.95 million by 2032 and the 85+ cohort increasing by nearly 59%. Large metropolitan LGAs such as Whittlesea, Monash, Whitehorse, Boroondara and Knox account for the greatest share of residents and will drive future palliative care demand, amplified by rising multimorbidity and cultural diversity. Females outnumber males across most LGAs, and nearly half of older adults are overseas-born, with substantial CALD communities concentrated in Monash, Whitehorse and Whittlesea. Language diversity is pronounced, with 29% of older adults speaking a language other than English and over 80,000 residents reporting limited English proficiency, underscoring the need for interpreters and culturally adapted care. First Nations peoples represent 9,391 residents, with the largest communities in Whittlesea, Yarra Ranges and Knox. These demographic shifts highlight the importance of equity-focused planning, culturally

competent models and targeted outreach to meet growing and complex palliative care needs.
Shifting disease patterns are reshaping palliative care needs.
Between 2019 and 2024, disease patterns across Eastern Melbourne LGAs shifted significantly. Cancer prevalence declined across most LGAs, and cardiovascular trends were mixed, while dementia and respiratory conditions rose. Dementia cases increased most notably in Knox and Mitchell, while respiratory illnesses increased in Manningham and Knox. Palliative care separations grew from 1,606 to 1,817, with 70% of diagnoses occurring in people aged 70 and over, underscoring the ageing profile of care needs. Palliative care interventions demonstrated strong effectiveness in reducing pain and psychological distress, particularly for non-malignant conditions such as dementia and neurological diseases, which achieved improvement rates above 80%. However, malignant conditions showed lower responsiveness. Access to specialist palliative care remains late for most patients, with only 20.9% receiving care three months before death; early access is more common for neurodegenerative diseases (31.6%) and cancers (27.9%) but remains low for dementia and chronic organ failure. These trends signal growing complexity and the need for proactive, condition-specific approaches to palliative care planning.
Rising deaths and persistent chronic disease burden highlight growing end-of-life care needs.
Mortality across the Eastern Melbourne region has risen steadily from 2013 to 2024, driven by population growth and ageing. LGAs such as Whittlesea, Monash, Whitehorse and Boroondara account for the highest absolute deaths, while outer LGAs like Mitchell and Murrindindi maintain higher standardised death rates. Chronic, progressive conditions dominate mortality, with dementia now the leading cause overall, particularly among women, and coronary heart disease remaining the top cause for men. Cancer continues to contribute significantly, alongside non-malignant conditions such as COPD, heart failure and diabetes. Gendered patterns persist: women live longer but experience advanced frailty and dementia, while men have higher premature and avoidable deaths, with rates nearly double those of women. These trends underscore the need for targeted strategies addressing dementia care, chronic disease management and earlier palliative care engagement, particularly for men and high-mortality LGAs.
Rising demand and complexity are outpacing current funding and capacity.
Services across all settings report rapidly increasing referrals, higher multimorbidity, more dementia and more people wishing to die at home. Capacity and funding have not kept pace. Referral thresholds have tightened and some cohorts, especially those with fluctuating disease trajectories, risk falling between service boundaries.
Growth in non-admitted palliative care signals future pressures and opportunities to increase capacity.
While hospital admissions for palliative care grew by 15% between 2019–20 and 2024–25, non-admitted episodes increased by 60% for the 75+ age group, signalling a shift towards community-based care. While this growth alleviates pressure on inpatient services, it underscores the need and opportunity to increase capacity and resources in non-admitted care models, particularly for older populations, and signals future demand pressures as utilisation among the 55–74 age group

continues to rise.
High turnover and uneven expertise create variability in palliative care capability.
High turnover, transient workforce patterns and erosion of dedicated specialist positions have contributed to uneven skills in core palliative care tasks. Identifying the terminal phase, managing anticipatory medications and leading goals-of-care and ACP conversations are areas of particular variability. Staff also report high emotional burden and anxiety when discussing prognosis and end of life.
GP engagement in palliative care remains inconsistent, hindered by systemic and role clarity issues.
While some GPs are highly engaged, palliative care is not consistently treated as “core business” in general practice. Limited remuneration, competing priorities and fragmented employment models mean GPs may be less involved in proactive identification, home visits and case conferences. Confusion about roles between GPs, specialist services and generalist providers can undermine shared care and continuity.
Fragmented systems and patchy digital adoption hinder seamless palliative care coordination.
Stakeholders describe a system with multiple providers, complex referral processes and limited real-time information sharing. Hybrid paper–electronic workflows make ACPs and care plans difficult to locate when needed. Emerging digital solutions, including MyHealthRecord integration, secure messaging and platforms such as PalCare Go, are promising but adoption is patchy.
Timely access to medications, advice and after-hours support remain critical gaps.
RACHs and community providers report difficulties accessing palliative medicines and specialist advice after hours. Many facilities lack IMPREST supplies and syringe drivers. Locum reluctance to prescribe opioids or sedatives, and limited clarity about anticipatory prescribing, can delay symptom relief and place pressure on families and staff.
Low awareness, persistent misconceptions, and stigma around palliative care continue to influence timely access to palliative care and conversations about ACP.
Palliative care is still widely associated only with imminent death. This perception, along with fear and misunderstanding about palliative medicines, contributes to late referrals and avoidance of ACP. Clinicians often feel ill-equipped to initiate values-based conversations outside crisis points.
Cultural, linguistic and systemic barriers limit access to safe, inclusive palliative care.
First Nations peoples, CALD communities, people with disability and people living with dementia face additional barriers, including cultural and linguistic challenges, low health literacy, limited culturally safe workforce capacity and declining availability of spiritual and psychosocial care. People with dementia often fall between generalist and specialist services.
Informal carers experience burden but access to support is limited.

Informal carers shoulder much of the responsibility for home and residential palliative care but report limited guidance, respite and emotional support. Advice services note that most calls for help come from family members rather than clinicians, underscoring the need to better support carers in navigating the system.
Uneven service distribution highlights the need for investment in underserved areas.
Palliative care services in the EMPHN region are heavily concentrated in inner metropolitan LGAs, with inpatient units located in Banyule, Knox, Monash and Boroondara, and private facilities in Maroondah and Monash. Community specialist teams and consultative services operate from hubs such as Mitcham and Heidelberg, but coverage is sparse in outer LGAs, including Mitchell and Murrindindi, which lack any physical provider presence and rely solely on outreach. Nillumbik and Whittlesea also have limited infrastructure and no dedicated inpatient beds, creating equity challenges for residents in growth corridors who require complex symptom management or urgent admission. This urban-centric distribution highlights the need for targeted investment in underserved areas and improved access pathways to ensure timely, equitable palliative care across the catchment.
Strengthening primary care and aged care capacity is critical to meet future needs.
Workforce capacity across the EMPHN region shows steady growth in GP numbers and chronic disease management services, but distribution is uneven. Aged care providers have declined from 338 to 313 services, contrasting sharply with rapid growth in the 85+ population. GP FTEs in residential aged care have improved overall, but service delivery remains variable across LGAs, highlighting persistent gaps in rural and outer growth areas. These trends underscore the need for targeted workforce strategies, integrated care models and investment in aged care capacity to meet rising demand and ensure equitable access.
Future system pressures and reform impacts
The Voluntary Assisted Dying (VAD) Amendment Bill introduced in 2025 proposes significant reforms to improve access and flexibility within the VAD framework. Key changes include removing restrictions on clinicians initiating discussions about VAD, broadening eligibility criteria, and expanding authorised practitioners to include nurses. While these reforms are intended to improve patient access and choice, they are expected to increase demand on palliative care and advance care planning (ACP) services. This will add complexity to workforce planning, service coordination and clinical governance across the palliative care system. It is important to note that VAD service delivery is not funded under the Greater Choice for At Home Palliative Care (GCfAHPC) program. PHNs must not use grant funding to commission or deliver VAD services, remunerate VAD practitioners, or support state or territory VAD practitioner training. Notwithstanding these funding constraints, legislative changes will require integration into existing palliative care models, including updates to governance frameworks, workforce capability and training, and alignment with ACP processes. Ensuring safe and equitable implementation will require clear clinical protocols, culturally responsive approaches, and targeted investment in

workforce development, training and accountability mechanisms.

Strategic opportunities and recommended directions

Table 2 summarises potential opportunities identified that could strengthen access to high-quality, home-based palliative care over the next three years, addressing workforce gaps, cultural equity, medicine access, and system coordination - aligned with Greater Choice for at Home Palliative Care priorities.

Table 2: Summary of recommendations

Recommendation	Summary of Actions (Key Activities)	GCfAHPC Impact Area Alignment
Strengthen early identification, anticipatory planning and ACP across all settings	Embed earlier ACP and goals-of-care discussions into routine chronic disease and aged-care reviews; support values-based planning; normalise anticipatory planning across settings; strengthen proactive identification of people with life-limiting illness.	Workforce education & awareness; Community awareness; Palliative care medicines (anticipatory prescribing & ACP)
Build capability and confidence across generalist workforces	Provide concise, practical training for generalists; develop GP-friendly tools and symptom guides; build capability in end-of-life conversations, symptom management and prescribing; strengthen skills across general practice, RACHs, home care and disability services.	Workforce education & awareness
Increase GP engagement and embed clearer shared-care models	Establish clearer shared-care pathways; clarify GP, specialist and community provider roles; strengthen incentives and support for home visits and case conferences; promote GP-led models and peer-mentoring opportunities.	Workforce education & awareness
Improve communication, information-sharing and digital connectivity	Streamline referral pathways; integrate palliative referrals into practice software; strengthen feedback loops; improve interoperability and digital documentation; promote use of HealthPathways and digital tools for coordination.	Coordination and integration
Ensure timely access to	Expand anticipatory prescribing;	Medicines &

palliative medicines, anticipatory prescribing and after-hours clinical support	standardise medication guidance with referral acceptance; improve after-hours access to advice; strengthen IMPREST and syringe driver availability; support timely symptom control in home and RACH settings.	anticipatory prescribing; RACH capability
Address inequities for CALD communities, First Nations peoples, people with disability and people living with dementia	Co-design culturally safe models; strengthen ACCHO and community-controlled partnerships; provide tailored resources; build cultural capability; develop dementia-appropriate pathways and disability-inclusive palliative supports.	Priority populations; Cultural safety
Strengthen support for informal carers across home, community and RACH settings	Embed carer support into pathways; expand access to practical tools, emotional support, and navigation; enable carer-specific consultations; improve availability of respite and structured carer supports.	Community awareness
Improve geographic equity	Expand outreach and telehealth; strengthen RACH and home in-reach; target GP engagement in under-served LGAs; build partnerships to support consistent pathways across diverse geographies.	Priority populations; Workforce education & awareness

Taken together, these recommendations describe a more connected, capable and person-centred palliative care system for Eastern Melbourne. They focus on enabling earlier identification, clearer communication, culturally safe care and better support for families across all settings, to enable high-quality palliative care for individuals at home and in the community, regardless of where they live or which services they enter the system through. EMPHN will work with key stakeholders in the region to agree on the potential opportunities to focus on as part of activities under the GCfAHPC program.

Next steps and recommendations:

- **Embed earlier identification and anticipatory care planning** into routine workflows across general practice, community services and RACHs.
- **Strengthen GP palliative care capability and confidence** through short, practical education and GP-friendly point-of-care resources, supported by peer learning and mentoring.
- **Strengthen shared-care and coordination** by clarifying roles and expectations, simplifying referrals, and improving feedback loops and digital interoperability so

information follows the person across services and settings.

- **Improve access and equity** by prioritising timely palliative medicines/anticipatory prescribing and reliable after-hours advice.

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Abbreviations

Abbreviation	Description
ABS	Australian Bureau of Statistics
ACP	Advance Care Planning
AIHW	Australian Institute of Health and Welfare
ASR	Age-Standardised Sate
CALD	Culturally and Linguistically Diverse
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency department
EMPHN	Eastern Melbourne Primary Health Network
EOLC	End of life care
ERP	Estimated resident population
FTE	Full-time equivalent
FY	Financial Year
GCfAHPC	Greater Choice for At Home Palliative Care

Abbreviation	Description
GP	general practitioner
IRSD	Index of Relative Socio-Economic Disadvantage
IRSAD	Index of Relative Socio-Economic Advantage and Disadvantage
LGA	Local Government Area
MBS	Medicare Benefits Schedule
NP	Nurse Practitioner
PCNA	Palliative Care Needs Assessment
PHN	Primary Health Network
RACH	Residential Aged Care Home
SEIFA	Social Economic Index for Areas

1. Background

Palliative and end-of-life care (EOLC) is a key component of Australia's health system, with the *National Palliative Care Strategy 2018* shaping the priority areas for palliative and EOLC nationally. The *National Consensus Statement: Essential elements for safe high-quality end-of-life care*, describes a best practice approach to caring for people who are at the end of their life, particularly when in hospital settings.[1] These national strategies underpin Victoria's *End of Life and Palliative Care Framework*, which guides improvements for providers across all sectors, setting a foundation for EOLC and palliative care in Victoria.[2]

Primary Health Networks (PHNs) play a pivotal role in strengthening local service systems, enhancing access, and addressing inequity. As commissioners funded by the Commonwealth, PHNs are responsible for improving the efficiency and effectiveness of primary care and ensuring that services are responsive to the needs of people who are at risk of poor health outcomes. Palliative care is a national priority and PHNs are funded by the Australian Department of Health, Disability and Ageing (DHDA) to deliver activities under the Greater Choice for At Home Palliative Care (GCfAHPC) program, based on locally identified palliative and EOLC needs, that increase access to palliative care at home and in the community.

These national and State directions recognise that early identification, effective communication, and well-integrated systems are critical for improving experiences and outcomes for people with life-limiting illness, their families, and carers. For Eastern Melbourne PHN (EMPHN), understanding how palliative care is currently experienced across the region, and where system improvements, partnership opportunities, and workforce support are most needed, serves to align program activities and workplans associated with palliative and ELOC to these strategic priorities and desired program outcomes.

1.1 Context

The EMPHN catchment is characterised by demographic diversity and rapid population change. Ageing, multimorbidity and increasing dementia prevalence are contributing to rising complexity in palliative care needs across the region. Communities vary significantly in their cultural, linguistic and socioeconomic profiles, shaping different expectations, levels of health literacy, and experiences of accessing palliative care.

Stakeholders have highlighted ongoing challenges, including rapidly increasing demand and rising clinical complexity, variable workforce confidence to deliver palliative care, and persistent misconceptions and stigma surrounding palliative care and advance care planning (ACP).

1.2 Purpose of this document

This Palliative Care Needs Assessment (PCNA) has been developed to provide a clear, up-to-date and evidence-based understanding of palliative and EOLC needs across the EMPHN catchment. It draws on refreshed quantitative analysis, service mapping and targeted stakeholder engagement to build on insights from EMPHN's 2019 PCNA.

The purpose of the document is to translate this evidence into a set of actionable priorities that guide EMPHN's activities over the coming years as part of the GCfAHPC program. Specifically, the assessment aims to identify opportunities to:

- Improve access to timely, coordinated and compassionate care close to home.
- Strengthen capability within general practice, aged care and other primary care settings.

[1] Australian Commission on Safety and Quality in Health Care, 2023
[2] Victorian Department of Health, 2016

- Address cultural, linguistic and attitudinal barriers that limit engagement.
- Streamline pathways across primary, community, acute and specialist services.
- Enhance support for carers.
- Position the regional system to meet increasing demand and complexity.

1.3 Limitations and considerations

This PCNA references multiple data sources to establish an evidence base that supports future planning for activities that supports palliative and EOLC improvement in the EMPHN region. Datasets include information gathered from the Victorian Department of Health, the Australian Bureau of Statistics (ABS), other sources of publicly available data, and de-identified data from general practice within the region. The following factors should be noted when interpreting findings:

- **Data sources**: Analysis relied on publicly available data at PHN and LGA levels, with Victorian and national averages used as benchmarks where available. While these sources are reliable, they may not fully capture local nuances or recent service changes. There are constraints in the data quality that limit the complete interpretation of specific demographic nuances around gender diversity, LGBTQI+ individuals, people living with disability, First Nations populations, culturally and linguistically diverse (CALD) populations and other hardly reached populations.
- **Workforce insights:** Quantitative data on palliative care workforce capacity (e.g., FTE, service locations) was not available for analysis. The assessment does highlight capability gaps where they have been identified. There is an opportunity for further exploration of workforce data, should additional information become available in the future.
- **Stakeholder engagement:** Consultations were conducted over a two-week period from 24 November to 05 December and provided valuable insights. However, engagement was limited to a small number of stakeholders. Broader engagement will be important to validate and deepen sector-specific insights.
- **Recommendations:** The recommendations provided reflect areas for consideration in future workplans rather than a prioritised or recommended sequence of work. Policy changes and funding shifts may influence the application of these recommendations.

2. Methodology

The PCNA draws on multiple data sources and methods to develop a picture of current and future needs. The approach combines quantitative analysis of population and service use data, service mapping across care settings, and targeted stakeholder engagement to capture qualitative insights on access, quality and capability.

2.1 Data analysis, sources and gaps

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

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

Where possible, national and State comparators (i.e. South Eastern Melbourne PHN and North West Melbourne PHN) are also provided. Table 3 outlines the key data sources used to inform this needs assessment, including their origin and period of coverage.

Table 3: Data sources used for EMPHN PCNA

Data source	Organisation	Period
2023–2025 EMPHN Health Needs Assessment	EMPHN	2023
2019 EMPHN Palliative Care Needs Assessment	EMPHN	2019
AIHW Palliative care service in Australia (PCSiA) various releases	Australian Institute of Health and Welfare	2020 – 2023
AIHW Mortality Over Regions and Time (MORT) books, Primary Health Networks	Australian Institute of Health and Welfare	2019 - 2023
Census	Australian Bureau of Statistics	2021
Victorian Admitted Data Sets (VAED)	Vic Gov	2019 - 2024

2.3 Service mapping

Palliative care and EOLC services in the EMPHN region were mapped at a high level to identify availability, distribution and integration between services, based on available data sourced from public information (i.e. service directories), EMPHN-held data, and stakeholder consultations. This includes:

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

Mapping provides an overview of identified service types, coverage and integration points across the EMPHN region.

2.4 Stakeholder consultation

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

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

In total, 31 stakeholders were consulted through seven 60-minute consultation sessions conducted between 24 November and 05 December 2025. A full list of stakeholders engaged to inform this PCNA is available at Appendix item A.

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

2.5 Consumer and Carer Survey

As an additional data source to the quantitative analysis and stakeholder consultations, a survey was administered to provide insight into palliative care needs across the EMPHN region. The survey combined closed-ended questions for quantitative trends with open-ended questions, ensuring a balanced understanding of service gaps, workforce challenges, and consumer experiences.

The survey was developed and administered to consumers and carers. This survey sought to capture lived experiences, preferences, and unmet needs in accessing palliative care services. It was disseminated through EMPHN's WiseCrowd panel to ensure broad representation and was administered between 03 December and 10 December 2025.

The survey provided insights from service users, enabling an additional understanding of palliative care needs across the region. Detailed survey instruments, including questions, are in the Appendix.

3. Needs assessment data analysis

The following analysis examines the demography, epidemiological status, service utilisation, and mortality patterns within the EMPHN region to identify key drivers of palliative care needs and inform future planning and activities.

3.1 Demography

Population and gender distribution trends in the EMPHN region

Population distribution varies across Eastern Melbourne's 12 LGAs. The size and nature of the local populations will drive demand for palliative care in the coming decade. Large metropolitan LGAs, particularly Whittlesea (247,165 residents), Monash (184,544), Whitehorse (181,141), Boroondara (176,171) and Knox (170,121) account for the largest share of the regional population (Table 4). These LGAs also show the highest per-capita population density, led by Whittlesea at 159.6 per 1,000 population. As these areas continue to age, they are expected to drive the greatest proportion of future palliative care demand, amplified by rising multimorbidity, greater cultural diversity and increasing numbers of people preferring to age in place. In contrast, smaller LGAs such as Murrindindi (1,649 residents) and Mitchell (22,942) represent only a small portion of the total population.

Across all LGAs, females (790,331) outnumber males (758,738). This is consistent across each LGA, except Murrindindi, with a slightly higher male population (855 males, compared to 794 females).

Table 4: EMPHN LGA population, female male and rate per 1,000.

LGA	Female	Female per 1,000 pop	Male	Male per 1,000 pop	Total	Total per 1,000 pop
Banyule	62,739	40.5	58,973	38.1	121,712	78.6
Boroondara	91,645	59.2	84,526	54.6	176,171	113.7
Knox	86,796	56.0	83,325	53.8	170,121	109.8
Manningham	65,568	42.3	61,538	39.7	127,106	82.1
Maroondah	52,421	33.8	49,170	31.7	101,591	65.6
Mitchell	11,324	7.3	11,618	7.5	22,942	14.8
Monash	92,545	59.7	91,999	59.4	184,544	119.1
Murrindindi	794	0.5	855	0.6	1,649	1.1
Nillumbik	28,411	18.3	27,688	17.9	56,099	36.2
Whitehorse	93,575	60.4	87,566	56.5	181,141	116.9
Whittlesea	124,202	80.2	122,963	79.4	247,165	159.6
Yarra Ranges	80,311	51.8	78,517	50.7	158,828	102.5
Total	**790,331**	**510.2**	**758,738**	**489.8**	**1,549,069**	**1,000**

Source: ABS census, 2021

Actionable Insight:

Populations in large metropolitan LGAs such as Whittlesea, Monash, Whitehorse, Boroondara and Knox will be the primary drivers of future palliative care demand in Eastern Melbourne. Rural LGAs like Mitchell and Murrindindi, while small, pose access challenges that require flexible, outreach-based models. Overall, these trends underscore the importance of targeted resource allocation and scalable service models to meet both current and emerging needs.

Age distribution trends across EMPHN LGAs

The significant population growth across some LGAs in the EMPHN region is coupled with an ageing population (Table 5). The LGAs with largest population density in the 65+ cohort include Whittlesea

(35.5 per 1,000 population), Knox (29.0 per 1,000 population), Whitehorse (28.9 per 1,000 population), Boroondara (29.8 per 1,000 population), Yarra Ranges (27.5 per 1,000 population) and Monash (27.3 per 1,000 population). In contrast, the proportion of younger age groups has declined slightly despite absolute growth. These shifts indicate that EMPHN is not only growing but also ageing.

