Palliative Care Australia
Matters of life and death

Australia's palliative care workforce: Challenges and opportunities

Results from the 2024 National Palliative Care Workforce Survey

SEPTEMBER 2025

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Foreword

Over the next seven years following the publication of this report, the number of Australians turning 85 will triple. It's in many ways a good news story, with the generation born during the baby boom of the late 1940s benefitting from radical improvements in medicine and an associated increase in life expectancy. But it also brings serious challenges.

This major demographic shift will have profound changes for our health and aged care systems. We will need to adjust not only to the sheer numbers of additional consumers with complex needs, but also to changing expectations of our care services, changing carer roles and a changing fiscal environment.

The palliative care workforce is already at the front line of these changes, and the survey results described in this report highlight their experiences, both positive and less positive.

People choose to work in palliative care because it is rewarding and meaningful. One in every three respondents working in specialist palliative care services had worked there for more than 20 years. We need to keep spreading the word about how fulfilling a career in palliative care can be.

We can also see in our survey results that efforts to build palliative care confidence and capability across the health and aged care systems is bearing fruit. But there is much more to do, and it is vital that we continue to explain what a palliative approach involves wherever relevant.

Respondents also told us about the challenges they deal with on a daily basis. Across all parts of the workforce – specialist palliative care services as well as primary care, aged care and other parts of health - survey results highlight a strong workforce perception that demand for palliative care is rising, but that it has not been matched by corresponding increases in service or workforce investment.

PCA interprets the survey findings as a clear warning from the palliative care workforce: without adequate funding and staffing, the delivery of high-quality, timely care for people with terminal illness is at serious risk. We already know that the average time prior to death that someone sees a specialist palliative care service *for the first time* is just 15 days, despite evidence clearly showing that good outcomes are linked to early referral.

It is beyond the scope of this report to identify what system-wide responses are needed to turn these trends around. But doing nothing is not an option if we are to attract and retain the workforce that will provide palliative care.

Dr Peter Allcroft
Chair, Palliative Care Australia
Palliative Care Physician

Palliative Care Australia

Palliative Care Australia is the national peak body for palliative care. PCA represents those who work towards high quality palliative care for all Australians who need it. Working closely with consumers, our Member Organisations and the palliative care workforce, we aim to improve access to and promote palliative care.

Acknowledgements

Palliative Care Australia thanks survey respondents, who generously offered their time to consider and complete the 2024 National Palliative Care Workforce Survey.

The 2024 PCA National Palliative Care Workforce Survey and this report would not have been possible without the efforts of Les Winton from Winton Research & Insights. PCA is grateful to Les for his time, his advice and his dedication to promoting better palliative care.

Palliative Care Australia is located in Canberra. We acknowledge the traditional custodians of these lands and waters, the Ngunnawal and Ngambri Peoples, and pay our respects to Elders past and present. We extend that same respect to, and acknowledge the continuing cultures and contribution of, Aboriginal and Torres Strait Islander Peoples across Australia.

What is palliative care?

The *National Palliative Care Strategy*, endorsed by all Australian governments, reflects the World Health Organisation's definition of palliative care:

> *Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*

Contents

1. Summary

1.1. This report

This report shares findings from the 2024 National Palliative Care Workforce Survey. The insights presented reflect the views of 1,400 health and aged care professionals, workers and volunteers on critical issues affecting the delivery of palliative and end-of-life care.

The report describes workforce perceptions of:

- demand for palliative care
- adequacy of funding and resources
- recruitment and retention challenges
- preparedness to provide a palliative approach in all health and aged care services
- integration between the various services that provide care to people with life-limiting illnesses
- the introduction of voluntary assisted dying in all states.

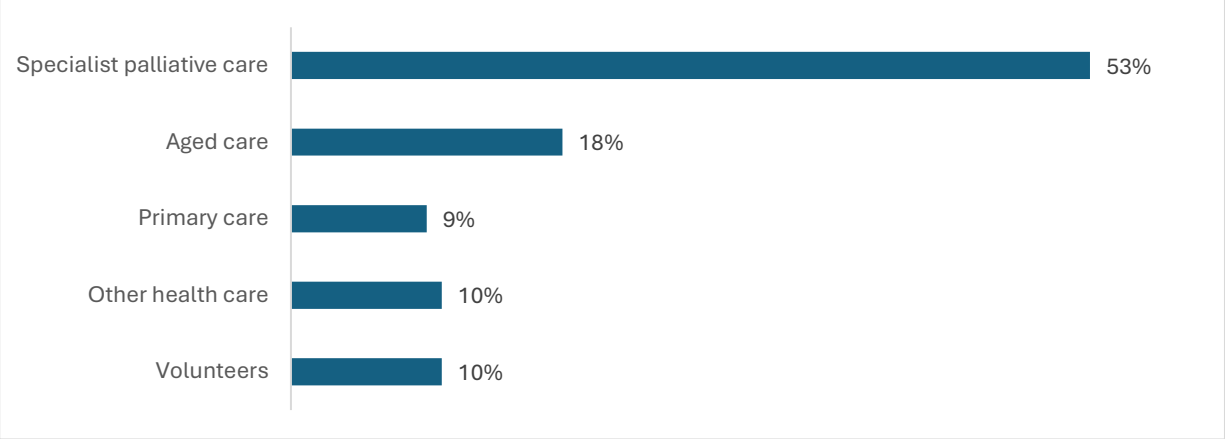
Other PCA reports that present findings from the National Palliative Care Workforce Survey are:

- The case for improved remuneration of palliative care in primary care (February 2025)
- Palliative care workforce wellbeing (October 2024).[1]

1.2. Survey participants

The National Palliative Care Workforce Survey was open to all people working or volunteering in palliative care. The 1,400 participants were drawn from all health and aged care settings where palliative care is provided. Over half of all respondents (53%, or 738 people) worked in specialist palliative care services. A further 10% were palliative care volunteers. Other respondents worked in aged care (18%), primary care (10%) and other health care settings (10%) including oncology services, hospital Emergency Departments and Intensive Care Units.

Figure 1: Survey participants, by setting (n=1,400)



More information about participants is provided in Appendix 2.

Survey questions were tailored to the different service settings where participants worked. All respondents answered questions about a set of core issues (including perceptions of demand, resourcing, wellbeing and collaboration with other services). There were additional questions for respondents from each setting, for example about perceived impacts of recent reforms to aged care and primary care for participants working in those areas. Specialist palliative care respondents were invited to answer additional questions about their perceptions of after-hours care provision and specialist workforce challenges.

The survey sought information about workforce experiences and perceptions. Findings therefore reflect respondents' views, not the official positions of the services for whom they work, or objective data about service provision.

1.3. Findings

Demand is increasing, but funding is constrained

Survey results indicate that the palliative care workforce is resilient, but under significant strain.

Across all areas of health and aged care where palliative care is provided, the results reveal **a clear workforce perception that need for palliative care is increasing, but has not been accompanied by necessary additional investment in services or the workforce**. Difficulty recruiting and retaining suitably skilled professionals was a particularly important concern for specialist palliative care respondents.

The combination of increasing demand for care, funding constraints and workforce shortages places significant demands on services, professionals and volunteers. Survey responses indicate that this situation curtails patient and family access to essential palliative and end-of-life care, and contributes to high reported levels of workplace stress. In PCA's view, the survey findings represent a warning from the palliative care workforce that funding and workforce constraints jeopardise high-quality, timely care of people with terminal illness.

> *"Exponential increase in demand for services is expected with minimal foresight or planning."*
>
> *"[There is] … growing need for palliative care without a corresponding increase in funding and staffing."*
>
> -Specialist palliative care respondents

The specialist palliative care workforce faces growing pressures

Among specialist palliative care respondents:

- 90% of respondents said the service where they worked had experienced increased demand for care in the previous year - but only 28% said the service was adequately funded to meet demand for care.
- 69% reported difficulty recruiting staff, and 48% reported difficulty retaining staff, at the service where they worked.
- 80% reported increased workplace stress or anxiety.
- Half (50%) had considered leaving their job due to work pressures.

In addition, 44% of specialist palliative care professionals and 7% of palliative care volunteers reported experiencing burnout at least "quite often". This is higher than for all respondents, of whom over a third (36%) reported experiencing signs of burnout at least quite often.

> *"[The greatest workforce challenge is] … emotional burnout from working at capacity too long and often".*
>
> -Specialist palliative care respondent
>
> *"…[An] extreme nursing shortage has [led to] … burnout and extreme physical and mental fatigue, pressure and stress on nurses".*
>
> -Aged care respondent

Resource constraints impact patient care

Survey findings indicate that a combination of growing need, constrained funding, and workforce shortages have the potential to compromise the care of people with life-limiting illness, who make up an estimated 92% of all deaths annually.[2] In specialist palliative care services:

- Only 33% agreed the service where they worked had sufficient staff to ensure *high quality* care for every patient.
- A minority (37%) agreed that the service had sufficient staff to ensure *timely access to care* to every patient.
- Just over half (52%) agreed the service where they work had capacity to admit / care for all patients who required it.

> *"We are so understaffed to provide optimal care and also we do not have enough allocated palliative care beds."*
>
> *"Workload due to patient-staff ratio makes it difficult to provide the much-needed quality time with patients and families."*
>
> -Specialist palliative care respondents

Palliative care is appropriate from time of diagnosis with a life-limiting condition, including alongside curative treatment,[3] with early commencement of palliative care offering demonstrated benefits for patient and family experiences and for care outcomes.[4] **Survey findings indicate considerable variation in reported use of prognosis-based eligibility criteria in specialist palliative care**. A majority of specialist palliative care respondents agreed that the service where they work applies life-expectancy based eligibility criteria, at least sometimes (59% for inpatient care, 62% for outpatient and community-based services).

Among those who reported working for a service with prognosis-based eligibility criteria, nearly a quarter (24%) indicated that the service where they work limited access to those with an anticipated life expectancy of three months or less, with a further 17% reported limiting access to those with an anticipated life expectancy of six months or less.

> *"... [Entry criteria at] ... each community palliative care service differs predominantly due to funding availability."*
>
> *"Our local pall care referral service has told us not to refer people until later in their disease."*
>
> *"Patients may have complex care needs but don't meet referral criteria for specialist palliative care".*
>
> -Primary care respondents

Survey responses indicate that after-hours specialist palliative care is limited by funding, staffing and safety concerns. Only 16% of specialist palliative care respondents agreed that funding for the service where they work is sufficient to provide out-of-hours care to all patients who need it, and just 21% agreed that the service where they work has enough staff to provide out-of-hours care to all eligible patients. Over a third (34%) agreed that the service where they work limits or prohibits after-hours care for some population groups due to safety risk for staff. A significant minority (30%) said that ability to provide after-hours palliative care has declined over the past 3 to 5 years, at the service where they work.

> *"There is no way we will ever have enough in-patient beds for all who need palliative care, so we need better 24-hour staffed and resourced community services... mandated to provide certain aspects of care such as 24-hour call outs".*
>
> -Specialist palliative care respondent

The palliative care workforce in all health and aged care services is stretched

The challenges for specialist palliative care are reflected in other health and aged care settings. Reflecting on the situation at the service where they work in the previous year, respondents from the broader health and aged care workforce reported that:

- Demand for palliative care had increased (72% of primary care respondents agreed with this statement, as did 76% of those working in other health care settings, and 80% of aged care respondents).
- Funding was not adequate to meet the need for palliative care outside of specialist palliative care services: in primary care, only 11% of respondents agreed that funding was adequate, while in other health service areas including oncology, Emergency Departments and Intensive Care Units, 21% of respondents agreed that this was the case.
- Many respondents said they had insufficient time to meet patients' palliative care needs (53% of primary care respondents reported having sufficient time to meet the palliative care needs of patients; among those working in other health setting this was 66%).

Aged care respondents were more optimistic than those working in other settings about both adequacy of funding to provide palliative care, with 39% of aged care respondents agreeing that the service where they work was adequately funded to provide palliative care in the last year.

However, aged care respondents had mixed views about whether the overall quality of palliative care in aged care had improved over the last 1-2 years, during which time significant aged care reforms intended to ensure palliative care is "core business" have been introduced consistent with the recommendations of the Royal Commission into Aged Care Quality and Safety. Nearly half of aged care respondents reported either no change (37%) in the quality of palliative care provided over that period, or decreased quality (12%), while 44% said the quality of palliative care has improved.

The health and aged care workforce needs support to provide a palliative approach

Many respondents working in aged care, primary care and other health services expressed confidence in their ability to provide a palliative approach to care:

- 72% of primary care respondents reported sufficient expertise to respond to patients' palliative care needs, as did a majority (60%) of those working in other health services.

Self-reported confidence to initiate palliative care conversations early was very high among respondents:

- 96% of primary care respondents and 95% of those working in other health care settings agreed that early discussion of palliative care is critical.

- Very few respondents felt uncomfortable to refer patients to specialist palliative care (just 10% of primary care respondents and 4% of respondents working other health care settings reported discomfort about referring).
- Most respondents agreed that they are comfortable to raise palliative care proactively, rather than waiting for patients, carers or family members to do so (80% of primary care respondents, 87% of those working in other health care settings).

> *"We commence palliative care conversations on admission. This means we are better able to support individual palliative care needs and remain more person-centred in our care"*
>
> -Aged care respondent

Importantly, these respondents are likely to be among those most committed to providing a palliative approach in their diverse areas of specialisation. They see themselves as part of Australia's palliative care workforce, and their responses demonstrate that many health and aged care professionals regard palliative and end-of-life care as essential workforce capabilities. However, as a self-selecting group committed to this area, their responses should not be interpreted as reflecting the general attitudes, skills or knowledge of the broader health and aged care workforce.

Survey results suggest an opportunity to improve timely access to specialist advice about the management of palliative patients. Reported access to advice of this kind varied somewhat by setting:

- 69% of aged care respondents agreed they had timely access to specialist advice about the management of palliative patients.
- This was 65% for primary care respondents, and 57% for those working in other areas of health care.

Survey results also found a workforce perception that coordination of care across settings can be improved. For example, only 18% of primary care respondents felt that the boundaries between their role and the role of specialist palliative care services was clear.

Asked what would improve access to palliative care, respondents drew attention to better coordination of care across settings:

> *"Better integration between hospitals and aged care [would improve access]".*
>
> *"Specialist palliative care providers working with general practitioners".*
>
> *"Better coordination with GPs, oncology and other services referring in".*
>
> -Specialist palliative care respondents

There may be particular opportunities to improve integrated provision of after-hours care for those with life-limiting illness. Just under half of all respondents (48%) who worked for a specialist palliative care service offering after-hours care agreed that their service has strong partnerships with other services that provide after-hours care to their patients.

Voluntary Assisted Dying presents new issues for the palliative care workforce

Respondents working in specialist palliative care and primary care services in jurisdictions where VAD has been introduced (i.e. all states but neither territory) were asked about VAD.

It should be noted that VAD laws are different in each state and have different implications for the responsibilities of health professionals and provider organisations. Importantly, specialist palliative care services and clinicians have varying degrees of involvement in supporting VAD requests depending on their state. The results reported in this section are general and are not broken down by state, nor are findings linked to the respective legislation or service arrangements in each state.

Half of those asked about VAD (49%) said that the introduction of VAD had actually increased demand for palliative care, while just 2% said it had decreased demand for palliative care. A further 18% said the introduction of VAD had had no impact on demand.

Survey respondents indicated that the introduction of Voluntary Assisted Dying schemes presents new challenges for the palliative care workforce, as well as opportunities to provide quality end-of-life care. The majority of those who engage directly with VAD, and/or with patients exploring VAD, are comfortable with their role:

- In specialist palliative care, 73% of respondents said they were comfortable discussing VAD with patients, families and carers while 82% were comfortable directing patients and carers to VAD information and supporting their decisions.
- Among primary care respondents, 65% were comfortable discussing VAD with patients and carers, and 73% were comfortable directing patients and carers to information and supporting their decisions.

> *"I am proud to be able to support my patients and their family through a dignified passing that my patient has independently chosen."*
>
> -Primary care respondent

Survey results indicate that VAD is contributing to demands on palliative care services:

- 75% of specialist palliative care respondents agreed that more patients, families and carers want to discuss VAD, while 54% of primary care respondents agreed this was the case.

The introduction of VAD attracted much commentary from survey respondents. As noted above, the implementation of VAD varies in different jurisdictions and the experiences of those working in

specialist palliative care and primary care varies from state to state. The direct quotes from respondents presented below exemplify the themes raised in relation to VAD.

> *"The paperwork involved in processing VAD applications and coordinating consultations has increased our workload tremendously".*
>
> *"Handling VAD-related consultations means we spend less time providing direct patient care".*
>
> -Specialist palliative care respondents

VAD presents practical and ethical considerations for the palliative care workforce:

- A majority (67%) of specialist palliative care respondents, and half (50%) of primary care respondents feel supported by their organisation to facilitate patient choice in relation to VAD.
- 81% of specialist palliative care respondents, and 57% of primary care respondents, agreed they have access to adequate information to understand their roles and responsibilities in relation to VAD.
- 46% of primary care respondents *disagreed* that their practice or services is appropriately recompensed for VAD services.

> *"This is all unfunded work and pressure is placed on GPs to provide services at no cost to their patient".*
>
> - Primary care professional
>
> *"Staff are made to feel like they are doing the wrong thing when a patient asks for VAD".*
>
> *"Unfortunately, I feel that access to VAD is a first option for rural and remote patients rather than a second option after a patient has received equitable access to good palliative care".*
>
> -Specialist palliative care respondents

1.4. Opportunities to strengthen the palliative care workforce

These survey findings indicate opportunities to strengthen and better support the palliative care workforce. These include:

- Increased investment in response to increased demand for palliative care in the context of a growing population of ageing Australians.
- Improved access to timely specialist clinical advice about the care of patients in primary care and aged care, who require palliative care and end-of-life care.
- Enhanced coordination between specialist palliative care services and other health and aged care services.

- Continued focus on professional education, training and funding support to build the capacity and capability of the specialist palliative care workforce.
- Continued investment in professional education and training to build knowledge and skills in a palliative approach across the aged care, primary care and broader health workforce.
- Enhanced attention to workforce wellbeing, particularly in specialist palliative care.
- Targeted strategies for workforce sustainability in specialist palliative care.
- Greater recognition of the challenges presented by the interface between palliative care and VAD, and ongoing efforts to provide policy and role clarity for the palliative care workforce.

2. *Why we work in palliative care:* Survey respondents' perspectives

National Palliative Care Workforce Survey participants said they choose to work in palliative care because:

We make a difference

"I make a concrete positive difference in the lives of people who are often experiencing the hardest/worst/ [most] distressing time of their lives."