Table 5: LGA by age and rate per 1,000 population3

LGA Name	0 – 14	15 -24	25 – 44	45 – 64	65+
Banyule	14.0	8.6	21.3	22.1	**20.0**
Boroondara	18.1	16.2	29.0	30.1	**29.8**
Knox	18.8	13.0	29.5	30.3	**29.0**
Manningham	13.3	9.7	19.3	21.7	**21.6**
Maroondah	12.0	7.4	18.0	18.3	**16.4**
Mitchell	3.6	1.7	4.7	4.1	**3.4**
Monash	18.4	17.0	34.4	30.9	**27.3**
Murrindindi	0.2	0.1	0.3	0.3	**0.4**
Nillumbik	6.7	4.9	7.5	10.0	**11.1**
Whitehorse	18.7	15.8	32.0	31.8	**28.9**
Whittlesea	33.0	19.7	50.1	44.9	**35.5**
Yarra Ranges	19.0	12.0	26.0	27.5	**27.5**

Source: ABS census, 2021

Actionable insight:

The data highlights a clear need for differentiated palliative care strategies across the EMPHN region. LGAs such as Boroondara, Knox, Monash, Whittlesea and Whitehorse have aging populations, indicating immediate pressure on palliative care services and the need for workforce and infrastructure expansion. Further, Whittlesea's large population of younger people suggests opportunities for proactive long-term planning rather than reactive investment.

First Nations population and distribution across the EMPHN region

First Nations peoples represent 9,391 residents across the EMPHN region, equating to 6.06 per 1,000 population (Table 7). Of this group, 1,778 are aged 50 and over (Table 6).

Table 6: EMPHN population aged over 50 by Indigenous status (FY 2023-2024)

People aged 50 and over by Indigenous status FY 2023 - 24			
First Nations	Non-Indigenous	Unknown	First Nations (%)
1,778	526,401	17,033	0.3%

Source: ABS census 2021

The distribution of the First Nations population is disparate with the largest communities located in Whittlesea (2,444 people, 1.58 per 1,000), Yarra Ranges (1,754, 1.13 per 1,000) and Knox (1,106, 0.71 per 1,000) (Table 7). These LGAs collectively account for more than half of the region's First Nations

[3] See **Error! Reference source not found.** for comprehensive table with absolute figures

population and therefore have greater need for scalable, community-based models of culturally appropriate palliative care delivered in partnership with ACCHOs. Small LGAs such as Murrindindi (33 people) and Manningham (303 people) may present a different challenge, where limited local services and geographic distance necessitate the need for outreach, navigation support and culturally competent primary care that can identify palliative care needs early.

Table 7: First Nations population and rate per 1000 population

LGA Name	First Nations population	Rate per 1,000 pop EMPHN
Banyule	798	0.52
Yarra Ranges	1,754	1.13
Whittlesea	2,444	1.58
Monash	492	0.32
Whitehorse	557	0.36
Manningham	303	0.20
Mitchell	435	0.28
Boroondara	488	0.32
Maroondah	646	0.42
Murrindindi	33	0.02
Knox	1,106	0.71
Nillumbik	335	0.22
Total	**9,391**	**6.06**

Source: ABS census 2021

Actionable insight:

The population of First Nations people is spread across the region highlighting the importance of embedding cultural safety, trust, family-centered decision-making and choice across all palliative care pathways in the Eastern Melbourne region. Without deliberate action, the disparities in palliative and end-of-life outcomes for First Nations peoples will continue to widen.

CALD population rates and distribution across the EMPHN region

Cultural and linguistic diversity varies widely across the EMPHN region with particularly large migrant communities concentrated in a small number of metropolitan LGAs. Across the region, the most common overseas countries of birth were China (95,295 residents, 61.5 per 1,000 population) and India (57,137 residents, 36.9 per 1,000), followed by England (40,486; 26.1 per 1,000), Malaysia (29,539; 19.1 per 1,000) and Sri Lanka (22,712; 14.7 per 1,000) (

Table 8).

The population born overseas is highly concentrated in Monash, Whitehorse and Whittlesea. Monash alone includes 21,827 residents born in China (14.1 per 1,000), 13,529 born in India (8.7 per 1,000), 6,293 from Malaysia (4.1 per 1,000) and 7,368 from Sri Lanka (4.8 per 1,000) (

Table 8). Whitehorse has similarly large Chinese and Indian communities (22,812 and 6,876 residents, respectively) and a significant Malaysian-born population (5,803 residents). Whittlesea has a particularly large Indian community (11,732 residents, 11.2 per 1,000) alongside sizeable Sri Lankan and English-born populations.

By contrast, LGAs such as Murrindindi, Mitchell, Nillumbik and Yarra Ranges have much smaller communities born overseas. While absolute demand may be lower, the risk within these LGAs is limited service awareness and visibility: people may be geographically dispersed, have limited access

to interpreters or culturally aware clinicians, and be less likely to encounter information about palliative care or advance care planning in their own language.

Table 8: Born elsewhere - most common country of birth (top 5) excluding ambiguous categories (i.e. born elsewhere). Number and rate per 1,000 population. Cells highlighted in green represent the highest values, red represent the lowest values for each LGA.

LGA Name	China		India		England		Malaysia		Sri Lanka	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Banyule	3,331	2.2	2,268	1.5	3,348	2.2	1,103	0.7	844	0.5
Boroondara	13,942	9.0	4,543	2.9	4,951	3.2	3,909	2.5	1,585	1.0
Knox	8,749	5.7	5,478	3.5	5,364	3.5	4,071	2.6	3,918	2.5
Manningham	13,895	9.0	2,412	1.6	2,481	1.6	4,706	3.0	869	0.6
Maroondah	4,023	2.6	2,160	1.4	3,692	2.4	1,214	0.8	629	0.4
Mitchell	48	0.0	1,047	0.7	535	0.4	38	0.0	142	0.1
Monash	21,827	14.1	13,529	8.7	3,008	1.9	6,293	4.1	7368	4.8
Murrindindi	0	0.0	0	0.0	49	0.0	0	0.0	0	0.0
Nillumbik	419	0.3	322	0.2	2,347	1.5	208	0.1	148	0.1
Whitehorse	22,812	14.7	6,876	4.4	3,992	2.6	5,803	3.8	2,668	1.7
Whittlesea	5,256	3.4	17,324	11.2	2,974	1.9	1,730	1.1	4,093	2.6
Yarra Ranges	993	0.6	1,178	0.8	7,745	5.0	464	0.3	448	0.3
Total	**95,295**	**61.5**	**57,137**	**36.9**	**40,486**	**26.1**	**29,539**	**19.1**	**22,712**	**14.7**

Source: ABS, 2021

Among people aged 65 and over, 120,420 were born overseas, 133,131 in Australia, and 12,505 have an unknown country of birth, yet 45.3% of older residents are overseas-born (Table 9). This profile signals a palliative care environment in which many people, particularly in metropolitan areas, will approach life-limiting illness and end of life with different expectations, decision-making norms and help-seeking patterns.

Table 9: EMPHN population aged 65 and over by country of birth (FY 2023 - 2024)

People aged 65 and over by country of birth			
Born overseas	Born in Australia	Unknown	Born overseas (%)
120,420	133,131	12,505	45.3%

Source: ABS census 2021

Actionable insight:

LGAs with large CALD communities will require palliative care models that combine strong clinical capability with interpreters, cultural awareness and competency, and flexible, family-centred communication practices. Services will need to respond to differing beliefs about prognosis disclosure, preferences for treatment, and norms around collective versus individual decision-making. Targeted community engagement, partnerships with multicultural organisations and investment in a culturally competent workforce will be critical to enabling earlier, less crisis-driven engagement with palliative care. At the same time, LGAs with smaller CALD communities should not be overlooked, with region-wide interpreter access, clinician training and tailored information to support equitable end-of-life outcomes.

While English remains the dominant language, spoken by 989,143 residents (638.5 per 1,000 population, Table 10), the population who speak non-English language is concentrated in specific LGAs. These communities present varied communication and cultural needs that must be addressed in service planning.

Table 10: Language spoken at home number and rate per 1,000 population in EMPHN - most common (top 5).

	English		Chinese		Indo Aryan		Greek		Italian	
LGA Name	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Banyule	92,390	59.6	6,010	3.9	2,213	1.4	2,239	1.5	2,876	1.9
Boroondara	119,302	77.0	24,298	15.7	4,753	3.1	4,946	3.2	2,406	1.6
Knox	116,583	75.3	1,8411	11.9	7,926	5.1	1,755	1.1	1,428	0.9
Manningham	65,535	42.3	28,705	18.5	3,363	2.2	6,884	4.4	3,888	2.5
Maroondah	77,821	50.2	7,025	4.5	2,328	1.5	570	0.4	659	0.4
Mitchell	17,609	11.4	95	0.1	1,587	1.0	150	0.1	259	0.2
Monash	79,477	51.3	37,920	24.5	16,963	11.0	10,502	6.8	3,100	2.0
Murrindindi	1,496	1.0	0	0.0	0	0.0	0	0.0	8	0.0
Nillumbik	49,591	32.0	747	0.5	339	0.2	431	0.3	640	0.4
Whitehorse	103,248	66.7	39,267	25.4	8,277	5.3	4,036	2.6	1,821	1.2
Whittlesea	125,926	81.3	9,649	6.2	24,547	15.9	7,780	5.0	8,895	5.7
Yarra Ranges	140,165	90.5	1,679	1.1	1,197	0.8	403	0.3	1,149	0.7
Total	**989,143**	**638.5**	**173,806**	**112.2**	**73,493**	**47.4**	**39,696**	**25.6**	**27,129**	**17.5**

Source: ABS Census, 2021

Chinese languages represent the largest non-English group, with 173,806 speakers (112.2 per 1,000 population), clustered in Whitehorse (25.35 per 1,000), Monash (24.48) and Manningham (18.53). Indo-Aryan languages account for 73,493 speakers (47.44 per 1,000), concentrated in Whittlesea (15.85), Monash (10.95) and Whitehorse (5.34). Other language groups such as Greek (39,696 speakers) and Italian (27,129 speakers) remain prominent in Whittlesea, Monash, Manningham and Whitehorse. These concentrations indicate high demand for interpreter support and culturally adapted approaches to care, including prognosis discussions, advance care planning (ACP) and family decision-making.

Among people aged 65 and over, nearly 29% speak a language other than English at home, representing 76,337 individuals (Table 11). This is a substantial proportion and highlights the need for culturally responsive care for older populations.

English proficiency patterns further underscore demand for interpreters and communication challenges. Although most residents speak English well, 80,307 people (51.8 per 1,000 population) report speaking English “not well” or “not at all” (Appendix item C). The highest concentrations of limited English proficiency (LEP) occur in Monash (15,218 residents), Whittlesea (16,865), Whitehorse (14,270) and Manningham (9,743). These LGAs are likely to experience greater communication barriers and require enhanced language support within palliative and end-of-life pathways.

Furthermore, Religious diversity adds an additional layer of complexity. While secular/no religion and Christianity dominate across the EMPHN region, Monash, Manningham and Whittlesea have notable proportions of Buddhism (up to 7%), Islam (up to 9%) and Hinduism (up to 7.5%) (Appendix item D). These variations influence care preferences, decision-making norms and expectations around end-of-life practices.

CALD communities may face barriers such as delayed engagement with palliative care, lower awareness of available services and ACP processes, and reliance on family members for interpretation, which can introduce complexity in communication and decision-making. These factors increase the risk of uncertainty, reduced clarity around prognosis and care options, and a higher likelihood of accessing care in acute or crisis-based settings rather than through planned, community-based pathways.

To address these challenges, resource allocation must prioritise:

- Interpreter availability and translated materials.

- Staff training in cultural competence.
- Community-level education tailored to linguistic and cultural norms.

Equity is a core pillar of EMPHN's organisational strategy, recognising that access and outcomes are shaped by factors like culture and religion, among others. EMPHN is committed to directing investment where it is most needed and most impactful, guided by evidence, data and co-design with communities. Addressing language and cultural diversity is central to this goal, as these factors directly influence access, appropriateness and safety of care.

Table 11: EMPHN population aged 65 and over by language used at home (FY 2023 - 24)

People aged 65 and over by language used at home			
Other language	English	Unknown	Other language (%)
76,337	177,453	12,223	28.7%

Source: ABS Census, 2021

Actionable insight:

Around 29% of older adults in the EMPHN region speak a language other than English at home, over 80,000 residents have limited English proficiency concentrated in key LGAs, and areas such as Monash, Manningham and Whittlesea also show higher proportions of non-Christian faiths including Buddhism, Islam and Hinduism. Planning for both linguistic and cultural complexity needs to be maintained across the region by ensuring interpreter access, culturally competent staff, and leveraging and building capacity in clinical and non-clinical staff who are multi-lingual. Future planning for models of care that respect diverse religious practices and decision-making norms to deliver equitable and person-centred end-of-life care should also be taking into consideration.

Socio-economic indicators across the EMPHN region

SEIFA data shows that several LGAs, including Banyule, Boroondara, Manningham and Nillumbik, sit in decile 10 across most indices, indicating high levels of education, occupation advantage and economic resources (Table 12). These characteristics are associated with higher health literacy, greater capacity for navigating complex care pathways and potentially earlier engagement with palliative care and advance care planning (ACP).

LGAs such as Whittlesea (IRSD decile 6; IRSAD decile 7), Mitchell (IRSD decile 7; IEO decile 6) and Murrindindi (IRSD and IRSAD decile 7) show relatively lower scores, and therefore greater socio-economic vulnerability.

Table 12: Socio-economic indicators across EMPHN LGAs 2021. Cells highlighted in green represent the highest values, red represent the lowest values.

LGA Name	Index of Relative Socio-economic Disadvantage		Index of Relative Socio-economic Advantage and Disadvantage		Index of Economic Resources		Index of Education and Occupation	
	Score	Decile	Score	Decile	Score	Decile	Score	Decile
Banyule	1,058	10	1,064	10	1,030	9	1,079	10
Boroondara	1,090	10	1,131	10	1,054	10	1,153	10
Knox	1,042	9	1,029	9	1,041	10	1,021	9
Manningham	1,056	10	1,075	10	1,059	10	1,080	10
Maroondah	1,041	9	1,035	9	1,030	9	1,042	9
Mitchell	1,000	7	968	7	1,030	9	945	6

Monash	1,042	9	1,067	10	1,016	8	1,086	10
Murrindindi	1,005	7	971	7	1,012	8	970	7
Nillumbik	1,093	10	1,088	10	1,111	10	1,074	9
Whitehorse	1,043	9	1,067	10	1,011	8	1,093	10
Whittlesea	990	6	981	7	1,018	8	980	8
Yarra Ranges	1,041	9	1,014	9	1,054	10	1,001	8

Source: ABS Census 2021

LGAs such as Knox, Maroondah, Monash, Whitehorse and Yarra Ranges fall mostly within deciles 8–9, indicating generally favourable socio-economic conditions with some variation. These areas may contain pockets of disadvantage that are not visible at the LGA level but could influence palliative-care needs within specific neighbourhoods.

Actionable insight:

SEIFA patterns suggest potential differences in need, access and vulnerability, highlighting the value of tailoring palliative care strategies to local socio-economic context. While high-advantage areas may demonstrate stronger capacity for self-directed and preference-sensitive care, lower-scoring LGAs may benefit from enhanced outreach, navigation support and health-literacy initiatives to help ensure equitable end-of-life experiences.

Aged care utilisation rates and care insights

Across the EMPHN region, 183,501 adults aged 65+ are still living independently in the community (Table 13). This represents a substantial cohort approaching, or already within, the age ranges where palliative, supportive and complex chronic care needs are statistically more likely to escalate. The largest populations aged 55+ living at home occur in Whittlesea (26,317), Whitehorse (23,563), Boroondara (23,588), Monash 20,221 and Knox (20,449). This data suggests these LGAs may represent the core geographic areas where growth in future palliative care demand may be expected.

Across the region, the 55-64 cohort is the largest ageing-in-place segment, totalling 33,277 people, followed by 29,122 people aged 65–74 (Table 13; Appendix item E for gender distribution of adults living at home). While 55–64 year-olds represent the biggest 'ageing in place' cohort numerically, the 65–74 group sits at the threshold where multimorbidity, frailty and palliative care needs begin to emerge more prominently and therefore is a critical focus for early identification and planning. The LGAs with the largest 65–74 populations are Whittlesea (3,670), Whitehorse (3,624), Yarra Ranges (3,520), Knox (3,500) and Boroondara (3,469). These communities are likely to see increased demand for palliative care needs in the short term.

Table 13: Number of adults aged over 55 years living at home across age groups in EMPHN region by LGA

LGA Name	55 - 64	65 – 74	75 - 84	85 +	Grand Total
Banyule	3,181	2,886	2,158	1,264	**16,299**
Boroondara	3,794	3,469	3,086	2,002	**23,588**
Knox	3,973	3,500	2,620	1,334	**20,449**
Manningham	2,338	2,104	2,433	1,487	**13,849**
Maroondah	2,641	2,253	1,811	1,049	**13,717**
Mitchell	395	238	114	45	**2,045**
Monash	3,252	2,885	3,055	2,215	**20,221**
Murrindindi	54	38	14	4	**200**
Nillumbik	1,046	935	547	214	**4,580**
Whitehorse	4,043	3,624	3,467	2,351	**23,563**
Whittlesea	4,761	3,670	2,743	1,244	**26,317**
Yarra Ranges	3,799	3,520	2,389	1,032	**18,673**
Grand Total	**33,277**	**29,122**	**24,437**	**14,241**	**183,501**

Source: ABS Census, 2021

Among people aged 65 and over, 54,823 (20.6%) live alone, while 194,266 live with others and 16,979 have an unknown household status (see Table 14). Living alone can increase vulnerability and complexity in care planning, particularly at end of life.

Table 14: EMPHN population aged 65 and over by relationship in household (FY 2023 - 24)

People aged 65 and over by relationship in household			
Lives alone	Lives with others	Unknown	Lives alone (%)
54,823	194,266	16,979	20.6%

Source: AIHW, 2024

In addition, 59,330 people aged 55 and over (13.3%) require assistance with core activities (Table 15), highlighting a significant cohort with functional limitations that may accelerate the need for supportive and palliative care services.

Together, this data points to a growing segment of older adults in the EMPHN region who may face heightened care complexity, underscoring the importance of proactive service planning and targeted outreach strategies.

Table 15: EMPHN population aged 65 and over by need for assistance with core activities (FY 2023-24)

People aged 65 and over by need for assistance with core activities			
Requires assistance	Does not require assistance	Unknown	Requires assistance (%)
59,330	367,299	18,012	13.3%

Source: AIHW, 2024

Actionable insight:
The EMPHN region has a substantial ageing population living independently, with 20.6% of older adults living alone and over 13% requiring assistance with core activities. These factors, combined with concentrated cohorts in key LGAs, indicate potential rising complexity in palliative care needs. This demographic profile signals a need for proactive, community-based palliative care strategies that prioritise early identification, tailored support for those living alone, and integrated services to manage functional decline and multimorbidity.

Care type utilisation

Most people age in place until around age 85, after which aged care support provided to people living independently at home declines, coinciding with increased transition into RACHs (Table 16). Aged care supports in the home rises steadily from age 65, peaking between 75 – 84.

Table 16: People aged 50+ using aged care by care type (Percentage calculated as no population data to calculate rate) in the EMPHN catchment

Age Group	Home Care				Permanent residential care			
	Female		Male		Female		Male	
	No.	%	No.	%	No.	%	No.	%
50–54	10	0.2%	1	0.0%	1	0.0%	2	0.1%
55–59	8	0.1%	1	0.0%	2	0.1%	0	0.0%
60–64	12	0.2%	6	0.2%	5	0.2%	3	0.1%
65–69	373	7.0%	174	5.5%	70	2.3%	68	3.4%
70–74	720	13.4%	398	12.6%	149	4.9%	157	7.8%

75–79	1,099	20.5%	592	18.7%	321	10.6%	276	13.8%
80–84	1,331	24.9%	797	25.2%	598	19.7%	435	21.7%
85–89	1,081	20.2%	768	24.2%	866	28.5%	541	27.0%
90–94	570	10.6%	340	10.7%	712	23.4%	401	20.0%
95–99	130	2.4%	84	2.7%	279	9.2%	108	5.4%
100+	20	0.4%	7	0.2%	36	1.2%	16	0.8%
Total	**5,354**	**100.0**	**3,168**	**100.0**	**3,039**	**100.0**	**2,007**	**100.0**

Source: ABS Census, 2021

From 85 onwards, aged care support provided to people living independently at home declines as RACHs become predominant, with occupancy rates remaining high (81.6% in FY23 to 84.4% in FY24, as seen in Table 17), signalling sustained demand and limited alternatives.

Table 17: Occupancy rate of aged care services in the EMPHN catchment FY23-FY 24

Year	Occupancy rate in Residential Care
FY23	81.6%
FY24	84.4%

Source: ABS Census, 2021

Gender patterns are notable: women account for most aged care support provided to people living independently at home and RACH residents overall (60%), reflecting longer life expectancy, while men enter RACHs earlier (between ages 75 – 84), likely reflecting earlier functional decline or less informal support.[4]

These patterns have major implications for palliative care planning:

- On-site palliative capability
- After-hours clinical decision support
- Dementia-informed care models
- Workforce development
- ACP and goals-of-care documentation processes

Actionable insight:

Demand will increase for high-acuity and end-of-life services in residential settings. Workforce planning and integrated palliative pathways are essential to meet these evolving needs. Strategic resource allocation should anticipate the surge in care requirements for those aged 85+, ensuring capacity for both quality of life and dignified EOLC.

Utilisation of permanent and respite care

Across the EMPHN region, patterns of permanent and respite aged-care utilisation reveal both the scale of aged-care dependency and the emerging pressures associated with an ageing population (Table 18).

Permanent residential aged care remains heavily concentrated in a small number of LGAs, particularly

[4] Australian Bureau of Statistics, *Life expectancy, 2022–2024* — life tables. Life expectancy at birth in Australia was 81.1 years for males and 85.1 years for females. Life expectancy, 2021 - 2023 | Australian Bureau of Statistics

Monash, Boroondara, Whitehorse, Manningham and Knox. There is clear year-on-year growth in several LGAs. Whittlesea experienced the largest increase—an additional 186 permanent residents in just 12 months—perhaps reflecting the rapid ageing and expansion of the population.

Whitehorse also recorded substantial growth, adding 122 permanent residents, while Manningham and Boroondara showed steady upward trends. Even small changes in these large LGAs represent significant shifts in service needs given the population size of the LGAs.

Several LGAs—most notably Whittlesea, Monash, Boroondara and Manningham—show notable increases in respite use between 2023 and 2024. Rising respite demand may be a proxy indicator of carer strain, unmet home-care needs and growing complexity that becomes harder to manage without short-term respite support. The increase in Whittlesea, which saw 33 additional respite users, is particularly meaningful when viewed alongside its sharp growth in permanent RACH residents. This convergence suggests an increasing demand environment. Meanwhile, LGAs such as Mitchell and Murrindindi continue to record low numbers overall.

RACHs will remain a major setting of palliative care needs, particularly in high-demand LGAs where permanent RACH residents exceed 1,500 people. The steady rise of permanent residents coupled with increasing respite use suggests that both RACHs and home-care systems are experiencing mounting pressure.

Overall, this data highlights a region-wide shift towards greater aged-care dependency, intensifying complexity and increasing touchpoints with the palliative care system. These dynamics reinforce the need for coordinated planning across primary care, community services, RACHs and specialist palliative providers to meet the growing volume and acuity of care required.

Table 18: Number of patients utilising permanent and respite care by LGA (Jun 2023 - Jun 2024). Cells highlighted in green indicate the greatest percentage decreases in service utilisation, while cells in red indicate the greatest percentage increases.

LGA Name	Permanent			Respite			Total		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Banyule	992	1,006	1.41	47	38	-19.15	1,039	1,044	0.48
Boroondara	1,729	1,776	2.72	70	95	35.71	1,799	1,871	4.00
Knox	1,366	1,381	1.10	52	52	0.00	1,418	1,433	1.06
Manningham	1,371	1,428	4.16	76	88	15.79	1,447	1,516	4.77
Maroondah	1,105	1,135	2.71	52	63	21.15	1,157	1,198	3.54
Mitchell	229	218	-4.80	5	13	160.00	234	231	-1.28
Monash	1,978	2,012	1.72	79	106	34.18	2,057	2,118	2.97
Murrindindi	91	95	4.40	9	7	-22.22	100	102	2.00
Nillumbik	387	443	14.47	21	33	57.14	408	476	16.67
Whitehorse	1,477	1,599	8.26	91	77	-15.38	1,568	1,676	6.89
Whittlesea	1,146	1,332	16.23	74	107	44.59	1,220	1,439	17.95
Yarra Ranges	811	877	8.14	53	53	0.00	864	930	7.64

Source: ABS Census, 2021

Actionable insight:

Permanent aged-care admissions are rising sharply in high-population LGAs, while respite use is also increasing, signalling mounting pressure on both residential and home-care systems and highlighting carer strain and unmet community support needs. Planning should prioritise capacity-building in high-growth LGAs, strengthen carer support and home-care services, and embed palliative care capability within RACHs to manage escalating complexity.

Projected demographic shifts and implications for palliative care in EMPHN

Across the projection horizon (2017 – 2032) every age group in the EMPHN catchment shows sustained growth, with no periods of decline or plateau (Table 19). Younger cohorts (0–35 and 35–65) are projected to increase by about 24% over 15 years, reflecting steady demographic expansion. However, older age groups are projected to grow at a markedly faster pace. The 65–80 population rises by approximately 33%, while the 85+ cohort increase by nearly 59%, from 34,086 in 2017 to 54,291 in 2032. Overall, the catchment population expands by 26%, from 1.54 million to 1.95 million, with annual growth rates of around 1.5% for the total population and exceeding 3% for the oldest group. These changes are practically significant, as they represent a substantial shift in age distribution toward cohorts most associated with complex health needs.

Table 19: Population projections for EMPHN catchment by age group, 2017–2032

Year	0-35	35-65	65-80	85+	Total
2017	719,678	584,633	206,502	34,086	**1,544,899**
2018	736,309	591,876	211,260	34,933	**1,574,378**
2019	753,441	599,635	216,092	35,818	**1,604,986**
2020	769,814	607,795	221,066	36,604	**1,635,279**
2021	785,098	615,931	226,323	37,646	**1,664,998**
2022	799,707	624,444	231,399	38,550	**1,694,100**
2023	812,730	633,417	236,451	39,724	**1,722,322**
2024	824,777	642,793	241,305	40,783	**1,749,658**
2025	835,335	652,380	246,282	42,010	**1,776,007**
2026	845,133	661,496	251,443	43,314	**1,801,386**
2027	854,230	670,404	256,249	44,783	**1,825,666**
2028	862,778	679,900	261,231	46,061	**1,849,970**
2029	870,516	690,597	265,311	47,847	**1,874,271**
2030	877,957	702,333	268,764	49,497	**1,898,551**
2031	885,806	713,666	271,937	51,366	**1,922,775**
2032	893,651	725,247	273,751	54,291	**1,946,940**

Source: ABS, Population Projections SA2 EMPHN

Actionable insight:

Demand for palliative care will rise across all age bands, but disproportionately among the oldest residents, where morbidity, frailty, and end-of-life care requirements are highest. The near doubling of the 85+ population signals escalating pressure on specialist palliative care services, RACHs, and workforce capacity. Resource allocation must anticipate these trends, prioritising investment in skilled staff, infrastructure, and community supports. The steady, projected growth provides a reliable basis for long-term planning, but it also underscores the need for sustained, incremental capacity building to avoid service shortfalls as demographic momentum accelerates.

3.2 Epidemiology

Disease prevalence in Eastern Melbourne LGAs

Between 2019 and 2024, the EMPHN region experienced notable shifts in key disease patterns across LGAs (Table 20). Cancer cases fell across most LGAs, while cardiovascular trends were mixed with

notable declines in some areas but increases in others.

Dementia exhibited the most change, with cases in Knox increasing from 294 to 416 cases (a 41.50% increase) and a slight increase in Mitchell from 5 cases to 17. Reductions were seen in Banyule (411 to 254, -38.20%). Respiratory conditions worsened, particularly in Manningham (from 5,595 to 9,516, +70.08%) and Knox (10,649 to 14,297, +34.26%).

These figures highlight that while cancer and cardiovascular disease prevalence improved in many LGAs, the rise in dementia and respiratory illnesses signals the need for palliative care to better support people with dementia, and their carers, given the specific challenges that can arise compared to other chronic diseases.

Table 20: Prevalence of key diseases by EMPHN LGA from 2019-20 to 2024-25, total population

Year	LGA Group	Cancer (n)	Cardiovascular system (n)	Dementia/ Alzheimer's (n)	Respiratory system (n)
FY2019 - FY2020	Banyule	1,379	6,099	411	6,661
	Boroondara	1,893	7,485	425	10,085
	Knox	1,741	8,346	294	10,649
	Manningham	1,327	5,635	331	5,595
	Maroondah	1,412	5,615	304	7,757
	Mitchell	148	883	5	2,267
	Monash	1,435	7,583	364	9,308
	Murrindindi	29	174	3	313
	Nillumbik	757	2,210	131	3,005
	Whitehorse	2,142	8,899	352	10,605
	Whittlesea	1,595	10,689	304	16,152
	Yarra Ranges	1,971	8,471	272	13,181
FY2022 - FY2023	Banyule	1,370	5,221	245	7,370
	Boroondara	1,682	7,243	310	11,059
	Knox	1,622	8,680	314	14,761
	Manningham	1,231	6,940	265	9,156
	Maroondah	1,260	5,516	214	7,821
	Mitchell	152	987	8	2,299
	Monash	1,416	7,965	462	11,547
	Murrindindi	23	170	1	230
	Nillumbik	693	2,452	82	3,286
	Whitehorse	1,884	9,397	354	13,441
	Whittlesea	1,782	13,935	387	25,117
	Yarra Ranges	2,020	8,299	281	13,530
FY2024 - FY2025	Banyule	1,285	4,989	254	7,745
	Boroondara	1,592	6,852	290	11,330
	Knox	1,670	8,971	416	14,297
	Manningham	1,105	6,659	317	9,516
	Maroondah	1,164	5,253	251	8,971
	Mitchell	164	1,006	17	2,607
	Monash	1,147	7,284	265	11,743

	Murrindindi	13	102	1	137
	Nillumbik	736	2,435	92	3,099
	Whitehorse	1,780	9,156	320	13,981
	Whittlesea	1,428	11,096	338	20,882
	Yarra Ranges	2,082	8,569	295	14,716

Source: ABS, National Health Survey 2022

Actionable insight:
Dementia and respiratory conditions are rising in absolute terms across several LGAs, while cancer generally declined and cardiovascular trends remain mixed. This shift signals a growing need for palliative care models that prioritise dementia-specific support for patients and carers, alongside planning for increased respiratory care demand, as these conditions present distinct clinical and resource challenges compared to cancer and cardiovascular disease.

Age distribution of palliative care diagnosis at separation

The age distribution of palliative care diagnoses at separation demonstrates a strong and consistent concentration among older age groups, as would be expected (Table 21). Across all three years, patients aged 70 and above account for most cases, at 72% in 2019–20 (70–79: 28%, 80+: 44%) and 70% in 2024–25 (70–79: 25%, 80+: 45%). There was overall growth in total separations from 1,606 to 1,817 during this time. Middle-aged groups (50–69) show gradual growth, particularly the 50–59 cohort, which rose from 7% to 9%, suggesting earlier onset of complex conditions requiring palliative intervention.

Table 21: Age distribution of palliative care diagnosis at separation 2019-20 to 2024-25

Age Group	2019-2020		2022-23		2024-25	
	No.	%	No.	%	No.	%
20-29	0	0%	5	0%	3	0%
30-39	22	1%	18	1%	10	1%
40-49	46	3%	53	3%	43	2%
50-59	110	7%	130	8%	167	9%
60-69	278	17%	261	15%	314	17%
70-79	450	28%	403	24%	454	25%
80+	700	44%	815	48%	825	45%
Grand Total	**1606**	**100**	**1685**	**100**	**1817**	**100**

Source: AIHW PCSiA

Actionable insight:
Older adults (70+) continue to represent the largest proportion of palliative care separations, with the 80+ group accounting for nearly half of these. Middle-aged cohorts show gradual growth. Service planning must prioritise capacity for older cohorts and anticipate rising demand among 50–69-year-olds, requiring scalable models and workforce strategies to manage increasing complexity and volume.

Improvements after palliative care intervention – distress related to pain and psychological/ spiritual problems

In 2022, palliative care interventions showed strong effectiveness in reducing distress related to pain for people with life-limiting illnesses, though outcomes varied by diagnosis. Overall, non-malignant

conditions achieved the highest pain improvement rates with 77.5% of cases reporting that distress related to pain improved or remained at a low level after intervention (Table 22). Within this group, the greatest reductions were seen for neurological and dementia-related conditions. Alzheimer's dementia had an improvement of 85.3% from palliative care interventions, while other dementia conditions showed 83.1% improvement. Cardiovascular disease (76.1%) and respiratory failure (79.2%) also demonstrated strong results.

In contrast, malignant conditions had lower improvement rates, averaging 68.2%, with specific cancers such as colorectal (66.7%), pancreas (66.8%), and bone/soft tissue (65.2%) showing the least improvement. Central nervous system malignancies were an exception, achieving 76.4% improvement. These patterns suggest that while palliative care is generally effective, reducing distress related to pain remains more challenging for cancer patients compared to those with non-malignant conditions, highlighting the need for strategies that are focused on identification and management of pain-related distress for people with a malignant diagnosis.

Psychological and spiritual concerns showed even higher improvement rates after intervention. On average, non-malignant conditions demonstrated a greater level of responsiveness to intervention (82.7% improvement across all non-malignant diagnosis). People with an Alzheimer's/Dementia diagnosis experienced the greatest improvement at 91.6%, followed by sepsis (89.9%), other dementia (88.8%), and stroke (88.7%) (Appendix item G). Significant improvement in psychological and spiritual concerns was also seen in people with cardiovascular disease and end-stage kidney disease (82.4%). Malignant conditions had slightly lower improvement rates, averaging 77.9% across all presentations.

Table 22: Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention, by diagnosis, 2022

Diagnosis	Pain improved after treatment	Pain not improved after treatment	% of pain improved after treatment
Malignant	*59,715*	*87,527*	*68.2%*
Lung	12,321	17,820	69.1%
Colorectal	6,052	9,074	66.7%
Other gastrointestinal	5,469	7,986	68.5%
Prostate	4,938	7,278	67.8%
Pancreas	4,682	7,011	66.8%
Breast	4,420	6,518	67.8%
Gynaecological	3,490	5,178	67.4%
Haematological	3,314	4,673	70.9%
Other primary malignancy	2,704	3,982	67.9%
Head and Neck	2,720	3,952	68.8%
Other urological	2,574	3,832	67.2%
Skin	2,030	2,999	67.7%
Unknown primary malignancy	1,459	2,204	66.2%
Central nervous system	1,668	2,182	76.4%
Malignant – not further defined	1,122	1,684	66.6%
Bone and soft tissue	752	1,154	65.2%
Non-malignant	*24,134*	*31,129*	*77.5%*
Respiratory failure	5,000	6,315	79.2%
Other non-malignancy	4,507	6,033	74.7%
Cardiovascular disease	3,787	4,974	76.1%
End stage kidney disease	1,774	2,405	73.8%
Other dementia	1,770	2,130	83.1%
Other neurological disease	1,318	1,673	78.8%
Alzheimer's dementia	1,270	1,488	85.3%
Motor Neurone Disease	999	1,344	74.3%
Sepsis	947	1,200	78.9%

Stroke	826	1,021	80.9%
End stage liver disease	719	1,001	71.8%
Non-malignant – not further defined	761	953	79.9%
Multiple organ failure	364	462	78.8%
Diabetes & complications	n.p.	n.p.	n.p.
HIV/AIDS	n.p.	n.p.	n.p.

Source: AIHW PCSiA

Actionable insight:

Overall, Non-malignant conditions consistently show higher improvement rates for distress related to both pain and psychological/spiritual problems resulting from palliative care intervention. These trends highlight the relevance and impact of palliative care interventions for non-malignant conditions, despite palliative care often being associated with cancers.

Improvements after palliative care intervention – Carers and families

Palliative care interventions demonstrated variable effectiveness in improving or maintaining family and carer problems at a low level after intervention, depending on the severity of issues at the start of the care phase (Appendix item H). When problems were mild, improvement was most likely, with 83.6% of cases showing positive outcomes, indicating strong responsiveness to early-stage concerns. For cases where problems were absent at the start, improvement or stability was achieved in 69.4% of phases, suggesting that some issues emerged or persisted despite intervention. However, effectiveness dropped significantly for more complex situations: moderate problems improved in only 53.7% of cases, and severe problems improved in 64.4%, highlighting the challenges of addressing entrenched or high-intensity family and carer issues.

Actionable insight:

These findings highlight that palliative care interventions are most effective when family and carer issues are mild or identified early, with an 83.6% improvement rate, but effectiveness drops sharply for moderate problems (53.7%). This suggests a need for proactive screening and early psychosocial support for carers, as well as specialised, intensive interventions for families facing moderate to severe challenges to prevent escalation and improve overall care outcomes.

Timeliness of Specialist Palliative Care Access in the Last Year of Life

In 2022, access to specialist palliative care at least three months before death varied significantly by cause of death. Overall, only 20.9% of people who received palliative care in the last year of life began receiving specialist care three months or more before death, indicating that most patients enter specialist care late in their illness trajectory (Table 23). People with neurodegenerative diseases had the highest rates of early access at 31.6%, reflecting greater recognition of long-term care needs for progressive conditions. Malignant neoplasms (cancers) followed at 27.9%, suggesting relatively better integration of palliative care in oncology compared to other conditions.

In contrast, those with heart disease (12.1%), dementia/Alzheimer's (11.3%), and other causes (11.4%) were far less likely to receive early specialist care, and rates were lowest for cerebrovascular disease (4.9%). These patterns suggest that while cancer and neurodegenerative conditions are more likely to lead to timely palliative care referrals, people with chronic organ failure or dementia often miss out on early support, limiting opportunities for symptom management and family planning.

Table 23: Proportion of people who received specialist palliative care in the last year of life with the first receipt at least 3 months before death by cause of death

Cause of death	Received specialist palliative care 3 months before death (n)	Received specialist palliative care within the last year of their life (n)	% of people receiving specialist pal care 3 months before death
Malignant neoplasm	8,206	29,433	27.9%

Heart disease	576	4,766	12.1%
Cerebrovascular disease	140	2,852	4.9%
Renal disease	74	720	10.3%
Liver disease	79	823	9.6%
Respiratory disease	451	2,636	17.1%
Neurodegenerative disease	324	1,025	31.6%
Dementia/Alzheimer's disease/Senility	264	2,344	11.3%
Other	971	8,526	11.4%
Total	**11,085**	**53,125**	**20.9**

Source: AIHW PCSiA

Actionable insight:

Most people receive specialist palliative care late in their illness, with only 20.9% starting care at least three months before death. This limits opportunities for symptom control, advance care planning, and family support. The particularly low rates for heart disease (12.1%), dementia (11.3%), and cerebrovascular disease (4.9%) highlight a critical need for earlier identification and referral pathways for non-cancer conditions to ensure equitable, timely palliative care and improve quality of life in the final months.

3.3 Service use

Patients presenting with palliative diagnoses

Between 2019–20 and 2024–25, the number of patients presenting with palliative diagnoses increased steadily from 1,188 to 1,328 (12% increase), reflecting rising demand for palliative care services (Table 24) Cancer remains the predominant diagnosis, accounting for around 71% of all presentations across all years, although there was a decline slightly from 74% in 2019–20 to 71% in 2024–25. Non-cancer conditions collectively represent nearly 30% of presentations. Septicaemia shows the most significant increase, rising by 97% (from 36 cases in 2019–20 to 71 in 2024–25). Presentations for lung diseases due to external agents and cerebrovascular disease also increased, while COPD declined by 42% (from 55 to 32 cases). Heart failure remains relatively stable, contributing around 4% of cases annually.

Table 24: Proportion of patients presenting with a palliative diagnosis across EMPHN region between 2019 and 2025

Palliative diagnoses	Proportion of total presentations					
	2019-20		2022-23		2024-25	
	No.	%	No.	%	No.	%
Cancers	878	74%	867	71%	942	71%
Cerebrovascular disease	54	5%	64	5%	59	4%
Chronic obstructive pulmonary disease (COPD)	55	5%	41	3%	32	2%
Heart failure and complications and ill-defined heart disease	50	4%	52	4%	56	4%
Influenza and pneumonia	32	3%	34	3%	35	3%

Injuries to specific parts of the body	14	1%	22	2%	31	2%
Kidney failure	35	3%	33	3%	41	3%
Lung diseases due to external agents	29	2%	49	4%	54	4%
Other ill-defined causes	5	0%	15	1%	7	1%
Septicaemia	36	3%	42	3%	71	5%
Total	**1,188**	**100**	**1,219**	**100**	**1,328**	**100**

Source: AIHW PCSiA

Actionable insight:
Cancer-related palliative care presentations continue to be the most common, though there is a gradual shift towards non-cancer diagnoses. This underscores the need for service models that can respond to a broader range of clinical needs and anticipate increasing complexity in palliative care provision, beyond cancer diagnoses, as awareness and understanding of palliative care, and the conditions it relates to, continues to increase.

Palliative care hospital admissions

Palliative care-related hospitalisations in Eastern Melbourne have increased steadily over the past five years (Table 25), rising from 1,561 admissions in 2019-20 to 1,788 in 2024-25, a growth of around 15%. Public hospital admissions consistently account for most cases, representing 74–80% of all presentations annually, and have grown from 1,153 to 1,437, indicating an increasing reliance on public sector capacity. In contrast, private hospital admissions have fluctuated, peaking at 408 in 2019-20 before declining to 351 in 2024-25, suggesting a gradual shift away from private facilities. The overall upward trend reflects increasing demand for palliative care services, driven by population ageing and rising complexity of care needs.

Table 25: Palliative care-related hospitalisations by admission source, for EMPHN 2019-20 to 2024-25

Year	Admissions source		
	Private (n)	Public (n)	Total presentations (n)
2019-20	408	1,153	1,561
2020-21	341	1,035	1,376
2021-22	362	1,127	1,489
2022-23	361	1,292	1,653
2023-24	387	1,369	1,756
2024-25	351	1,437	1,788
Total	**2,210**	**7,413**	**9,623**

Source: AIHW PCSiA

Actionable insight:
Public hospitals are the primary providers of palliative care admissions in EMPHN, with demand rising steadily, while private hospital utilisation is declining. Future planning could explore alternative models to address growing demand and reduce pressure on the public system, recognising that as case complexity increases, people are more likely to prefer care in public hospitals, which are better equipped to meet the needs of complex cases compared to private hospitals.

Public hospital admissions to palliative care beds and units show a clear age-related pattern across all three periods, with older cohorts dominating across all admission sources (Table 26). In 2024–25, patients aged 70+ accounted for just over 70% of all admissions (70–79: 25%, 80+: 45.4%), consistent with previous years. The 80+ group remains the largest contributor, particularly for transfers from aged care facilities (71%) and acute hospitals (46%). Younger age groups (under 50) remain minimal, collectively just over 3% of admissions.