"Making a positive impact on families at a difficult and sad time in their lives."

"Meaningful work."

"Providing patient and family-centred care that makes a difference."

We support families and carers

"Supporting people and their families through one of life's greatest challenges is so rewarding and worthwhile."

"Helping families and patients make the most of living with a terminal illness."

"Supporting families to care for loved ones in their own home."

"Supporting the families left behind."

"The support and compassion I can provide to the patients and families to promote a peaceful death and bereavement."

" ...Being able to make a positive difference for the client and for the carer. In many ways what we do shapes the bereavement of those close to the person as much as we help the client through their last days."

We provide holistic care

"I love the autonomy of the community role, and the holistic medicine that I am able to practice... putting the patient right in the centre of every decision that is made."

"Palliative care professionals understand more than just the physical aspect of care."

"Providing holistic care and systems navigation support for carers and making a meaningful impact."

"Supporting patients at end of life by providing quality holistic nursing care."

Our care enables good deaths

"It is wonderful to be able to support patients.... and to provide them with a good and dignified death while supporting the patient and their loved ones."

"It is so very rewarding being able to work with clients and their families during a vulnerable time to improve their quality of life, assist them to achieve any appropriate goals and have a peaceful and dignified death."

"Helping someone have a good end is a good goal."

"Helping people achieve a 'good death'."

"Facilitating a good death. For all."

"Ensuring medications are used appropriately and symptoms managed. Ensure a good death."

"Helping people die well and supporting their families along the way."

Our care provides dignity and comfort

"Providing comfort to families and patients and developing therapeutic relationships to achieve their goals and provide adequate symptom management."

"Ensuring the person is respected and valued during their time in care, and that wishes are honoured."

"Being able to provide a dignified pain-free end of life and supporting families through bereavement."

"Ensuring people pass away with dignity."

"Being able to recognise and treat symptoms to help patients live or die as comfortably as possible."

We work as a team

"Working as part of a multidisciplinary team to champion a client's comfort and choices, support peers and families/loved ones to make informed decisions, culminating in a good death, regardless of when that is likely to happen, or what stage of the palliative process the client is in."

"The team I work in where all disciplines are considered equal."

"Our team have a close bond and we support each other."

"The multidisciplinary team approach."

"Teamwork with patients and families."

Our care supports legacy and meaning at end of life

"Being able to be compassionate towards the person and giving them some small reason to smile in their last days. Be that in the ability to provide music, time, laughter, their favourite beer or wine, or view the sunrise one last time, I don't believe anyone should die alone, and spending time with them is an honour and a privilege. Being with them after death and caring for their bodies, is also an undeniable absolute honour and privilege. It is the last thing I can do for someone."

"The opportunity to provide life improvement when people have limited time left."

"Helping families leave a legacy they wanted to leave."

"Enabling the wishes of the person and how they want to die."

"Creating space to honour every person's story and their wishes as they approach end of life."

Our work is fulfilling

"It gives the most job satisfaction, just seeing patients going from being overwhelmed, anxious, not knowing what to or expect to seeing them calm, taking control and making the most with the time they have is greatly rewarding."

"It is simply my passion."

"Personal satisfaction that I am able to utilise my knowledge."

"I feel that my work is appreciated."

"Highly engaged workforce creates an inclusive and supportive culture."

It's a privilege to support dignified deaths."

"I feel a great honour in walking this path with the person and their families."

"Being able to provide care to the residents at the end of their life."

"It is a privilege to assist someone in remaining at home for end-of-life care and a greater privilege in making sure this time is comfortable."

"It's an absolute honour to walk alongside a person and their family at such a critical time in their life."

"The satisfaction of making the final months, weeks, days, hours and minutes the best they can be for all involved."

"It is a privilege to be able to provide a supported, safe, and pain-free passing to all my patients and their families."

3. About the National Palliative Care Workforce Survey

3.1. Method

The 2024 National Palliative Care Workforce Survey heard from 1,400 health and aged care professionals, workers and volunteers. The survey aimed to hear the perspectives of Australia's palliative care workforce on priority issues and challenges affecting the delivery of palliative and end-of-life care. It asked about issues including:

- demand for care
- organisational capacity
- workforce sustainability (including recruitment and retention in specialist palliative care), and wellbeing
- integration of care across specialist palliative care, primary care and aged care services
- the introduction of Voluntary Assisted Dying (VAD) in most jurisdictions.

The survey was launched in National Palliative Care Week (19-25 May 2024) and was open until 11 August 2024. Anyone who worked or volunteered for a health or aged care service providing palliative care was welcome to complete it. The survey was promoted via social media, digital platforms, traditional media and direct invitations. PCA member organisations promoted the survey to their members and networks.

The survey took a non-probabilistic approach, meaning participants were not selected for demographic or professional characteristics considered to make them representative of the palliative care sector. As a result, the findings cannot be presumed to represent the views of *all* palliative care professionals or volunteers. However, the survey achieved a significant volume of informed responses (1,400), with participation from people working in all key settings where palliative care is provided. Consequently, the responses are a reliable reflection of the views and experiences of palliative care professionals and volunteers with the interest, motivation and time to take part.

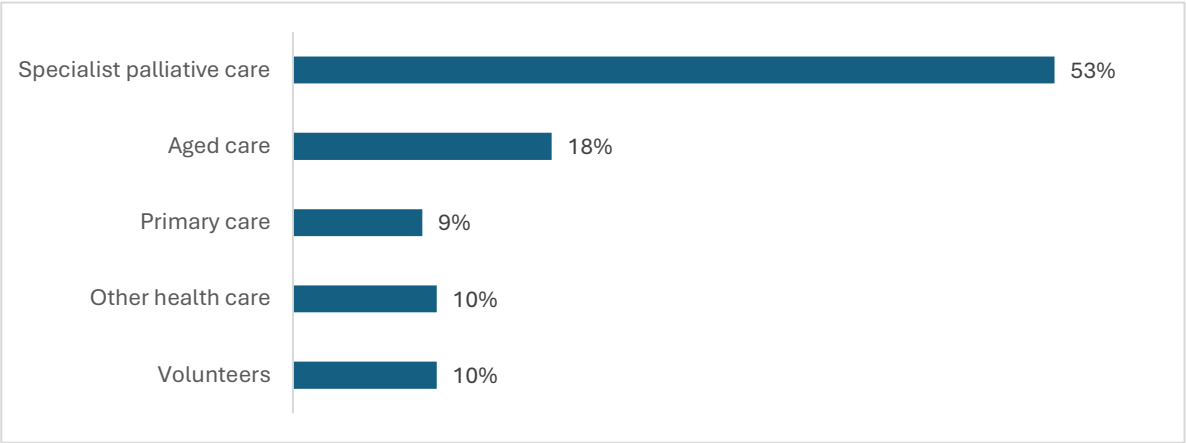
As the survey sought information about workforce experiences, the findings in this report reflect the views and perceptions of participating professionals and volunteers, rather the official positions of the services for whom respondents work, or objective data about service provision.

3.2. Respondents

The 1,400 respondents to the National Palliative Care Workforce Survey reflect the range of health and aged care settings where palliative care is provided. Just over half of all respondents (53%, n=738) worked in specialist palliative care services. A further 10% (n=144) volunteered in palliative care. As

most palliative care volunteers are based in specialist palliative care services, the total proportion of respondents from specialist palliative care was likely over 60%. Other respondents were drawn from aged care (18%, n = 148), primary care (9%, n=130) and other health care settings (10%, n = 144).

Figure 1. Respondents, by sector (n=1,400)



Of the 10% who worked in other health care settings, 38% worked in oncology, followed by Emergency Departments (9%) and Intensive Care Units (9%). The remainder worked in a wide variety of clinical areas specialising in the care of people with chronic and life-limiting illnesses (among these, kidney care, dementia care, stroke care, heart care, respiratory care, geriatric care, paediatric care and paramedicine were represented).

In addition:

- Respondents were drawn from all states and territories, with response rates aligning closely with the distribution of population across jurisdictions.
- Half of all respondents (50%) worked or volunteered in cities, 30% worked in a major regional centre and 28% worked in a rural or remote area.[5]
- Nearly nine in every ten survey respondents (88%) worked or volunteered in direct care or service delivery roles, with the remainder working in a leadership, management or executive position.[6]
- On average, respondents had 14 years' experience in palliative care, while 45% of respondents held at least a decade's experience, and 27% had worked in palliative care for 20 years or more.
- Nurses were a majority of survey respondents in all settings except primary care. They comprised 64% of specialist palliative care respondents, 55% of aged care respondents and 42% of those working in other health care settings. In primary care, medical practitioners were the single largest group of respondents (42%).

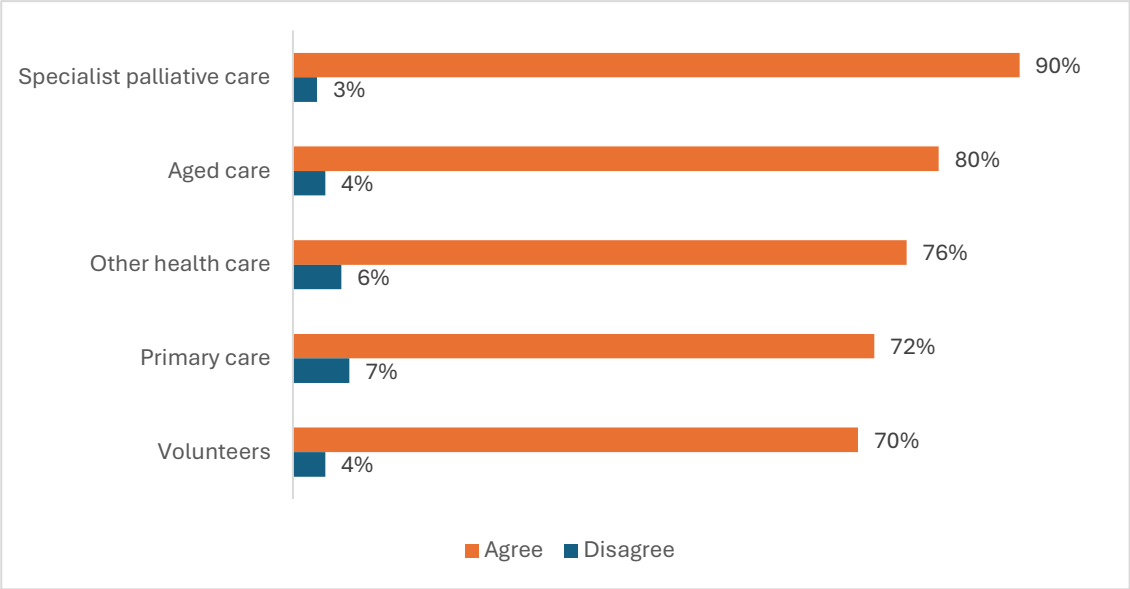
More detail about Australia's palliative care workforce is provided in Appendix 1.
More information about respondents is provided in Appendix 2.

4. Detailed survey findings

4.1. Demand for palliative care is increasing

Survey results demonstrate a clear perception among respondents that demand for palliative care is increasing. Among respondents, this view was most strongly felt among those working in specialist palliative care. Here, 90% of respondents reported that the service where they work had experienced increased demand for care in the previous year. However, as Figure 2 (below) indicates, the perception that demand is increasing was consistently high across all areas of health and aged care where palliative care is provided.

Figure 2. Proportion of respondents who agreed / disagreed that the service where they work had experienced increasing demand for care in the past year (n=734)

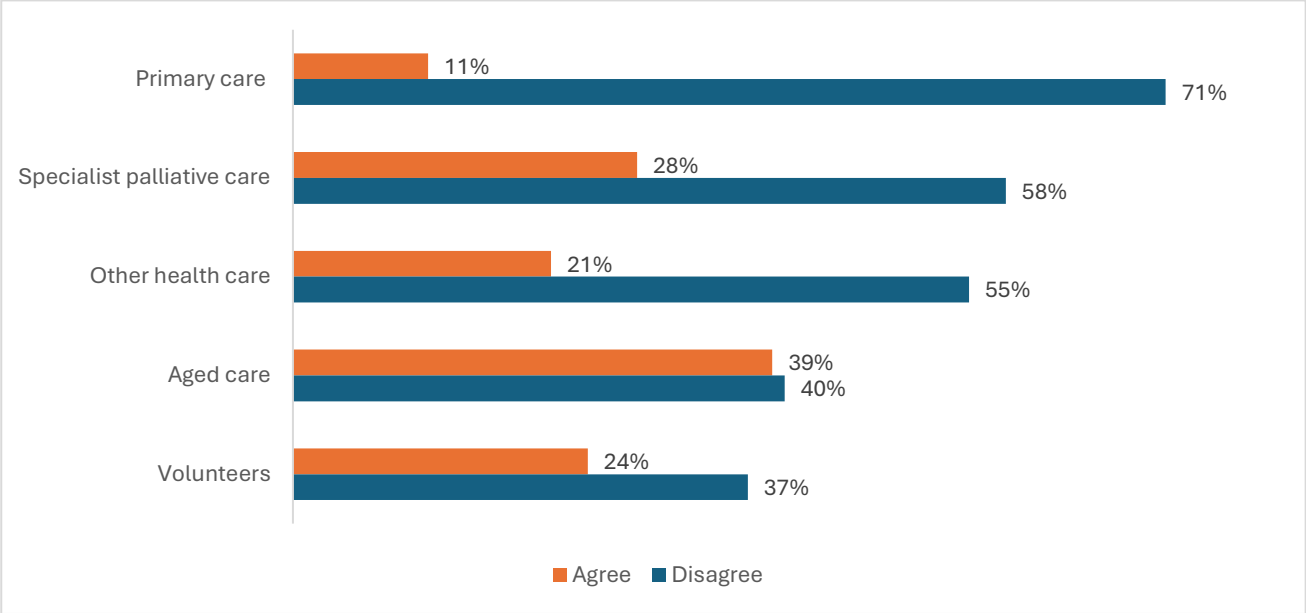


4.2. Funding is not adequate to meet growing need

Findings indicate a strong workforce perception that health and aged care services are not adequately funded to meet increasing need for palliative care.

This concern was most pronounced among primary care respondents, where just 11% agreed that funding was adequate to meet demand for palliative care in the service where they work, in the previous year. Among specialist palliative care professionals, fewer than a third of respondents (28%) agreed that the service where they worked was adequately funded to meet need. Although aged care workers were comparatively less concerned about adequacy of funding, only a minority (39%) agreed that funding was adequate to provide palliative care in the service where they work, in the past year.

Figure 4. Proportion of respondents who agreed/ disagreed that funding for the service where they work was adequate to meet demand for care, in the past year (n=734)



Specialist palliative care funding

When asked **"What is the most significant challenge for the workforce?"** many specialist palliative care respondents identified inadequate funding and resourcing:

"Funding and resource support. Exponential increase in demand for services is expected with minimal foresight or planning."

"The growing need for palliative care without a corresponding increase in funding and staffing."

"Pressure of wanting to do it all but unable to due to inadequate funding to do extra hours".

"[Lack of] funding to employ staff, particularly allied health staff like pharmacists".

4.3. Workplace stress is high, especially in specialist palliative care

Across all settings, survey respondents report high levels of workplace stress. Among specialist palliative care respondents:

- 80% reported experiencing increased workplace stress or anxiety in the past year.
- 50% reported that they had considered leaving their job in the last year due to work pressures.

Across all settings, over one third (36%) of survey respondents reported experiencing signs of burnout quite often or more frequently, and a significant minority (12%) reported experiencing burnout all the time or very often. This was highest in specialist palliative care services, where 44% of professionals and 7% of volunteers reported experiencing signs of burnout quite often or more frequently.

Workplace stress and burnout

When asked **"What is the most significant challenge for the workforce?"**, specialist palliative care respondents said:

"Burnout can be high, given the nature of the caseload".

"Emotional burnout from working at capacity too long and often".

Asked about the **overall quality of palliative care in aged care**, aged care respondents said:

"...[An] extreme nursing shortage has [led to] ... burnout and extreme physical and mental fatigue, pressure and stress on nurses".

"Burnout is a constant issue, especially with the after-hours shifts, which are long and emotionally draining".

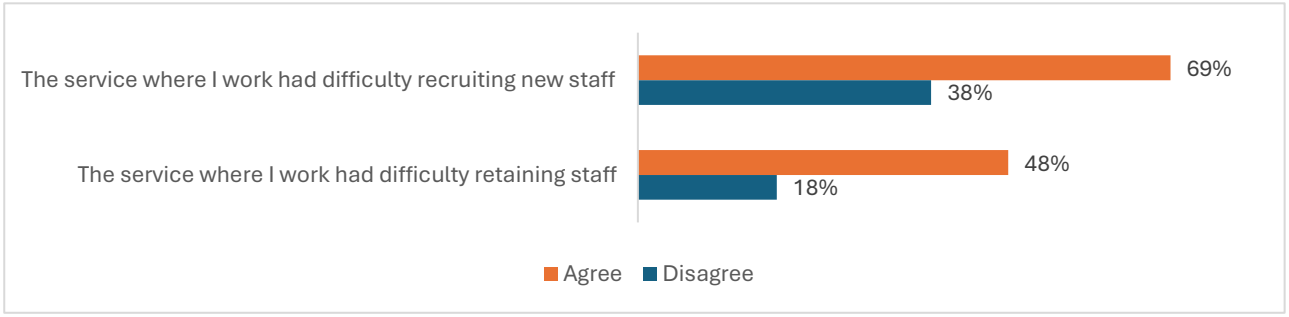
Asked about **the impacts of Medicare reforms**, primary care respondents said:

"We need to be compensated fairly for the work we do, especially given the emotional toll it takes".

"GPs feel overwhelmed due to time and cost constraints".

Survey results suggest several issues contribute to high reported rates of workplace stress. In addition to the challenge of rising demand combined with constrained funding, difficulty recruiting and retaining staff was a significant issue for respondents, particularly those working in specialist palliative care services. Here, 69% reported difficulty recruiting staff and 48% reported difficulty retaining staff at the service where they work in the past year.

*Figure 5. Proportion of specialist palliative care respondents who agreed /disagreed that the service where they work had **difficulty recruiting and retaining staff** in the past year (n=734)*



Staffing issues in specialist palliative care

When asked **"what is the single greatest challenge for the palliative care workforce?"** many specialist palliative care respondents identified persistent short-staffing:

"Not enough staff to meet demand and working many hours overtime."

"Workload due to patient-staff ratio makes it difficult to provide the much-needed quality time with patients and families."

"It is a crazy situation, [there are] not nearly enough staff most of the time."

"We are so understaffed to provide optimal care and also we do not have enough allocated palliative care beds."