Table 26: Age distribution of palliative admission source 2019-20 to 2024-25

Year	Age group	Admission from private residence		Statistical Admission		Transfer from acute hospital/extended care/rehab/geri centre		Transfer from aged care residential facility		Transfer from Transition Care bed based program		Grand Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2019-2020	15-19	-	-	-	-	-	-	-	-	-	-	-	-
	20-29	-	-	-	-	-	-	-	-	-	-	-	-
	30-39	15	2.6%	4	0.8%	3	0.6%	0	0.0%	0	0.0%	22	1.4%
	40-49	14	2.4%	17	3.5%	15	3.0%	0	0.0%	0	0.0%	46	2.9%
	50-59	45	7.7%	30	6.1%	34	6.9%	1	2.9%	0	0.0%	110	6.8%
	60-69	119	20.4%	77	15.7%	78	15.8%	4	11.8%	0	0.0%	278	17.3%
	70-79	164	28.1%	143	29.2%	134	27.1%	5	14.7%	4	66.7%	450	28.0%
	80+	226	38.8%	218	44.6%	230	46.6%	24	70.6%	2	33.3%	700	43.6%
	Grand Total	**583**	**100**	**489**	**100**	**494**	**100**	**34**	**100**	**6**	**100**	**1606**	**100**
2023-24	15-19	-	-	-	-	-	-	-	-	-	-	-	-
	20-29	-	-	-	-	-	-	-	-	-	-	-	-
	30-39	5	1%	4	0.87%	3	0.6%	0	0.0%	0	0.0%	12	0.8%
	40-49	17	3%	16	3.49%	13	2.6%	0	0.0%	0	0.0%	46	3.0%
	50-59	47	9%	21	4.59%	24	4.8%	0	0.0%	0	0.0%	92	6.1%
	60-69	81	16%	60	13.10%	65	13.1%	2	6.9%	2	66.7%	210	13.9%
	70-79	141	27%	116	25.33%	128	25.8%	6	20.7%	1	33.3%	392	26.0%
	80+	231	44%	241	52.62%	264	53.1%	21	72.4%	0	0.0%	757	50.2%
	Grand Total	**522**	**100**	**458**	**100**	**497**	**100**	**29**	**100**	**3**	**100**	**1509**	**100**
2024-25	15-19	0	0%	1	0%	0	0%	0	0%	0	0%	1	0.1%
	20-29	2	0%	0	0%	1	0%	0	0%	0	0%	3	0.2%
	30-39	6	1%	4	1%	0	0%	0	0%	0	0%	10	0.6%
	40-49	26	4%	9	2%	8	2%	0	0%	0	0%	43	2.4%
	50-59	69	10%	48	8%	49	10%	1	2%	0	0%	167	9.2%
	60-69	129	19%	108	18%	75	15%	2	5%	0	0%	314	17.3%
	70-79	173	25%	139	23%	132	27%	9	22%	1	100%	454	25.0%
	80+	284	41%	290	48%	222	46%	29	71%	0	0%	825	45.4%
	Grand Total	**689**	**100**	**599**	**100**	**487**	**100**	**41**	**100**	**1**	**100**	**1817**	**100**

Source: AIHW PCSiA

Actionable insight:
There is a growing proportion of admissions originating from hospitals and aged care facilities, signalling the need for integrated pathways between acute, residential, and community care to manage rising complexity and volume.

In 2023–24, palliative care utilisation within the EMPHN region continued to be strongly age-dependent, with the 75+ age group accounting for the vast majority of activity across both admitted and non-admitted settings (Appendix item K). Admitted patient episodes for this cohort reached 3,398 (258.6 per 10,000 population), significantly higher than any other age group, although slightly down from 3,525 in 2022–23. Middle-aged groups (55–74) showed a slight increase, indicating growing demand among those approaching older age brackets. The most notable trend, however, was the sharp rise in non-admitted palliative care events, which surged by approximately 60% for the 75+ group—from 31,554 episodes (2,480 per 10,000) in 2022–23 to 51,192 (3,896 per 10,000) in 2023–24. Similar growth patterns were observed across Victoria and nationally, suggesting a systemic shift towards community-based palliative care delivery.

Actionable insight:
While the growth in non-admitted palliative care alleviates pressure on inpatient services, it underscores the need and opportunity to increase capacity and resources in non-admitted care models, particularly for older populations, and signals future demand pressures as utilisation among the 55–74 age group continues to rise.

Socioeconomic data for palliative care services in EMPHN (Table 27) reveals higher utilisation rates among those in the most disadvantaged areas (quintile 1). For admitted patient palliative care in 2023–24, EMPHN recorded 69.2 episodes per 10,000 population in quintile 1, more than double the rate in quintile 4 (29.7) and above quintile 2 (35.6). This aligns with State and national trends, though EMPHN's rates for the most disadvantaged group are notably higher than Victoria (44.2) and the national average (47.5), indicating a stronger concentration of hospital-based palliative care among lower socioeconomic communities in Eastern Melbourne.

Table 27: Palliative care hospitalisations, by socioeconomic status, per 10,000 population, 2022 – 2024 FY

Year	PHN	1	2	3	4	5
2022-23	EMPHN	67.7	41.7	34.9	30.7	34.7
	Vic	44.8	40.0	33.2	29.3	33.4
	National	47.3	43.9	37.7	31.9	33.1
2023-24	EMPHN	69.2	35.6	34.5	29.7	34.8
	Vic	44.2	42.0	35.1	28.8	34.3
	National	47.5	45.9	39.7	32.6	34.2

Source: AIHW PCSiA

Non-admitted care shows an even greater disparity (Table 28): EMPHN's quintile 1 rate increased from 549.6 per 10,000 in 2022–23 to 754.6 in 2023–24 reflecting a 37% increase. Similar growth occurred across all quintiles, but the gap between the most and least disadvantaged remains substantial.

Table 28: Non-admitted palliative care service events, by socioeconomic status, per 10,000 population, 2022 – 2024 FY

Year	PHN	1	2	3	4	5
2022-23	EMPHN	549.6	339.2	378.0	321.1	391.6
	Vic	403.5	420.5	346.2	266.3	282.4
	National	368.0	349.4	303.5	217.9	235.6
2023-24	EMPHN	754.6	535.2	576.0	469.5	574.7
	Vic	519.3	580.8	455.7	376.4	414.2
	National	414.6	430.3	351.1	260.9	285.6

Source: AIHW PCSiA

Actionable insight:
Socioeconomic disadvantage is strongly associated with higher palliative care utilisation, particularly in non-admitted settings, and highlights the need and opportunity to integrate targeted resource planning and equity-focused strategies to address complex care needs in vulnerable populations.

Attendance by a palliative care physician (MBS-subsidised) across the EMPHN region remains markedly lower than State and national averages. During 2023–24, EMPHN recorded an overall attendance rate of 34 people per 100,000 population and 185 services per 100,000, with an average of 5.4 services per person, compared to Victoria's 212 people and 1,382 services per 100,000 and the national rate of 1,171 people and 6,207 services per 100,000 (Table 29). This disparity suggests restricted access to specialist palliative physicians. With respect to case-conferencing services (Table 30), the EMPHN region had a rate of 22.1 services per 100,000 in 2023–24, versus 155.1 in Victoria and 879.5 nationally, indicating limited multidisciplinary coordination. Age distribution reinforces this pattern, with MBS-subsidised palliative medicine attendance and case conference activity concentrated in older cohorts (75+), yet far below State and national service volumes.

Table 29: MBS-subsidised palliative medicine attendance services provided by palliative medicine physicians/specialists and people receiving them, by Primary Health Network (PHN), 2022-2024 FY

Year	PHN	Attendance in a consulting room or hospital			Attendance in other settings			Palliative medicine attendances Subtotal		
		People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person[10]
2022-2023	EMPHN	-	175.9	-	-	-	-	34.6	176.4	5.1
	Vic	123.6	1,182.9	16.7	21.7	94.8	12.2	220.1	1,278.8	30.2
	National	861.9	5,283.8	111.1	147.6	292.1	36.0	1,153.0	5,868.8	136.0
2023-2024	EMPHN	-	183.9	-	-	1.2	-	34.0	185.1	5.4
	Vic	124.3	1,114.3	18.2	25.2	144.1	9.4	212.0	1,381.8	33.7
	National	854.9	4,892.9	98.2	107.7	276.9	31.4	1,171.2	6,206.6	135.3

Table 30: MBS-subsidised palliative medicine case conference services provided by palliative medicine physicians/specialists and people receiving them, by Primary Health Network (PHN), 2022-2024 FY

Year	PHN	Organise and	Participate in a	Organise and	Participate in a	Palliative

		coordinate a community case conference			community case conference			coordinate a discharge case conference			discharge case conference			medicine case conferences Subtotal		
		People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person	People per 100,000 pop	Services per 100,000 pop	Services per person
2022-2023	EMPHN	3.4	3.7	1.1	-	-	-	9.6	17.9	1.9	-	-	-	12.2	23.6	1.9
	Vic	39.6	51.3	6.4	5.7	7.0	2.1	45.4	89.3	8.1	9.0	13.8	1.7	88.6	171.1	11.4
	National	155.1	163.1	16.1	261.9	324.4	19.6	205.0	329.8	29.1	34.7	60.0	13.4	590.4	957.1	43.0
2023-2024	EMPHN	2.8	3.3	1.2	-	-	-	8.8	17.1	1.9	-	-	-	12.1	22.1	1.8
	Vic	33.6	45.0	6.6	2.0	2.4	1.2	45.5	88.5	7.0	-	-	-	85.2	155.1	9.8
	National	129.2	185.1	19.4	232.4	295.2	14.7	199.7	315.8	25.7	16.3	28.8	9.8	562.6	879.5	42.3

Source: AIHW PCSiA

Actionable insight:
While Victoria and Australia show steady growth in both attendances and case conferences, EMPHN's minimal increase over the two-year period points to persistent gaps in specialist-led palliative care. These findings underscore the opportunity to implement targeted strategies to improve access to palliative medicine specialists and enhance collaborative care models within Eastern Melbourne.

Actionable insight:
This analysis highlights that palliative care patients in the EMPHN region rely on resident carers, with Whittlesea showing the highest dependency. A persistent minority living alone without a carer represents a potentially vulnerable group requiring targeted support and improved data capture for planning.

3.4 Mortality

Absolute deaths have increased across most EMPHN LGAs from 2013 to 2024, reflecting population growth and ageing. Larger LGAs such as Monash (1,162 deaths in 2013 to 1,527 in 2024), Whitehorse (1,116 to 1,232) and Boroondara (1,138 to 1,140, peaking at 1,248 in 2022) show substantial volumes and a visible rise over time (Table 31). Whittlesea, a growth corridor, increased from 829 deaths in 2013 to 1,316 in 2024, a 58.8% increase, making it one of the most rapidly growing contributors to regional mortality. Mitchell and Murrindindi have smaller absolute numbers (Mitchell: 206 to 340; Murrindindi: 112 to 131), but a clear upward trend. Most LGAs recorded a peak in 2022, followed by a slight decrease in 2023–2024, consistent with State and national patterns. Despite this easing, deaths in 2024 remain above 2013 levels across all LGAs.

Table 31: Number of deaths by LGA from 2013 - 2024

LGA Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Banyule	826	852	885	799	885	855	1,002	884	878	1,057	948	953
Boroondara	1,138	1,122	1,138	1,146	1,128	1,049	1,156	999	1,055	1,248	1,177	1,140
Knox	942	985	962	1,010	1,011	901	1,095	1,011	1,064	1,261	1,099	1,152

Manningham	731	817	906	890	935	847	1,001	948	968	1,151	1,068	1,047
Maroondah	768	810	859	808	781	763	880	804	826	920	876	847
Mitchell	206	224	206	209	244	238	280	258	278	303	323	340
Monash	1,162	1,242	1,312	1,273	1,285	1,204	1,480	1,314	1,441	1,570	1,522	1,527
Murrindindi	112	126	114	112	127	124	142	117	117	149	148	131
Nillumbik	229	276	245	269	227	254	291	281	299	350	325	333
Whitehorse	1,116	1,179	1,119	1,171	1,066	1,007	1,247	1,108	1,202	1,300	1,234	1,232
Whittlesea	829	856	915	919	992	960	1,178	1,139	1,115	1,258	1,244	1,316
Yarra Ranges	768	836	876	897	805	832	931	886	931	1,111	948	992

ABS MORT books

Actionable insight:

The mortality rate in EMPHN region is rising across almost all LGAs, with a particular increase in Monash and Whittlesea. This underlines the need for regional capacity-building rather than focusing solely on one or two areas and suggests that palliative care demand will continue to grow, especially in high-growth outer metropolitan areas.

Mortality across Eastern Melbourne

Standardised death rates across EMPHN LGAs show relative stability over time with clear geographic variation. Lower-mortality LGAs include Boroondara (declining from 4.5 to 4.2 per 1,000 between 2013 and 2024), Manningham (4.3–4.1) and Whitehorse (4.7 down to 4.3) (Table 32). Monash sits in the mid-range (4.5 rising slightly to 4.7), while Nillumbik and Banyule are similar, around 4.3–5.0. Higher rates are observed in Knox (consistently around 5.0–5.5), Maroondah (5.1–5.6), Whittlesea (5.1–5.8), Mitchell (5.3–6.2) and Murrindindi (5.3–6.3). Although there are small year-to-year fluctuations, the overall pattern is a persistent gradient: inner, higher-SES LGAs generally have lower death rates; outer growth and regional LGAs have higher rates. There is minimal evidence of dramatic deterioration between 2013 and 2024, but several LGAs (e.g. Banyule, Monash, Whittlesea) show a slight uptick in recent years, which may reflect ageing populations and pandemic-related impacts.

Table 32: Standardised death rate per 1,000 population by LGA from 20013 - 2024

LGA Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Banyule	5.1	4.8	4.8	4.8	4.7	4.6	4.9	4.8	4.8	4.9	4.9	5
Boroondara	4.5	4.4	4.5	4.4	4.3	4.2	4.1	3.9	3.9	4	4.2	4.2
Knox	5.5	5.4	5.4	5.3	5.2	5	5	4.9	5	5	5	5
Manningham	4.3	4.2	4.2	4.3	4.3	4.1	4.1	4	4	4.1	4.1	4.1
Maroondah	5.5	5.5	5.6	5.6	5.4	5.1	5.1	5.1	5.2	5.2	5.2	5.1
Mitchell	6.2	5.7	5.7	5.4	5.3	5.3	5.5	5.4	5.4	5.3	5.4	5.6
Monash	4.5	4.4	4.6	4.6	4.5	4.3	4.4	4.3	4.5	4.5	4.6	4.7
Murrindindi	6.3	6	5.9	5.7	5.6	5.6	6	5.7	5.4	5.3	5.4	5.4
Nillumbik	4.7	5	4.9	5	4.5	4.3	4.3	4.4	4.5	4.6	4.5	4.5
Whitehorse	4.7	4.7	4.6	4.5	4.3	4.1	4.1	4.1	4.3	4.2	4.3	4.3

Whittlesea	5.8	5.5	5.5	5.3	5.3	5.1	5.3	5.3	5.3	5.2	5.2	5.3
Yarra Ranges	5.1	5.1	5.2	5.3	5.1	4.9	4.8	4.8	4.9	5	5	5

ABS MORT books

Actionable insight:
Eastern Melbourne's palliative care needs are unevenly distributed, with higher per-capita mortality – and likely higher burden of advanced illness – in Mitchell, Murrindindi, Whittlesea, Knox and Maroondah. Targeted investment in outreach, community-based palliative care and navigation support in these LGAs maybe critical to achieving equitable end-of-life outcomes.

Leading causes of death across Eastern Melbourne

Mortality is dominated by chronic, progressive conditions, with a clear gendered pattern in the EMPHN region (Table 33). For women, dementia including Alzheimer disease is the leading cause of death (3,343 deaths; ASR 45.9 per 100,000), and the leading cause overall (5,075 deaths; ASR 41.8). For men, coronary heart disease remains the top cause (2,776 deaths; ASR 59.3), followed by dementia (1,732; ASR 35.4) and lung cancer (1,261; ASR 27.4). Cardiovascular disease is prominent across both sexes, with coronary heart disease and cerebrovascular disease together accounting for 7,544 deaths region-wide (ASR 42.3 and 24.5 respectively). Cancer remains a major contributor, particularly lung (2,193 deaths; ASR 21.5), colorectal (1,480; ASR 14.4), prostate (1,103; ASR 23) and breast cancer (948; ASR 17.8). Non-malignant conditions with long trajectories are also prominent: COPD (1,506 deaths; ASR 13.7), heart failure and other ill-defined heart disease (1,346; ASR 11.3) and diabetes (1,308; ASR 11.7). Accidental falls are a contributing cause overall (1,506 deaths; ASR 12.8), underscoring frailty and injury-related end-of-life pathways in older adults.

Table 33: Cause of death and age-standardised rate (ASR) in EMPHN 2019 – 2022 (Cells highlighted in red represent the highest values, green represent the lowest values.)

Cause of death	Person			Female		Male	
	Rank	No.	ASR (per 100,000)	No.	ASR (per 100,000)	No.	ASR (per 100,000)
Dementia including Alzheimer disease	1	5,075	41.8	3,343	45.9	1,732	35.4
Coronary heart disease	2	4,741	42.3	1,965	28.2	2,776	59.3
Cerebrovascular disease	3	2,803	24.5	1,658	24.6	1,145	24.0
Lung cancer	4	2,193	21.5	932	16.7	1,261	27.4
COPD	5	1,506	13.7	729	11.6	777	16.4
Accidental falls	6	1,506	12.8	779	11.0	727	15.1
Colorectal cancer	7	1,480	14.4	693	12.0	787	17.2
Heart failure and complications and ill-defined heart disease	8	1,346	11.3	783	10.8	563	11.7
Diabetes	9	1,308	11.7	632	9.5	676	14.4
Prostate cancer	10	1,103	9.9			1103	23.0
Influenza and pneumonia	11	1,096	9.0	635	8.7	461	9.3
Coronavirus disease 2019 (COVID-19)	12	1,059	9.2	505	7.3	554	11.6
Pancreatic cancer	13	996	9.7	514	9.0	482	10.5
Kidney failure	14	970	8.2	517	7.3	453	9.3
Breast cancer	15	958	9.7	948	17.8		
Other ill-defined causes	16	820	7.7	431	6.8	389	8.7
Cardiac arrhythmias	17	765	6.3	485	6.6		
Parkinson disease	18	732	6.5			460	9.7

Cancer of unknown or ill-defined primary site	19	702	6.5	361	5.9	341	7.3
Suicide	20	690	8.7			505	13.1
Hypertensive disease	-	-	-	346	4.6	-	-
Ovarian cancer	-	-	-	321	6.0	-	-
Diseases of the musculoskeletal system and connective tissue	-	-	-	291	4.5	-	-
Liver Cancer	-	-	-	-	-	396	8.6
Leukaemia	-	-	-	-	-	341	7.4

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

Actionable insight:

These patterns point to a palliative-care environment dominated by dementia, cardiovascular disease, cancer and frailty-related conditions. Service models will need strong capability in dementia care, management of advanced cardiorespiratory disease, and falls-related decline, with close integration between acute, community and residential aged care settings.

Mortality in the region rose for both sexes between 2018 and 2022, but the increase was more pronounced among men. Male deaths (Appendix item N) climbed by 30.7% from 4,300 to 5,620, compared with a 20.8% rise in female deaths (Appendix item O) from 4,634 to 5,600. Age-standardised death rates also grew faster for men (489.8 to 578.6 per 100,000) than women (381.2 to 421.5 per 100,000), narrowing the gap with national averages. Women maintained a higher median age at death (86.3 to 87.0 years) than men (81.5 to 82.3 years), reflecting longer life expectancy. Premature deaths (<75 years) remained greater for men, falling proportionally but increasing in absolute terms (1,457 to 1,742), while women saw a slight proportional decline and stable numbers (1,074 to 1,120). Potential Years of Life Lost under 75 rose more sharply for men (23,719 to 27,023 person-years) than women (16,503 to 17,302), and potentially avoidable deaths were consistently higher among men (743 to 796) than women (around 450–470), with potentially avoidable death rates nearly double for men (95–100 per 100,000) than women (low- to mid-50s). Overall, men experienced steeper increases in mortality and avoidable deaths, while women continued to live longer but with advanced frailty and dementia.

Actionable insight:

Implement targeted strategies to reduce premature and avoidable deaths among men, including proactive screening, chronic disease management, and health promotion initiatives, while strengthening end-of-life planning for older women with advanced frailty and dementia.

4. Stakeholder consultations

4.1 Consultation process

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

- RACHs
- ACP providers
- Health Network Palliative Care Units
- Community Palliative Care Providers
- Residential in-reach services
- Palliative Care Advice Services
- Pharmaceutical Societies
- General Practice staff
- Eastern Metropolitan Region Palliative Care Consortium

While a rapid consultation process was undertaken to inform this needs assessment, EMPHN intends on continuing to engage and work with palliative care stakeholders in the region on the implications of this PCNA, and how the needs of the community can be addressed through targeted activities and workplans.

4.2 Emerging themes

1. Rising demand and complexity outpacing current funding and capacity

Across the EMPHN region, stakeholders consistently described rapidly increasing demand and rising clinical complexity in palliative care, driven by an ageing population, multimorbidity and the growing prevalence of dementia. This escalation is occurring without perceived commensurate increases in funding to account for the steady growth in both referrals and clinical complexity, meaning they are unable to meet rising demand. Services noted that the growing preference for people to remain and die at home adds additional layers of coordination and resource intensity, which has led to services prioritising the most acute and complex patients for access to palliative care services to manage finite capacity. The resources needed to support the delivery of safe, timely and high-quality home-based care may be poorly understood.

Community-based services echoed these pressures, describing substantial growth in the numbers of patients needing palliative care, without proportional financial support. One specialist palliative care service provider noted that their service has grown almost four-fold in the number of patients requiring support over the past seven years, without a corresponding increase in funding. This has created significant strain on workforce capacity and responsiveness. Stakeholders also highlighted that the EMPHN catchment is among the fastest-ageing regions in Victoria, predicting that increasing multimorbidity and dementia will further stretch existing resources and models of care.

Residential aged care and generalist providers are similarly experiencing the impact of rising acuity. RACHs are caring for older, frailer residents with more complex needs, including advanced cognitive impairment and bariatric care requirements, which present both safety and resource challenges. Collectively, these pressures mean that some specialist and community palliative care services are having to narrow who they can accept, simply because demand is outstripping capacity. As referral criteria tighten in response to rising acuity and limited resourcing, stakeholders noted a growing risk

that people with complex or fluctuating illness trajectories may not meet thresholds for support and may instead fall between service boundaries." There are individuals who, "*five to ten years ago would have died due to their malignancy, however, now they are living with their chronic illness, creating gaps in care.*"[5]

Actionable insight:

Increasing multimorbidity, dementia prevalence and the number of people living longer with a life-limiting condition indicate that existing service models may not fully align with emerging levels of complexity. This highlights the need for system-wide collaboration, capability-building and shared planning efforts to improve responsiveness to these broader cohorts and changing patterns of need.

2. High turnover and inconsistent capability are undermining palliative care quality and access

Across all stakeholders, workforce issues were a prominent theme. Services described difficulty recruiting and retaining skilled nurses, compounded by high turnover, particularly among overseas staff who are often a more transient workforce. This staff turnover is perceived to have contributed to a gradual erosion and deskilling of specialist expertise, as dedicated palliative care roles have increasingly been replaced by more generalist positions.