Staffing issues in specialist palliative care *(continued)*

Respondents also identified recruitment, retention and workforce sustainability challenges:

"Many of our experienced staff are within 5 years of retiring and our younger staff still need significant support in their clinical decision making."

"Very specialised skills across all health professionals, including nursing and allied health – recruiting staff who are qualified to employ in the speciality field."

"Lack of trained experienced clinicians".

Perceived inadequacy of remuneration may also contribute to high reported rates of workplace stress, and burnout. In specialist palliative care, 44% of respondents reported their work was not adequately remunerated. In primary care, inadequate remuneration of palliative care activity was a significant issue for almost all respondents, with just 11% reporting adequate remuneration of palliative care activity.

Across all settings, half (50%) of all respondents reported that their overall wellbeing had improved since the COVID-19 emergency period. This may indicate a resilient and adaptable workforce that managed well under the challenging conditions created by the COVID-19 emergency response. However, it also suggests ongoing high demands and the lasting impacts of the COVID-19 emergency period on the workforce, as indicated in the responses to open-ended survey questions below.

Impacts of the COVID-19 emergency period

When asked **"Are there any impacts of the COVID-19 emergency period on wellbeing that you would like to share?"**, specialist palliative care respondents said:

"Residual burnout from working in health during COVID".

"The impact is still felt by all. We have not recovered."

"As nurses we were absolutely smashed through COVID and things are really only just starting to settle."

"It greatly impacted me during COVID-19 emergency period having patients dying alone."

"The palliative care workforce has not yet recovered in many places."

Some respondents also identified potential positive impacts:

"Palliative care got better recognition which I think is a good thing."

"I wonder if COVID actually improved understanding of and conversation around palliative care?"

These survey responses indicate an opportunity to strengthen workplace support for palliative care professionals. Just 36% of respondents were satisfied with overall workplace support for self-care, and 18% were specifically dissatisfied with access to debrief, counselling and/or supervision. Close to half (47%) of all respondents were *not* aware of any self-care resources for people providing palliative

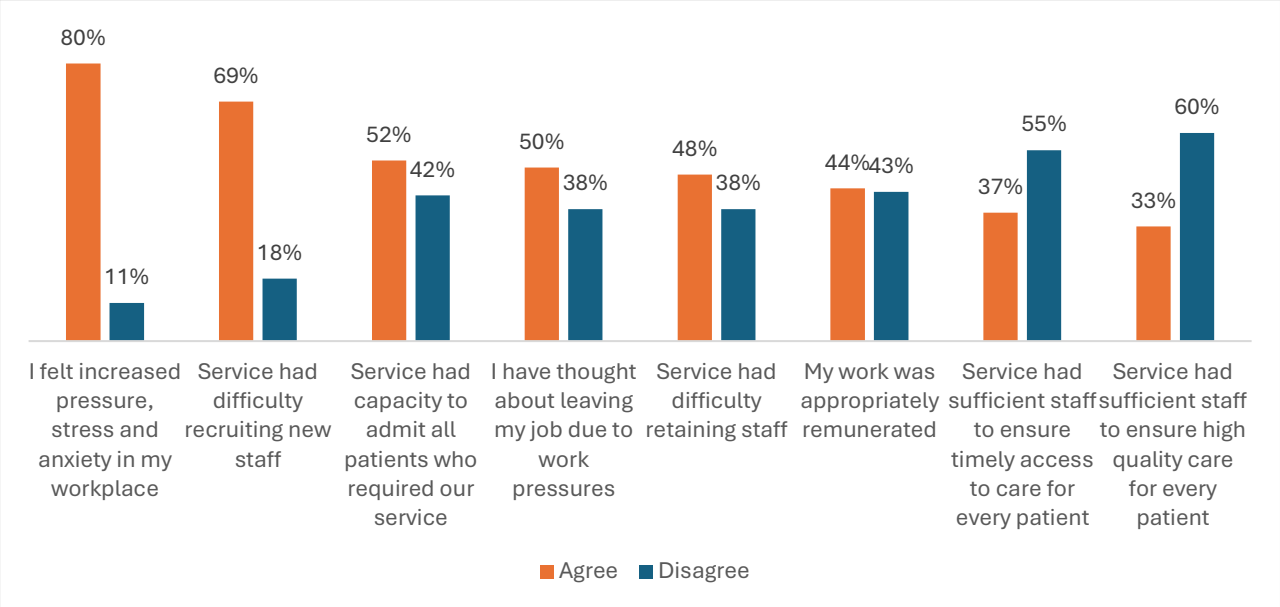
care. These findings indicate the importance of workplace and sector-led efforts to support wellbeing and self-care, to ensure the palliative care workforce can respond to current and future need for care.

4.4. Funding and staffing challenges impact patient care

Survey responses indicate that the demand, funding and workforce challenges described above have an impact on patient access to care, and on quality and timeliness of care. These impacts are clearest in the responses of those working in specialist palliative care. In that setting:

- A minority (37%) agreed the service where they work had sufficient staff to ensure timely care for every patient in the past year
- 33% agreed their service had sufficient staff to ensure high quality care for every patient.
- Just over half (52%) expressed confidence that the service where they work had capacity to admit and care for everyone who required their care, in the past year.

Figure 6. Specialist palliative care respondents' views on issues affecting the service where they work in the past year (n=734)



In other health care and aged care settings respondents similarly reported that patient access to care is affected by high demand and constrained resourcing. For example:

- Just over half (53%) of primary care respondents agreed they had enough time to meet patient's palliative care needs.
- 66% of those working in other health care settings reported having sufficient time to meet patients' palliative care needs.

Impacts of high demand and resource constraints on patient care

In all settings where palliative care is provided, respondents identified impacts on patient care.

When asked **"What is the most significant challenge for the workforce?"**, specialist palliative care respondents said:

"[We don't] have the staff to provide adequate holistic care in the community. Our service does not employ a nurse practitioner or any holistic therapists like music or arts which is a real lack for our community".

"In my district, we have minimal to no psychosocial support for patients and families"

"Inadequate FTE and funding for allied health staff".

Asked about experiences of referring patients to specialist palliative care, primary care respondents said:

"I think the palliative care service is probably overwhelmed… they are obviously time poor".

"The local referral pall care service has cut back substantially and no longer does… outreach".

"We have an excellent palliative care service but they are stretched by their resources".

"Palliative care consultants are almost impossible to access".

"In remote towns in the Northern Territory, …palliative care services are very rare".

"There is not enough capacity/ resources in the local palliative care community team".

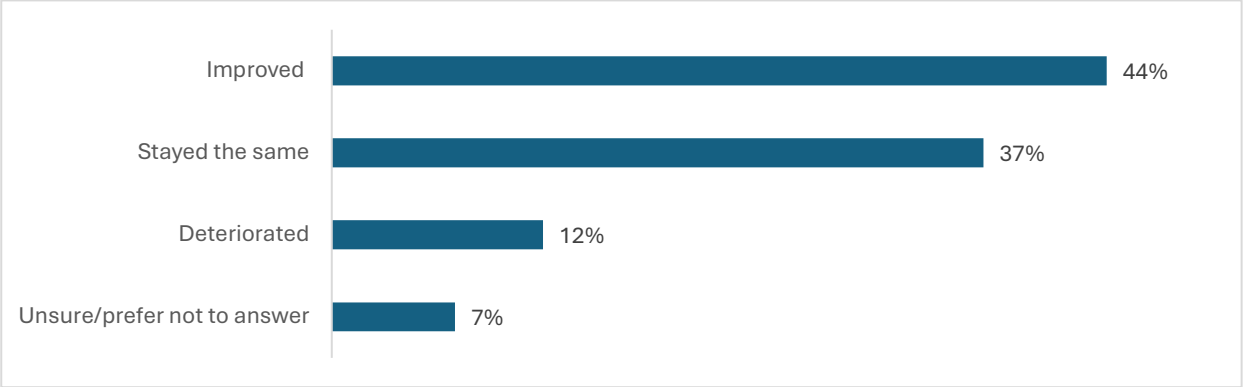
When compared with responses from those working in health care services, aged care respondents were relatively optimistic about service capacity to provide palliative care. Here:

- 83% agreed that the service where they work provides palliative care to all residents/ services users who need it.
- 75% agreed that the service where they work can meet the palliative care needs of most or all residents / service users.

While positive, these responses should not be assumed to be indicative of overall palliative care quality or capacity across the aged care system. Survey participants are likely to be amongst those most committed to providing a palliative approach in aged care, and their responses may therefore also reflect leading practice in this area.

As Figure 7 (below) indicates, aged care respondents had mixed views on the question of whether overall quality of palliative care in aged care has improved in the last one to two years, during which time reforms intended to cement palliative care as "core business" in aged care have commenced.

Figure 7. Aged care respondents' perception of change in the overall quality of palliative care in aged care, over the last one to two years (n=248)



Palliative care in aged care

When asked to comment on change in the overall quality of palliative care in the aged care service where they work over the last 1-2 years, some aged care respondents identified positives:

"More education and funding into palliative care staffing".

"Increase in staff education and skill development/assessment with regard to palliative care practices".

"Additional external support from the specialist palliative care team. Working together to ensure the best end of life care".

"Health service employed a specialist palliative care Nurse Practitioner".

"Increased awareness of the different services that can be beneficial to clients on a palliative pathway".

"Consumers have more of an idea as to what they want in their palliative care, and what we provide, and what they need. More consumers feel they have a say in their palliative care".

"Leisure and lifestyle used to cease when we shifted focus to the person's need for palliative care. Now we have changed the way we care and we document that care".

Other respondents identified continued challenges:

"Funding in small rural areas has not increased in line with demand. Specialist palliative care is sporadic and not collaborative in approach".

"Lack of GPs in aged care, limited support from the local palliative care service".

"One of the doctors who attends the facility is very reluctant to prescribe anticipatory palliative medication, resulting in delays in appropriate treatment".

"Green [aged care] workforce, not yet skilled in having advance care conversations".

Staff who are not competent or confident providing the best palliative care, which has decreased consistent standard of care over all shifts".

Some GPs require training [in palliative care] to change their attitude".

4.5. Access to specialist palliative care is not assured

Life expectancy-based eligibility criteria are variable and may limit access to care

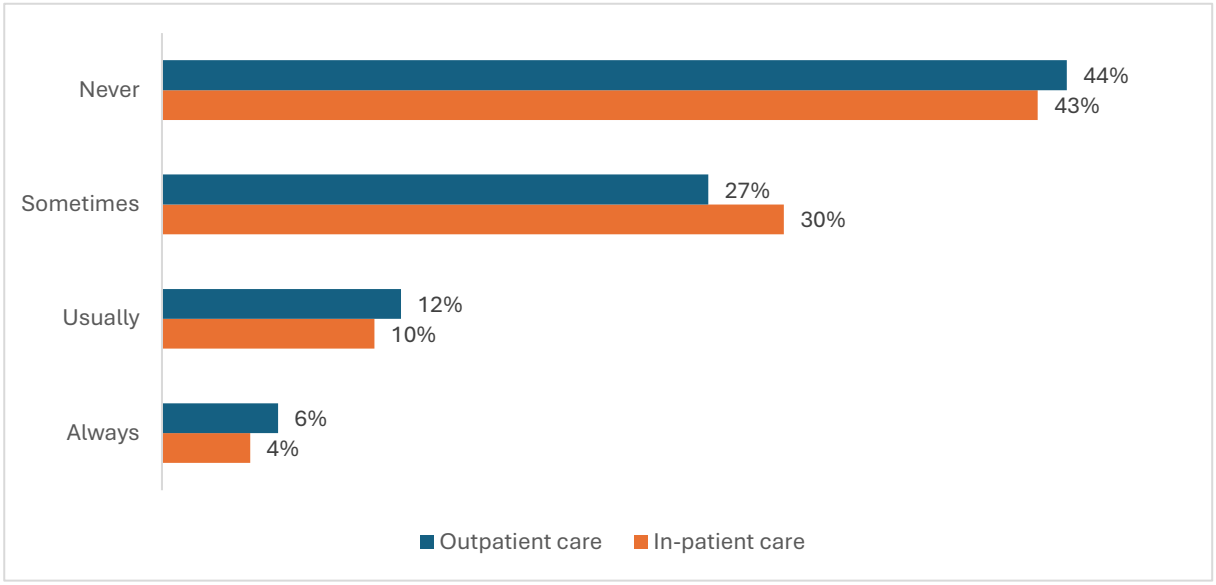
Palliative care is appropriate from time of diagnosis, and evidence consistently indicates that clinical and quality of life outcomes are best when palliative care is commenced early.[7] However, late commencement of palliative care is increasingly the norm in Australia. Recent AIHW data indicates that, on average, people who receive specialist palliative care first do so just 15 days before their death.[8] Survey results provide some evidence to suggest that in a resource-constrained environment, specialist palliative care services are forced to ration access to care by limiting eligibility on the basis of anticipated life expectancy.

Among specialist palliative care respondents, the majority of respondents agreed that the service where they work restricts access to care based on life expectancy, at least sometimes:

- 59% of respondents said that the service where they work always, usually or sometimes restricts access to *inpatient care based on life expectancy*
- 62% of respondents said that the service where they work always, usually or sometimes restricts access to *outpatient or community-based care* on the basis of life expectancy.

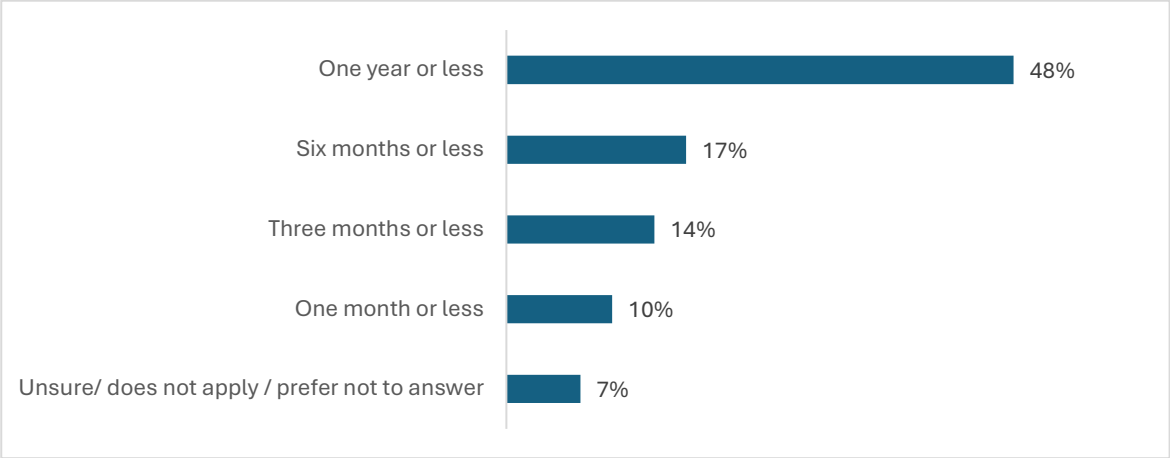
As Figure 8 below illustrates, it was most common for respondents to report that this requirement applies *sometimes* (as distinct from usually, or always). This may indicate a degree of service discretion in applying prognosis-based eligibility criteria, as well as variation in how services approach this issue.

Figure 8. Specialist palliative care respondents' views on the extent to which the service where they work restricts access to in-patient care (n=394) and outpatient care (n=598), based on life expectancy



Among those who reported that the service where they work applies life-expectancy based eligibility, 24% said that the service where they work limits eligibility to those with a life expectancy of three months or less, while a further 17% said that the service restricts access to those with an anticipated life expectancy of six months or less.

Figure 9. Proportion of specialist palliative care respondents reporting different life expectancy-based eligibility criteria (n=142)



Eligibility for specialist palliative care

Primary care respondents identified late referral, and restrictive prognosis-based eligibility, as challenges when referring patients to specialist palliative care.

When asked "**What other difficulties or issues have you experienced with referring patients to palliative care services?"** primary care respondents said:

"... [Entry criteria at] ... each community palliative care service differs predominantly due to funding availability."

"Our local pall care referral service has told us not to refer people until later in their disease."

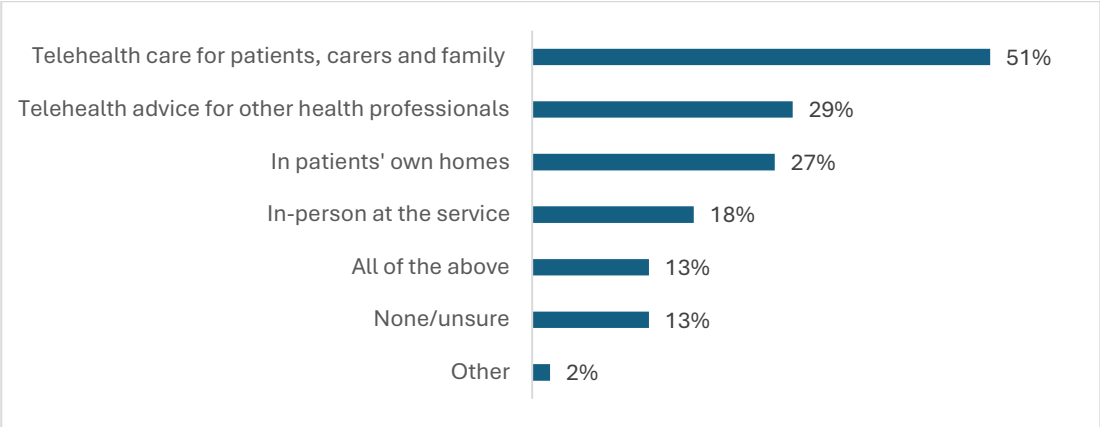
"Patients may have complex care needs but don't meet referral criteria for specialist palliative care".

Face-to-face after-hours patient care is constrained

Access to after-hours care is essential to quality palliative care. The *National Palliative Care Standards for Specialist Palliative Care Services* set an expectation that specialist palliative care services should provide after-hours care.[9]

Eight in every 10 survey respondents (80%) who work in a specialist palliative care service said that the service where they work provides after-hours care. However, as the graph below illustrates, respondents were more likely to report that their service provides telehealth care than in-person clinical care.

Figure 10. Proportion of specialist palliative care respondents reporting that the service where they work provides after-hours care (n=734)

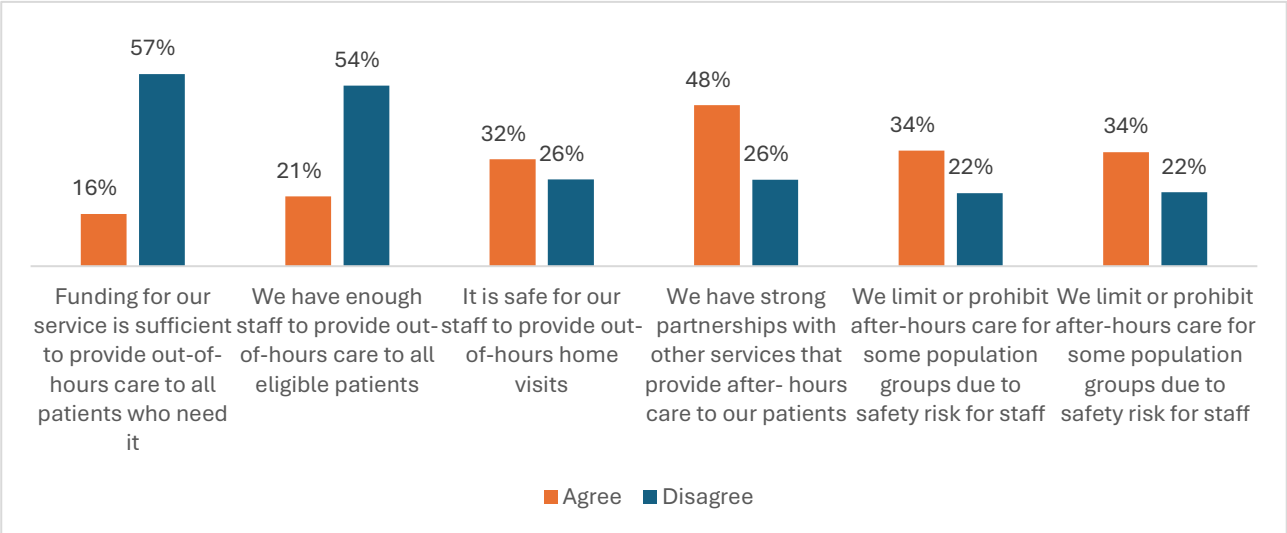


Survey findings indicate a workforce perception that funding and workforce constraints, together with staff safety concerns, limit the provision of in-person after-hours specialist palliative care for patients. As illustrated in the Figure 11 below:

- Only 16% agreed that funding for their service was sufficient to provide out-of-hours care to all patients who need it.
- Only 21% agreed that that the service where they work had enough staff to provide after-hours care to all eligible patients.
- Over one-third of respondents (34%) agreed that it is safe for staff to provide out-of-hours home visits.

In addition, 30% of respondents agreed that the ability of their service to provide after-hours care had declined over last 3-5 years.

Figure 11. Specialist palliative care respondents' views on provision of after-hours care (n=734)



After-hours specialist palliative care

When asked "**What is the most significant opportunity to improve access to palliative care?",** many specialist palliative care respondents identified improved after-hours care provision:

"Face-to-face after-hours support is the key to improving access".

"Have a 24/7 service for both malignant and non-malignant disease with access to medical and allied health".

Some respondents emphasised the value of face-to-face patient care, including in community settings:

"Telehealth is helpful, but it can't replace the need for a nurse or doctor to be physically present, especially in critical moments".

"There is no way we will ever have enough in-patient beds for all who need palliative care, so we need better 24-hour staffed and resourced community services... mandated to provide certain aspects of care such as 24-hour call outs".

Others drew attention to the valuable role of telehealth and virtual care after-hours:

"Patients have found that a 24-hour phone service is most beneficial to their care".

"Government should look at telehealth service overnight that is run by doctors and NPs".

"[Create]... virtual ED access to palliative care and aged care stream".

Asked to comment on change in the quality of palliative care in aged care, respondents working in aged care facilities also highlighted the positive role of high-quality telehealth care:

"COVID reinforced telehealth services as a viable solution for rural communities".

"We went from a local GP service who was unable to attend regular review, to a remote health assessment service who engaged a specialist Nurse Practitioner".

4.6. Voluntary Assisted Dying presents new issues for the palliative care workforce

Voluntary Assisted Dying in the National Palliative Care Workforce survey

A subset of survey respondents were asked a series of questions about Voluntary Assisted Dying (VAD). These 867 respondents included:

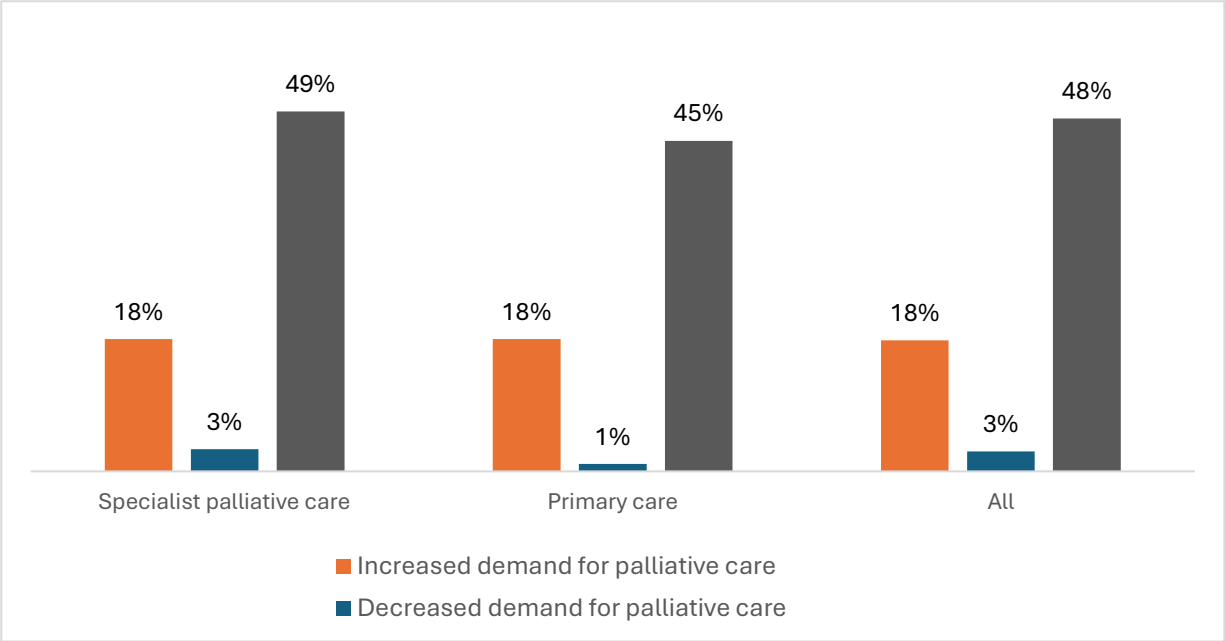
- Respondents working in specialist palliative care settings
- Respondents working in primary care settings
- Respondents in all states, but not in the Australian Capital Territory or Northern Territory (because VAD had not yet been implemented in those jurisdictions)

Respondents working in specialist palliative care and primary care services in jurisdictions where VAD has been introduced (i.e. all states but neither territory) were asked about VAD. It should be noted that VAD laws are different in each state and have different implications for the responsibilities of health professionals and provider organisations. Importantly, specialist palliative care services and clinicians have varying degrees of involvement in supporting VAD requests depending on their state. The results

reported in this section are general and are not broken down by state, nor are findings linked to the respective legislation or service arrangements in each state.

Half of those asked about VAD (49%) said that the introduction of VAD had actually increased demand for palliative care, while just 2% said it had decreased demand for palliative care. A further 18% said the introduction of VAD had had no impact on demand. These proportions were consistent in both specialist palliative care and primary care settings.

Figure 12: Perceived impact of the introduction of VAD on demand for palliative care (n=696)



The introduction of VAD attracted much commentary from survey respondents. As noted above, the implementation of VAD varies in different jurisdictions and the experiences of those working in specialist palliative care and primary care varies from state to state. The direct quotes from respondents presented below exemplify the themes raised in relation to VAD.

Benefits of the introduction of VAD

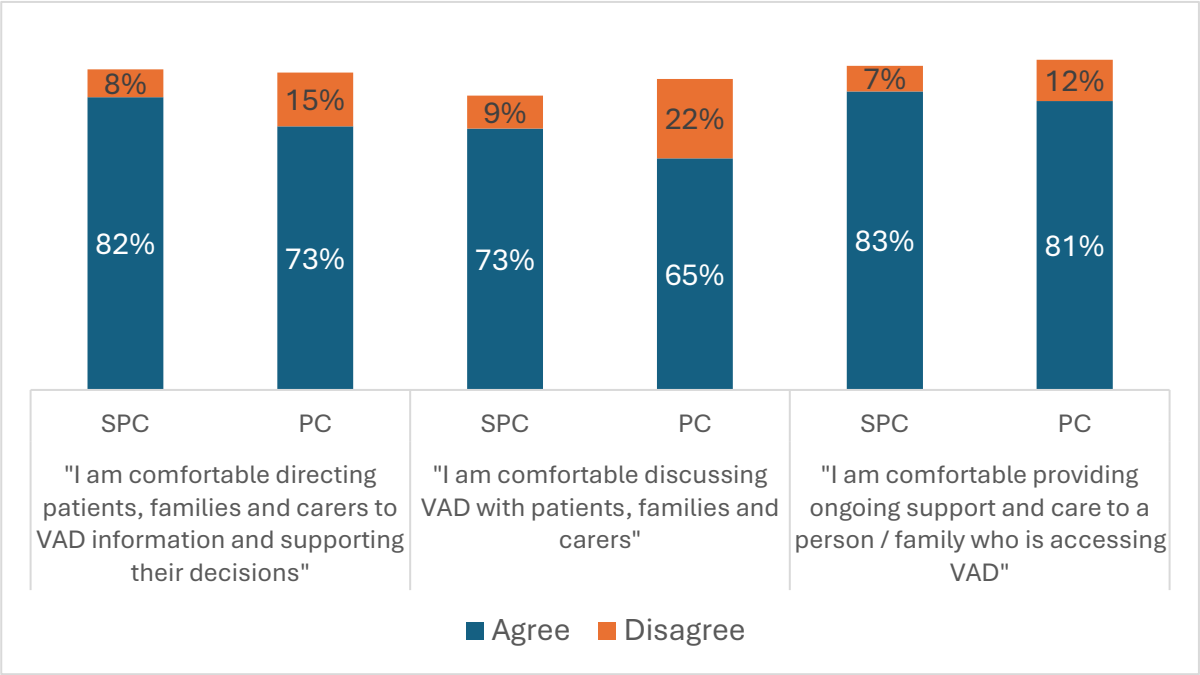
"It has made patients in general more interested in discussing end-of-life options as well as the role of Palliative care."

"I am proud to be able to support my patients and their family through a dignified passing that my patient has independently chosen."

Primary care professionals

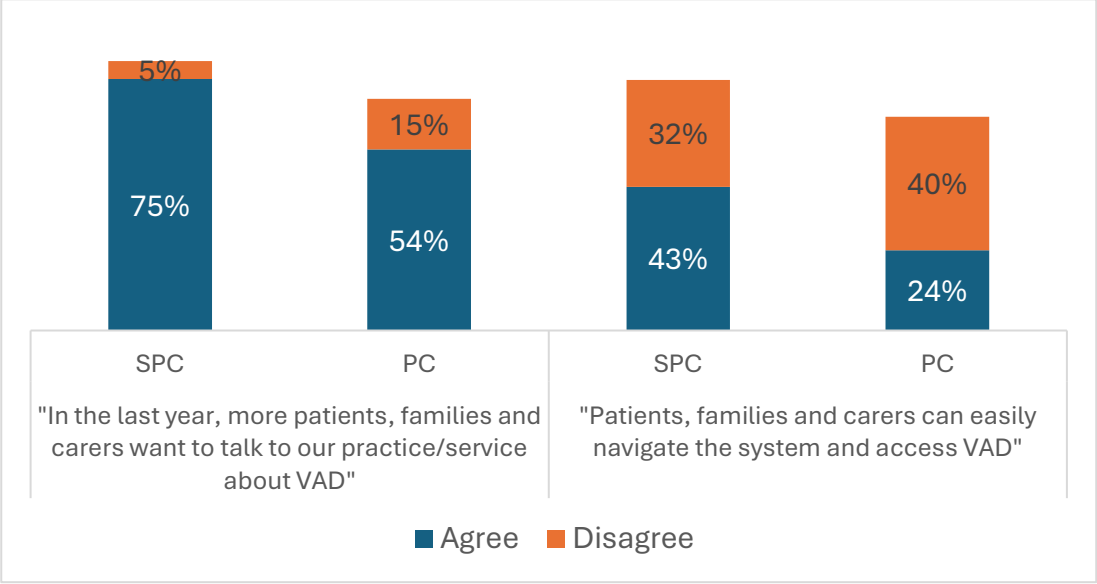
Respondents were presented with a series of agree/disagree statements about VAD. The great majority of respondents expressed comfort with their roles in relation to VAD, as shown in the figure over the page.

Figure 13: Views on VAD in Specialist Palliative Care (SPC) (n= 696) and Primary Care (PC settings) (n=113)



Respondents in specialist palliative care were more likely than those in primary care to agree that "In the past year, more patients, families and carers want to talk to our practice/service about VAD", or that "Patients, families and carers can easily navigate the system and access VAD."

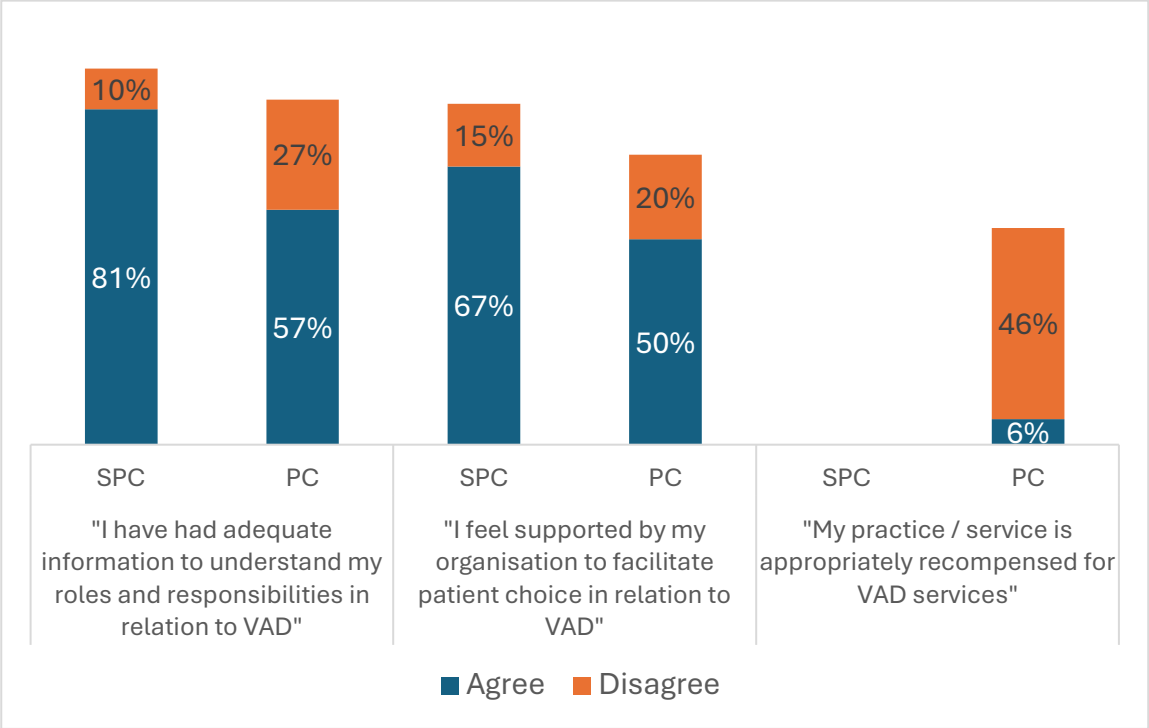
Figure 14: Impact of the introduction of VAD on demand for palliative care, among specialist palliative care (SPC) (n=696) and primary care (PC) (n=113) respondents



Specialist palliative care workers were also more likely than primary care workers to agree that "I have had adequate information to understand my roles and responsibilities in relation to VAD" and that "I feel supported by my organisation to facilitate patient choice in relation to VAD.

Just 6% of primary care respondents agreed that "My practice/service is appropriately recompensed for VAD services," while 46% disagreed. This statement was not presented to respondents working in specialist palliative care because the funding models for these two settings are very different.

Figure 15: Views on VAD in specialist palliative care (SPC) (n=696) and primary care (PC) (n=116) settings



Funding barriers in primary care

"This is all unfunded work and pressure is placed on GPs to provide services at no cost to their patient."

"Long complex discussions are needed with family, which of course is not well-funded under Medicare."

-Primary care professionals

Challenges in palliative care services from the introduction of VAD

"Conversations with patients wanting VAD and being turned down are difficult to navigate."

"The presence of VAD complicates conversations about other end-of-life care options."

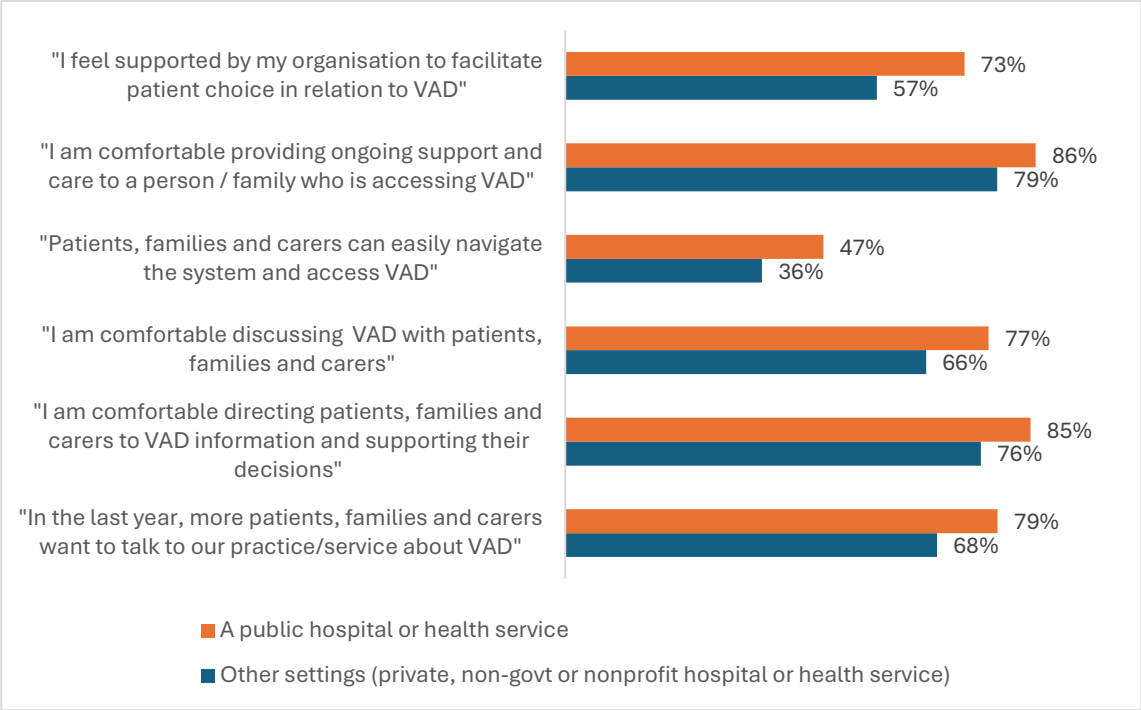
"The paperwork involved in processing VAD applications and coordinating consultations has increased our workload tremendously."