Long-standing community and network staff reflected on this workforce shift, noting that specialist palliative care nurses were once funded and embedded in regional teams, but over time, specialist positions have decreased. This results in a workforce with variable capability in core palliative care tasks, such as recognising the terminal phase, managing anticipatory medications, and conducting goals-of-care and ACP conversations. Stakeholders noted how identifying the terminal phase can "feel like a scramble", with some staff confidently implementing anticipatory orders while others seek clarification from GPs, in-reach teams, ED clinicians or the Palliative Care Advice Service—often about whether a resident is truly entering the terminal phase, how to adjust symptom-management medications, or whether existing anticipatory orders remain appropriate. These patterns highlight inconsistency in practice and uncertainty in decision making at the point of deterioration. Other stakeholders also pointed to *"lower levels of education and transient staff"* impacting the quality of palliative care offered and being delivered.

Beyond technical skills, stakeholders also report a high emotional burden for staff, particularly when navigating conversations on ACP. Stakeholders perceive that many clinicians experience distress during these conversations, fearing they may diminish patient hope. ACP providers noted that junior doctors are often expected to lead complex end-of-life conversations without adequate training or enough time. Stakeholders emphasised that these conversations *"can't [be] rush[ed], need to have time, space and energy"* [6]

Actionable insight:

High workforce turnover and the erosion of specialist roles are perceived to be contributing to inconsistent capability across core palliative care tasks, resulting in variability in care quality and increased emotional burden on staff. A focus on workforce confidence, capability, and retention is needed to support provision of core palliative care services and improve patient experience and outcomes.

[5] – Advice Care Service representative.

[6] - ACP Stakeholder representative

3. GP engagement, role clarity, and shared-care models of care are essential for improving palliative care

Across all stakeholder groups consulted, GP engagement was described as essential to providing high quality palliative care. At the same time, GP engagement was reported to be inconsistent and often difficult to achieve. While some GPs are seen as exemplary, going above and beyond, often in their own time, structural and cultural barriers limit their consistent involvement in palliative care and ACP. Specialist palliative care and community palliative care providers described the difficulty of getting GPs involved in palliative care for people at home and in the community, noting that palliative care is not always seen as *"core business"* within general practice.

The lack of remuneration for GPs to engage in palliative care was also identified as a key barrier, with stakeholders highlighting that current funding models do not include an MBS item for GPs to identify and deliver palliative care. As a result, GPs prioritise care activities for which renumeration clearly exists.

Confusion around roles and responsibilities further complicates care coordination. Stakeholders noted uncertainty between GPs, specialist services and generalist providers, particularly about who leads, who coordinates and who supports at different stages. Network members also noted that GPs may see very few palliative patients each year, meaning they are *"out of practice"* or often do not have the necessary skills and capabilities to effectively engage in the palliative care process. This gap underscores the need for alternative models that embed shared-care principles and provide clear guidance on responsibilities. It was suggested that the PHN provide a *"new GP starter"*[7] PHN package, promoting local referral pathways and access to palliative care services, responsibilities, and resuming in-practice talks that involve all clinic staff.

Specialist clinicians highlighted the need for more explicit shared-care arrangements, noting that specialist teams can sometimes assume primary responsibility for care without maintaining strong engagement with the GP, which creates a disconnect when responsibility is later transferred back. Others emphasised that, even with strengthened generalist capability, decisions related to opioid and sedative use and the care of the actively dying remain clinically high-risk. As such, generalist providers will continue to require timely specialist support, rather than full delegation, in many situations.

Actionable insight:

GP engagement in palliative care remains inconsistent, with varying confidence and clarity around end-of-life responsibilities. Shared-care arrangements could be strengthened with training and practical tools for GPs that clarify definitions and expectations, streamlining referral pathways amongst providers, and improved communication channels. Incentivising consistent engagement of GPs in anticipatory planning and symptom management would also be beneficial. There may be opportunities to identify sustainable business practices that support GPs to be engaged in shared care with palliative care specialists.

4. System fragmentation, poor data visibility and lack of interoperable digital infrastructure undermine continuity of care

All stakeholder groups described a fragmented system, with multiple services, inconsistent referral processes and limited ability to share information in real time. Stakeholders noted there is *"no seamless communication between services"*[8] and services often feel disjointed, creating frustration and delays for both patients and providers. Specialist palliative care teams echoed this notion and noted situations where patients are discharged without clear documentation of hospital stays or forward care plans, leaving teams scrambling to piece together information.

[7] General Practice representative
[8] Pharmaceutical Society of Australia representative

Digital systems were consistently described as a significant barrier to seamless care. Stakeholders called for improved interoperability across electronic medical record (EMR) systems, noting that a more unified approach would reduce duplication and the time spent sourcing clinical information. Others highlighted the limitations of hybrid paper–electronic workflows, where documents such as ACPs may only be uploaded after discharge, making them difficult to access during admission into palliative care services when they are most needed.

Despite these limitations, there is optimism about the emerging digital solutions and opportunities. While in its early stages, the potential for palliative care systems to integrate with MyHealthRecord was seen as a promising development that could enable timely access to palliative care documentation and ACPs. Community providers are also beginning to adopt platforms like 'PalCare Go' and secure messaging, but uptake, particularly among GPs, remains limited and referral processes are still perceived to be complex and time consuming. Stakeholders agreed that simplifying these processes could encourage greater GP participation and improve coordination.

Actionable insight:

Stakeholders consistently described difficulties related to communication, documentation and clinical handover across hospitals, community providers, RACHs and primary care. There may be opportunities to improve information sharing between providers, standardised referral processes and enhance data visibility to better enable care coordination.

5. Timely access to medications, advice and after-hours support remain critical gaps

RACHs and specialist palliative care providers repeatedly highlighted delays and variability in access to medications and expert advice, particularly after hours and on weekends. Stakeholders, especially those from RACHs, described the challenges experienced when residents deteriorate unexpectedly. Many RACHs do not have access to either IMPREST medication supplies or syringe drivers, leaving staff reliant on locum GPs and / or hospitals to access palliative care medicines. This can result in prolonged periods without adequate support for residents who are actively dying, creating stress for staff and families alike.

Locum GPs were described as reluctant to prescribe palliative medications, often due to limited trust in nursing teams or unfamiliarity with palliative care and palliative medicine protocols. These delays are difficult to explain to families, who expect timely symptom relief but are told *"they have to wait [for the prescription to be authorised]"*[9] .

Specialist palliative care clinicians pointed to structural gaps in after hours and weekend support, noting that care coordination and navigation between services - such as linking RACHs, GPs, after-hours medical services, emergency departments (EDs) and community palliative care teams - remains inconsistent and that initiating palliative care for new patients outside standard hours can be difficult. The Victorian Palliative Care Advice Service is partly filling after hours service gaps, offering a 7am–7pm phone service, staffed by specialist palliative care nurses and consultants, which provides guidance and links patients to appropriate care without requiring formal diagnosis. Stakeholders perceived that advice helplines and nurse practitioner roles are critical enablers, particularly for RACHs that cannot access GPs after hours noting that *"a helpline [or]…having a nurse practitioner to support the area and aged care would be good."*[10]

Actionable insight:

Gaps in after-hours support were widely cited, both in RACHs and community settings. This suggests there would be value in approaches that support timely access to clinical advice, anticipatory prescribing and palliative care medications.

[9] RACH representative
[10] RACH representative

6. Low awareness, persistent misconceptions, and stigma around palliative care continue to influence timely access to palliative care and conversations about ACP

Across all stakeholder groups, individuals reported that palliative care is still widely perceived as synonymous with imminent death, which continues to shape how and when people access support contributing to late referrals and reluctance to engage in open conversations about prognosis, death and dying. Stakeholders observed *"people think palliative care is only end of life"* [11], noting that many patients and families still regard palliative care as synonymous with dying, only engage once deterioration is significant.

Misunderstandings about palliative medications further contribute to hesitancy and fear. Some stakeholders reported that families at times express fears that symptom-management medications are a form of assisted dying which contributes to hesitancy and reluctance to approach the subject. *"Some families see it as assisted dying – 'can you up the dose' etc. – the palliative care medicines are not to speed up dying, it is more to make them comfortable."*[12]

Similar barriers affect ACP which stakeholders repeatedly described as conceptually challenging and often poorly understood by both the community and the workforce. Even when ACPs are completed, they may not align with the treatment that is ultimately needed or clinically appropriate as a person's condition evolves. Stakeholders described how the emotional weight of ACP contributes to avoidance, with many staff feeling anxious that initiating these discussions may diminish hope or cause distress for patients and families. This sense of discomfort and perceived risk around having care conversations was reported as a key reason why ACP is often delayed or not discussed at all.

Across community palliative care settings, (such as GP settings) ACP conversations are frequently not occurring early enough. Providers described situations where "*conversations are not being had with older people in their homes, GPs aren't doing ACP, and those managing in home care don't feel they have the skills… so decisions are being made at crisis."* [13]Limited dedicated ACP workforce further exacerbates this variability. Many services no longer maintain ACP-specific roles, with ACP responsibilities absorbed into existing clinician FTE, resulting in inconsistent practice, variable confidence, and reduced opportunities for proactive planning.

Despite these challenges, stakeholders highlighted emerging opportunities to reframe ACP in ways that resonate more strongly with patients, families and clinicians. Approaches that emphasise iterative, values-based discussions rather than static documents are gaining traction, with stakeholders describing efforts to shift practice by *"reframing ACP to not planning for now but into the future… emphasising the discussion that you have around the future is the important thing."*[14].

Actionable insight:

Stakeholder reflections indicate that limited awareness, persistent misconceptions and variability in workforce capability continue to delay timely engagement with both palliative care and ACP. These findings point to opportunities to explore strengthening community-facing messaging, supporting culturally safe and values-based conversations, and building capability across generalist and community-based roles to initiate ACP and palliative conversations earlier and more confidently. A focus on normalising palliative care as a quality-of-life–enhancing approach, and ACP as a routine, iterative planning process, may help shift perceptions and improve access across the region.

7. Equity gaps persist for CALD communities, First Nations people, people with disability and those with dementia

[11] ACP Provider
[12] RACH representative
[13] In home palliative care provider representative
[14] Director of palliative care

Stakeholders note significant equity gaps remain for key populations such as First Nations, CALD communities, people with disability and those with dementia, driven by cultural, structural and workforce-related barriers, which are compounded by declining access to spiritual and psychosocial care.

Stakeholders reported low First Nations access, highlighting limited awareness of services and challenges navigating palliative care at home and in the community. *"First Nations individuals [are not] accessing [palliative care services] as much as they could be… They don't know what is available and unsure how to access it."*[15].

CALD communities experience additional barriers related to cultural preferences, stigma, communication norms and limited culturally responsive workforce capacity.[16] Stakeholders perceive that families from some cultural backgrounds may avoid discussing death, may expect curative treatments to continue longer, or may defer decision-making to extended family rather than the individual. These cultural norms often intersect with language barriers, low health literacy and limited access to interpreters, making palliative and end-of-life discussions more complex and time intensive. Providers highlighted that staff often feel underprepared to navigate these nuances, particularly where cultural practices around dying, symptom expression or family involvement differ significantly from western approaches and expectations.

A reduction in spiritual care roles across some services was seen as compounding these challenges, as spiritual care workers often play a key bridging role for CALD communities—supporting meaning-making, facilitating conversations about preferences, and creating culturally safe spaces to express fears or uncertainty. As one stakeholder observed, *"by cutting the wellbeing and spiritual care, they are not serving the CALD communities… there is no support for CALD patients to chat about their fears and preferences."*[17] Without this layer of support, clinicians reported greater difficulty engaging CALD patients and families in future care planning / ACP, and discussions about comfort-focused approaches.

These gaps were also seen to contribute to delayed engagement with palliative care services, misunderstandings about the intent of care, and increased distress for families when patients deteriorate unexpectedly. Several stakeholders emphasised that cultural responsiveness is not only about translation or communication tools but about ensuring staff understand cultural values around illness, autonomy, disclosure, spirituality and family roles, and have the confidence and time to adapt their approach accordingly. GPs also noted that due to the level of specificity needed to deliver culturally appropriate and safe care to people of CALD communities, there should be *"special interest GPs"*[18] that provide tailored palliative care support to specific populations to ensure high quality and appropriate care.

Disability emerged as a significant area of unmet need, with stakeholders emphasising that current disability and aged care settings are often not equipped to deliver complex palliative care. Advice Service clinicians noted that many RACHs and disability accommodation services lack the clinical capability, workforce skill-mix and 24-hour nursing required for people with disability who have life-limiting conditions.[19]

Dementia was consistently identified as an area where current palliative care access, models and supports do not adequately meet people's needs. Stakeholders emphasised concern that mainstream palliative care models are not well-suited to meet the needs of this cohort. Stakeholders described dementia as fundamentally different from other life-limiting conditions: prolonged, unpredictable,

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[15] Palliative care nurse practitioner; palliative care clinical coordinator
[16] Australian Government Department of Health / Australian Healthcare Associates, *Exploratory Analysis of Barriers to Palliative Care: Issues Report on People from Culturally and Linguistically Diverse Backgrounds*.
Palliative Care Australia, *Culturally and Linguistically Diverse Communities and Palliative Care – Position Statement*.
Leonard R et al., "The end-of-life needs of Aboriginal and immigrant communities: a challenge to conventional medical models", *Frontiers in Public Health*, 2023.
[17] ACP provider
[18] General Practice representative
[19] Palliative Care Advice service representative

and characterised by gradual functional decline rather than discrete episodes of deterioration. This makes it difficult for services to identify the palliative phase, anticipate symptom escalation, or apply traditional eligibility criteria that rely on clear prognostic milestones.

Providers emphasised that people living with dementia frequently fall between service boundaries—too "stable" for specialist palliative care, but too complex for generalist palliative care services to manage confidently. Behavioural symptoms, difficulties with communication, and challenges assessing pain or distress mean that dementia care often requires more time, continuity and relational knowledge than the system is currently structured to provide. As one stakeholder reflected, *"[people with dementia] are marginalised and isolated… the system is not designed for people with dementia."* [20]

Stakeholders reported that families of people with dementia often feel unsupported and unsure how to interpret changing symptoms, and that staff lack confidence in recognising when a person is transitioning toward end of life. This contributes to crisis-driven hospital presentations, delayed symptom management and distress for both families and staff. Stakeholders also noted that dementia care frequently lacks advocacy, with some people entering RACHs solely because the community system cannot offer the level of support required.

Actionable insight:
Several priority population groups experience persistent barriers to accessing coordinated, culturally safe, and appropriate palliative care. These populations require tailored models of support that better meet their palliative care needs. Enabling this requires strengthened partnerships between palliative care services and community-controlled organisations, enhanced data collection on priority populations, and engagement with these populations to co-design culturally responsive resources and care pathways.

8. Informal carers carry significant burden with limited structured support

Informal carers are central to palliative care supports in both home and RACH settings, yet stakeholders consistently described limited structured support for their emotional, psychological and financial needs. Stakeholders emphasised that informal carers carry substantial responsibility but often do so with limited guidance and respite. *"Informal carers make a difference – many have their own issues, and there is no support out there for them either."* [21] Carers may also experience distress when navigating complex decisions or care transitions without adequate preparation or professional support. These challenges can contribute to feelings of uncertainty and high levels of burden, particularly when care needs escalate or services are fragmented.

Advice Service stakeholders highlighted that family members and friends are frequently the primary instigators of contact, underlining the need for more direct support and guidance: *"90% of calls are from family and friends – how to have conversations when they notice changes and how do they get support – therefore families and friends need to be targeted [with education and awareness material relating to palliative care]."* [22]

Actionable insight:
Informal carers play a pivotal role in palliative and EOLC yet many report high levels of stress, limited guidance and inconsistent access to information. This underscores the value of exploring opportunities to embed carer support more formally within palliative care activities, service models

[20] Eastern Metropolitan Region Palliative Care Consortium representative
[21] Eastern Metropolitan Region Palliative Care Consortium representative
[22] Palliative care advice service representative

and pathways. Strengthening access to practical resources, emotional support, coaching and navigation could help improve outcomes for both carers and consumers.

4.3 Consumer and Carer Survey

As an additional data source to the quantitative analysis and stakeholder consultations, a survey was administered to consumers and carers to provide insight into palliative care needs across the Eastern Melbourne region, including lived experience, preferences, and unmet needs in accessing palliative care services. The survey combined closed-ended questions for quantitative trends with open-ended questions, ensuring a balanced understanding of service gaps, workforce challenges, and consumer experiences.

The survey was disseminated through EMPHN's WiseCrowd panel to ensure broad representation and was administered between 3-10 December 2025. The survey received 19 responses. Detailed survey instruments, including questions, are in Consumer and Carer Survey

Appendix item P.

Awareness and education

Across consumers and carers surveyed, 79% 'agree' or 'strongly agree' that they are aware and understand the difference between palliative and EOLC (

Question Number	Question	Response options	
1	Which Local Government Area (LGA) do you live in?	Banyule Boroondara Knox Manningham Maroondah Mitchell	Monash Murrindindi Nillumbik Whitehorse Whittlesea Yarra Ranges
2	I am aware of and understand the difference between palliative and end of life care.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree	
3	GPs have an important role to play in supporting people to receive palliative care at home and in the community.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree 5 - Strongly agree	
4	I am confident and comfortable to have conversations about death and dying.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree	
5	I know what an Advance Care Plan is and how to complete one.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree 5 - Strongly agree	
6	I know what services are available within my region that provide palliative care at home and in the community.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree	

		5 - Strongly agree
7	Palliative care services in the region are well coordinated across hospitals, community providers, and general practice.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
8	Have you or a person you care for received palliative care or discussed palliative care options?	No Yes
9	I / the person I care for was provided with clear information about palliative care options and services early on when I / the person I care for developed a life limiting illness.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
10	I / the person I care for received quality palliative care at home and in the community that met needs and preferences.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
11	I would be interested in education and awareness on topics relating to palliative care.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
12	What would make it easier for patients and families to access timely, high-quality palliative care at home or in the community?	Free text
13	From your perspective, how could the system better support carers' wellbeing, including financial and cultural considerations, throughout the palliative care journey?	Free text

Appendix item Q). However, 16% 'disagree' or 'strongly disagree' emphasising that there is still need for education and awareness in the Eastern Melbourne catchment area. One participant reporting, *"some people still think it means a process that only commences in the last few days of life".*[23]

When asked about ACP familiarity and if participants know how to complete ACP forms (Appendix item R), while 63% of participants responded 'agree', 32% responded 'disagree' or 'strongly disagree', further supporting the need for further education and awareness.

Overall, 94% of consumers and carers surveyed 'agreed' or 'strongly agreed' that they were interested in education and awareness topics related to palliative care (Table 34) indicating there are still gaps in awareness not only in the community, but for people currently experiencing palliative care as a carer or consumer.

Table 34: I would be interested in education and awareness on topics relating to palliative care

I would be interested in education and awareness on topics relating to palliative care.		
Response	No.	%
Strongly disagree	-	-

[23] Consumer and Carer survey participant

Disagree	-	-
Neutral	1	5%
Agree	9	47%
Strongly agree	9	47%
Total	19	100%

Actionable insight:
There is a clear need for targeted education and awareness initiatives to address misconceptions about palliative care and ACP, even among those currently engaged in care. Without intervention, these gaps will continue to delay timely access to services and informed decision-making.

Clear communication, information and navigation

In response to the question 'I / the person I care for was provided with clear information about palliative care options and services early on when I / the person I care for developed a life limiting illness' 11 survey participants chose not to respond while half of those that did 'agree' while the remainder 'disagree' or 'strongly disagree' (except one 'neutral') (Table 35). Despite the small sample size this does suggest more needs to be done to strengthen information available to support people understand what palliative care options and services are available. One consumer commented in the survey *"many patients only learn about palliative care late in their illness."*[24]

Table 35: I / the person I care for was provided with clear information about palliative care options and services early on when I / the person I care for developed a life limiting illness

I / the person I care for was provided with clear information about palliative care options and services early on when I / the person I care for developed a life limiting illness		
Response	No.	%
Strongly disagree	1	5%
Disagree	2	11%
Neutral	1	5%
Agree	4	21%
Strongly agree	-	-
Blank	11	58%
Total	19	100%

Only 5% of participants reported that they knew what palliative care services are available at home and in the community, with 58% of participants responding 'disagree' or 'strongly disagree' (Table 36). Participants suggested practical solutions to improve navigation and awareness, including information on palliative care pathways in the form of brochures in GP clinics, chemists and hospitals, and council-run information nights detailing local services, costs and eligibility.

Table 36: I know what services are available within my region that provide palliative at home care and in the community

I know what services are available within my region that provide palliative care at home and in the community		
Response	No.	%
Strongly disagree	4	21%
Disagree	7	37%
Neutral	3	16%
Agree	4	21%

[24] Consumer and Carer survey participant

Strongly agree	1	5%
Total	19	100%

Actionable insight:
There is a need for culturally sensitive communication, early information, and clear navigation pathways. Without this, patients and carers risk feeling isolated and uninformed, leading to delayed referrals and inequitable access to palliative care services.

Coordination across services and quality palliative care

While 53% of carers and consumers remained neutral, 37% 'disagree' or 'strongly disagree' that palliative care services in Eastern Melbourne are well coordinated across hospitals, community providers and general practice. Only 2 participants agree (Table 37). Additionally, 73% of consumers either 'agree' or 'strongly agree' that GPs have an important role to play in supporting people to receive palliative care (Table 38). One participant stated that *"coordination among healthcare providers is critical… GP is the key point in the coordination of care delivery."*[25]

Table 37: Palliative care services in the region are well coordinated across hospitals, community providers, and general practice

Palliative care services in the region are well coordinated across hospitals, community providers, and general practice		
Response	No.	%
Strongly disagree	3	16%
Disagree	4	21%
Neutral	10	53%
Agree	2	11%
Strongly agree	-	-
Total	19	100%

Table 38: GPs have an important role to play in supporting people to receive palliative care at home and in the community

GPs have an important role to play in supporting people to receive palliative care at home and in the community		
Response	No.	%
Strongly disagree	-	-
Disagree	1	5%
Neutral	4	21%
Agree	5	26%
Strongly agree	9	47%
Total	19	100%

While 11 participants did not respond, 27% indicated neutrality or disagreement that they or their loved one received high-quality palliative care that met their needs. Only 16% of participants agree their needs were met (Table 39).