"Handling VAD-related consultations means we spend less time providing direct patient care."

-Specialist palliative care professionals

The figure below shows differences in responses to different statements by whether respondents worked in a specialist palliative care service in a public hospital or health service or in another setting, such as a private, non-government or nonprofit hospital or health service). For example, respondents in other settings were much less likely (57%) than those in public hospitals (73%) to agree that "I feel supported by my organisation to facilitate patient choice in relation to VAD."

Figure 16: Perceptions of VAD by public vs private/non-government service setting (n=668)



Ethical conflicts

"Hospital policy forbids discussion of VAD unless the patient identifies it as a topic they want to explore."

"The residential aged care facilities that I consult in have taken a 'we don't want to know what's happening' approach."

"Staff are made to feel like they are doing things wrong when a patient asks for VAD."

"I work in a Catholic hospital that does not permit staff to discuss VAD."

"Those clients who are linked with a Catholic health service find it unfortunate that they are not able to be supported by their specialist clinician within that service due to the Catholic beliefs."

"Staff report feeling unprepared for the emotional complexities of VAD."

- Specialist palliative care workers and primary care workers

Access barriers, especially in rural and regional areas and for the less mobile

"Unfortunately, I feel that access to VAD is a first option for rural and remote patients rather than a second option after a patient has received equitable access to good palliative care."

"It is extremely difficult for patients to access in rural areas. Telehealth would be great, but it is not available for VAD out here."

-Specialist palliative care workers

4.7. Volunteers are essential to the palliative care workforce

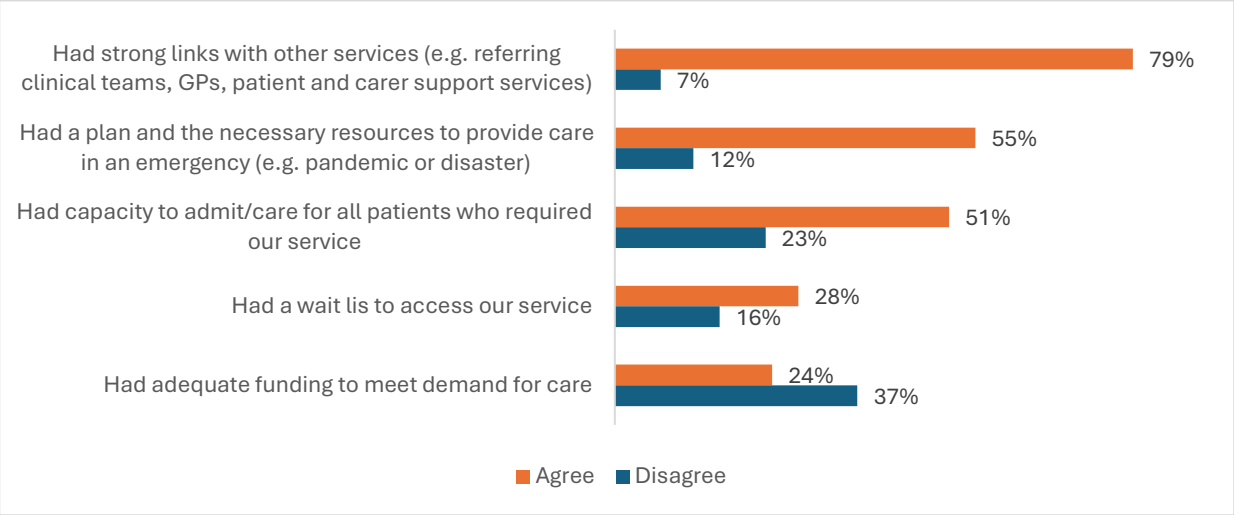
Volunteers comprised 10% of the participants in the National Palliative Care Workforce Survey, or 144 people. On all survey questions, responses from volunteers were consistent with the those of other respondents.

Similar to all participants, responses from the majority of volunteers reflected concerns about funding adequacy and service capacity:

- Only 24% of volunteers agreed that funding for the service where they volunteer was adequate to meet demand for care, in the previous year.
- Just over half (51%) agreed that the service where they volunteer had capacity to admit / care for all patients who required care, in the previous year.

Most volunteers (79%) agreed that the service where they volunteer has strong links with other services that provide care to patients.

Figure 17: Volunteer perspectives on the service where they work, in the past year (n=148)



Volunteer perspectives on workforce challenges

Like other participants, when asked **"What is the most significant challenge for the palliative care workforce?"** volunteers identified funding constraints, staff shortages and limited time to provide quality, person-centred palliative care.

Volunteers also identified the specific impact of constrained funding on the viability of palliative care volunteering:

"There isn't sufficient funding to provide patient comfort items."

"Funding e.g. for volunteers service, which has minimal funding in rural remote areas."

"Lack of resources to spend time with patients and their families."

Volunteer perspectives on workforce challenges *(continued)*

Volunteers drew attention to the difficulty of **recruiting and retaining the volunteer workforce**. In response to the question "What is the single greatest challenge for the workforce?", volunteer respondents said:

"Recruiting enough volunteers to meet client needs."

"Keeping volunteers long term."

"Finding staff and volunteers."

"Retaining/ training sufficient volunteers."

"Need more volunteers/ and funding."

Volunteers' views on better support for volunteering

When asked **"What would improve access to palliative care?"** volunteers identified more awareness of, and better support for, palliative care volunteers. They said:

"For doctors, clinicians and hospital palliative care workers etc to make positive use of volunteer services".

"Take time to talk to volunteers in palliative care, as we are talking with and are with patients on a regular basis".

"Having a Nurse Unit Manager who supports volunteers and encourages them".

"Harness volunteers in the community and provide appropriate training and support".

4.8. Palliative care capacity in the broader health and aged care workforce varies

Survey respondents who work in aged care, primary care and other areas of health care (outside of specialist palliative care) can be assumed to be among those most committed to providing a palliative approach in their diverse areas of specialisation. These respondents see themselves as part of Australia's palliative care workforce. Their responses indicate generally high self-rated confidence and ability to provide quality palliative and end-of-life care among this cohort; and demonstrate that many health and aged care professionals recognise the importance of a palliative approach to care. However, their responses should not be interpreted as reflecting the overall capacity or confidence of the broader health and aged care workforce to respond to current need, or future growth in demand, for palliative care.

Reported confidence to have palliative care conversations early is strong

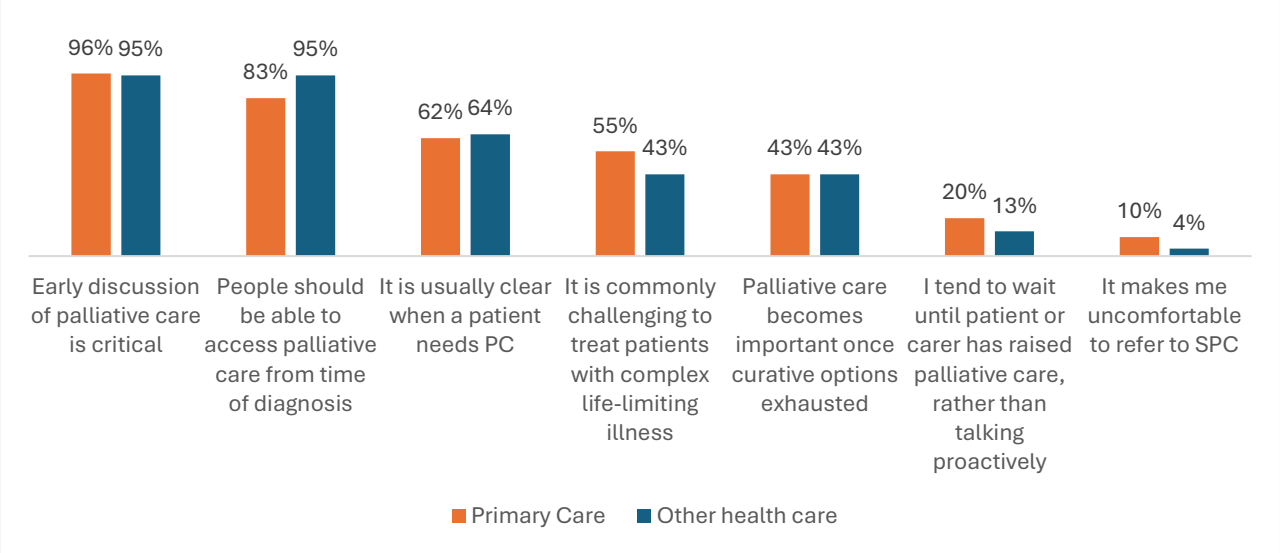
A majority of survey respondents working in areas of health care other than specialist palliative care reported confidence in their ability to provide a palliative approach to care:

- 72% of primary care respondents self-reported that they had sufficient expertise in palliative care to meet the needs of patients.
- Among those working in other health services, 60% reported sufficient expertise to meet the palliative care needs of patients.

Clinicians working in a range of health settings demonstrated strong understanding of essential aspects of a palliative approach. As illustrated in Figure 18 (over the page), most respondents:

- value early discussions about palliative care with patients
- recognise the importance of early referral to palliative care
- are comfortable referring patients to specialist palliative care services
- raise the subject of palliative care proactively, rather than waiting for patients or families

Figure 18. Percentage of respondents working primary care (n=129), and other health care settings (n=141), who agreed with key statements about palliative care.



Across settings, respondents reported high confidence to proactively raise the topic of advance care planning:

- This was highest among aged care respondents, 88% of whom reported confidence in this area.
- Among primary care respondents, 82% reported confidence in this area.
- In other health settings, 67% of respondents expressed confidence to proactively raise advance care plans / directives.

Because of the nature of this survey – where respondents opted into participation – these findings are likely to reflect the views of health professionals who are most committed to providing a quality palliative approach to care. Findings should not be understood as reflecting the confidence in and knowledge about palliative care among the wider health and aged care workforce.

Early conversations about end-of-life care preferences

Across primary care, aged care and other health care settings, respondents emphasised the benefits of early conversations about advance care planning and end-of-life care preferences.

When asked about change in the quality of palliative care in aged care in the services where they work, over the last 1-2 years, **aged care respondents** said:

"We commence palliative care conversations on admission. This means we are better able to support individual palliative care needs and remain more person-centred in our care"

"Very focused on any change in a residents' care needs. Early discussions with family so resident, staff and family are all aware of the process of palliative care".

Early conversations about end-of-life care preferences *(continued)*

Primary care respondents, commenting on the perceived impact of recent Medicare reforms, drew attention to the challenging nature of these conversations for health professionals:

"There are limited resources to support GPs approach the topic of palliative care with their patients.... There are very few human resources/ health professionals to provide end of life and support in the community, so GPs have limited referral options.

"There is still a stigma attached to palliative care, that it is insinuating end-of-life care, not symptom management and providing the best quality of life with dignity that can be offered"

"There is... death avoidance, making it hard to open discussions about advance care planning"

"Education needs to be whole practice and clinic... promote it to the practice managers and nurses."

Closer links with specialist palliative care are required

While many respondents reported having the confidence to commence important conversations about palliative and end-of-life care early, survey results also indicate some areas where additional support is required to improve capacity to provide a palliative approach. Areas of lower self-reported confidence among health and aged care respondents to the survey included:

- Knowing when to commence palliative care
- Ability to access timely clinical advice for the management of palliative patients

A significant minority of respondents working in health settings other than specialist palliative care reported that they usually find it clear when a patient requires palliative care: 38% of those working in primary care, and 36% of all those working in other health care settings.

A significant minority of respondents working in all health and aged care settings reported lacking timely access to specialist advice about the management of patients. This was consistent across settings: 35% of those working in primary care reported lacking timely access to specialist advice, as did 34% of respondents working in both aged care and other health care settings.

Responses from primary and other health care clinicians also indicate opportunities to better coordinate care and strengthen collaboration between specialist palliative care and other health care services providing care to people with life-limiting conditions. While 88% of specialist palliative care respondents felt the service where they work had strong links with other services (including general practices), the view from aged care and primary care respondents was quite different. In aged care, 64% of aged care respondents reported close links with specialist palliative care services, and just 18% of primary care respondents felt the boundaries between their responsibilities of a patient's GP and the responsibilities of palliative care services are clear.

Closer links between services

Respondents working in all settings identified the importance of closer links and collaboration between services.

Commenting on their experiences of referring patients to specialist palliative care and their perception of recent Medicare reforms, primary care respondents drew attention to the value of collaboration with specialist palliative care:

"We receive a fantastic service from visiting palliative care physicians".

"The local [specialist palliative care] service is brilliant and very easy to deal with".

Some expressed the need for closer collaboration:

"...there is no connection between GPs and palliative care providers, so longer phone [consultations] will not improve the options for consumers who require palliative care."

"[I would like the] ... ability to collaborate, apart from [just] receiving letters".

"[More]... communication between GPs and pall care – case conferencing is critical".

When asked "**What is the most significant opportunity to improve access to palliative care?",** specialist palliative care respondents identified opportunities to improve collaboration between services and systems:

"Better integration between hospitals and aged care".

"Specialist palliative care providers working with general practitioners".

"Better coordination with GPs, oncology and other services referring in".

Responses from specialist palliative care professionals suggest there may be particular opportunities to enhance coordinated after-hours care provision across services. 26% of respondents who worked for a specialist palliative care service providing after-hours care reported that the service where they work did *not* have strong partnerships with other services providing after-hours care to their patients.

These results indicate the ongoing need for education and training to support primary care professionals to understand the principles of a palliative approach in primary care, as set out in the National Palliative Care Standards for all Health and Aged Care Services.

5. Next steps

5.1. Key issues for the palliative care workforce

The 2024 National Palliative Care Workforce Survey highlights a skilled workforce that is deeply committed but under growing pressure.

Across all the areas of health and aged care where palliative care is provided, professionals and volunteers reported increasing demand for palliative care, without matching growth in funding or staffing. Those working in specialist palliative care identified an urgent challenge recruiting and retaining appropriately skilled clinical staff. Burnout and workplace stress are common across all areas, but presented most strongly as an issue for the specialist palliative care workforce.

Results also indicate a clear workforce perception that timely access to quality palliative care—particularly after hours and for people not yet in their final weeks or months of life —is impacted by funding constraints and workforce shortages. Among specialist palliative care respondents, only one-third (33%) were confident that the service where they work had adequate staff to ensure high quality care for every patient who required it.

Despite these challenges, results indicate that many professionals across the broader health and aged care workforce are committed to providing a palliative approach to care. These engaged professionals are confident in their ability to provide a palliative approach. They are particularly committed to starting early conversations about end-of-life care preference and needs. Given the nature of the 2024 National Palliative Care Workforce Survey, these results likely reflect the perspectives of the health and aged care professionals who are most engaged and committed to providing palliative care. Survey findings also indicate opportunities to support wider adoption of a palliative approach to care by the health and aged care workforce, including by improving coordination between the various services that care for people with life-limiting conditions and their families.

These findings point to the need for continued investment in workforce wellbeing, service integration, and support for all professionals delivering palliative care across Australia.

5.2. Actions to support the palliative care workforce

Findings indicate opportunities to better support the palliative care workforce. These include:

- Increased investment in response to increased demand for palliative care in the context of a growing population of ageing Australians.
- Improved access to timely specialist clinical advice about the care of patients in primary care and aged care, who require palliative care and end-of-life care.

- Enhanced coordination between specialist palliative care services and other health and aged care services.
- Continued focus on professional education, training and funding support to build the capacity and capability of the specialist palliative care workforce.
- Continued investment in professional education and training to build knowledge and skills in a palliative approach across the aged care, primary care and broader health workforce.
- Enhanced attention to workforce wellbeing, particularly in specialist palliative care.
- Targeted strategies for workforce sustainability in specialist palliative care.
  Greater recognition of the challenges presented by the interface between palliative care and VAD, and ongoing efforts to provide policy and role clarity for the palliative care workforce

Appendix 1:

Palliative care service and workforce context

1. About palliative care

Palliative care is a holistic multidisciplinary approach that aims to enhance quality of life for patients, and families and carers, who are facing the challenges associated with life-limiting illness.[10]

Palliative care:

- Is appropriate from early in the course of illness, including alongside treatments intended to prolong life.
- Is based on effective communication, shared decision-making and personal autonomy.
- Affirms life and recognises that dying is part of life – it is provided while a person lives with life-limiting illness, and is not directed at either bringing forward or delaying death.
- Should be available to all people with advanced progressive illness, regardless of diagnosis.[11]
- Is focused on pain management, symptom control, the coordination of care and holistic wellbeing (physical, psychosocial, and spiritual).[12]

Australia's National Palliative Care Strategy (2018), to which all Australian governments are signatory, reflects the World Health Organisation's definition of palliative care:

> *Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*

2. Population need for palliative care

Need for palliative care in Australia is increasing rapidly, driven by population ageing and rising rates of chronic and life-limiting illness. Currently, an estimated 92% of deaths each year are from predictable causes potentially amenable to palliative care.[13] The five leading causes of death are all life-limiting conditions.[14] The number of deaths each year is expected to increase around 30% by 2040,[15] with the majority requiring palliative care. There were 101,000 palliative care-related hospitalisations in 2023, and a 37% increase in palliative care hospitalisations between 2016 and 2023.[16] Need for palliative care is expected to double by 2050.[17] Complexity of need among those with life-limiting diagnoses is growing, as more people age with frailty and multiple health conditions.

This situation places increasing pressure on all providers of health care to people with life-limiting conditions. Of those with a life-limiting condition, 38% will see a specialist palliative care service in

their last year of life.[18] On average, they will first see a specialist palliative care service just 15 days before their death.[19] An estimated 92% of people living in residential aged care would benefit from palliative care, [20] yet only 3% see a palliative medicine specialist in their last year of life.[21] People with diagnoses other than cancer are less likely to receive specialist palliative care: in 2019-20 an estimated 68% of all Australians who died of cancer received specialist palliative care, compared with 31% of those who died of organ failure and 14% of those who died of frailty.[22]

These figures highlight that access to palliative care in health and aged care settings outside of specialist palliative care is essential to the clinical care and quality of life of people with terminal diagnoses. Yet there is minimal data available about the provision or quality of palliative care in these settings. This is a significant gap in our understanding of palliative care services in Australia.

3. Changing service systems

The health service landscape in which palliative care is provided is changing. Voluntary Assisted Dying (VAD) is legislated in all jurisdictions except the Northern Territory. Aged care, primary care and workforce scope of practice reforms are ongoing. Workforce shortages impact the health of many Australian communities, particularly in rural and remote areas. The COVID-19 emergency period placed previously unforeseen demands on health workers, services and on people affected by life-limiting illness, and also prompted rapid innovation in virtual health care. Use of telehealth consultations among palliative care specialists increased 200% between 2020 and 2022 alone,[23] and telehealth appointments now account for half of all non-admitted palliative patient care episodes.[24] These changes all have potential implications for palliative care workforce wellbeing and capacity to provide quality care.

4. The palliative care workforce

A multidisciplinary and cross-system approach

Palliative care is a multidisciplinary approach, and the workforce that delivers it is diverse. People with life-limiting illness may receive care from:

- Specialist palliative care teams – including palliative care physicians, nurses and allied health professionals with advanced training and experience, as well as specialist palliative care social workers, spiritual care practitioners, trained palliative care volunteers and art and music therapists,
- Primary care clinicians – including General Practitioners, nurses and allied health professionals (such as community pharmacists, paramedics, physiotherapists, occupational therapists, speech pathologists, dieticians and Aboriginal and Torres Strait Islander health workers and practitioners).

- Clinical teams and professionals who commonly provide care to people with life-limiting diagnoses (for example oncology, renal and dementia services)[25]
- Aged care professionals, including nurses, allied health professionals and personal care workers.

All health and aged care professionals who care for people with life-limiting illness should have basic palliative care competency, including to manage physical symptoms, support medication management, provide or refer to psychosocial and spiritual support services, and discuss prognosis and goals of care.[26] It is common for palliative care needs to fluctuate, and to change quickly, requiring collaboration between specialist palliative care teams and other services and professionals that care for those with life-limiting conditions.

The specialist palliative care workforce

The specialist palliative care workforce comprises 330 palliative care physicians (300 full-time equivalent), and 3,700 palliative care nurses.[27] This workforce is employed in around 200 services, which collectively provided care to approximately 70,100 patients in 2023.[28]

Most of the specialist palliative care workforce is employed in hospitals (70% of specialist palliative care doctors, 51% of specialist palliative care nurses).[29] This workforce covers a range of settings including hospital-based palliative care wards, hospices, outreach and consultancy to other hospital areas, and outreach community-and home-based care.

The majority of specialist palliative care professionals (83% of doctors and 71% of nurses) work in metropolitan areas.[30] The role of the GP, and the primary care team, can take on particular importance in rural and remote areas, where access to specialist medical care for life-limiting illness is generally more limited than in metropolitan areas.[31]

Reflecting the situation across Australian health care services, many senior and experienced palliative care nurses are approaching an age where they may choose to retire.[32] The age profile in palliative care nursing is older than for the nursing workforce generally:

- 31.7% of palliative care nurses are aged 55 or older[33] (whereas for all nurses this is 23.9%).[34]
- Just 20% of the palliative care nursing workforce are aged under 35,[35] whereas this is 33% for all nurses.[36]

Two in 2 in 3 palliative care physicians are women (nearly twice as high as for all specialist medical doctors).[37]

The palliative care workforce in other health and aged care settings

Data about general practice, aged care and other health workforce involvement in palliative care is very limited. There is some Australian data to indicate that around a quarter of General Practitioners

find provision of palliative care to be among the most rewarding aspects of their role.[38] However there is no standard national (or jurisdiction-level) collection of data about palliative care activity or quality outside of specialist palliative care services. This constitutes a significant gap in knowledge about patient experience, access to care, and workforce readiness to provide palliative care in primary care settings in Australia.

Palliative care volunteers

Palliative care volunteers are an important part of palliative care teams. They provide support and companionship to people receiving palliative care, their family, and carers. Volunteers may provide psychosocial support, carer respite, grief and bereavement support.[39] The purpose is to reduce distress during dying, death and bereavement.[40] Volunteers might "take a client out for a coffee or a walk, write a biography or life story, help transport people to appointments, or be present at memorial services."[41]

In most states and territories, palliative care peak organisations offer training and support for palliative care services. Volunteers are often supported by specialist palliative care services, and they provide support in a wide range of settings include hospice, residential aged care, hospital, community settings and people's own homes.

PCA is not aware of any reliable estimate of the number of palliative care volunteers nationally, however as an indication in NSW there were an estimated 1,049 active palliative care volunteers in 2024, supported by 38 volunteer services.[42]

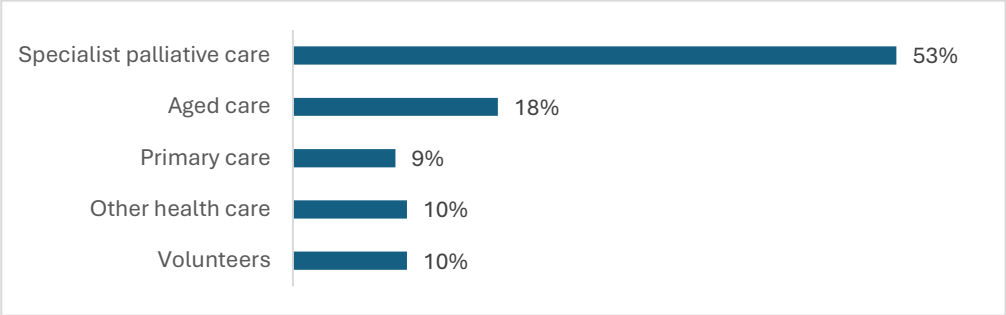
Ten percent of survey respondents were volunteers. Section 3 provides information about responses from volunteers.

Appendix 2:

Additional detail about survey respondents

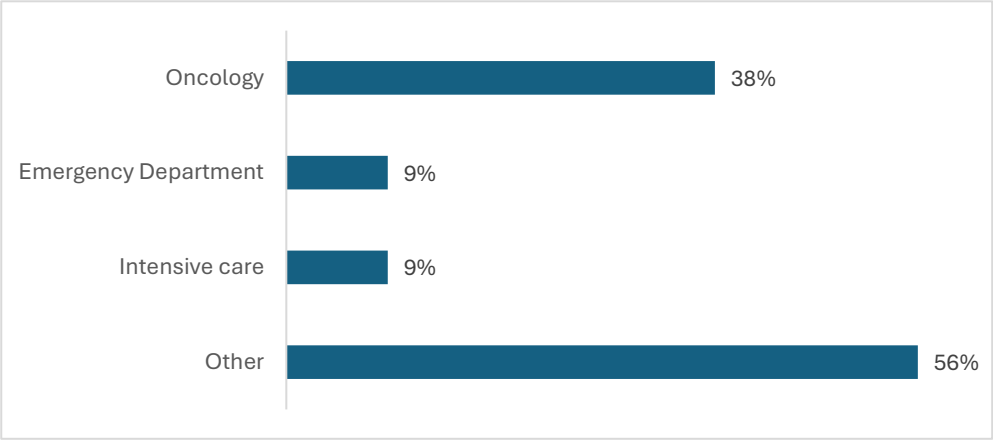
The 1,400 respondents to the National Palliative Care Workforce Survey reflect the range of health and aged care settings where palliative care is provided. Just over half of all respondents (53%, n=738) worked in specialist palliative care services. A further 10% (n=144) volunteered in palliative care. As most palliative care volunteers are based in specialist palliative care services, the total proportion of respondents from specialist palliative care was over 60%. Other respondents were drawn from aged care (18% n = 148), primary care (9%, n=130) and various other health care settings (10% n = 144).

Figure 1. Respondents, by sector



Of the 10% who worked in other health care settings, almost a quarter worked in oncology, followed by Emergency Departments and Intensive Care Units. The remainder worked in a wide variety of clinical areas specialising in the care of people with chronic and/or life-limiting illnesses (among these, kidney care, dementia care, stroke care, heart care, respiratory care, geriatric care, rehabilitation, paediatric care and paramedicine were represented).

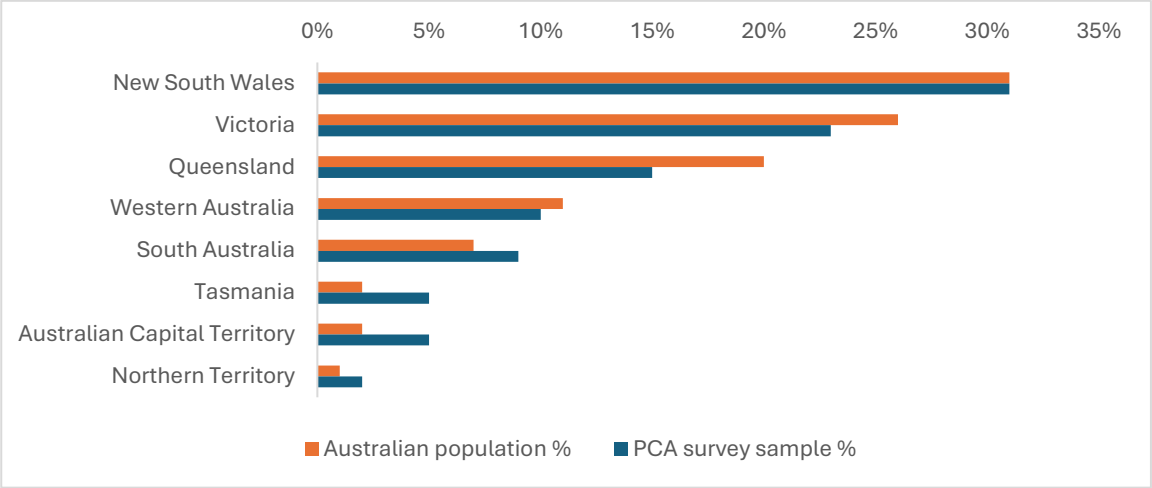
Figure 2. Respondents who work in other areas of health care (excluding primary care and specialist palliative care)



Location

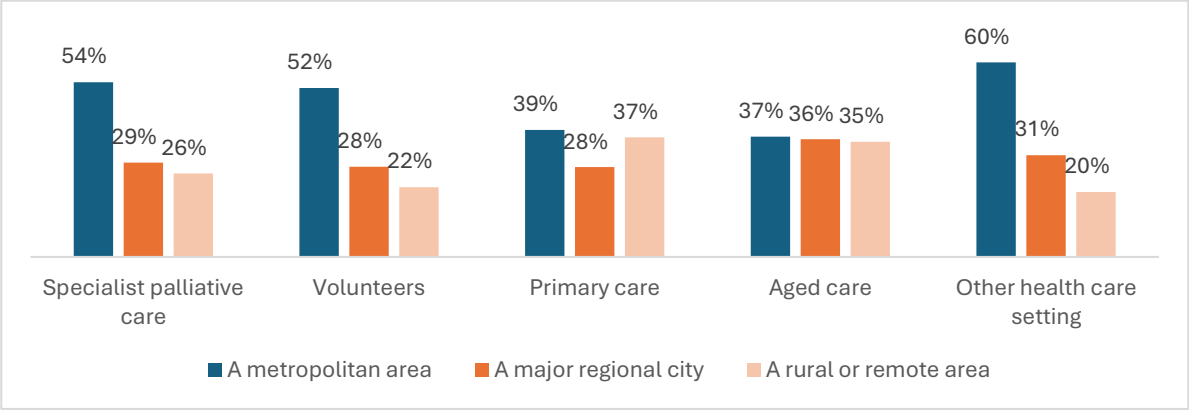
Respondents were drawn from all states and territories, with response rates aligning closely with the geographic distribution of the Australian population.

Figure 2. Respondents, by state and territory



While half of all respondents (50%) worked or volunteered in cities, 30% worked in a major regional centre and 28% worked in a rural/remote area.[43] This is a strong response rate from those living and working in rural and regional areas, given that available data - which is limited to specialist palliative care - indicates that the palliative care workforce (84% of specialist doctors, 72% of specialist nurses) is concentrated in cities .[44] Respondents' geographic distribution varied somewhat by setting, as the graph below indicates.

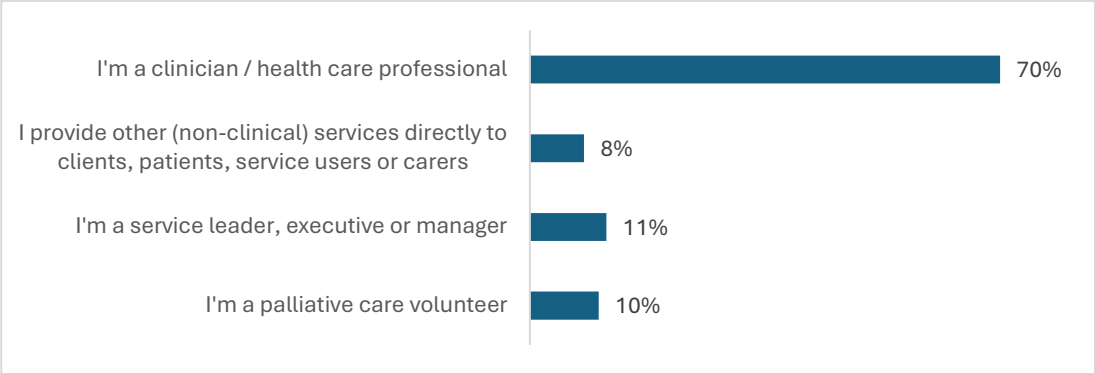
Figure 3. Respondents' location, by sector



Role and profession

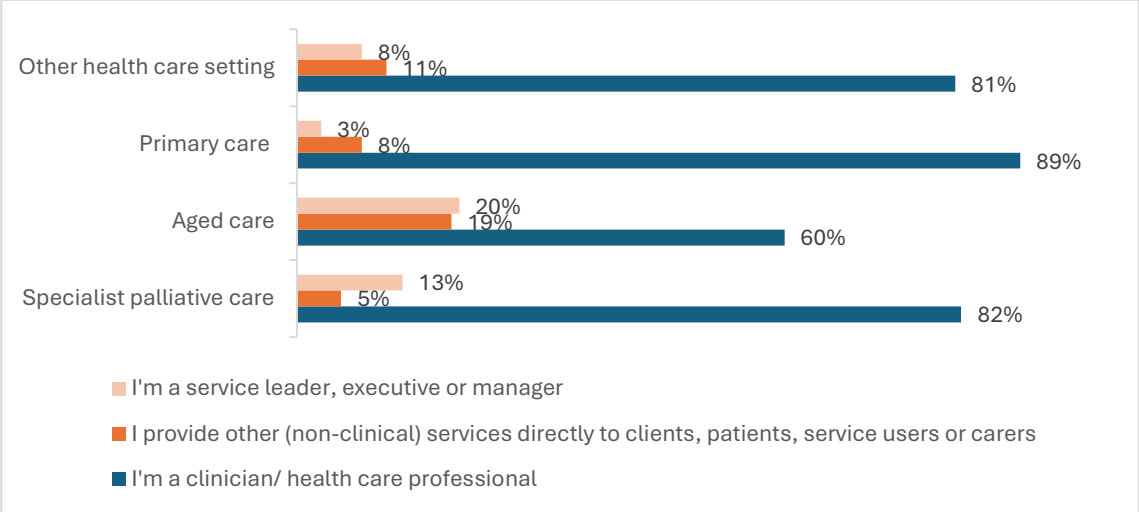
Nearly nine every ten survey respondents (88%) worked in direct care or service delivery roles (including as volunteers), with the remainder working in a leadership, management or executive role.[45]

Figure 4. Respondents' roles



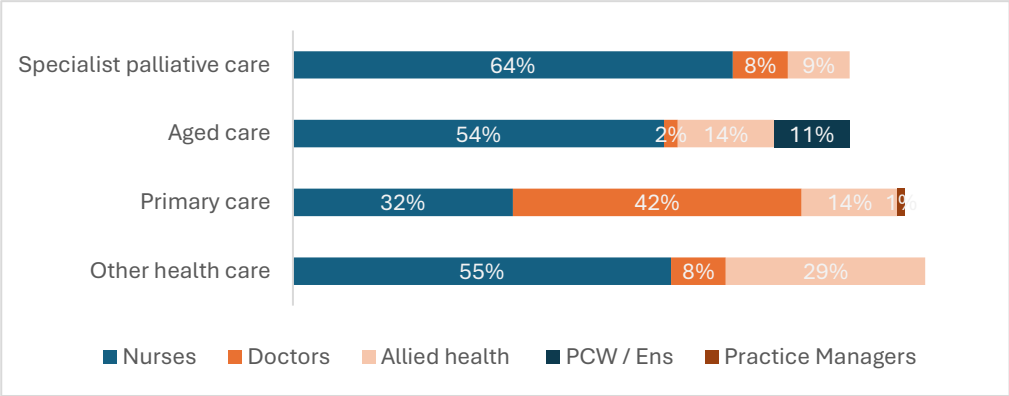
This distribution was similar across sectors, as illustrated below.

Figure 5. Respondents' roles, by setting



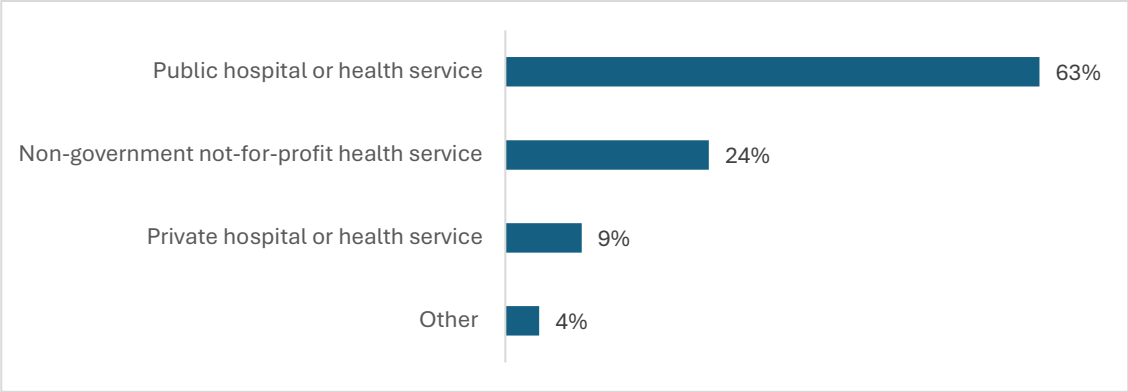
As the single largest health profession, nurses unsurprisingly were a majority of survey respondents in all settings, other than primary care. Here, medical practitioners (GPs and Rural Generalists) were the single largest group of professional respondents.