Table 39: I / the person I care for received quality palliative care at home and in the community that met needs and preferences

I / the person I care for received quality palliative care at home and in the community that met needs and preferences		
Response	No.	%

[25] Consumer and Carer survey participant

Strongly disagree	1	5%
Disagree	2	11%
Neutral	2	11%
Agree	3	16%
Strongly agree	-	-
Blank	11	58%
Total	19	100%

Actionable insight:

Many carers and consumers perceive poor coordination across palliative care services in Eastern Melbourne, highlighting the need for integrated care and stronger GP involvement. There is an opportunity to develop coordinated care models that positions GPs as central connectors, supported by clear referral pathways.

Carers Support

Survey responses revealed carers are often overlooked, with limited financial, emotional and cultural support. Participants called for carers to be recognised as having needs distinct from consumers, with dedicated funding, subsidies, paid leave and workplace flexibility to ease financial strain. Emotional wellbeing needs included counselling, peer support and debriefing sessions, while cultural safety required better interpreter access and tailored support for CALD communities. Practical needs such as respite, training and clear navigation pathways were also highlighted. As one respondent noted *"families are expected to fill all the gaps that currently exist in our health care system,"* [26]underscoring the need for better support for carers throughout the palliative care journey.

Actionable insight:

Implementation of dedicated carer support programmes (financial, emotional and cultural), and practical resources such as respite services and training for equipment and medication management will work to improve carer palliative care experiences.

[26] Consumer and Carer survey participant

5. Service mapping

Specialist Palliative Care Services

Specialist Palliative care services in the EMPHN catchment can be categorised into three types of service providers:

- Specialist inpatient units
- Community specialist care teams (hospice, respite and outreach specialist services delivered in home-based settings)
- Consultancy teams (providing advice, support education and training to health professional in the sector).

The region includes seven specialist inpatient services within public (5) and private (3) hospitals:

1. Austin Health Palliative Care Unit,
2. Northern Health Inpatient Palliative Care Unit,
3. Monash Health McCulloch House,
4. Eastern Health-Wantirna Health Palliative Care Unit,
5. St Vincent's - Caritas Christi Hospice,
6. Ringwood Private Hospital Palliative Care Unit,
7. Cabrini Acute Palliative Care Unit (Private).

Five multidisciplinary community providers deliver specialist palliative care at home (2 Public, 3 Private):

1. Eastern Palliative Care,
2. Banksia Palliative Care Service,
3. Cabrini Home-Based Palliative Care (Private),
4. Home Hospice Australia (Private),
5. Melbourne City Mission Palliative Care (Private).

Palliative care consult services are associated with 3 inpatient facilities (Austin Health Palliative Care Unit, Northern Health Palliative Care Unit, Cabrini Acute Palliative Care Unit), providing information and support to health professionals across the region.

Within the EMPHN catchment there are a total of 113 public inpatient palliative care beds (including the 28 beds at Caritas Christi Kew) with an additional 30 beds across the private facilities at St Vincent's Hospital acute unit in Fitzroy and Cabrini Acute Palliative Care Unit in Malvern. There are also a small number of beds at Ringwood Private Hospital. Other specialist palliative care services are provided by services adjacent to the catchment (Cabrini Hospital in Prahran, Home Hospice Australia, Melbourne City Mission Palliative Care, the Victorian Paediatric Palliative Care Service, Very Special Kids in Malvern and Fernlea in Emerald).

There are no standalone hospices in the region. All hospice-style beds are located within hospital settings.

Table 40 provides an overview of specialist palliative care services across the EMPHN catchment and nearby areas, outlining each provider's location, service types, local government areas served, referral pathways and available capacity.

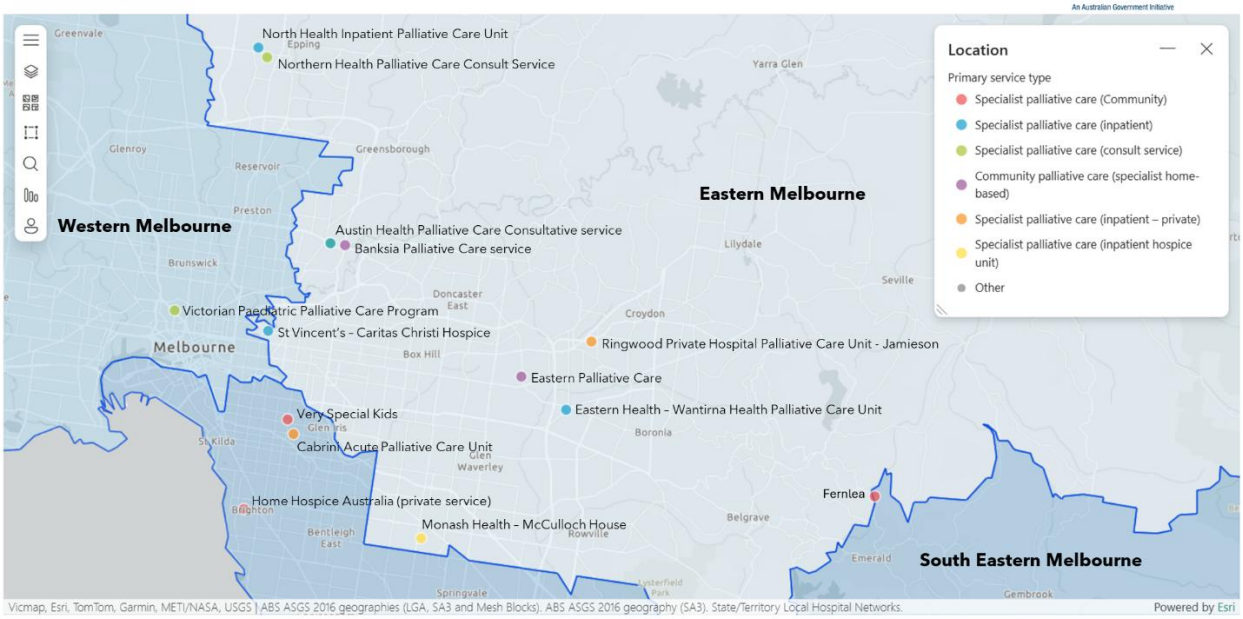
Table 40: Palliative care service map for EMPHN catchment and near surrounds

Service provider	Location	Inpatient	Community (Home based)	Consult	Capacity
Eastern Palliative Care	Mitcham		✓		Community only – no inpatient beds
Eastern Health -Wantirna Health Palliative Care Unit	Wantirna South	✓			32-total palliative beds
Banksia Palliative Care Service	Heidelberg		✓		Community only – no inpatient beds
Austin Health Palliative Care Unit + Consult service	Heidelberg	✓		✓	21 total palliative beds Consult service model
Monash Health -McCulloch House	Clayton	✓			16 total palliative beds
Northern Health Inpatient Palliative Care Unit + Consult service	Epping	✓	✓	✓	16 total palliative beds Consult service model
St Vincent's - Caritas Christi Hospice	Kew	✓			28-total palliative beds (+ 8 private)
Ringwood Private Hospital Palliative Care Unit -Jamieson (Private)	Ringwood East	✓			Bed numbers not specified (Private)
Cabrini Acute Palliative Care Unit (Private hospital)	Malvern	✓	✓	✓	22-total palliative beds (Private) Community Consult service
Home Hospice Australia (private service)	Victoria		✓		Private-Community only – no inpatient beds
Melbourne city mission palliative care	Thornbury		✓		Private Community only – no inpatient bed
Very Special Kids	Malvern		✓		Community only – no inpatient beds
Victorian Paediatric Palliative Care Program	Parkville			✓	Consult service model
Fernlea	Emerald		✓		Community only – no inpatient bed

Source: Web Search

Figure 1: Map of Palliative Care services in EMPHN region

EMPHN Palliative Care Service Map



Geographic spread of EMPHN services

Across the EMPHN catchment, palliative care services are concentrated in inner metropolitan LGAs, with inpatient units located in Banyule (Heidelberg), Knox (Wantirna South), Monash (Clayton), and Boroondara (Kew), as well as private facilities in Maroondah (Ringwood East) and Monash (Malvern). These sites provide most of the region's bed-based capacity, while community specialist teams operate from locations such as Mitcham (Whitehorse) and Heidelberg (Banyule), alongside consultative services linked to major hospitals.

Coverage is notably thinner in outer LGAs, where Mitchell and Murrindindi have no physical provider presence and rely entirely on outreach or consultative models. Capacity also varies significantly: LGAs such as Nillumbik and Whittlesea have limited on-site infrastructure and no dedicated inpatient options. In contrast, inner LGAs like Banyule and Monash host multiple service types, including consult teams and private facilities. Underserviced areas include Nillumbik, Whittlesea, where geographic distance and absence of inpatient beds constrain timely access to specialist care. These patterns highlight a strong urban concentration and suggest potential equity challenges for residents in northern and eastern growth corridors, particularly for those requiring complex symptom management or rapid admission pathways.

While some services including Victorian Paediatric Palliative Care program, Very Special Kids, Cabrini Acute Palliative Care Unit and Home Hospice Australia are outside the EMPHN catchment boundary on the map, they have been included as patients and carers may still access these locations due to their proximity to the region's borders.

5.1 Workforce mapping

GPs in Eastern Melbourne

The total number of GPs across the EMPHN region has grown steadily over the past six years, increasing by 4.2%, from 2,696 in 2019-2020 to 2,810 in 2024-2025 (Table 41). 2022 – 2023 saw the highest number of GPs in the region at 2,825. GP growth is uneven across LGAs, Boroondara and Monash consistently maintain the highest number of GPs, with Boroondara peaking at 547 GPs in 2022–2023 before a slight decline. Mitchell shows the most significant proportional increase, rising from 96 to 134 GPs, whereas rural areas like Murrindindi remain critically low, fluctuating between 17 and 23 GPs. These patterns underscore the need for targeted workforce strategies, particularly in rural and slower-growth LGAs, to ensure equitable healthcare provision across the region.

Table 41: Total number of GPs in EMPHN region - (Cells highlighted in red represent the highest values, green represent the lowest values per LGA.)

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	271	268	293	313	318	304
Boroondara	464	476	525	547	516	484
Knox	348	342	359	354	380	366
Manningham	262	273	311	317	296	275
Maroondah	222	223	230	218	208	217
Mitchell	96	91	90	90	107	134
Monash	411	413	445	470	444	475
Murrindindi	17	19	23	23	17	20
Nillumbik	122	114	124	121	127	131
Whitehorse	434	427	442	472	477	470
Whittlesea	388	370	371	382	373	407
Yarra Ranges	281	267	282	309	285	291
Eastern Melbourne	**2,696**	**2,675**	**2,775**	**2,825**	**2,810**	**2,810**

Source: HeaDS UPP Tool, 2025

When adjusted for population, Table 42 demonstrates that GP capacity has remained relatively stable between 2019 – 2020 and 2024 – 2025, averaging around 2.8 – 3.0 occasions of services per 10,000 Estimated Resident Population. Boroondara consistently records the highest service rate, peaking at 3.8 in 2021–2022, while Nillumbik and Whittlesea recorded the lowest rate at 1.7–1.9 and 2.6 respectively. Rural LGAs such as Murrindindi show a notable decline from 4.7 in 2019–2020 to 3.2 in recent years; this reduced service availability could be due to the decline in GPs available in the Murrindindi LGA. For most LGAs and the catchment overall, services per 10,000 peaked in 2021 – 2022, likely reflecting residual impacts from the COVID-19 pandemic.

Table 42: Number of GP services per 10,000 Estimated Resident Population (ERP) in EMPHN region - (Cells highlighted in red represent the highest values, green represent the lowest values).

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	2.8	-	3.2	3.3	2.9	3
Boroondara	3.2	-	3.8	3.5	3.5	3.2
Knox	2.6	-	2.5	2.6	2.6	2.5
Manningham	3.2	-	3.3	3.1	2.9	2.8
Maroondah	2.5	-	2.4	2.6	2.4	2.4
Mitchell	2.8	-	2.8	2.7	2.4	2.4
Monash	3.1	-	3.3	3.3	3.1	3
Murrindindi	4.7	-	3.3	3.3	3.2	3.2
Nillumbik	1.7	-	1.7	1.9	1.9	1.9
Whitehorse	2.8	-	3	2.9	2.9	3
Whittlesea	2.7	-	2.8	2.6	2.6	2.6
Yarra Ranges	3	-	2.9	2.8	2.8	2.8
Eastern Melbourne	**2.8**	**-**	**3**	**2.9**	**2.8**	**2.8**

Source: HeaDS UPP Tool, 2025

Actionable Insight:

These patterns suggest that while overall service levels are steady, disparities persist between urban and rural LGAs, potentially impacting equity of access. Strategic workforce planning and targeted interventions are needed to address gaps in low-service LGAs and prevent further decline in rural coverage.

GPs and chronic disease and complex care management

The number of GP services for chronic disease and complex care management across the EMPHN region has grown substantially from 612,104 occasions of service provided by GPs in 2019–2020 to 804,000 occasions of service in 2024–2025, reflecting a strong upward trend in demand for these services (Table 43). All LGAs in the EMPHN catchment experienced increases, with the most significant growth observed in Knox (from 64,104 services to 90,516 services) and Monash (from 67,359 services to 103,327 services), while Mitchell more than doubled in service volume, rising from 18,432 to 29,243 services. Although smaller LGAs such as Murrindindi remain low in service numbers, they still show gradual growth. This consistent rise in services provided suggests an increasing burden of chronic disease and complexity in patient care across the region. These trends highlight the need for enhanced capacity in primary care, investment in chronic disease management programs, and integrated care models to meet growing demand and prevent system strain, particularly in high-growth LGAs and areas with historically limited resources.

Within the EMPHN region, the number of GP full-time equivalents (FTE) providing chronic disease and complex care management has increased significantly from 151.1 in 2019 – 2020 to 200.3 in 2024 – 2025, reflecting growing workforce capacity in this area (Table 44). All LGAs show an upward trend, with the most notable increases in Knox (from 16.2 to 22.3), Monash (from 17.2 to 26.1), and Whittlesea (from 27.4 to 35), while Mitchell had nearly doubled its FTE from 4.6 to 7.5. Smaller LGAs such as Murrindindi remain low, fluctuating between 1.5 and 2.0, indicating persistent workforce limitations in rural areas. This growth aligns with rising demand for chronic disease management services, yet the uneven distribution of FTEs suggests potential access challenges for some communities.

Table 43: Number of services by GPs - Chronic disease / complex care management 2019 – 2025, EMPHN

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	38,698	45,014	44,089	48,933	54,716	61,670
Boroondara	47,991	52,770	46,328	54,063	55,999	65,512
Knox	64,104	73,269	63,328	70,842	78,404	90,516
Manningham	59,993	70,009	74,617	76,413	73,392	74,831
Maroondah	38,916	42,656	38,771	40,372	42,760	51,274
Mitchell	18,432	18,901	15,080	16,156	20,538	29,243
Monash	67,359	76,071	73,293	82,209	90,092	103,327
Murrindindi	6,377	7,306	7,278	8,065	8,522	7,504
Nillumbik	18,486	19,949	17,508	19,912	21,244	23,218
Whitehorse	99,810	108,373	101,009	107,817	107,167	112,641
Whittlesea	111,492	124,556	113,392	122,668	127,511	139,186
Yarra Ranges	60,227	64,464	59,855	63,743	70,810	77,210
Eastern Melbourne	**612,104**	**682,432**	**635,705**	**691,346**	**727,624**	**804,000**

Source: HeaDS UPP Tool, 2025

Table 44: GP Full time equivalent FTE providing chronic disease / complex care management 2019 – 2025, EMPHN

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	9.7	11.2	11	12.2	13.6	15.3
Boroondara	12.1	13.2	11.7	13.7	14.2	16.6
Knox	16.2	18.4	16	17.7	19.4	22.3
Manningham	14.7	17	18.2	18.7	18.1	18.4
Maroondah	9.2	10.1	9.2	9.7	10.6	12.6
Mitchell	4.6	4.7	3.8	4.1	5.2	7.5
Monash	17.2	19.3	18.6	20.8	22.8	26.1
Murrindindi	1.5	1.7	1.7	1.9	2	1.8
Nillumbik	4.6	5	4.4	5	5.3	5.8
Whitehorse	23.9	25.9	24.3	26.2	26.3	27.8
Whittlesea	27.4	30.7	28.1	30.5	31.9	35
Yarra Ranges	14.9	15.8	14.7	15.7	17.5	19
Eastern Melbourne	**151.1**	**167.9**	**157.3**	**171.3**	**181.1**	**200.3**

Source: HeaDS UPP Tool, 2025

Actionable Insight:

Demand for chronic disease and complex care management services across the EMPHN region has surged by nearly 32% since 2019–2020, with Knox, Monash, and Mitchell showing the most significant growth, while GP workforce capacity has expanded by a similar margin but remains unevenly distributed, particularly in rural LGAs. These trends highlight the need for targeted investment in chronic disease programs, workforce planning, and integrated care models to ensure equitable access, especially in high-growth LGAs and resource-limited rural areas.

Aged care services

The number of aged care providers (i.e. both RACHs, and home care packages) across the EMPHN region has shown a gradual decline over the five-year period, falling from 338 services in 2019–2020 to 313 in 2023–2024 (Table 45). The decline in available services contrasts greatly with the region's growth, particularly among those aged 85+, where the population has increased by approximately 17% between 2019 and 2025 (from 35,818 to 42,010; see Table 19). While some LGAs such as Boroondara and Monash maintained relatively stable service levels, others experienced notable reductions. Banyule decreased from 27 to 21 services, and Knox from 40 to 32, while Maroondah dropped from 46 to 37. Smaller LGAs like Murrindindi and Mitchell remained static at very low levels (4 and 5 services respectively).

Table 45: Number of operational aged care services located in EMPHN, 2019 - 2025

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	27	26	18	19	21	-
Boroondara	45	45	47	47	47	-
Knox	40	40	34	34	32	-
Manningham	31	31	31	31	29	-
Maroondah	46	46	40	37	37	-
Mitchell	5	5	5	5	5	-
Monash	50	55	61	60	61	-
Murrindindi	4	4	4	4	4	-
Nillumbik	8	9	9	9	9	-

Whitehorse	41	40	35	33	32	-
Whittlesea	30	29	28	30	32	-
Yarra Ranges	21	20	20	19	19	-
Eastern Melbourne	**338**	**337**	**316**	**312**	**313**	**-**

Source: ABS Census, 2021

The number of GP full-time equivalents (FTE) providing services in RACHs across LGAs in the EMPHN region has increased steadily from 84.8 in 2019–2020 to 106.7 FTEs in 2024–2025 (Table 46), indicating a gradual strengthening of workforce capacity in this sector. While GP FTEs increased by 26% (from 84.8 to 106.7), the region's population grew by 10.7% (from 1,604,986 in 2019 to 1,776,007 in 2025). This means workforce growth across the whole region outpaced population growth, suggesting a relative improvement in GP availability per capita rather than a decline. Most LGAs show consistent growth, with Banyule rising from 75.7 to 107.7 FTEs and Knox from 79.8 to 104.9 FTEs, while Monash increased from 86.3 to 111.8 FTEs. Murrindindi stands out with the highest FTE figures throughout the period, climbing from 133.9 to 153.8, suggesting a concentration of RACHs in this rural area. Despite overall gains, some LGAs such as Boroondara and Nillumbik remain comparatively lower, highlighting uneven distribution.

GP services delivered in residential aged care facilities across the EMPHN region has fluctuated over the six-year period, peaking at 564,854 occasions of service in 2023–2024 before declining to 511,765 in 2024–2025 (Table 47). While overall occasions of service numbers remain high, trends vary across LGAs. Manningham recorded the largest increase, rising from 91,288 services in 2019–2020 to a peak of 144,188 in 2021–2022 before falling sharply to 74,827 in 2024–2025. Mitchell experienced a substantial increase from 7,803 to 132,530 in occasions of services, indicating a major shift in service delivery or demand. On the other hand, some LGAs such as Banyule and Knox show moderate growth, while others like Nillumbik and Murrindindi remain comparatively low throughout.

Table 46: GP Full time equivalent FTE that provide services in Residential Aged Care facilities 2019 – 2025, EMPHN

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	75.7	85.2	78.9	90.1	99.8	107.7
Boroondara	64.9	65.8	53.1	65.5	68.3	75.6
Knox	79.8	90.6	73.6	86.1	91	104.9
Manningham	94.5	104.1	92.6	100.5	103.1	113
Maroondah	79	84.2	72.6	84.4	93.2	102.5
Mitchell	81.3	85.5	70.5	78.5	81.3	92.6
Monash	86.3	93	77.9	90.6	99.7	111.8
Murrindindi	133.9	144.1	137.1	148.4	151.5	153.8
Nillumbik	62.7	70.4	61.7	74.5	82.4	87.7
Whitehorse	101.9	107.9	91.4	105.1	107.9	112.7
Whittlesea	95.1	107.5	95.2	109	118.9	127.3
Yarra Ranges	83.1	90.4	79.8	90.6	99.5	105.9
Eastern Melbourne	**84.8**	**92.6**	**79.8**	**91.8**	**98.1**	**106.7**

Source: HeaDS UPP Tool, 2025

Table 47: Number of occasions of services by GPs in RACHs 2019 - 2025

LGA Name	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Banyule	30,494	23,162	23,114	22,173	26,966	33,516

Boroondara	67,545	61,546	65,049	90,006	101,432	99,207
Knox	38,857	39,677	44,798	39,269	43,899	41,567
Manningham	91,288	90,587	144,188	141,390	128,910	74,827
Maroondah	20,438	20,851	19,771	17,736	19,491	21,984
Mitchell	7,803	7,189	6,522	6,939	51,087	132,530
Monash	59,436	58,597	56,981	63,394	68,938	68,668
Murrindindi	3,099	3,104	3,039	2,881	3,553	3,206
Nillumbik	55,422	39,482	38,596	43,875	29,118	21,109
Whitehorse	36,014	41,030	47,202	53,109	60,860	62,821
Whittlesea	33,145	25,505	24,432	28,116	34,041	34,001
Yarra Ranges	56,416	47,135	44,606	44,931	48,401	45,670
Eastern Melbourne	**489,962**	**445,482**	**506,624**	**541,239**	**564,854**	**511,765**

Source: HeaDS UPP Tool, 2025

Actionable Insight:

The number of aged care providers (i.e. both RACHs, and home care packages) across Eastern Melbourne has declined slightly over time, even as GP workforce capacity in RACHs has grown and occasions of service volumes have fluctuated greatly. This disparity between the number of providers, occasions of service, and workforce growth highlights the need for strategic planning to stabilise aged care provision, address uneven distribution of GPs, and ensure consistent, equitable access for older residents across all LGAs.

6. Recommendations and opportunities

The following recommendations have been developed in direct response to the demographic trends, utilisation patterns and stakeholder insights identified throughout this needs assessment. They reflect the region's rapidly ageing population, increasing multimorbidity and dementia prevalence, cultural and linguistic diversity and the significant pressures faced by generalist and specialist workforces across Eastern Melbourne. Together, these findings highlight the need for a more connected, capable and person-centred palliative care system that enables earlier identification, clearer communication, culturally safe practices and consistent support for people, families and carers across all settings, including RACHs, primary care and community services. Each recommendation is grounded in the evidence presented in this assessment and aligned to the priority areas of the GCfAHPC program to support cohesive system development and improved end-of-life outcomes for the Eastern Melbourne community.

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
6.1 Focus on activities to strengthen early identification, anticipatory planning and ACP across all settings	• EMPHN's mortality profile is dominated by chronic, progressive conditions such as dementia, cardiovascular disease, COPD, diabetes and cancer, with deaths rising particularly in the 65–84 and 85+ age groups. • GPs, community providers and RACHs are increasingly managing people who are living longer with multimorbidity and frailty, often experiencing multiple crises before death. • Stakeholders, including GPs and ACP providers, described ACP as occurring too late and often under crisis conditions, with variable confidence to initiate conversations about goals of care. • Earlier, values-based discussions embedded in routine chronic disease and aged-care reviews can better align care with preferences, reduce avoidable hospitalisation and provide clearer guidance for families and clinicians. • Population trends amplify urgency, with Whittlesea, Knox, Whitehorse and Boroondara among the highest density LGAs for older adults. Projected growth of the 85+ cohort by nearly 59% by 2030 signals further escalating demand.	• Workforce education and awareness • Community awareness • Palliative Care Medicines (anticipatory prescribing & ACP)
6.2 Build consistent palliative-care capability and confidence across generalist workforces	• GPs and practice managers reported a marked rise in multimorbidity and complexity in both clinics and nursing homes, with some describing palliative care as now "day-to-day medicine" rather than a niche activity. • Capability remains uneven. Most GPs consulted reported feeling	• Workforce education and awareness

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
	unsure about end-of-life conversations and prescribing palliative medicines such as morphine, midazolam and clonazepam drops, and are anxious about medico-legal risks when medications are kept at home. • Staff turnover, part-time work across multiple sites and declining face-to-face work post-COVID further erode confidence. • Stakeholders emphasised that most GPs do not need extensive training, but concise, GP-friendly resources (for example, one-page symptom and dosing guides, pragmatic NPS-style seminars and short, real-world GP-led education) would make a substantial difference. • Targeted capability-building across general practice, RACHs, in home care and disability services is critical to delivering consistent, high-quality palliative care. • Eastern Melbourne's aging population, several of this older population living at home, and rising dementia prevalence mean clinicians and nurses will increasingly manage complex patients. • Victoria's overall physician density remains low, reinforcing reliance on generalist capacity and capability, meaning complex cases may still face bottlenecks in specialist medical input.	
6.3 Increase GP engagement and embed clearer shared-care models	• While some GPs described experiencing highly integrated palliative roles in RACHs and home care, others reported "stepping away" from palliative patients and handing care to tertiary or specialist providers. • As reported in stakeholder consultations, fewer GPs are doing home visits, and palliative appointments are often squeezed in before or after normal sessions, with limited remuneration and no dedicated time blocks. • Fragmented employment models, with GPs working across multiple practices, make continuity hard and can lead to reluctance to complete death certificates if clinicians have not been closely involved. • Stakeholders emphasised that palliative care works best when GPs remain core partners rather than "just script writers", supported by clear shared-care arrangements with community	• Workforce education and awareness

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
	palliative services (such as Eastern Palliative Care), expectations about roles, and practical incentives (for example, item numbers or loadings for home visits and case conferences). • Population growth and ageing like that seen in Whittlesea, where there is a large population and mortality has increased by nearly 60% since 2013, highlights the need for strong GP engagement in high growth and ageing LGAs. • EMPHN can help by amplifying GP-led models, registrar placements with palliative-oriented GPs, and neutral, collegial forums where GPs mentor each other. • Palliative care hospitalisations rose 15% over five years, with public hospitals supporting most of this increase. This further indicates the need for shared care models and pathways to relieve hospitals of supporting the increasing need of palliative care.	
6.4 Improve communication, information-sharing and digital connectivity	• GPs and practice managers highlighted referral and communication friction as a major barrier to integrated palliative care. • Home visits and palliative support are often provided to existing patients only, because referral pathways for new patients are time-consuming and systems (such as EPC's online form) are perceived as "clunky". • Limited interoperability (for example, lack of seamless HealthLink or practice software integration for referrals and shared information) results in duplication and discourages engagement. • Where EPC is involved, coordination and documentation are viewed positively, but awareness is variable and some GPs are unaware that community palliative care services can be involved before the terminal phase. • Stakeholders proposed simple, practice-integrated referral options (for example, direct messages via practice software, pre-populated templates) and clearer feedback loops. • PHN-facilitated promotion of HealthPathways, POLAR-driven quality improvement reports and whole-practice education (not just targeting owners) were also seen as enablers. • Eastern Melbourne recorded a 60% increase in non-admitted	• Coordination and integration

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
	palliative care episodes for older cohorts in 2023-24. This increase in utilisation emphasises the need for coordinated digital systems to support community-based care providers communicate and coordinate between services. • Outer LGAs like Whittlesea and Mitchell face higher mortality and lower service provider density, making efficient and integrated connectivity for communication and files essential for equitable and timely access to care.	
6.5 Ensure timely access to palliative medicines, anticipatory prescribing and after-hours clinical support	• RACH and GP stakeholders consistently reported gaps in timely access to palliative medicines and after-hours advice. Some GPs fear medico-legal consequences of prescribing and leaving opioids at home without clear guidance, while locum doctors may be reluctant to initiate or adjust palliative regimens. • Many palliative visits occur outside normal hours, with limited financial recognition, which makes sustained GP involvement difficult. • GPs suggested that simple, standardised information included with referral acceptances (for example, a brief guide to scripts, storage, home medication security, anticipatory medication sets and who to contact for advice) would reduce fear and normalise prescribing. • Strengthening after-hours pathways, reinforcing the role of advice services, improving IMPREST access and syringe driver availability in RACHs, and advocating for appropriate funding for home visits and complex end-of-life care would help ensure people receive timely symptom control in their usual place of care. • Growing populations of 85+ and high RACH occupancy (84.4% in FY24) further signal demand for anticipatory prescribing and after-hours support.	• Medicines and anticipatory prescribing; RACH capability
6.6 Address inequities for CALD communities, First Nations peoples, people with disability and people living with dementia	• EMPHN's population data highlights large CALD populations, an ageing cohort of women with advanced dementia and frailty, and geographic gradients in mortality. • Stakeholders noted that First Nations, refugee and multi-language groups face unique barriers related to beliefs about illness, death, and care settings.	• Priority populations; cultural safety;

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
	• GPs identified potential for “special interest” roles in palliative care for specific populations, recognising that generic approaches do not always meet cultural or spiritual needs. • At the same time, dementia remains a leading cause of death. Providers noted that current models often do not fit dementia trajectories or disability-related complexity, leaving people to fall between generalist and specialist boundaries. • Tailored, co-designed models, culturally safe hospital- and home-based care, and better integration with community-controlled and specialised services are essential to close these gaps. • Monash, Whitehorse and Whittlesea have the largest CALD communities, with up to approximately 45% of the older population overseas born and nearly 29% speaking a language other than English at home. • There are just over 9,000 First Nations people in Eastern Melbourne, with Whittlesea, Yarran Ranges and Knox being home to more than half of this population, requiring culturally safe models and ACCHO partnerships. • Dementia prevalence and mortality trends reinforce the need for tailored models for disability and cognitive illnesses.	
6.7 Strengthen support for informal carers across home, community and RACH settings	• GPs described that short appointments often focus primarily on the patient, leaving limited time to explore carer needs. • Carers may need separate consultations for their own health, coping and practical planning, which are not always easy to arrange. • Many of the former “wrap-around” supports (such as volunteers, massage, music therapy, biography programs and structured bereavement support) have been reduced or lost due to funding changes, increasing emotional and practical load on families. • Advice and coordination services report that most calls come from family members seeking guidance when they notice change or deterioration. Stakeholders emphasised that when GPs and palliative teams are actively engaged, families feel more supported and see greater value in primary care. • Embedding carer assessment and support into pathways, making	• Community awareness and support

Recommendation	Evidence & Rationale	GCfAHPC Impact Area Alignment
	resources easier to access, and enabling GPs to book time specifically for carers would help sustain home-based care and improve experiences in both community and RACH settings. • Most patients live with another person or have a resident carer, but 4-11% live alone without support, representing a vulnerable group. • Rising respite use in certain LGAs signals growing carer strain.	
6.8 Improve geographic equity through flexible models, outreach and region-wide coordination	• Mortality and service mapping show a clear gradient across LGAs: inner, higher-advantage LGAs such as Boroondara, Manningham and Whitehorse have lower standardised death rates and better local service density, while outer-metropolitan and rural LGAs like Whittlesea, Knox, Maroondah, Mitchell and Murrindindi have higher death rates and potentially fewer local options. • Absolute deaths are rising in almost all LGAs, with Whittlesea showing particularly sharp growth. At the same time, general practice itself is fragmented, with contractor models and variable cohesion within clinics. • Eastern Melbourne's palliative medicine attendance rate (34 people per 100,000) is far below the state's (212 people per 100,000), and limited multidisciplinary coordination of case conferences, suggesting limited specialist access to outer LGAs. • GPs and practice managers suggested PHN–clinic collaboration over the next three years that pairs PHN staff with palliative-engaged GPs to visit practices, promote local pathways and services like EPC, and share practical, locality-specific scenarios. • Flexible outreach (including telehealth), RACH and home in-reach, and targeted engagement of specific GPs within under-served LGAs were highlighted as practical ways to reduce geographic inequity and ensure people receive coordinated care regardless of where they live.	• Priority populations workforce education and awareness

Appendices

Appendix 1: Stakeholders consulted

Appendix item A - Stakeholder consultations

Stakeholder Group	Organisations participated	Date Consulted	Purpose
1	• Kirkbrae Presbyterian Homes • Isomer Aged Care • Cumberland Aged Care • Advent Care Whitehorse	24 November 2025	To understand current strengths, challenges, and coordination needs within Residential Aged Care Homes, while exploring emerging trends, service gaps, and workforce capability to identify opportunities for collaboration and integration.
2	• Banksia Palliative Care	26 November 2025	To understand current strengths, challenges, and coordination needs within community-based palliative care, while exploring emerging trends, service gaps, and workforce capability to identify opportunities for collaboration and integration.
3	• VIC Palliative Care Advice Service • Pharmaceutical Society of Australia	26 November 2025	To explore how Palliative Care Advice Services and Pharmaceutical aspects are currently implemented across the EMPHN region, identify barriers and enablers to consistency and accessibility, and understand community awareness to improve coordination.
4	• Eastern Palliative Care • Eastern Health & Eastern Health Residential In Reach Service	26 November 2025	To understand hospital-based palliative care models, examine integration with community services, and identify emerging trends, gaps, and workforce capacity to enhance continuity of care and patient experience.
5	• Eastern Metropolitan Region Palliative Care Consortium • Eastern End of Life Care Network	27 November 2025	To explore diverse approaches to community-based palliative care within consortium member organisations, assess how these models integrate with primary care and specialist services, and collaboratively identify emerging trends, service gaps, and workforce capacity challenges.
6	• Austin Health Palliative Care & ACP	28 November 2025	To explore how ACP is currently implemented across

7	• Eastern Health ACP • Dr Dan Medical Clinic • GP in Boronia	05 December 2025	the EMPHN region, identify barriers and enablers to consistency and accessibility, and understand workforce capacity and community awareness to improve coordination. To understand how GPs are currently involved in palliative care, explore practical approaches to supporting patients and families in the community, examine how referral pathways and collaboration with specialist services work in practice, and identify emerging trends, service gaps, and workforce challenges from a primary care perspective

Appendix 2: Quantitative data analysis tables

Demographics

Appendix item B - LGA by age (absolute and rate per 1,000)

LGA Name	0 - 14		15 - 24		25 - 44		45 - 64		65+		Total
	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.
Banyule	21,731	14.0	13,320	8.6	33,064	21.3	30,981	22.1	22,616	20.0	121,712
Boroondara	28,111	18.1	25,068	16.2	44,901	29.0	46,098	30.1	31,993	29.8	176,171
Knox	29,156	18.8	20,153	13.0	45,747	29.5	44,923	30.3	30,142	29.0	170,121
Manningham	20,649	13.3	15,021	9.7	29,919	19.3	33,469	21.7	28,048	21.6	127,106
Maroondah	18,561	12.0	11,436	7.4	27,937	18.0	25,482	18.3	18,175	16.4	101,591
Mitchell	5,637	3.6	2,628	1.7	7,264	4.7	5,257	4.1	2,156	3.4	22,942
Monash	28,505	18.4	26,407	17.0	53,334	34.4	42,292	30.9	34,006	27.3	184,544
Murrindindi	284	0.2	192	0.1	413	0.3	545	0.3	215	0.4	1,649
Nillumbik	10,380	6.7	7,563	4.9	11,652	7.5	17,121	10.0	9,383	11.1	56,099
Whitehorse	28,955	18.7	24,462	15.8	49,571	32.0	44,717	31.8	33,436	28.9	181,141
Whittlesea	51,121	33.0	30,584	19.7	77,679	50.1	55,013	44.9	32,768	35.5	247,165
Yarra Ranges	29,498	19.0	18,559	12.0	40,275	26.0	42,642	27.5	27,854	27.5	158,828
Total	**272,588**	**176.0**	**195,393**	**126.1**	**421,756**	**272.3**	**388,540**	**272.0**	**270,792**	**250.8**	**1,549,069**

Appendix item C - English proficiency. Absolute and rater per 1000 population

LGA Name	Speaks English only		Speaks other language and speaks English Very well or well		Speaks other language and speaks English Not well or not at all	
	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000
Banyule	92,390	59.6	22,670	14.6	3,059	2.0
Boroondara	119,302	77.0	44,355	28.6	7,266	4.7
Knox	116,583	75.3	40,845	26.4	7,209	4.7
Manningham	65,535	42.3	48,005	31.0	9,743	6.3
Maroondah	77,821	50.2	16,700	10.8	3,986	2.6
Mitchell	17,609	11.4	3,769	2.4	426	0.3
Monash	79,477	51.3	82,372	53.2	15,218	9.8
Murrindindi	1,496	1.0	53	0.0	0	0.0
Nillumbik	49,591	32.0	4,651	3.0	410	0.3
Whitehorse	103,248	66.7	57,228	36.9	14,270	9.2
Whittlesea	125,926	81.3	93,467	60.3	16,865	10.9
Yarra Ranges	140,165	90.5	11,276	7.3	1,855	1.2
Total	**989,143**	**638.5**	**425,391**	**274.6**	**80,307**	**51.8**

Source: ABS Census 2021

Appendix item D - Distribution of religious affiliation by LGA 2021

LGA Name	Buddhism	Secular, other or no religion	Other religions	Islam	Judaism	Hinduism	Christianity
Banyule	1.9	43.6	0.6	2.4	0.1	1.8	44.5
Boroondara	3.3	45.2	0.6	1.1	0.9	2.6	41.5
Knox	4.3	41.6	1.2	1.5	0.1	3.6	42.7
Manningham	4.4	37.4	1.1	3.4	0.3	1.9	46.7
Maroondah	2.2	45.8	1	0.9	0.1	1.9	43.1
Mitchell	0.8	42.6	2.7	1.6	-	1.3	43.4
Monash	7.2	35.8	1.4	2.7	0.4	7.5	39.3
Murrindindi	0.8	50.1	0.6	0.2	-	0.1	37.5
Nillumbik	1	50.1	0.4	0.8	0.1	0.6	42.6
Whitehorse	5.4	43.9	1.1	1.6	0.2	3.8	38.6
Whittlesea	3.3	24.3	4	9	-	6.2	47.2
Yarra Ranges	1	53.9	0.6	0.3	0.1	0.5	37.8
Total	**35.6**	**514.3**	**15.3**	**25.5**	**2.3**	**31.8**	**504.9**

Source: ABS Census, 2021

Appendix item E - ABS Census, 2021 - Proportion of adults living at home, Females (F) and Males (M)

LGA Name	55 - 64			65 - 74			75 - 84			85 +			Grand Total
	F	M	Total	F	M	Total	F	M	Total	F	M	Total	
Banyule	1,996	1,185	3,181	1,953	933	2,886	1,601	557	2,158	986	278	1,264	**16,299**
Boroondara	2,538	1,256	3,794	2,407	1,062	3,469	2,344	742	3,086	1,534	468	2,002	**23,588**
Knox	2,529	1,444	3,973	2,461	1,039	3,500	1,940	680	2,620	979	355	1,334	**20,449**
Manningham	1,535	803	2,338	1,512	592	2,104	1,842	591	2,433	1,089	398	1,487	**13,849**
Maroondah	1,663	978	2,641	1,611	642	2,253	1,396	415	1,811	798	251	1,049	**13,717**
Mitchell	217	178	395	131	107	238	73	41	114	33	12	45	**2,045**
Monash	2,070	1,182	3,252	1,951	934	2,885	2,300	755	3,055	1,625	590	2,215	**20,221**
Murrindindi	31	23	54	22	16	38	4	10	14	4	0	4	**200**
Nillumbik	665	381	1,046	631	304	935	391	156	547	167	47	214	**4,580**
Whitehorse	2,598	1,445	4,043	2,512	1,112	3,624	2,673	794	3,467	1,812	539	2,351	**23,563**
Whittlesea	3,104	1,657	4,761	2,531	1,139	3,670	2,016	727	2,743	918	326	1,244	**26,317**
Yarra Ranges	2,301	1,498	3,799	2,321	1,199	3,520	1,688	701	2,389	744	288	1,032	**18,673**
Total	**21,247**	**12,030**	**33,277**	**20,043**	**9,079**	**29,122**	**18,268**	**6,169**	**24,437**	**10,689**	**3,552**	**14,241**	**183,501**

Source: ABS census, 2021

Epidemiology

Appendix item F: Key diseases by LGA percentage change from 2019 – 2024. Cells highlighted in green represent the largest decrease in percentage change, red represent the largest increase in percentage change per LGA.

LGA Name	Cancer	Cardio	Dementia	Respiratory
Banyule	-6.8%	-18.2%	-38.2%	16.3%
Boroondara	-15.9%	-8.5%	-31.8%	12.4%
Knox	-4.1%	7.5%	41.5%	34.3%
Manningham	-16.7%	18.2%	-4.2%	70.1%
Maroondah	-17.6%	-6.5%	-17.4%	15.7%
Mitchell	10.8%	13.9%	240.0%	15.0%
Monash	-20.1%	-3.9%	-27.2%	26.2%
Murrindindi	-55.2%	-41.4%	-66.7%	-56.2%
Nillumbik	-2.8%	10.2%	-29.8%	3.1%
Whitehorse	-16.9%	2.9%	-9.1%	31.8%
Whittlesea	-10.5%	3.8%	11.2%	29.3%
Yarra Ranges	5.6%	1.2%	8.5%	11.7%

Source: AIHW Mortality Over Regions and Time (MORT) books [Data set].

Appendix item G - Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention, by selected characteristics, 2022

Diagnosis	Improved after treatment	No improvement after treatment	Proportion of improvement after treatment
Malignant	**69,212**	**88,814**	**77.9**
Lung	14,210	18,235	77.9
Colorectal	7,131	9,161	77.8
Other gastrointestinal	6,334	8,143	77.8
Prostate	5,688	7,214	78.8
Pancreas	5,480	7,070	77.5
Breast	4,986	6,545	76.2
Gynaecological	4,001	5,257	76.1
Haematological	3,852	4,836	79.7
Other primary malignacy	2,984	3,855	77.4
Head and Neck	3,318	4,166	79.6
Other urological	3,056	3,975	76.9
Skin	2,398	3,038	78.9
Unknown primary malignancy	1,814	2,304	78.7
Central nervous system	1,791	2,217	80.8
Malignant - not further defined	1,296	1,650	78.5
Bone and soft tissue	873	1,148	76.0
Non-malignant	**26,611**	**32,159**	**82.7**
Respiratory failure	**5,184**	**6,585**	**78.7**
Other non-malignancy	5,148	6,311	81.6
Cardiovascular disease	4,168	5,060	82.4
End stage kidney disease	2,019	2,450	82.4
Other dementia	1,918	2,159	88.8
Other neurological disease	1,505	1,757	85.7

Alzheimer's dementia	1,358	1,482	91.6
Motor Neurone Disease	968	1,361	71.1
Sepsis	1,153	1,282	89.9
Stroke	936	1,055	88.7
End stage liver disease	878	1,072	81.9
Non Malignant - not further defined	821	924	88.9
Multiple organ failure	436	518	84.2
Diabetes and its complications	n.p.	n.p.	n.p.
HIV/AIDS	n.p.	n.p.	n.p.