Figure 6. Participants professions, by sector



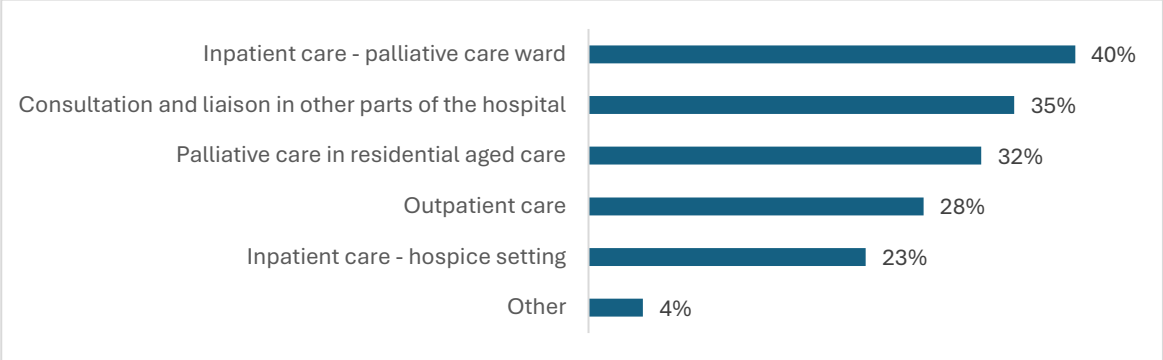
Among specialist palliative care respondents, a majority worked in public hospitals or health services, as the figure below illustrates.

Figure 7. Specialist palliative care respondents, place of employment.



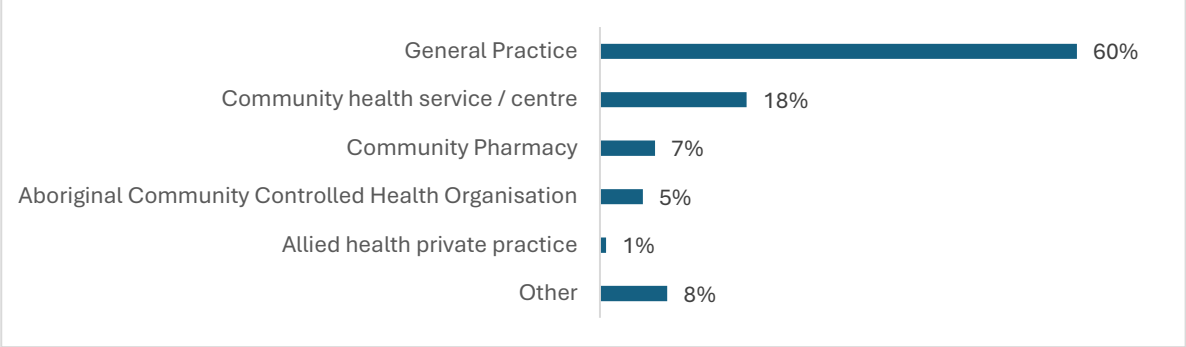
Of these services, 54% provided inpatient care (either in a hospice or hospital palliative care ward) and 71% provided community-based care.[46]

Figure 8. Types of care, provided at services where specialist palliative care respondents worked



Among those working in primary care settings, most worked in General Practice:

Figure 8: Work setting, General Practice respondents

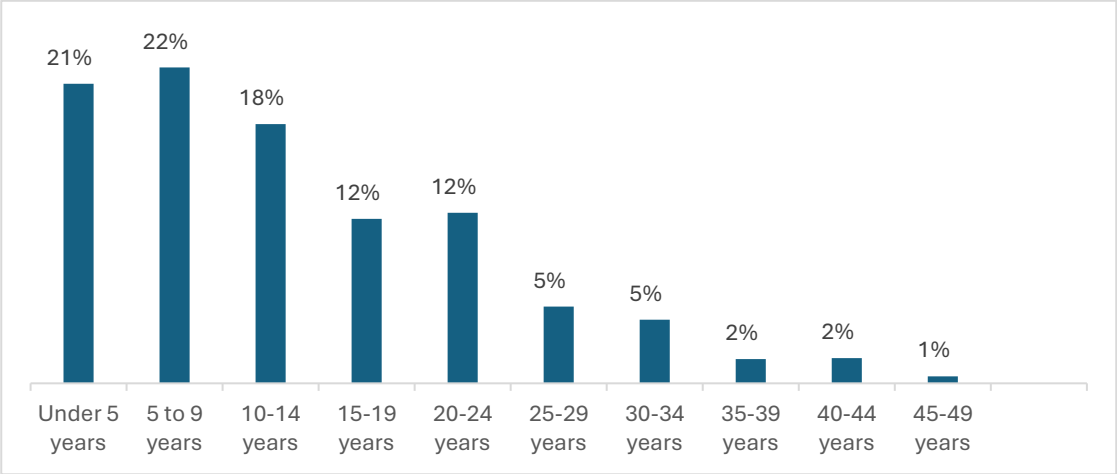


Years of experience

The survey cohort was very experienced in the provision of palliative care:

- 45% of respondents held at least a decade's experience
- 27% had worked for 20 or more years in palliative care
- Average years' experience was 14 years

Figure 9. Respondents' years of experience in palliative care



Appendix 3:

Survey questionnaire

Survey of the National Palliative Care Workforce Across Health and Aged Care Settings

This short survey is for **everyone** who works or volunteers in **any service that provides palliative care** in Australia. This includes all people working or volunteering in **specialist palliative care services**, and those providing **palliative care** as part of their work in **primary care, aged care and other health care settings**.

It will take you about 15 to 20 minutes, or a little bit longer if you kindly complete the voluntary open-ended questions, as so many respondents have already done.

Your answers help Palliative Care Australia (PCA) and our Member Organisations around the country to advocate for the palliative care workforce, and everyone who needs palliative care.

It is important for you to know that the information you provide in this survey is completely confidential. It's important to us that you feel free to express yourself in the interests of those you care for and those you work with.

For more information about how **PCA protects your privacy and confidentiality**, read PCA's Privacy Policy; CLICK HERE. https://palliativecare.org.au/palliative-care-australia-privacy-policy/

Depending on your role and where you work, **you may be asked questions about**: workforce pressures, demand for services, the National Palliative Care Standards, after-hours care, your wellbeing at work, voluntary assisted dying, and palliative care in primary care or aged care. You can stop the survey at any time, and resume when ready to do so..

Click **next** to start the survey.

Section A – Basic demographics and roles, + branching question [for everyone]

Section B – PC Worker Section

Section C – General practice/primary care worker section

Section D – Aged care worker section

Section E – Other Healthcare section, e.g. clinical specialists

Section F – Volunteer section

Section G – Everyone: Wellbeing and self-care section [for everyone]

Section A – Basic demographics and roles, + branching question

QA1. How many years of experience do you have in palliative care overall?

- Under 5 years
- 5 to 9 years
- 10-14 years
- 20-24 years
- 25-29 years
- 30-34 years
- 35-39 years
- 40-44 years
- 45-49 years
- 50+years
- No experience in palliative care

QA2. Do you, or the organisation you work or volunteer for, provide clinical palliative care or other direct palliative care services to patients, carers, clients or service users?

- Yes
- No

QA3. Do you work or volunteer in:

- A metropolitan area
- A regional city or town
- A rural or remote area
- Both/all

QA4. Please select your State or Territory:

- New South Wales
- Victoria
- Queensland
- South Australia
- Western Australia
- Tasmania
- Australian Capital Territory
- Northern Territory

QA5 What is your gender?

- Male/man
- Female/woman
- Non-binary
- I use another term [optional field for preferred term]
- I'd prefer not to say

QA6. What is your age?

- 19-24 years
- 25-29 years
- 30-34 years
- 35-39 years
- 40-44 years
- 45-49 years
- 50-54 years
- 55-59 years
- 60-64 years
- 65-69 years
- 70+ years

- I'd prefer not to say

QA7. Which best describes your role (in palliative care)? [If you have more than one role in palliative care, please answer for your primary role.]

- I'm a clinician / health care professional **>QA9**
- I provide other (non-clinical) services directly to clients, patients, service users or carers **>QA9**
- I'm a service leader, executive or manager **>QA9**
- I'm a palliative care volunteer – **GO TO SECTION F**
- Other (specify .....) **>QA8**

If Other to Q7, Ask

QA8. Which best describes your role?

- Consumer or carer – Go to QA8b
- Academic or researcher – Go to QA8b
- State or territory government (non-clinical role e.g. policy or program management) - Go to QA8b
- Commonwealth government (non-clinical role e.g. policy or program management) - Go to QA8b
- Non-government organisation (non-clinical role e.g. policy or program management) - Go to QA8b
- Other [specify.....] – Go to QA8b

If 'OTHER' to QA7, Ask:

QA8b. In your view, what is the most significant challenge for the palliative care workforce?

Write in: .....

If 'OTHER' to QA7, Ask:

QA8c. In your view, what is the most significant opportunity to improve access to palliative care?

Write in: .....
Terminate with thanks.

ASK ALL

QA9. Which best describes your area of expertise in palliative care?

- Adults
- Children (0-18)
- Both

Dividing (branching) questions:

ASK ALL

QA10a. Which setting do you mostly work in? (Please choose ONE that applies best!)

- **Specialist palliative care.** (For example, you work for a specialist palliative care service in a hospital, hospice or community setting.) – GO TO SECTION B – PALLIATIVE CARE SETTING
- **Aged care. (**For example, you work for an aged care service that provides care for people who have health needs that may include palliative care.) – GO TO SECTION D – AGED CARE SETTING
- **Primary care.** (For example, you work in General Practice, an Aboriginal or Torres Strait Islander health service, community pharmacy or another primary care setting where patients may require palliative care.) –
  GO TO SUPPLEMENTARY Q BELOW THEN TO SECTION C – PRIMARY CARE SETTING (ALLIED HEALTH PRIVATE PRACTICE GO TO SECTION E SEE BELOW)
- **Other health care setting.** (eg, you work in a clinical specialty such as Oncology, Intensive Care or paramedicine, or in allied health private practice) GO TO SECTION E – OTHER HEALTH CARE SETTING
- **None of the above.** Terminate interview with thanks

SUPPLEMENTARY Q10b FOR PRIMARY CARE RESPONDENTS only:

- Q10b Which best describes the service where you work:
- General Practice (GO TO SECTION C)
- Aboriginal Community Controlled Health Organisation (GO TO SECTION C)*
- Community Health Service / Centre (GO TO SECTION C)*
- Urgent Care Clinic (GO TO SECTION C)*
- Community Pharmacy (GO TO SECTION C)*
- Allied health private practice (GO TO SECTION E OTHER HEALTH CARE)*
- Other (please specify) (GO TO SECTION C)*

***ALL** GO TO SECTION C – PRIMARY CARE SETTING **EXCEPT ALLIED HEALTH PRACTICE (GO TO OTHER HEALTH CARE)**

Section B – Specialist Palliative Care

These questions are about the palliative care service where you work.

QB1. Which best describes your role:

- **Palliative care physician [Please specify .....]** **1**
- **Other medical specialist** [Please specify .....] 2
- **Nursing professional** [Please specify below:]
  - Enrolled Nurse
  - Registered Nurse
  - Nurse Practitioner

  Other [Please specify .....]

Allied health or other professional [Please specify below:]

- Aboriginal or Torres Strait Islander Health Worker
- Allied health assistant
- Chaplain / Spiritual care provider
- Dietitian/ nutritionist
- Exercise physiologist
- Grief and bereavement counsellor
- Massage therapist
- Music or art therapist
- Occupational therapist
- Paramedic
- Pharmacist
- Physiotherapist
- Psychologist
- Recreational therapist
- Social worker
- Speech and language pathologist
- Other [please specify .....)
- **Palliative care volunteer – GOTO SECTION F**
- **Other** [please specify .....]

QB1b Which best describes the service where you work?:

- A **public** hospital or health service
- A **private** hospital or health service
- Non-government not-for-profit health service
- Other [please specify]
- Prefer not to say

QB2a Does the service where you work provide:

- Inpatient care – hospital palliative care ward – ask **QB2b**
- Inpatient care - hospice setting – ask QB2**b**
- Consultation and liaison in other parts of the hospital – ask QB2**b**
- Outpatient care – ask QB2**c**
- Community-based care – Ask **QB2c**
- Palliative care in residential aged care services ask QB2**c**
- **Other [please specify……] – ask QB3**

IF CODES 1 OR 2 IN QB2a, ASK:

QB2b Does your service restrict access to <u>inpatient</u> care based on a patient's life expectancy?

- Always – Go to QB2d
- Usually– Go to QB2d
- Sometimes– Go to Q2d
- Never– Go to Q2d
- Unsure– Go to Q2d
- Does not apply/prefer not to answer– Go to Q2d

IF CODES 3, 4, 5 OR 6 QB2a, ASK:

QB2c Does your service restrict access to <u>outpatient</u> or community-based care based on a patient's life expectancy?

- Always
- Usually
- Sometimes
- Never
- Unsure
- Does not apply/prefer not to answer

IF ANSWERED 'ALWAYS' OR 'USUALLY' IN QB2b OR QB21c, ASK:

QB2d What life expectancy is used to assess whether a patient can access your service?

- A few days
- A week
- A month or less
- Two months or less
- Three months or less
- Six months or less
- 12 months or less
- Longer than 12 months
- Unsure
- Does not apply/prefer not to answer

Choose the options that best match your view.

QB3. In the past year, the service where I work:	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
Experienced **increasing demand** for care							
Had capacity to **admit / care for** all patients who required our service							
Had **adequate funding** to meet demand for care							
Had **strong links** with other services (e.g. referring clinical teams, General Practitioners, patient and carer support services)							
Had a **wait list** to access our service							
Had a plan and the necessary resources **to provide care in an emergency** (e.g. pandemic or disaster)							
Assessed our services against the National Palliative Care Standards 5th ed. (2018).							

QB4. How often does your team assess your services against the National Palliative Care Standards? [refer: National Palliative Care Standards - Palliative Care Australia]*

- Monthly
- Quarterly
- Annually
- Never
- Unsure

QB5. Do you know where you can find tools to help your team assess against the National Palliative Care Standards?

- Yes
- No

These questions are about workforce pressures.

Choose the options that best match your view.

QB6. In the past year:	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ prefer not to answer
The service where I work had difficulty **recruiting** new staff							
The service where I work had difficulty **retaining** staff							
The service where I work had sufficient staff **to ensure timely access** to care for every patient							
The service where I work **had sufficient staff** to ensure high quality care for every patient							
I have **felt increasing pressure, stress and anxiety** in my workplace							
I have **thought about leaving my job** due to work pressures							
My work in palliative care was appropriately remunerated							

These questions are about after-hours care at the service where you work.

QB7. Does the service where you work or volunteer provide after-hours care?
*(After-hours care means clinical care or advice provided **outside 8am to 6pm weekdays, outside 8am and 12 noon on Saturday, and all day Sunday**, for people whose health condition cannot wait for treatment until regular care is available. This is the definition used in the National Palliative Care Service Development Guidelines.)*

- Yes
- No
- Unsure

QB8. Which of the following does your service provide out-of-hours?

- Telehealth or telephone clinical advice (for patients, carers or family members)
- In-person clinical care at patients' own homes
- In-person clinical care at the service where you work
- Telephone or telehealth clinical advice for other health professionals
- All of the above
- Other
- None of these/unsure

QB9. Thinking about the service where you work, please choose the options that best match your view:	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
Our **ability to provide after-hours care has declined** over the last 3-5 years							
We limit or prohibit after-hours care for some population groups due to **safety risk for staff**							
Funding for our service is sufficient to provide out-of-hours care to all patients who need it							
We have **enough staff** to provide out-of-hours care to all eligible patients							
We have **strong partnerships** with other services that provide after- hours care to our patients							
It is **safe for our staff** to provide out-of-hours home visits							

QB10. In your view, what is the most significant challenge for the palliative care workforce?

Write in: .....

QB11. In your view, what is the most significant opportunity to improve access to palliative care?

Write in: .....

Your views on Voluntary Assisted Dying – This section is optional/non-mandatory

These questions are about the introduction of Voluntary Assisted Dying (VAD) in some jurisdictions.

VAD is now provided in the majority of Australian jurisdictions. While Voluntary Assisted Dying (VAD) is not part of the palliative care model, it is an important health and social issue that affects people with life-limiting illnesses.

ASK ALL EXCEPT ACT AND NT **QC6. Choose the options that best match your view.**	**Strongly disagree**	**Disagree somewhat**	**Neither/ nor**	**Agree somewhat**	**Strongly agree**	**Unsure**	**Does not apply/ Prefer not to answer**
In the last year, more patients, families and carers **want to talk to our practice/service about VAD**							
I **am comfortable directing** patients, families and carers to VAD information and supporting their decisions							
I **am comfortable discussing VAD with patients, families and carers**							
My practice / service **is appropriately recompensed** for VAD services							
Patients, families and carers **can easily navigate** the system and access VAD							
I am comfortable providing **ongoing support and care** to a person / family who is accessing VAD							
I have had **adequate information** to understand my roles and responsibilities in relation to VAD							
I **feel supported by my organisation to facilitate patient choice** in relation to VAD							

ASK ALL EXCEPT ACT AND NT
QC7. In your view, has the introduction of VAD:

- Increased demand for palliative care
- Decreased demand for palliative care
- Had no impact on demand for palliative care
- Unsure
- Does not apply

ASK ALL EXCEPT ACT AND NT
QC8. Has the introduction of VAD had other impacts that you would like to provide information about?

Please write in: .....
F GO TO SECTION G

Section C – General practice/primary care

QC1: Which best describes your role:

- **General Practitioner**
- **Rural Generalist**
- **Other medical specialist [please specify……]**
- **Practice Manager**
- **Nursing professional** [Specify below:}
  - Enrolled Nurse
  - Registered Nurse
  - Nurse Practitioner
  - Other [please specify enter ……]

Allied health or other professional [Please specify below:]

- Aboriginal or Torres Strait Islander Health Worker
- Allied health assistant
- Chaplain / Spiritual care provider
- Dietitian/ nutritionist
- Exercise physiologist
- Grief and bereavement counsellor
- Massage therapist
- Music or art therapist
- Occupational therapist
- Paramedic
- Pharmacist
- Physiotherapist
- Psychologist
- Recreational therapist
- Social worker
- Speech and language pathologist
- Other [please specify ……)
- **Other [please specify ……]**

QC1b Which best describes the service where you work:

- General Practice1
- Aboriginal Community Controlled Health Organisation
- Community Health Centre / Service
- Community Pharmacy
- Ambulance service / paramedicine
- Other (please specify ……)

These questions are about the General Practice or other service where you work.
Choose the options that best match your view.