Source, AIHW Palliative Care Measures data tables 2022

Appendix item H - Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention, by selected characteristics, 2022

Problem severity at phase start	Carer problems improved after intervention	Carer problems did not improve after intervention	Proportion of carer problems that improved after intervention
Absent	28,550	41,126	69.4
Mild	44,813	53,597	83.6
Moderate	9,355	17,409	53.7
Severe	1,314	2,040	64.4

Source, AIHW Palliative Care Measures data tables 2022

Appendix item I - Number of full time equivalent employed health practitioners in specialist palliative care workforce per 10,000 population by State/Territory, 2022

State/Territory	Palliative medicine physicians			Palliative care nurses			Total		
	Number	FTE	FTE per 100,000 population	Number	FTE	FTE per 100,000 population	Number	FTE	FTE per 100,000 population
New South Wales	119	108.4	1.3	1,037	965.8	11.8	1,156	1,074.2	13.2
Victoria	81	71.5	1.1	1,105	938.6	14.2	1,186	1,010.1	15.2
Queensland	63	59.1	1.1	678	609.5	11.5	741	668.6	12.6
Western Australia	31	26.9	1.0	378	314.0	11.2	409	340.9	12.2
South Australia	24	18.2	1.0	282	236.6	13.0	306	254.8	14.0
Tasmania	9	10.0	1.8	101	88.3	15.5	110	98.3	17.2
Australian Capital Territory	3	3.5	0.8	64	62.6	13.7	67	66.1	14.5
Northern Territory	4	3.8	1.5	46	42.3	16.9	50	46.1	18.4

Source, AIHW Palliative Care Measures data tables 2022

Appendix item J - Number of full-time equivalent employed health practitioners in specialist palliative care workforce per 100,000 population, from 2018 - 2022

Year	Palliative medicine physicians			Palliative care nurses			Total		
	Number	FTE	FTE per 100,000 population	Number	FTE	FTE per 100,000 population	Number	FTE	FTE per 100,000 population
2018	271	259.2	1.0	3,528	3,047.4	12.2	3,799	3,306.6	13.2
2019	292	272.9	1.1	3,658	3,156.6	12.5	3,950	3,429.5	13.5
2020	302	278.6	1.1	3,798	3,278.5	12.8	4,100	3,557.1	13.9
2021	311	289.2	1.1	3,518	3,079.5	12.0	3,829	3,368.7	13.1
2022	334	301.3	1.2	3,692	3,258.7	12.5	4,026	3,560.0	13.7

Source, AIHW Palliative Care Measures data tables 2022

Service Use

Appendix item K - Palliative care-related hospitalisations and non-admitted patient primary palliative care service events (episode level), EMPHN and age group, 2023-24

Year	PHN	Admitted Patient Palliative Care (NHMD)									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2022 - 2023	EMPHN	16.0	0.6	40.0	1.0	341.0	8.1	1494.0	47.1	3525.0	277.1
	Vic	66.0	0.7	192.0	1.1	1604.2	9.0	7235.1	53.2	14504.5	287.4
	National	919.5	2.3	925.0	1.4	6466.0	9.4	31953.9	58.4	60119.8	302.8
2023-2024	EMPHN	7.0	-	37.0	0.9	328.0	7.7	1661.0	51.9	3398.0	258.6
	Vic	62.0	0.8	202.0	1.1	1556.0	8.5	8056.0	58.6	14853.0	282.6
	National	908.0	2.2	1045.0	1.5	6840.0	9.8	34810.0	63.0	62403.0	300.6

Year	PHN	Non-admitted Patient Palliative Care (NHMD)									
		0-14		15-34		35-54		55-74		75+	
		No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop	No.	Per 10,000 pop
2022-2023	EMPHN	164.0	6.0	622.0	15.3	5281.0	125.9	19175.0	603.9	31554.0	2480.4
	Vic	873.0	9.6	2871.1	16.3	21233.5	118.6	86747.7	638.0	112217.9	2223.5
	National	7003.0	17.4	10813.0	16.5	70275.8	102.2	298702.8	545.6	375765.9	1892.6
2023-2024	EMPHN	168	-	993	23.1	6,238	145.5	27,706	865.9	51,192	3896.2
	Vic	1,135	14.8	4,011	21.6	25,320	138	113,796	827.8	171,440	3261.3
	National	7,042	17.4	11,966	17.2	78,436	111.8	351,739	636.6	473,393	2280.7

Source: AIHW PCSiA

Appendix item L – Hospital separations by diagnosis related groups, public and private hospitals (2019-2025)

Year	LGA Name	Private	Private	Public	Public	Total	Total
2019-2020	Banyule	52	0.127	105	0.091	157	0.101
	Boroondara	48	0.118	73	0.063	121	0.078
	Knox	33	0.081	113	0.098	146	0.094
	Manningham	53	0.13	96	0.083	149	0.095
	Maroondah	23	0.056	81	0.07	104	0.067
	Mitchell	0	0	5	0.004	5	0.003
	Monash	34	0.083	105	0.091	139	0.089
	Murrindindi	1	0.002	4	0.003	5	0.003
	Nillumbik	28	0.069	45	0.039	73	0.047
	Whitehorse	63	0.154	118	0.102	181	0.116
	Whittlesea	38	0.093	271	0.235	309	0.198
	Yarra Ranges	35	0.086	137	0.119	172	0.11
	Grand Total	**408**	**1**	**1,153**	**1**	**1,561**	**1**
2022-23	Banyule	61	0.169	156	0.121	217	0.131
	Boroondara	49	0.136	70	0.054	119	0.072
	Knox	25	0.069	131	0.101	156	0.094
	Manningham	71	0.197	130	0.101	201	0.122
	Maroondah	29	0.08	75	0.058	104	0.063
	Mitchell	1	0.003	4	0.003	5	0.003
	Monash	21	0.058	125	0.097	146	0.088
	Murrindindi	0	0	7	0.005	127	0.004
	Nillumbik	21	0.058	53	0.041	74	0.045
	Whitehorse	46	0.127	99	0.077	145	0.088
	Whittlesea	19	0.053	339	0.262	358	0.217
	Yarra Ranges	18	0.05	103	0.08	121	0.073
	Grand Total	**361**	**1**	**1,292**	**1**	**1,653**	**1**

2024-25	Banyule	48	0.137	168	0.117	216	0.121
	Boroondara	50	0.142	71	0.049	121	0.068
	Knox	19	0.054	131	0.091	150	0.084
	Manningham	51	0.145	141	0.098	192	0.107
	Maroondah	31	0.088	72	0.05	103	0.058
	Mitchell	1	0.003	5	0.003	6	0.003
	Monash	29	0.083	149	0.104	178	0.1
	Murrindindi	0	0	3	0.002	3	0.002
	Nillumbik	12	0.034	65	0.045	77	0.043
	Whitehorse	57	0.162	106	0.074	163	0.091
	Whittlesea	16	0.046	400	0.278	416	0.233
	Yarra Ranges	37	0.105	126	0.088	163	0.091
	Grand Total	**351**	**1**	**1,437**	**1**	**1,788**	**1**

Source: AIHW PCSiA

Appendix item M - Carer availability across EMPHN catchment 2019–20 to 2024–25

Year	LGA Name	Carer not needed not applicable	Lives alone has a carer	Lives alone has no carer	Lives in a mutually dependent situation	Lives with another has a non-resident carer	Lives with another has a resident carer	Lives with another has no carer	Missing or not recorded	Grand Total
2019-20	Banyule	6	1	1	13	-	16	-	-	37
	Boroondara	5	-	2	1	-	6	-	3	17
	Knox	3	-	6	1	-	18	2	-	30
	Manningham	3	-	2	3	1	15	4	-	28
	Maroondah	2	-	2	1	1	17	2	1	26
	Mitchell	-	-	-	-	-	2	-	-	2
	Monash	7	-	2	-	1	6	3	-	19
	Nillumbik	-	1	-	8	2	6	1	-	18
	Whitehorse	7	1	3	3	-	12	5	2	33
	Whittlesea	3	7	1	5	4	36	-	-	56
	Yarra Ranges	-	-	8	1	1	26	8	1	45
	Grand Total	**36**	**10**	**27**	**36**	**10**	**160**	**25**	**7**	**311**
2022-23	Banyule	7	4	-	4	3	18	-	2	38
	Boroondara	6	-	-	2	-	10	-	2	20
	Knox	1	3	2	4	-	7	1	-	18
	Manningham	6	4	1	5	-	18	3	1	38
	Maroondah	2	2	1	1	-	7	-	-	13
	Mitchell	-	-	-	-	-	2	-	-	2
	Monash	3	1	-	1	2	13	1	-	21
	Murrindindi	-	-	-	1	-	2	-	-	3
	Nillumbik	1	-	2	5	1	3	-	-	12
	Whitehorse	4	1	1	1	2	9	1	-	19
	Whittlesea	10	8	1	13	6	39	6	1	84
	Yarra Ranges	4	1	1	2	1	13	1	-	23

	Grand Total	**44**	**24**	**9**	**39**	**15**	**141**	**13**	**6**	**291**
2024-25	Banyule	3	2	-	7	2	16	2	1	33
	Boroondara	2	-	-	1	-	8	1	1	13
	Knox	1	5	6	6	1	10	1	-	30
	Manningham	6	2	-	3	-	11	-	-	22
	Maroondah	-	2	1	4	1	2	1	-	11
	Mitchell	-	-	-	1	-	1	-	1	3
	Monash	4	3	-	2	-	11	1	-	21
	Nillumbik	-	-	1	2	-	2	1	-	6
	Whitehorse	2	3	6	3	1	9	1	2	27
	Whittlesea	5	4	-	9	2	43	4	2	69
	Yarra Ranges	-	1	2	12	1	12	2	-	30
	Grand Total	**23**	**22**	**16**	**50**	**8**	**125**	**14**	**7**	**265**

Source: AIHW PCSiA

Mortality

Appendix item N - Death due to all causes combined - Male, 2018-2022

Year					Premature Deaths(aged under 75)			Potentially avoidable deaths (PAD)		Potentially avoidable deaths (PAD)		
	Total deaths	Age-standardised rate (per 100,000)	Rate ratio (relative to all of Australia)	Median age at death (years)	No.	%	Age-standardised rate (per 100,000)	PYLL under 75 (person-years)	PYLL under 75 rate (per 1,000)	PAD	%	Age-standardised rate (per 100,000)
2018	4300.0	489.8	0.8	81.5	1457.0	33.9	183.3	23719.0	33.3	743.0	51.0	95.1
2019	4845.0	536.9	0.9	81.4	1607.0	33.2	199.1	25883.0	36.0	790.0	49.2	98.7
2020	4613.0	495.8	0.9	81.4	1535.0	33.3	187.2	24315.0	33.8	760.0	49.5	94.1
2021	4911.0	516.2	0.9	82.0	1569.0	32.0	192.4	24509.0	34.9	730.0	46.5	91.7
2022	5620.0	578.6	0.9	82.3	1742.0	31.0	214.8	27023.0	38.4	796.0	45.7	100.1

Source: AIHW MORT

Appendix item O - Death due to all causes combined - Female, 2018-2022

Year					Premature Deaths (aged under 75)			Potentially avoidable deaths (PAD)		Potentially avoidable deaths (PAD)		
	Total deaths	Age-standardised rate (per 100,000)	Rate ratio (relative to all of Australia)	Median age at death (years)	No.	%	Age-standardised rate (per 100,000)	PYLL under 75 (person-years)	PYLL under 75 rate (per 1,000)	PAD	%	Age-standardised rate (per 100,000)
2018	4634.0	381.2	0.9	86.3	1074.0	23.2	123.6	16503.0	22.9	466.0	43.4	55.5
2019	4776.0	382.6	0.9	86.5	1053.0	22.1	118.5	15277.0	21.1	473.0	45.0	54.7
2020	4757.0	372.6	0.9	86.6	1018.0	21.4	113.0	15478.0	21.3	449.0	44.1	51.1
2021	4892.0	377.6	0.9	86.5	1082.0	22.1	120.4	15988.0	22.5	452.0	41.8	51.6
2022	5600.0	421.5	0.9	87.0	1120.0	20.0	126.0	17302.0	24.3	453.0	40.5	52.7

Source: AIHW MORT

Consumer and Carer Survey

Appendix item P: Consumer and carers survey questions and response options

Question Number	Question	Response options	
1	Which Local Government Area (LGA) do you live in?	Banyule Boroondara Knox Manningham Maroondah Mitchell	Monash Murrindindi Nillumbik Whitehorse Whittlesea Yarra Ranges
2	I am aware of and understand the difference between palliative and end of life care.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree	
3	GPs have an important role to play in supporting people to receive palliative care at home and in the community.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree 5 - Strongly agree	
4	I am confident and comfortable to have conversations about death and dying.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree	
5	I know what an Advance Care Plan is and how to complete one.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree 5 - Strongly agree	
6	I know what services are available within my region that provide palliative care at home and in the community.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 – Agree 5 - Strongly agree	

7	Palliative care services in the region are well coordinated across hospitals, community providers, and general practice.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
8	Have you or a person you care for received palliative care or discussed palliative care options?	No Yes
9	I / the person I care for was provided with clear information about palliative care options and services early on when I / the person I care for developed a life limiting illness.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
10	I / the person I care for received quality palliative care at home and in the community that met needs and preferences.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
11	I would be interested in education and awareness on topics relating to palliative care.	1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree
12	What would make it easier for patients and families to access timely, high-quality palliative care at home or in the community?	Free text
13	From your perspective, how could the system better support carers' wellbeing, including financial and cultural considerations, throughout the palliative care journey?	Free text

Appendix item Q: I am aware of and understand the difference between palliative and end of life care.

I am aware of and understand the difference between palliative and end of life care		
Response	No.	%
Strongly disagree	1	5%
Disagree	2	11%

Neutral	1	5%
Agree	9	47%
Strongly agree	6	32%
Total	19	100%

Appendix item R: I know what an Advanced Care Plan is and how to complete one.

I know what an Advance Care Plan is and how to complete one		
Response	No.	%
Strongly disagree	2	11%
Disagree	4	21%
Neutral	-	-
Agree	12	63%
Strongly agree	1	5%
Total	19	100%

Appendix item S: I am confident and comfortable to have conversations about death and dying

I am confident and comfortable to have conversations about death and dying		
Response	No.	%
Strongly disagree	-	-
Disagree	2	11%
Neutral	2	11%
Agree	8	42%
Strongly agree	7	37%
Total	19	100%

Appendix item T: Have you or a person you care for received palliative care or discussed palliative care options?

Have you or a person you care for received palliative care or discussed palliative care options?		
Response	No.	%
No	11	58%
Yes	8	42%

Total	19	100%

Disclaimer, Executive Summary and Key Findings

Disclaimer

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Executive Summary

The Eastern Melbourne Primary Health Network (EMPHN) has undertaken a Palliative Care Needs Assessment (PCNA) to inform future actions under the Greater Choice for At Home Palliative Care (GCfAHPC) program. This needs assessment identifies service gaps, ongoing challenges, and emerging priorities for palliative care across the region, with a focus on improving access to timely, coordinated, and person-centred care delivered at home and within the community.

EMPHN's PCNA Key Findings

- Rapid ageing and rising multimorbidity are increasing demand: The EMPHN population is ageing rapidly, with more people living longer with chronic, complex, and progressive illnesses. Dementia, cardiovascular disease, COPD, diabetes, major cancers, and frailty-related falls are now leading causes of mortality, resulting in a growing need for complex and sustained palliative and end-of-life care.
- Geographic inequities persist: Inner metropolitan LGAs have lower mortality and greater service provision, whereas outer metropolitan and rural LGAs—such as Knox, Maroondah, Whittlesea, Mitchell, and Murrindindi—face higher per-capita death rates, fewer local services, and greater reliance on outreach care models.
- Service capacity lags behind demand: The overall capacity for palliative care is constrained, with specialist beds mainly located in inner LGAs. There is increasing dependence on community-based care, but aged care support, both at home and in residential facilities, is not keeping up with population growth and ageing trends.
- Workforce pressures limit access and quality: General practice, residential aged care homes (RACHs), and community services are bearing more responsibility for chronic disease and palliative care without comparable growth in workforce numbers or skills. Workforce pressures are most intense in growth corridors, further restricting timely access.
- Fragmented systems and digital gaps undermine coordination: Inconsistent digital infrastructure, fragmented referral pathways, and poor

information sharing hinder provider coordination. Advance care plans and goals-of-care documents are often difficult to locate when required, reducing continuity and increasing risks to care.

- Late access to specialist palliative care: Most people only receive specialist palliative care close to death, particularly those with non-cancer illnesses, limiting the opportunity for early symptom management, advance care planning, and coordinated family and carer support.
- After-hours care remains a critical gap: Access to palliative medicines, anticipatory prescribing, and specialist advice outside standard hours—especially for those in community and residential aged care settings—remains inconsistent, causing avoidable distress, unnecessary hospital presentations, and system pressure.

Methodology

The PCNA utilised a mixed-methods approach, drawing on both quantitative and qualitative evidence. Quantitative analysis included population, mortality, hospitalisation, primary care, aged care, and service utilisation data, with a focus on trends from 2013–2024 (mortality) and 2019–2025 (service and workforce indicators). Data were analysed at the EMPHN and LGA level to identify patterns, geographic differences, and equity gaps.

A consumer and carer survey provided direct insights from service users and carers, deepening the understanding of palliative care needs across the region. Targeted consultations were also conducted in November–December 2025 with stakeholders from RACHs, ACP providers, specialist and community palliative care services, in-reach and advice services, GPs, and primary care representatives. Feedback from these consultations was thematically analysed and triangulated with quantitative findings to validate trends, explain observed variation, and identify system-level opportunities for improvement.

Summary of Insights

Table 1 below presents a summary of insights from the PCNA, consolidating evidence from demographic analysis, mortality and epidemiology data, service utilisation trends, the consumer and carer survey, stakeholder consultations, and workforce and service mapping. These themes highlight the main drivers of demand, gaps in care, and emerging priorities for EMPHN, forming the basis for the following recommendations.

Table 1: Summary of Insights for EMPHN's Palliative Care Needs Assessment 2025

A rapidly growing, ageing and culturally diverse population shaping future palliative care demand.
Population trends in the Eastern Melbourne region reveal significant growth and ageing, with the total population projected to rise by 26% to 1.95 million by 2032 and the 85+ cohort increasing by nearly 59%. Large metropolitan LGAs such as Whittlesea, Monash, Whitehorse, Boroondara and Knox account for the greatest share of residents and will drive future palliative care demand, amplified by

rising multimorbidity and cultural diversity. Females outnumber males across most LGAs, and nearly half of older adults are overseas-born, with substantial CALD communities concentrated in Monash, Whitehorse and Whittlesea. Language diversity is pronounced, with 29% of older adults speaking a language other than English and over 80,000 residents reporting limited English proficiency, underscoring the need for interpreters and culturally adapted care. First Nations peoples represent 9,391 residents, with the largest communities in Whittlesea, Yarra Ranges and Knox. These demographic shifts highlight the importance of equity-focused planning, culturally competent models and targeted outreach to meet growing and complex palliative care needs.
Shifting disease patterns are reshaping palliative care needs.
Between 2019 and 2024, disease patterns across Eastern Melbourne LGAs shifted significantly. Cancer prevalence declined across most LGAs, and cardiovascular trends were mixed, while dementia and respiratory conditions rose. Dementia cases increased most notably in Knox and Mitchell, while respiratory illnesses increased in Manningham and Knox. Palliative care separations grew from 1,606 to 1,817, with 70% of diagnoses occurring in people aged 70 and over, underscoring the ageing profile of care needs. Palliative care interventions demonstrated strong effectiveness in reducing pain and psychological distress, particularly for non-malignant conditions such as dementia and neurological diseases, which achieved improvement rates above 80%. However, malignant conditions showed lower responsiveness. Access to specialist palliative care remains late for most patients, with only 20.9% receiving care three months before death; early access is more common for neurodegenerative diseases (31.6%) and cancers (27.9%) but remains low for dementia and chronic organ failure. These trends signal growing complexity and the need for proactive, condition-specific approaches to palliative care planning.
Rising deaths and persistent chronic disease burden highlight growing end-of-life care needs.
Mortality across the Eastern Melbourne region has risen steadily from 2013 to 2024, driven by population growth and ageing. LGAs such as Whittlesea, Monash, Whitehorse and Boroondara account for the highest absolute deaths, while outer LGAs like Mitchell and Murrindindi maintain higher standardised death rates. Chronic, progressive conditions dominate mortality, with dementia now the leading cause overall, particularly among women, and coronary heart disease remaining the top cause for men. Cancer continues to contribute significantly, alongside non-malignant conditions such as COPD, heart failure and diabetes. Gendered patterns persist: women live longer but experience advanced frailty and dementia, while men have higher premature and avoidable deaths, with rates nearly double those of women. These trends underscore the need for targeted strategies addressing dementia care, chronic disease management and earlier palliative care engagement, particularly for men and high-mortality LGAs.
Rising demand and complexity are outpacing current funding and capacity.
Services across all settings report rapidly increasing referrals, higher multimorbidity, more dementia and more people wishing to die at home. Capacity and funding have not kept pace. Referral thresholds have tightened and some cohorts, especially those with fluctuating

disease trajectories, risk falling between service boundaries.
Growth in non-admitted palliative care signals future pressures and opportunities to increase capacity.
While hospital admissions for palliative care grew by 15% between 2019–20 and 2024–25, non-admitted episodes increased by 60% for the 75+ age group, signalling a shift towards community-based care. While this growth alleviates pressure on inpatient services, it underscores the need and opportunity to increase capacity and resources in non-admitted care models, particularly for older populations, and signals future demand pressures as utilisation among the 55–74 age group continues to rise.
High turnover and uneven expertise create variability in palliative care capability.
High turnover, transient workforce patterns and erosion of dedicated specialist positions have contributed to uneven skills in core palliative care tasks. Identifying the terminal phase, managing anticipatory medications and leading goals-of-care and ACP conversations are areas of particular variability. Staff also report high emotional burden and anxiety when discussing prognosis and end of life.
GP engagement in palliative care remains inconsistent, hindered by systemic and role clarity issues.
While some GPs are highly engaged, palliative care is not consistently treated as “core business” in general practice. Limited remuneration, competing priorities and fragmented employment models mean GPs may be less involved in proactive identification, home visits and case conferences. Confusion about roles between GPs, specialist services and generalist providers can undermine shared care and continuity.
Fragmented systems and patchy digital adoption hinder seamless palliative care coordination.
Stakeholders describe a system with multiple providers, complex referral processes and limited real-time information sharing. Hybrid paper–electronic workflows make ACPs and care plans difficult to locate when needed. Emerging digital solutions, including MyHealthRecord integration, secure messaging and platforms such as PalCare Go, are promising but adoption is patchy.
Timely access to medications, advice and after-hours support remain critical gaps.
RACHs and community providers report difficulties accessing palliative medicines and specialist advice after hours. Many facilities lack IMPREST supplies and syringe drivers. Locum reluctance to prescribe opioids or sedatives, and limited clarity about anticipatory prescribing, can delay symptom relief and place pressure on families and staff.