QC2. In the past year, the practice or service where I work:	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
Has experienced **increased demand for palliative care**							
Had **access to timely clinical advice** about the management of palliative patients							
Was **adequately funded** to deliver palliative care							
Proactively raised the topic of **Advance Care Plans / Directives** with patients who have life-limiting conditions							
Had **sufficient expertise** in palliative care to meet the needs of patients							
Had **sufficient time** to meet the palliative care needs of patients							
Assessed our services against the National Palliative Care Standards for All Health Professionals and Aged Care Services (2022)							

This question is about recent changes to Medicare, for example patient and practice enrolment in MyMedicare.

QC3. Do you think these changes to Medicare:

- Will make it easier to provide palliative care in primary care
- Will make it harder to provide palliative care in primary care
- Will make no difference to palliative care in primary care
- Not familiar with MyMedicare

"This question is optional. We would appreciate your answer to this and other open-ended questions. It will help us understand the issues clearly"

QC4. Why? Please tell us more about why you think changes to Medicare will have this impact.

- Please write in:. . . . . .

Your views on referring patients to Palliative Care: [Please answer these questions only if you refer patients to specialist palliative care services]

QC5a. Choose the options that best match your view.	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
It is the responsibility of GPs to discuss palliative care with their patients							
People should be able to access palliative care from the time of diagnosis with a life-limiting condition							
I tend to wait until a patient, carer or family member has raised palliative care, rather than talking about palliative care proactively							
It is usually clear when a patient needs palliative care							
The boundaries are clear between the responsibilities of a patient's GP and the responsibility of palliative care services*							
I commonly find treating patients with complex life-limiting illness challenging							
It makes me uncomfortable to refer patients to specialist palliative care							
For people with life-limiting conditions, early discussion of palliative care is critical							
Palliative care becomes important once all curative treatments have been exhausted							
Care coordination in our practice includes providing primary palliative care for patients with life-limiting illness or frailty							

QC5b What other difficulties or issues have you experienced with referring patients to palliative care services?

Please write in: .....

Your views on Voluntary Assisted Dying – This section is optional/non-mandatory

These questions are about the introduction of Voluntary Assisted Dying (VAD) in some jurisdictions.

VAD is now provided in the majority of Australian jurisdictions. While Voluntary Assisted Dying (VAD) is not part of the palliative care model, it is an important health and social issue that affects people with life-limiting illnesses.

ASK ALL EXCEPT ACT AND NT **QC6. Choose the options that best match your view.**	**Strongly disagree**	**Disagree somewhat**	**Neither/ nor**	**Agree somewhat**	**Strongly agree**	**Unsure**	**Does not apply/ Prefer not to answer**
In the last year, more patients, families and carers **want to talk to our practice/service about VAD**							
I **am comfortable directing** patients, families and carers to VAD information and supporting their decisions							
I **am comfortable discussing VAD with patients, families and carers**							
My practice / service **is appropriately recompensed** for VAD services							
Patients, families and carers **can easily navigate** the system and access VAD							
I am comfortable providing **ongoing support and care** to a person / family who is accessing VAD							
I have had **adequate information** to understand my roles and responsibilities in relation to VAD							
I **feel supported by my organisation to facilitate patient choice** in relation to VAD							

ASK ALL EXCEPT ACT AND NT
QC7. In your view, has the introduction of VAD:

- Increased demand for palliative care
- Decreased demand for palliative care
- Had no impact on demand for palliative care
- Unsure
- Does not apply

ASK ALL EXCEPT ACT AND NT
QC8. Has the introduction of VAD had other impacts that you would like to provide information about?
Please write in: .....

F GO TO SECTION G
Section D – Aged care worker section

QD1. Which best describes your role:

- **General Practitioner**
- **Other medical specialist [please specify .....]**
- **Nursing professional**
  - Enrolled Nurse
  - Registered Nurse
  - Nurse Practitioner
  - Other [please enter .....]
- **Allied health or other professional [Please specify below:]**
  - Aboriginal or Torres Strait Islander Health Worker
  - Allied health assistant
  - Chaplain / Spiritual care provider
  - Dietitian/ nutritionist
  - Exercise physiologist
  - Grief and bereavement counsellor
  - Massage therapist
  - Music or art therapist
  - Occupational therapist
  - Paramedic
  - Pharmacist
  - Physiotherapist
  - Psychologist
  - Recreational therapist 20
  - Social worker 21
  - Speech and language pathologist
  - Other [please specify .....)
  - Personal care worker
  - Nursing assistant
  - Other [please specify .....]
  -

These questions are about the service where you work.

Choose the options that best match your view.

QD2. Which best describes the service where you work:

- Residential aged care service
- Community-based or in-home aged care service
- Both
- Other

QD3. In the past year, the service where I work:	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
Was **able to meet the palliative care needs** of (all or most) residents/service users							
Had **strong links** with specialist palliative care services							
Had **access to timely clinical advice** about the management of palliative patients							
Ensured that palliative care was provided to all residents / service users who needed it							
Assessed need for palliative care for each person entering our service							
Assessed our services against the National Palliative Care Standards for All Health Professionals and Aged Care Services (2022) [refer to https://palliativecare.org.au/national-palliative-care-standards/							
Was **adequately funded** to deliver palliative care							
Proactively raised the topic of **Advance Care Plans / Directives** with older people							
Has experienced increased demand for palliative care							

QD4. In the last 1-2 years, delivery of quality palliative care in the aged care service where I work has:

- Improved
- Deteriorated
- Stayed the same
- Unsure

QD5. Why? What do you think has led to this change?

Write in: .....

QD6. In your view, what is the most significant challenge for the palliative care workforce?

Write in: .....

QD7. In your view, what is the most significant opportunity to improve access to palliative care?

Write in: .....

F GO TO SECTION G
Section E – Other Healthcare section, eg clinical specialists

QE1 Which best describes your role:

- **Medical specialist**
  - [please describe.....]
- **Nursing professional [Specify below:]**
  - Enrolled Nurse
  - Registered Nurse
  - Nurse Practitioner
  - Other [please describe.....]

- **Allied health or other professional [Please specify below:]**
  - Aboriginal or Torres Strait Islander Health Worker
  - Allied health assistant
  - Chaplain / Spiritual care provider
  - Dietitian/ nutritionist
  - Exercise physiologist
  - Grief and bereavement counsellor
  - Massage therapist
  - Music or art therapist
  - Occupational therapist
  - Paramedic
  - Pharmacist
  - Physiotherapist
  - Psychologist
  - Recreational therapist
  - Social worker
  - Speech and language pathologist
  - Other [please specify .....)
- **Other [please enter.....] 2**

QE1b Which best describes the service where you work?

- Allied health private practice (branch to supplementary below)
- Ambulance service {GO TO QF2)
- Clinical speciality - in a **hospital** [branch to supplementary below]
- Clinical speciality - **private practice** [branch to supplementary below]
- Other [please specify] (GO TO QF2)

QE1c Which best describes the clinical speciality / area you work in?

- Emergency Department
- Intensive Care
- Cancer care
- Dementia care
- Stroke care
- Heart care
- Respiratory care
- Kidney care
- Geriatric care
- Rehabilitation
- Paediatric care
- **Other [please specify]**

These questions are about the health care service where you work.
Choose the options that best match your view.

QF2. In the past year, the practice or service where I work:.	Strongly disagree	Disagree somewhat	Neither / nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
Has experienced **increased demand for palliative care**							
Had **access to timely clinical advice** about the management of palliative patients							
Was **adequately funded** to deliver palliative care							
Proactively raised the topic of **Advance Care Plans / Directives** with patients who have life-limiting conditions							
Had **sufficient expertise** in palliative care to meet the needs of patients							
Had **sufficient time** to meet the palliative care needs of patients							
Assessed our services against the National Palliative Care Standards for All Health Professionals and Aged Care Services (2022) [refer to https://palliativecare.org.au/national-palliative-care-standards/							

Your views on referring patients to palliative care: [Please answer these questions if you refer patients to specialist palliative care services]

QF3. Choose the options that best match your view.	Strongly disagree	Disagree somewhat	Neither/ nor	Agree somewhat	Strongly agree	Unsure	Does not apply/ Prefer not to answer
People should be able to access palliative care from the time of diagnosis of a life-limiting condition							
I tend to wait until a patient, carer or family member has raised palliative care, rather than talking about palliative care proactively							

It is usually clear when a patient needs palliative care							
I commonly find treating patients with complex life-limiting illness challenging							
It makes me uncomfortable to refer patients to specialist palliative care							
For people with life-limiting conditions, early discussion of palliative care is critical							
Palliative care becomes important once all curative treatments have been exhausted							

F GO TO SECTION G

Section F: Volunteers section

Choose the option that best matches your view:

QF1. In the past year, the service where I work or volunteer:	**Strongly disagree**	**Disagree somewhat**	**Neither/ nor**	**Agree somewhat**	**Strongly agree**	**Unsure**	**Does not apply/ Prefer not to answer**
Experienced **increasing demand** for care							
Had capacity to **admit / care for** all patients who required our service							
Had **adequate funding** to meet demand for care							
Had **strong links** with other services (e.g. referring clinical teams, General Practitioners, patient and carer support services)							
Had a **wait list** to access our service							
Had a plan and the necessary resources **to provide care in an**							

emergency (e.g. pandemic or disaster)							
Assessed our services against the National Palliative Care Standards 5th ed. (2018).							

"These questions are optional. We would appreciate your answer to this and other open-ended questions. It will help us understand the issues clearly"

QF2. In your view, what is the most significant challenge for the palliative care workforce?

Write in: .....

QF3. In your view, what is the most significant opportunity to improve access to palliative care?

Write in: .....

F GO TO SECTION G

Section G: Wellbeing and self-care section [for everyone]

Self-Care

QG1 What do you most like about working (or volunteering) in palliative care?

- **Please write in: .....**

QG2. What self-care strategies do you use to maintain your well-being while working (or volunteering) in palliative care?

- **Please write in: .....**

QG3. How often do you experience signs of "burnout"* in your palliative care work?

- All the time
- Very often
- Quite often
- Not very often
- Never
- Prefer not to say

**These signs can include emotional exhaustion, depersonalisation or extreme fatigue.*

QG4. Which of these self-care materials are you familiar with:

- **ELDAC self-care materials**
- **PCA self-care materials**
- **State / territory palliative care organisations' self-care resources and/or education**
- **Other (please write in.....)**

QG5. Overall, how would you *currently* rate your wellbeing in the following areas?

(Slider):

	Very dissatisfied			Neutral			Very satisfied	**Unsure**	**Does not apply/ Prefer not to answer**
Mental health									
Physical health									
Emotional health									

Financial health									
My ability to do a good job									
Workplace support for self-care									
Access to de-brief, counselling and/or supervision as required									

Covid 19 and wellbeing

QG6 If you compare your wellbeing now, to during the COVID-19 emergency period, which best matches your situation?

- My wellbeing now is **about the same** as during the COVID-19 emergency period
- My wellbeing is **better now** than during the COVID-19 emergency period
- My wellbeing is **worse now** than during the COVID-19 emergency period

QG7 Are there any impacts of the COVID-19 emergency period on wellbeing that you would like to share more information about?

Please write in: .....

Resources and ongoing education

QG8a. Are there any specific resources (e.g., educational materials, guidelines) that you feel are lacking, or could be improved, in relation to palliative care?

- Yes – ASK QG8b
- No
- Unsure

If YES to Q8a:

QG8b If yes, what resources do you feel are lacking, or could be improved?

- **Please write in: .....**

QG9a. How interested are you in receiving ongoing education and training in topics related to palliative care?

- Extremely interested – ASK QE9b
- Very interested– ASK QE9b
- Quite interested– ASK QE9b
- Not very interested
- Not interested at all

QG9b. If (extremely/very/quite) interested, Which topics related to palliative care would be of most interest to you in ongoing education and training? Which areas are lacking in this respect?

- **Please write in: .....**

QG10. Would you like to receive information about opportunities to participate in future PCA research and consultation?*

- Yes – Please provide your preferred email address below
- No

PREFERRED EMAIL ADDRESS: .....@.....

*Palliative Care Australia collects this information *only* for the purpose of inviting your participation in future research and consultation. PCA will store your information securely consistent with the Privacy Act 1998 and our Privacy Policy: *https://palliativecare.org.au/palliative-care-australia-privacy-policy*. *To opt-out, email policy@palliativecare.org.au*.

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[1] Palliative Care Australia, October 2024 *Wellbeing in palliative care workforces: National Workforce Survey Findings Report 1;* and Palliative Care Australia, February 2025, *The case for improved remuneration of palliative care in primary care*.

[2] PCA estimate derived from Australian Bureau of Statistics 2023, *Deaths in Australia 2022* (Supplementary Table 1)*;* and Australian Institute of Health and Welfare 2024, *Palliative Care and Health Service Use for people with life-limiting conditions, Predictable Deaths Population*

[3] World Health Assembly 2014, Strengthening of palliative care as a component of comprehensive care throughout the life course (WHA 67.19) WHA, Geneva. This World Health Organisation definition is reflected in the National Palliative Care Strategy 2018, which is endorsed by all Australian jurisdictions.

[4] See Temel JS, Greer JA, Muzikansky A et al, Early palliative care for patients with metastatic non-small cell lung cancer, *New England Journal of Medicine,* 2010;363:733-742, also Palliative Care Australia *What is Palliative Care?*

[5] Total exceeds 100% as some respondents worked in more than one location (e.g. both a metropolitan and regional area, or across both a regional centre and a remote area).

[6] Total exceeds 100% as some respondents reported working in both clinical and leadership roles.

[7] See Temel JS, Greer JA, Muzikansky A et al, Early palliative care for patients with metastatic non-small cell lung cancer, *New England Journal of Medicine,* 2010;363:733-742, also Palliative Care Australia *What is Palliative Care? ;* also Petrillo L et al, 2024 *Why and How to integrate early palliative care into cutting-edge personalised cancer care,* American Society of Clinical Oncology Educational Book, 43(3) https://doi.org/10.1200/EDBK_100038

[8] Australian Institute of Health and Welfare 2024, *Palliative care and health service use for people with life-limiting conditions,* Access to specialist palliative care

[9] Palliative Care Australia, 2024, National Palliative Care Standards for Specialist Palliative Care Services (5.1)

[10] See note 3

[11] Palliative Care Australia, 2018, Palliative Care Service Development Guidelines, p6.

[12] See note 3

[13] PCA estimate derived from Australian Bureau of Statistics 2023, *Deaths in Australia 2022* (Supplementary Table 1)*;* and Australian Institute of Health and Welfare 2024, *Palliative Care and Health Service Use for people with life-limiting conditions, Predictable Deaths Population*

[14] Australian Bureau of Statistics, 2024, *Causes of Death Australia 2023*

[15] Australian Bureau of Statistics, *Population Projections, Table 1, Population projects, components of change and summary statistics,*

[16] Australian Institute of Health and Welfare, 2024, *Palliative Care Services in Australia, Admitted patient care*.

[17] Note this figure reflects a 2020 baseline, see: KPMG, May 2020. Investing to save, the economics of increased investment in palliative care in Australia, p32 Figure 12

[18] Australian Institute of Health and Welfare, 2024, Palliative care and health service use for people with life-limiting conditions

[19] Australian Institute of Health and Welfare, 2024, National Palliative Care Measures.

[20] Humphrey G, Inacio M, Lang C, Churches F, Sluggett K, Williaman H, Morgan D et al June 2024, Estimating potential palliative care needs for residential aged care: A population-based retrospective cohort study, Australasian Journal on Ageing, DOI: https://doi.org/10.1111/ajag.13345

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[22] Australian Institute of Health and Welfare, 2024, Palliative care and health service use for people with life-limiting conditions

[23] From 4,900 to 14,700, see Australian Institute of Health and Welfare, 2024 Palliative care services in Australia, Medicare-subsidised palliative medicine attendance and case conference services

[24]Australian Institute of Health and Welfare, 2024, Palliative care services in Australia, Medicare-subsidised palliative medicine attendance and case conference services

[25] Palliative Care Australia, 2022, National Palliative Care Standards for all Health Professionals and Aged Care Services, p8

[26] Palliative Care Australia, 2022, National Palliative Care Standards for all Health Professionals and Aged Care Services

[27] Australian Institute of Health and Welfare, 2025, Palliative Care Services in Australia, Workforce

[28] Australian Institute of Health and Welfare, 2025 Palliative Care Services in Australia, Palliative Care Outcomes

[29] Australian Institute of Health and Welfare, 2025, Palliative Care Services in Australia, Workforce

[30] Australian Institute of Health and Welfare, 2025, Palliative Care Services in Australia, Workforce

[31] Australian Institute of Health and Welfare, November 2023, Palliative care services in Australia, Workforce

[32] In 2022, 28% of nurses were aged 50 or older; see Australian Government Department of Health, Nursing Supply and Demand Study p3

[33] Australian Institute of Health and Welfare, 2024, Palliative Care services in Australia, *Workforce Data Table 1*

[34] Nursing and Midwifery Board, Nursing Workforce Snapshot at 30 June 2023

[35] Australian Institute of Health and Welfare, 2024, Palliative Care services in Australia, *Data Tables, Workforce, Table Wk1*

[36] Nursing and Midwifery Board, Nursing Workforce Snapshot at 30 June 2023

[37] Australian Institute of Health and Welfare, 2025, Palliative Care Services in Australia, Workforce

[38] Department of Health, March 2017, *Research into awareness, attitudes and provision of best practice advance care planning, palliative care & end of life care within general practice,* Charles Coulton & Catherine Boekel for Where to research.

[39] James MacDonald and Kate Bowman, 2024. Tracking the post-COVID recovery of palliative care volunteer services in NSW, Palliative Care NSW, Sydney.

[40] Palliative Care NSW About Volunteering

[41] See note 39

[42] See note 39

[43] This total exceeds 100% as some respondents worked in more than one location (e.g. both a metropolitan and regional area, or across both a regional centre and a remote area).

[44] Australian Institute of Health and Welfare, 2024, Palliative care services in Australia, *Workforce*

[45] Total exceeds 100% as some respondents reported working both in clinical and leadership roles.

[46] Total exceeds 100% as services may provide care in multiple settings.

Palliative Care Australia

Matters of life and death